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

FORM 10-Q

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

For the quarterly period ended June 30, 2024.

OR

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

For the transition period from _____ to_____ .

Commission file number: 001-33757

THE ENSIGN GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

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

29222 Rancho Viejo Road, Suite 127
San Juan Capistrano, CA 92675
(Address of Principal Executive Offices and Zip Code)

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

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

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

Indicate by check mark:								
whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.					☑	**Yes**	☐	No
whether the registrant has submitted electronically, every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).					☑	**Yes**	☐	No
whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act:								
Large accelerated filer ☑	Accelerated filer ☐	Non-accelerated filer ☐	Smaller reporting company ☐	Emerging growth company ☐				
If an emerging growth company, indicate if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.					☐	Yes	☐	No
whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).					☐	Yes	☑	**No**

As of July 22, 2024, 57,113,703 shares of the registrant's common stock, $0.001 par value, were outstanding.

THE ENSIGN GROUP, INC.

QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND SIX MONTHS ENDED JUNE 30, 2024
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PART I.

Item 1. FINANCIAL STATEMENTS

THE ENSIGN GROUP, INC.

UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands, except par values)

	June 30, 2024	December 31, 2023
ASSETS		
Current assets:		
Cash and cash equivalents	$ 477,336	$ 509,626
Accounts receivable—less allowance for doubtful accounts of $9,460 and $9,348 at June 30, 2024 and December 31, 2023, respectively	547,121	485,039
Investments—current	24,126	17,229
Prepaid income taxes	18,798	3,830
Prepaid expenses and other current assets	47,699	31,206
Total current assets	**1,115,080**	**1,046,930**
Property and equipment, net	1,177,822	1,090,771
Right-of-use assets	1,842,613	1,756,430
Insurance subsidiary deposits and investments	112,756	92,687
Deferred tax assets	66,572	67,124
Restricted and other assets	38,551	40,205
Intangible assets, net	6,703	6,525
Goodwill	77,241	76,869
TOTAL ASSETS	**$ 4,437,338**	**$ 4,177,541**
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 88,652	$ 92,811
Accrued wages and related liabilities	322,928	332,568
Lease liabilities—current	89,176	82,526
Accrued self-insurance liabilities—current	61,356	54,664
Other accrued liabilities	164,640	168,228
Current maturities of long-term debt	4,017	3,950
Total current liabilities	**730,769**	**734,747**
Long-term debt—less current maturities	143,559	145,497
Long-term lease liabilities—less current portion	1,720,250	1,639,326
Accrued self-insurance liabilities—less current portion	123,835	111,246
Other long-term liabilities	55,854	49,408
TOTAL LIABILITIES	**$ 2,774,267**	**$ 2,680,224**
Commitments and contingencies (Notes 15 and 20)		
EQUITY		
Ensign Group, Inc. stockholders' equity:		
Common stock: $0.001 par value; 150,000 shares authorized; 60,449 and 57,049 shares issued and shares outstanding at June 30, 2024, respectively, and 59,987 and 56,597 shares issued and shares outstanding at December 31, 2023, respectively	61	60
Additional paid-in capital	499,411	465,707
Retained earnings	1,275,657	1,142,653
Common stock in treasury, at cost, 3,400 and 3,390 shares at June 30, 2024 and December 31, 2023, respectively	(117,764)	(116,555)
Total Ensign Group, Inc. stockholders' equity	**1,657,365**	**1,491,865**
Non-controlling interest	5,706	5,452
Total equity	**$ 1,663,071**	**$ 1,497,317**
TOTAL LIABILITIES AND EQUITY	**$ 4,437,338**	**$ 4,177,541**

See accompanying notes to condensed consolidated financial statements.

THE ENSIGN GROUP, INC.

UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
	(In thousands, except per share data)			
REVENUE				
Service revenue	$ 1,030,574	$ 916,101	$ 2,035,059	$ 1,798,019
Rental revenue	5,711	5,244	11,398	10,167
TOTAL REVENUE	**$ 1,036,285**	**$ 921,345**	**$ 2,046,457**	**$ 1,808,186**
Expense:				
Cost of services	820,360	722,685	1,619,623	1,419,011
Rent—cost of services	53,272	49,760	105,148	96,397
General and administrative expense	56,194	53,430	113,352	105,321
Depreciation and amortization	20,488	17,596	40,145	34,708
TOTAL EXPENSES	**950,314**	**843,471**	**1,878,268**	**1,655,437**
Income from operations	85,971	77,874	168,189	152,749
Other income (expense):				
Interest expense	(2,040)	(2,023)	(4,004)	(4,059)
Interest income	7,084	3,542	13,544	7,526
Other income	1,049	1,660	3,933	3,219
Other income, net	**6,093**	**3,179**	**13,473**	**6,686**
Income before provision for income taxes	92,064	81,053	181,662	159,435
Provision for income taxes	20,883	16,963	41,521	35,376
NET INCOME	**71,181**	**64,090**	**140,141**	**124,059**
Less:				
Net income attributable to noncontrolling interests	174	97	299	214
Net income attributable to The Ensign Group, Inc.	**$ 71,007**	**$ 63,993**	**$ 139,842**	**$ 123,845**
NET INCOME PER SHARE ATTRIBUTABLE TO THE ENSIGN GROUP INC.				
Basic	$ 1.26	$ 1.15	$ 2.48	$ 2.23
Diluted	$ 1.22	$ 1.12	$ 2.41	$ 2.17
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING				
Basic	56,544	55,611	56,441	55,456
Diluted	58,013	57,260	57,969	57,190

See accompanying notes to condensed consolidated financial statements.

THE ENSIGN GROUP, INC.

UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(In thousands)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Treasury Stock Shares	Treasury Stock Amount	Non-Controlling Interest	Total
BALANCE - JANUARY 1, 2024	**56,597**	**$ 60**	**$ 465,707**	**$ 1,142,653**	**3,390**	**$ (116,555)**	**$ 5,452**	**$ 1,497,317**
Issuance of common stock to employees and directors resulting from the exercise of stock options	219	—	6,229	—	—	—	—	6,229
Issuance of restricted stock, net of forfeitures (Note 16)	88	—	6,165	—	—	—	—	6,165
Shares of common stock used to satisfy tax withholding obligations	—	—	—	—	—	(14)	—	(14)
Dividends declared ($0.0600 per share)	—	—	—	(3,414)	—	—	—	(3,414)
Employee stock award compensation	—	—	8,231	—	—	—	—	8,231
Acquisition of noncontrolling interest shares	—	—	(10)	—	—	—	—	(10)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	125	125
Noncontrolling interests attributable to subsidiary equity plan	—	—	14	—	—	—	(11)	3
Net income attributable to the Ensign Group, Inc.	—	—	—	68,835	—	—	—	68,835
BALANCE - MARCH 31, 2024	**56,904**	**$ 60**	**$ 486,336**	**$ 1,208,074**	**3,390**	**$ (116,569)**	**$ 5,566**	**$ 1,583,467**
Issuance of common stock to employees and directors resulting from the exercise of stock options	117	1	4,089	—	—	—	—	4,090
Issuance of restricted stock, net of forfeitures (Note 16)	38	—	—	—	—	—	—	—
Shares of common stock used to satisfy tax withholding obligations	(10)	—	—	—	10	(1,195)	—	(1,195)
Dividends declared ($0.0600 per share)	—	—	—	(3,424)	—	—	—	(3,424)
Employee stock award compensation	—	—	8,978	—	—	—	—	8,978
Acquisition of noncontrolling interest shares	—	—	(29)	—	—	—	—	(29)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	174	174
Noncontrolling interests attributable to subsidiary equity plan	—	—	37	—	—	—	(34)	3
Net income attributable to the Ensign Group, Inc.	—	—	—	71,007	—	—	—	71,007
BALANCE - JUNE 30, 2024	**57,049**	**$ 61**	**$ 499,411**	**$ 1,275,657**	**3,400**	**$ (117,764)**	**$ 5,706**	**$ 1,663,071**

(In thousands)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Treasury Stock Shares	Treasury Stock Amount	Non-Controlling Interest	Total
BALANCE - JANUARY 1, 2023	**55,661**	**$ 59**	**$ 415,560**	**$ 946,339**	**3,368**	**$ (114,626)**	**$ 1,468**	**$ 1,248,800**
Issuance of common stock to employees and directors resulting from the exercise of stock options	145	1	2,653	—	—	—	—	2,654
Issuance of restricted stock, net of forfeitures	102	—	5,068	—	—	—	—	5,068
Shares of common stock used to satisfy tax withholding obligations	(1)	—	—	—	1	(20)	—	(20)
Dividends declared ($0.0575 per share)	—	—	—	(3,215)	—	—	—	(3,215)
Employee stock award compensation	—	—	6,573	—	—	—	—	6,573
Acquisition of noncontrolling interest shares	—	—	(77)	—	—	—	—	(77)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	117	117
Noncontrolling interests attributable to subsidiary equity plan	—	—	6	—	—	—	(4)	2
Net income attributable to the Ensign Group, Inc.	—	—	—	59,852	—	—	—	59,852
BALANCE - MARCH 31, 2023	**55,907**	**$ 60**	**$ 429,783**	**$ 1,002,976**	**3,369**	**$ (114,646)**	**$ 1,581**	**$ 1,319,754**
Issuance of common stock to employees and directors resulting from the exercise of stock options	253	—	5,905	—	—	—	—	5,905
Issuance of restricted stock, net of forfeitures	54	—	—	—	—	—	—	—
Shares of common stock used to satisfy tax withholding obligations	(21)	—	—	—	21	(1,909)	—	(1,909)
Dividends declared ($0.0575 per share)	—	—	—	(3,231)	—	—	—	(3,231)
Employee stock award compensation	—	—	8,881	—	—	—	—	8,881
Acquisition of noncontrolling interest shares	—	—	(100)	—	—	—	—	(100)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	97	97
Noncontrolling interests attributable to subsidiary equity plan	—	—	(3,937)	—	—	—	3,940	3
Net income attributable to the Ensign Group, Inc.	—	—	—	63,993	—	—	—	63,993
BALANCE - JUNE 30, 2023	**56,193**	**$ 60**	**$ 440,532**	**$ 1,063,738**	**3,390**	**$ (116,555)**	**$ 5,618**	**$ 1,393,393**

See accompanying notes to condensed consolidated financial statements.

THE ENSIGN GROUP, INC.

UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)	Six Months Ended June 30, 2024	2023
Cash flows from operating activities:		
Net income	$ 140,141	$ 124,059
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	40,145	34,708
Amortization of deferred financing fees	531	536
Non-cash leasing arrangement	385	481
Impairment of long-lived assets	1,849	—
Deferred income taxes	552	47
Provision for doubtful accounts	718	2,250
Stock-based compensation	17,222	15,454
Cash received from insurance proceeds	199	750
Loss (Gain) on insurance claims and asset disposals	254	(749)
Litigation adjustment	(3,734)	(818)
Change in operating assets and liabilities		
Accounts receivable	(62,813)	(39,433)
Prepaid income taxes	(14,968)	4,186
Prepaid expenses and other assets	(15,538)	(516)
Cash surrender value of life insurance policy premiums	(10,725)	(12,132)
Deferred compensation liability	10,707	12,170
Operating lease obligations	400	(6,411)
Accounts payable	(5,559)	1,020
Accrued wages and related liabilities	(8,343)	(991)
Income taxes payable	—	25,240
Other accrued liabilities	650	(578)
Accrued self-insurance liabilities	19,568	8,832
Other long-term liabilities	608	(23)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**$ 112,249**	**$ 168,082**
Cash flows from investing activities:		
Purchase of property and equipment	(64,635)	(51,614)
Cash payments for business acquisitions	(494)	—
Cash payments for asset acquisitions	(64,896)	(399)
Escrow deposits	(646)	(1,202)
Cash from insurance proceeds	961	913
Cash proceeds from the sale of assets	1,988	18
Purchases of investments	(35,508)	(18,425)
Maturities of investments	19,267	7,862
Other restricted assets	(601)	412
NET CASH USED IN INVESTING ACTIVITIES	**$ (144,564)**	**$ (62,435)**
Cash flows from financing activities:		
Payments on debt	(1,958)	(1,958)
Issuance of common stock upon exercise of options	10,319	8,559
Repurchase of shares of common stock to satisfy tax withholding obligations	(1,209)	(1,929)
Dividends paid	(6,810)	(6,415)
Non-controlling interest distribution	(278)	(4)
Purchase of non-controlling interest	(39)	(177)
Payments of deferred financing costs	—	(19)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	**$ 25**	**$ (1,943)**
Net (decrease) increase in cash and cash equivalents	(32,290)	103,704
Cash and cash equivalents beginning of period	509,626	316,270
Cash and cash equivalents end of period	**$ 477,336**	**$ 419,974**

(In thousands)	Six Months Ended June 30, 2024	2023
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Cash paid during the period for:		
Interest	$ 3,488	$ 3,534
Income taxes	56,062	6,030
Lease liabilities	104,749	95,938
Non-cash financing and investing activity		
Accrued capital expenditures	$ 6,000	$ 5,000
Accrued dividends declared	3,424	3,231
Right-of-use assets obtained in exchange for new and modified operating lease obligations	124,133	352,131

See accompanying notes to condensed consolidated financial statements.

THE ENSIGN GROUP, INC.

NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Dollars, shares and options in thousands, except per share data)

1. DESCRIPTION OF BUSINESS

The Company — The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. The Company's independent subsidiaries provide health care services across the post-acute care continuum and engage in the ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare-related properties and ancillary businesses. As of June 30, 2024, the Company's independent subsidiaries operated 312 facilities and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. The Company's independent subsidiaries have a collective capacity of approximately 31,800 operational skilled nursing beds and 3,300 senior living units. As of June 30, 2024, the Company's independent subsidiaries operated 222 facilities under long-term lease arrangements and had options to purchase 12 of those 222 facilities. The Company's real estate portfolio consists of 120 owned real estate properties, which includes 90 facilities operated and managed by the Company's independent subsidiaries, 30 operations leased to and operated by third-party operators and the Service Center (defined below) location. Of those 30 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

Certain of the Company's wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide specific accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other independent subsidiaries. The Company also has a wholly-owned captive insurance subsidiary that provides some claims-made coverage to the Company's independent subsidiaries for general and professional liabilities, as well as coverage for certain workers' compensation insurance liabilities.

In 2022, the Company formed a captive real estate investment trust (REIT), which owns and manages its real estate business, called Standard Bearer Healthcare REIT, Inc. (Standard Bearer). The REIT structure provides the Company with an efficient vehicle for future acquisitions of properties that could be operated by Ensign's independent subsidiaries or other third parties. Standard Bearer has elected to be taxed as a REIT for U.S. federal income tax purposes. Refer to Note 6, *Standard Bearer* for additional information on Standard Bearer.

Each of the Company's independent subsidiaries are operated by wholly-owned subsidiaries that have their own management, employees and assets. References herein to the consolidated "Company" and "its" assets and activities in this Quarterly Report are 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 June 30, 2024 and for the three and six months ended June 30, 2024 and 2023 (collectively, the Interim Financial Statements) are unaudited. Certain information and note disclosures normally included in the 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, 2023, which are included in the Company's Annual Report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States (GAAP). The Company is the sole member or stockholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing operations, senior living operations and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interests within the equity section of its condensed consolidated balance sheets and the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interests in its condensed consolidated statements of income. The Interim Financial Statements include the accounts of all independent subsidiaries controlled by the Company through its ownership of a majority voting interest.

The preparation of the Interim Financial Statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Interim Financial Statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company's Interim Financial Statements relate to revenue, acquired property and equipment, goodwill, right-of-use assets, impairment of long-lived assets, lease liabilities, general and professional liabilities, workers' compensation and healthcare claims included in accrued self-insurance liabilities and income taxes. Actual results could differ from those estimates. Certain amounts in the prior period condensed balance sheet and statement of income have been reclassified to conform to the presentation of the current period financial statements. These reclassifications had no effect on the previously reported net income or total assets.

Recently Issued Accounting Pronouncements — In October 2023, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2023-06 *"Codification Amendments in Response to the SEC's Disclosure Update and Simplification Initiative,"* which amends U.S. GAAP to include 14 disclosure requirements that are currently required under SEC Regulation S-X or Regulation S-K. Each amendment will be effective on the date on which the SEC removes the related disclosure requirement from SEC Regulation S-X or Regulation S-K. The adoption is not expected to have a material impact on the Company's Interim Financial Statements as these requirements were previously incorporated under the SEC Regulations.

In November 2023, the FASB issued ASU 2023-07 "*Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures,*" which requires the Company to expand the breadth and frequency of segment disclosures to include additional information about significant segment expenses, the chief operating decision maker (CODM) and other items, and also require the annual disclosures on an interim basis. This guidance is effective for annual periods beginning after December 15, 2023, which will be the Company's fiscal year 2024, and in interim periods within fiscal years beginning after December 15, 2024, with early adoption permitted. The Company is currently evaluating the impact of the ASU on its Quarterly and Annual Reports.

In December 2023, the FASB issued ASU 2023-09 "*Income Taxes (Topic 740): Improvements to Income Tax Disclosures,*" which requires the Company to disclose disaggregated jurisdictional and categorical information for the tax rate reconciliation, income taxes paid and other income tax related amounts. This guidance is effective for annual periods beginning after December 15, 2024, which will be the Company's fiscal year 2025, with early adoption permitted. The adoption is expected to enhance the Company's Notes to the Consolidated Financial Statements. The Company is currently evaluating the impact of the ASU on its Annual Report.

3. REVENUE AND ACCOUNTS RECEIVABLE

The Company's service revenue is derived primarily from providing healthcare services to its patients. Revenue is recognized when services are provided to patients at the amount that reflects the consideration that the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care.

Disaggregation of Revenue

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

Revenue by Payor

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

Revenue from the Medicare and Medicaid programs accounted for 71.2% and 71.4% of all service revenue for the three and six months ended June 30, 2024, respectively, and 73.1% and 73.2% of all service revenue for the three and six months ended June 30, 2023, respectively. Settlements with Medicare and Medicaid payors for retroactive adjustments due to audits and reviews are considered variable consideration and are included in the determination of the estimated transaction price. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company's historical settlement activity. Consistent with healthcare industry practices, any changes to these revenue estimates are recorded in the period the change or adjustment becomes known based on the final settlement. The Company recorded adjustments to revenue which were not material to the Company's revenue for the three and six months ended June 30, 2024 and 2023.

Service revenue for the three and six months ended June 30, 2024 and 2023 is summarized in the following tables:

	Three Months Ended June 30,			
	2024		2023	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid[1][2]	$ 411,760	40.0 %	$ 359,781	39.3 %
Medicare	258,869	25.1	248,081	27.1
Medicaid — skilled	62,969	6.1	62,015	6.7
Total Medicaid and Medicare	**733,598**	**71.2**	**669,877**	**73.1**
Managed care	191,022	18.5	161,101	17.6
Private and other[3]	105,954	10.3	85,123	9.3
SERVICE REVENUE	**$ 1,030,574**	**100.0 %**	**$ 916,101**	**100.0 %**

(1) Medicaid payor includes revenue for senior living operations.
(2) Medicaid payor includes revenue related to state relief funding during the three months ended June 30, 2023.
(3) Private and other also includes revenue from senior living operations and all revenue generated in other ancillary services.

	Six Months Ended June 30,			
	2024		2023	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid[1][2]	$ 801,923	39.4 %	$ 700,045	38.9 %
Medicare	524,452	25.8	495,804	27.6
Medicaid — skilled	126,278	6.2	119,942	6.7
Total Medicaid and Medicare	**1,452,653**	**71.4**	**1,315,791**	**73.2**
Managed care	379,126	18.6	317,764	17.7
Private and other[3]	203,280	10.0	164,464	9.1
SERVICE REVENUE	**$ 2,035,059**	**100.0 %**	**$ 1,798,019**	**100.0 %**

(1) Medicaid payor includes revenue for senior living operations.
(2) Medicaid payor includes revenue related to state relief funding during the six months ended June 30, 2023.
(3) Private and other also includes revenue from senior living operations and all revenue generated in other ancillary services.

In addition to the service revenue above, the Company's rental revenue derived from triple-net lease arrangements with third parties are $5,711 and $11,398, respectively, for the three and six months ended June 30, 2024 and $5,244 and $10,167, respectively, for the three and six months ended June 30, 2023.

State relief funding

In 2023, the Company received state relief funding through Medicaid programs from various states, including healthcare relief funding under the American Rescue Plan Act (ARPA), increases in the Federal Medical Assistance Percentage (FMAP) under the Families First Coronavirus Response Act (FFCRA) and other state specific relief programs. The funding generally incorporates specific use requirements primarily for direct patient care including labor related expenses that are attributable to the COVID-19 pandemic or are associated with providing patient care. Due to the expiration of the COVID-19 Public Health Emergency in May 2023, the Company did not receive additional funding during the three and six months ended June 30, 2024. During the three and six months ended June 30, 2023, the Company received $17,580 and $44,844 in state relief funding and recognized $18,453 and $44,811, respectively, as revenue.

Balance Sheet Impact

Included in the Company's condensed consolidated balance sheets are contract balances, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no material contract liabilities and contract assets as of June 30, 2024 and December 31, 2023, or activity during the three and six months ended June 30, 2024 and 2023.

Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration. Accounts receivable as of June 30, 2024 and December 31, 2023, is summarized in the following table:

	June 30, 2024	December 31, 2023
Medicaid	$ 208,584	$ 178,285
Managed care	139,200	125,907
Medicare	86,496	85,512
Private and other payors	122,301	104,683
	556,581	**494,387**
Less: allowance for doubtful accounts	(9,460)	(9,348)
ACCOUNTS RECEIVABLE, NET	**$ 547,121**	**$ 485,039**

4. COMPUTATION OF NET INCOME PER COMMON SHARE

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
NUMERATOR:				
Net income	$ 71,181	$ 64,090	$ 140,141	$ 124,059
Less: net income attributable to noncontrolling interests	174	97	299	214
Net income attributable to The Ensign Group, Inc.	**$ 71,007**	**$ 63,993**	**$ 139,842**	**$ 123,845**
DENOMINATOR:				
Weighted average shares outstanding for basic net income per share	56,544	55,611	56,441	55,456
Basic net income per common share:	**$ 1.26**	**$ 1.15**	**$ 2.48**	**$ 2.23**

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
NUMERATOR:				
Net income	$ 71,181	$ 64,090	$ 140,141	$ 124,059
Less: net income attributable to noncontrolling interests	174	97	299	214
Net income attributable to The Ensign Group, Inc.	**$ 71,007**	**$ 63,993**	**$ 139,842**	**$ 123,845**
DENOMINATOR:				
Weighted average common shares outstanding	56,544	55,611	56,441	55,456
Plus: incremental shares from assumed conversion [(1)]	1,469	1,649	1,528	1,734
Adjusted weighted average common shares outstanding	**58,013**	**57,260**	**57,969**	**57,190**
Diluted net income per common share:	**$ 1.22**	**$ 1.12**	**$ 2.41**	**$ 2.17**

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 1,368 and 1,252 for the three and six months ended June 30, 2024, respectively, and 1,419 and 1,317 for the three and six months ended June 30, 2023, respectively.

5. FAIR VALUE MEASUREMENTS

The Company's financial assets include the captive insurance subsidiary's deposits and investments designated to support long-term insurance subsidiary liabilities and are carried at amortized cost basis of $63,826 and $59,530 as of June 30, 2024 and December 31, 2023, respectively. As of June 30, 2024 and December 31, 2023, the amortized cost basis of the Company's financial assets included in the captive insurance subsidiary's investments are considered to approximate the fair value of these financial assets and are derived using Level 2 inputs.

Also included are contracts insuring the lives of certain employees who are eligible to participate in non-qualified deferred compensation plans that are held in a rabbi trust. The cash surrender value of these contracts is based on funds that shadow the investment allocations specified by participants in the deferred compensation plan and are held at fair value. As of June 30, 2024, and December 31, 2023, the fair value of the investment funds was $51,941 and $41,216, respectively, which are derived using Level 2 inputs.

Additionally, the Company has other investments held at historical cost basis, which are not material, for which the fair value is derived using Level 3 inputs. The Company believes its amortized cost basis investments that were in an unrealized loss position as of June 30, 2024 and December 31, 2023 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

6. STANDARD BEARER

Standard Bearer's real estate portfolio consists of 115 of the Company's 120 owned real estate properties, of which 86 are operated and managed by the Company's independent subsidiaries and 30 are leased to and operated by third-party operators. Of those 30 operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

During the six months ended June 30, 2024, Standard Bearer acquired the real estate of five stand-alone skilled nursing operations and two campus operations for an aggregate purchase price of $63,412. These new additions are operated by seven of the Company's independent subsidiaries. Refer to Note 7, *Operation Expansions*, for additional information.

As part of the formation of Standard Bearer, certain of the Company's independent subsidiaries, Standard Bearer and Standard Bearer's independent real estate subsidiaries entered into several agreements that include leasing, management services and debt arrangements between the operations. All intercompany transactions have been eliminated in consolidation. Refer to Note 8, *Business Segments*, for additional information related to these intercompany eliminations as well as Standard Bearer as a reportable segment.

Intercompany master lease agreements

Certain of the Company's independent subsidiaries and 86 Standard Bearer independent real estate subsidiaries have entered into six triple-net master lease agreements (collectively, the Standard Bearer Master Leases). The lease periods range from 15 to 19 years with three five-year renewal options beyond the initial term, on the same terms and conditions. The rent structure under the Standard Bearer Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the independent subsidiaries are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties; (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. Rental revenue generated from Ensign affiliated operations was $19,156 and $37,162, respectively, for the three and six months ended June 30, 2024 and $16,128 and $32,059, respectively, for the three and six months ended June 30, 2023.

Intercompany management agreement

Standard Bearer has no employees. The Service Center provides personnel and services to Standard Bearer pursuant to the management agreement between Standard Bearer and the Service Center. The management agreement provides for a base management fee that is equal to 5% of total rental revenue and an incentive management fee that is equal to 5% of funds from operations (FFO) and is capped at 1% of total rental revenue, for a total of 6%. Management fee generated between Standard Bearer and the Service Center for the three and six months ended June 30, 2024 was $1,401 and $2,733, respectively. Management fees generated between Standard Bearer and the Service Center for the three and six months ended June 30, 2023 was $1,195 and $2,377, respectively.

Intercompany debt arrangements

Standard Bearer obtains its funding through various sources including operating cash flows, access to debt arrangements and intercompany loans. The intercompany debt arrangements include mortgage loans and the Credit Facility to fund acquisitions and working capital needs. The interest rate under the Credit Facility is a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum.

In addition, as the Department of Housing and Urban Development (HUD) mortgage loans and promissory note are entered into by real estate subsidiaries of Standard Bearer, the interest expense incurred from these debts are included in Standard Bearer's segment income. Refer to Note 15, *Debt*, for additional information related to these debts.

Equity Instrument Denominated in the Shares of a Subsidiary

As part of the formation of Standard Bearer in 2022, the Company established the Standard Bearer Healthcare REIT, Inc. 2022 Omnibus Incentive Plan (Standard Bearer Equity Plan). The Company may grant stock options and restricted stock awards under the Standard Bearer Equity Plan to employees and management of Ensign's independent subsidiaries. These awards generally vest over a period of five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of Standard Bearer, which is determined based on an independent valuation of Standard Bearer. The awards can be put to Standard Bearer at various prescribed dates, which in no event is earlier than six months after vesting of the restricted awards or exercise of the stock options. The Company can also call the awards, generally upon employee termination. During the six months ended June 30, 2024 and 2023, the Company did not grant any stock options nor restricted shares under the Standard Bearer Equity Plan.

7. OPERATION EXPANSIONS

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

2024 Expansions

During the six months ended June 30, 2024, the Company expanded its operations and real estate portfolio through a combination of long-term leases and real estate purchases, with the addition of 13 stand-alone skilled nursing operations and two campus operations. One of the stand-alone skilled nursing operations includes a long-term acute care hospital. Of these additions, Standard Bearer acquired the real estate of seven of these operations, all of which were leased back to the Company's independent subsidiaries. Refer to Note 6, *Standard Bearer,* for additional information on the purchase of real estate properties. These new operations added a total of 1,369 operational skilled nursing beds and 202 operational senior living units to be operated by the Company's independent subsidiaries. Included within the operational skilled nursing beds are 43 long-term acute care beds. In connection with the new operations obtained through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company entered into a separate operations transfer agreement with each prior operator as part of each transaction. The Company also invested in new ancillary services that are complementary to its existing businesses.

2023 Expansions

During the six months ended June 30, 2023, the Company expanded its operations through long-term leases, with the addition of 19 stand-alone skilled nursing operations. These new operations added a total of 1,764 operational skilled nursing beds operated by the Company's independent subsidiaries. In connection with the new operations obtained through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company entered into a separate operations transfer agreement with each prior operator as part of each transaction.

The Company’s acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return. The operations added by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not a meaningful representation of the Company’s current operating results or indicative of the integration potential of its newly acquired independent subsidiaries. The assets added during the six months ended June 30, 2024 were not material operations to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These additions have been included in the condensed consolidated balance sheets of the Company, and the operating results have been included in the condensed consolidated statements of income of the Company since the date the Company gained effective control.

8. BUSINESS SEGMENTS

The Company has two reportable segments: (1) skilled services, which includes the operation of skilled nursing facilities and rehabilitation therapy services and (2) Standard Bearer, which is comprised of selected real estate properties owned by Standard Bearer and leased to skilled nursing and senior living operators.

As of June 30, 2024, the skilled services segment includes 272 skilled nursing and 29 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. The Company's Standard Bearer segment consists of 115 owned real estate properties.

The Company also reports an “All Other” category that includes results from its senior living operations, which includes 11 stand-alone senior living operations and the senior living operations at 29 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. In addition, the "All Other" category includes mobile diagnostics, medical transportation, other real estate and other ancillary operations. Services included in the “All Other” category are insignificant individually, and therefore do not constitute a reportable segment.

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

Intercompany revenue is eliminated in consolidation, along with corresponding intercompany expenses. Segment income and loss is defined as profit or loss from operations before provision for income taxes, excluding gain or loss from sale of real estate, real estate insurance recoveries and impairment of long-lived assets. Included in segment income for Standard Bearer is expense for intercompany services provided by the Service Center as described in Note 6, *Standard Bearer*, as it is part of the CODM financial information.

The following tables set forth financial information for the segments:

	Three Months Ended June 30, 2024				
	Skilled Services	Standard Bearer	All Other[1]	Intercompany Elimination	Total
Service revenue[2]	$ 991,285	$ —	$ 44,340	$ (5,051)	$ 1,030,574
Rental revenue[3]	—	23,354	2,999	(20,642)	5,711
TOTAL REVENUE	**$ 991,285**	**$ 23,354**	**$ 47,339**	**$ (25,693)**	**$ 1,036,285**
Segment income (loss)	122,185	7,360	(37,481)	—	92,064
Income before provision for income taxes					**$ 92,064**
Depreciation and amortization	10,911	7,166	2,411	—	20,488
Interest expense[4]	$ —	$ 6,699	$ 339	$ (4,998)	$ 2,040

(1) All Other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) All Other rental revenue includes rental revenue associated with the Company's subleases to third parties of $1,089 for the three months ended June 30, 2024. Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with the Company's independent subsidiaries. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. Intercompany interest expense is eliminated in the "Intercompany Elimination" column.

	Three Months Ended June 30, 2023				
	Skilled Services	Standard Bearer	All Other [1]	Intercompany Elimination	Total
Service revenue[2]	$ 884,200	$ —	$ 35,535	$ (3,634)	$ 916,101
Rental revenue[3]	—	19,914	2,819	(17,489)	5,244
TOTAL REVENUE	**$ 884,200**	**$ 19,914**	**$ 38,354**	**$ (21,123)**	**$ 921,345**
Segment income (loss)	117,008	7,133	(42,988)	—	81,153
Loss on insurance recoveries from real estate					$ (100)
Income before provision for income taxes					**$ 81,053**
Depreciation and amortization	9,417	6,133	2,046	—	17,596
Interest expense[4]	$ —	$ 4,575	$ 304	$ (2,856)	$ 2,023

(1) All Other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's affiliated wholly owned healthcare facilities and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) All Other rental revenue includes rental revenue associated with the Company's subleases to third parties of $1,063 for the three months ended June 30, 2023. Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with the Company's independent subsidiaries. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. Intercompany interest expense is eliminated in the "Intercompany Elimination" column.

	Six Months Ended June 30, 2024				
	Skilled Services	Standard Bearer	All Other [1]	Intercompany Elimination	Total
Service revenue[2]	$ 1,960,887	$ —	$ 83,966	$ (9,794)	$ 2,035,059
Rental revenue[3]	—	45,555	5,945	(40,102)	11,398
TOTAL REVENUE	**$ 1,960,887**	**$ 45,555**	**$ 89,911**	**$ (49,896)**	**$ 2,046,457**
Segment income (loss)	248,994	14,618	(80,101)	—	183,511
Impairment of long-lived assets					(1,849)
Income before provision for income taxes					**$ 181,662**
Depreciation and amortization	21,447	13,995	4,703	—	40,145
Interest expense[4]	$ —	$ 12,676	$ 611	$ (9,283)	$ 4,004

(1) All Other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) All Other rental revenue includes rental revenue associated with the Company's subleases to third parties of $2,169 for the six months ended June 30, 2024. Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with the Company's independent subsidiaries. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. Intercompany interest expense is eliminated in the "Intercompany Elimination" column.

	Six Months Ended June 30, 2023				
	Skilled Services	Standard Bearer	All Other [1]	Intercompany Elimination	Total
Service revenue[2]	$ 1,735,123	$ —	$ 70,068	$ (7,172)	$ 1,798,019
Rental revenue[3]	—	39,631	5,382	(34,846)	10,167
TOTAL REVENUE	**$ 1,735,123**	**$ 39,631**	**$ 75,450**	**$ (42,018)**	**$ 1,808,186**
Segment income (loss)	230,353	14,352	(85,170)	—	159,535
Loss on insurance recoveries from real estate					(100)
Income before provision for income taxes					**$ 159,435**
Depreciation and amortization	18,481	12,099	4,128	—	34,708
Interest expense[4]	$ —	$ 9,144	$ 615	$ (5,700)	$ 4,059

(1) All Other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's affiliated wholly owned healthcare facilities and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) All Other rental revenue includes rental revenue associated with the Company's subleases to third parties of $1,771 for the six months ended June 30, 2023. Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with the Company's independent subsidiaries. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. Intercompany interest expense is eliminated in the "Intercompany Elimination" column.

Service revenue by major payor source were as follows:

	Three Months Ended June 30, 2024			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 403,127	$ 8,633	$ 411,760	40.0 %
Medicare	258,869	—	258,869	25.1
Medicaid-skilled	62,969	—	62,969	6.1
Subtotal	**724,965**	**8,633**	**733,598**	**71.2**
Managed care	191,022	—	191,022	18.5
Private and other[2]	75,298	30,656	105,954	10.3
TOTAL SERVICE REVENUE	**$ 991,285**	**$ 39,289**	**$ 1,030,574**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations.
(2) Private and other also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

	Three Months Ended June 30, 2023			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 352,380	$ 7,401	$ 359,781	39.3 %
Medicare	248,081	—	248,081	27.1
Medicaid-skilled	62,015	—	62,015	6.7
Subtotal	**662,476**	**7,401**	**669,877**	**73.1**
Managed care	161,101	—	161,101	17.6
Private and other[2]	60,623	24,500	85,123	9.3
TOTAL SERVICE REVENUE	**$ 884,200**	**$ 31,901**	**$ 916,101**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.
(2) Private and other also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

	Six Months Ended June 30, 2024			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 785,245	$ 16,678	$ 801,923	39.4 %
Medicare	524,452	—	524,452	25.8
Medicaid-skilled	126,278	—	126,278	6.2
Subtotal	**1,435,975**	**16,678**	**1,452,653**	**71.4**
Managed care	379,126	—	379,126	18.6
Private and other[2]	145,786	57,494	203,280	10.0
TOTAL SERVICE REVENUE	**$ 1,960,887**	**$ 74,172**	**$ 2,035,059**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations.
(2) Private and other payors also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

	Six Months Ended June 30, 2023			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 685,825	$ 14,220	$ 700,045	38.9 %
Medicare	495,804	—	495,804	27.6
Medicaid-skilled	119,942	—	119,942	6.7
Subtotal	**1,301,571**	**14,220**	**1,315,791**	**73.2**
Managed care	317,764	—	317,764	17.7
Private and other[2]	115,788	48,676	164,464	9.1
TOTAL SERVICE REVENUE	**$ 1,735,123**	**$ 62,896**	**$ 1,798,019**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.
(2) Private and other payors also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

9. PROPERTY AND EQUIPMENT - NET

Property and equipment, net consists of the following:

	June 30, 2024	December 31, 2023
Land	$ 157,147	$ 142,656
Buildings and improvements	858,472	803,155
Leasehold improvements	185,060	172,064
Equipment	366,891	339,383
Furniture and fixtures	4,241	4,192
Construction in progress	37,623	25,563
	1,609,434	**1,487,013**
Less: accumulated depreciation	(431,612)	(396,242)
PROPERTY AND EQUIPMENT, NET	**$ 1,177,822**	**$ 1,090,771**

Management evaluated its long-lived assets and recorded an impairment charge of $1,849 during the six months ended June 30, 2024. The Company determined there was no impairment during the three months ended June 30, 2024 and during the three and six months ended June 30, 2023. See also Note 6, *Standard Bearer* and Note 7, *Operation Expansions* for information on acquisitions during the six months ended June 30, 2024.

10. INTANGIBLE ASSETS - NET

		June 30, 2024			December 31, 2023		
Intangible Assets	**Weighted Average Life (Years)**	**Gross Carrying Amount**	**Accumulated Amortization**	**Net**	**Gross Carrying Amount**	**Accumulated Amortization**	**Net**
Assembled occupancy	0.4	$ 1,158	$ (955)	$ 203	$ 781	$ (742)	$ 39
Facility trade name	30.0	733	(452)	281	733	(439)	294
Customer relationships	18.4	4,582	(2,797)	1,785	4,582	(2,692)	1,890
TOTAL		**$ 6,473**	**$ (4,204)**	**$ 2,269**	**$ 6,096**	**$ (3,873)**	**$ 2,223**

During the three and six months ended June 30, 2024, amortization expense was $536 and $937, respectively, of which $303 and $606 was related to the amortization of right-of-use assets, respectively. Amortization expense for the three and six months ended June 30, 2023 was $357 and $761, respectively, of which $298 and $596 was related to the amortization of right-of-use assets, respectively.

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

Year	Amount
2024 (remainder)	$ 320
2025	234
2026	234
2027	234
2028	234
2029	234
Thereafter	779
	$ 2,269

Other indefinite-lived intangible assets consist of the following:

	June 30, 2024	December 31, 2023
Trade name	$ 889	$ 889
Medicare and Medicaid licenses	3,545	3,413
TOTAL	**$ 4,434**	**$ 4,302**

11. GOODWILL

Goodwill is subject to annual testing for impairment during the fourth quarter of each year. In addition, goodwill is tested for impairment if events occur or circumstances indicate that its carrying value may not be recoverable. There were no indicators of goodwill impairment noted during the three and six months ended June 30, 2024. The Company anticipates that the majority of goodwill recognized will be fully deductible for tax purposes as of June 30, 2024. Provided that goodwill corresponds to the acquisition of a business and not merely the acquisition of real estate property, the Company's Standard Bearer segment appropriately does not carry a goodwill balance. The following table represents activity in goodwill by the skilled services segment and "all other" category as of and for the six months ended June 30, 2024:

	Goodwill		
	Skilled Services	All Other	Total
January 1, 2024	**$ 67,886**	**$ 8,983**	**$ 76,869**
Additions	—	372	372
June 30, 2024	**$ 67,886**	**$ 9,355**	**$ 77,241**

12. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	June 30, 2024	December 31, 2023
Debt issuance costs, net	$ 2,439	$ 2,883
Long-term insurance losses recoverable asset	15,626	15,913
Capital improvement reserves with landlords and lenders	5,376	4,870
Deposits with landlords	2,690	2,661
Escrow deposits	646	1,216
Other	11,774	12,662
RESTRICTED AND OTHER ASSETS	**$ 38,551**	**$ 40,205**

Included in restricted and other assets as of June 30, 2024 and December 31, 2023 are anticipated insurance recoveries related to the Company's workers' compensation and general and professional liability claims that are recorded on a gross, rather than net, basis.

13. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2024	December 31, 2023
Quality assurance fee	$ 14,490	$ 14,035
Refunds payable	56,809	51,248
Resident advances	7,152	10,834
Cash held in trust for patients	6,222	6,215
Dividends payable	3,424	3,396
Property taxes	9,825	12,875
Accrued litigation (Note 20)	48,000	51,734
Other	18,718	17,891
OTHER ACCRUED LIABILITIES	**$ 164,640**	**$ 168,228**

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

14. INCOME TAXES

The Company recorded income tax expense of $41,521 and $35,376 during the six months ended June 30, 2024 and 2023, respectively, or 22.9% of earnings before income taxes for the six months ended June 30, 2024, compared to 22.2% for the six months ended June 30, 2023. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, offset by non-deductible expenses including non-deductible compensation.

The Company is not currently under examination by any major income tax jurisdiction. During 2024, the statutes of limitations will lapse on the Company's 2020 federal tax year and certain 2019 and 2020 state tax years. The Company does not believe the federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the six months ended June 30, 2024 and 2023.

15. DEBT

Debt consists of the following:

	June 30, 2024	December 31, 2023
Mortgage loans and promissory note	$ 150,430	$ 152,388
Less: current maturities	(4,017)	(3,950)
Less: debt issuance costs, net	(2,854)	(2,941)
LONG-TERM DEBT LESS CURRENT MATURITIES	**$ 143,559**	**$ 145,497**

Credit Facility with a Lending Consortium Arranged by Truist

The Company maintains a revolving credit facility between the Company and its independent subsidiaries, including Standard Bearer as co-borrowers, and Truist Securities (Truist) (the Credit Facility) with a revolving line of credit of up to $600,000 in aggregate principal amount with a maturity date of April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the Credit Facility). In addition, there is a commitment fee on the unused portion of the commitments that ranges from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

Borrowings made under the Credit Facility are guaranteed, jointly and severally, by certain of the Company’s wholly-owned subsidiaries, and are secured by a pledge of stock of the Company's material independent subsidiaries as well as a first lien on substantially all of such independent subsidiaries' personal property. The Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent 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 terms of the Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of (i) a maximum consolidated total net debt to consolidated EBITDA ratio (which shall not be greater than 3.75:1.00; provided that if the aggregate consideration for approved acquisitions in a six month period is greater than $50,000, then the ratio can be increased at the election of the Company with notice to the administrative agent to 4.25:1.00 for the first fiscal quarter and the immediately following three fiscal quarters), and (ii) a minimum interest/rent coverage ratio (which cannot be less than 1.50:1.00). As of June 30, 2024, there was no outstanding debt under the Credit Facility. The Company was in compliance with all loan covenants as of June 30, 2024.

Mortgage Loans and Promissory Note

As of June 30, 2024, the Company has 23 subsidiaries that have mortgage loans insured with HUD in the aggregate amount of $148,583, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates in a range of 3.1% to 4.2%, including fixed interest rates in a range of 2.4% to 3.3% per annum. In addition to the interest rate, the Company incurs other fees for HUD placement, including but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees based on the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0% and is reduced by 3.0% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

In addition to the HUD mortgage loans above, the Company has a promissory note of $1,847 that bears a fixed interest rate of 5.3% per annum and has a term of 12 years. The note, which was assumed as part of an acquisition, is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

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

Off-Balance Sheet Arrangements

As of June 30, 2024, the Company had approximately $26,895 of borrowing capacity under the Credit Facility pledged as collateral to secure outstanding letters of credit, which increased by $20,640 from December 31, 2023. The Company believes that its outstanding letters of credit as of June 30, 2024 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

16. OPTIONS AND AWARDS

Stock-based compensation expense consists of stock-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company’s condensed consolidated statements of income for the three and six months ended June 30, 2024 and 2023 was based on awards 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.

2022 Omnibus Incentive Plan (2022 Plan) — The Company has one stock incentive plan, the 2022 Omnibus Incentive Plan (the 2022 Plan), pursuant to which grants of the Company's securities may currently be made. Including the shares rolled over from the 2017 Omnibus Incentive Plan, the 2022 Plan provides for the issuance of 3,452 shares of common stock. The number of shares available to be issued under the 2022 Plan will be reduced by (i) one share for each share that relates to an option or stock appreciation right award and (ii) two shares for each share which relates to an award other than a stock option or stock appreciation right award (a full-value award). Non-employee director options, to the extent granted, will vest and become exercisable in three equal annual installments, or the length of the term if less than three years, on the completion of each year of service measured from the grant date. All other options generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. At June 30, 2024, the total number of shares available for issuance under the 2022 Plan was 860.

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

Stock Options

The Company used the following assumptions for stock options granted during the three months ended June 30, 2024 and 2023:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2024	173	4.4%	6.1 years	40.6%	0.2%
2023	191	3.7%	6.3 years	41.4%	0.3%

The Company used the following assumptions for stock options granted during the six months ended June 30, 2024 and 2023:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2024	354	4.4%	6.1 years	40.8%	0.2%
2023	413	3.9%	6.3 years	41.5%	0.3%

For the six months ended June 30, 2024 and 2023, 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
2024	354	$ 120.98	$ 55.39
2023	413	$ 90.31	$ 41.46

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended June 30, 2024 and 2023 and therefore, the intrinsic value was $0 at the date of grant.

The following table represents the employee stock option activity during the six months ended June 30, 2024:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2024	**3,991**	$ 62.65	1,887	$ 39.58
Granted	354	120.98		
Forfeited	(42)	82.22		
Exercised	(336)	30.75		
June 30, 2024	**3,967**	$ 70.34	1,881	$ 46.34

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of June 30, 2024 and December 31, 2023 is as follows:

Options	June 30, 2024	December 31, 2023
Outstanding	$ 211,650	$ 197,819
Vested	145,531	137,048
Expected to vest	61,779	56,759

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options. The aggregate intrinsic value of options that vested during the six months ended June 30, 2024 and 2023 was $18,073 and $13,639, respectively. The total intrinsic value of options exercised during the six months ended June 30, 2024 and 2023 was $29,894 and $29,741, respectively.

Restricted Stock Awards

The Company granted 42 and 137 restricted stock awards during the three and six months ended June 30, 2024, respectively. The Company granted 61 and 166 restricted stock awards during the three and six months ended June 30, 2023, respectively. All awards were granted at an issue price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the six months ended June 30, 2024 and 2023 ranged from $116.65 to $122.69 and $89.83 to $98.31, respectively. The fair value per share includes quarterly stock awards to non-employee directors. Included in the restricted stock award grants are $6,165 and $5,068 of annual bonuses that were settled in vested restricted stock awards during the six months ended June 30, 2024 and 2023, respectively.

A summary of the status of the Company's non-vested restricted stock awards as of June 30, 2024 and changes during the six months ended June 30, 2024 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2024	**431**	$ 78.91
Granted	137	119.44
Vested	(147)	88.54
Forfeited	(11)	80.17
Nonvested at June 30, 2024	**410**	$ 88.91

During the three and six months ended June 30, 2024, the Company granted 5 and 9, respectively, automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards ranged from $116.65 to $118.69 based on the market price on the grant date.

Long-Term Incentive Plan

On August 27, 2019, the Board approved the Long-Term Incentive Plan (the 2019 LTI Plan). The 2019 LTI Plan provides that certain employees of the Company who assisted in the consummation of the spin-off of The Pennant Group, Inc. (Pennant) from the Company in 2019 (spin-off) were granted shares of restricted stock upon successful completion of the spin-off. The 2019 LTI Plan provides for the issuance of 500 shares of Pennant restricted stock. The shares are vested over five years at 20% per year on the anniversary of the grant date. If a recipient is terminated or voluntarily leaves the Company, all shares subject to restriction or not yet vested are entirely forfeited. The total stock-based compensation related to the 2019 LTI Plan was approximately $208 and $414 for the three and six months ended June 30, 2024, respectively, compared to $211 and $402 for the three and six months ended June 30, 2023, respectively.

Stock-based compensation expense

Stock-based compensation expense recognized for the Company's equity incentive plans and long-term incentive plan for the three and six months ended June 30, 2024 and 2023 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
Stock-based compensation expense related to stock options	$ 5,518	$ 4,963	$ 10,506	$ 8,388
Stock-based compensation expense related to restricted stock awards	2,936	3,481	5,663	6,209
Stock-based compensation expense related to restricted stock awards to non-employee directors	524	437	1,040	857
TOTAL	**$ 8,978**	**$ 8,881**	**$ 17,209**	**$ 15,454**

In future periods, the Company expects to recognize approximately $75,356 and $31,859 in stock-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of June 30, 2024. Future stock-based compensation expense will be recognized over 3.9 and 3.6 weighted average years for unvested options and restricted stock awards, respectively. There were 2,086 unvested and outstanding options as of June 30, 2024, of which 1,916 shares are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest as of June 30, 2024 was 6.8 years.

17. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 99 independent skilled nursing and senior living facilities used in the Company's operations, 98 of which are under nine "triple-net" master lease agreements (collectively, the Master Leases), which range in terms from 13 to 20 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and 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 current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases. If the Company elects to renew the term of a Master Lease, the renewal will be effective to all, but not less than all, of the leased property then subject to the Master Lease. Additionally, four of the 99 facilities leased from CareTrust include an option to purchase that the Company can exercise starting on December 1, 2024. In the first quarter of 2024, the Company added two operations and extended the term for one of the Master Leases to 20 years. As a result, the total lease liabilities and right-of-use assets increased by $48,112 to reflect the new lease obligations.

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

The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The terms and conditions of the one stand-alone lease are substantially the same as those for the master leases described above. Total rent expense under the Master Leases was approximately $17,272 and $34,072 for the three and six months ended June 30, 2024, respectively, and $16,674 and $32,957 for the three and six months ended June 30, 2023, respectively.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. The Company is in compliance with requirements of the Master Leases as of June 30, 2024.

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

The Company leases facilities where its independent subsidiaries operate and certain administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. 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.

Eighty-two of the Company's independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases with CareTrust, are operated under 13 separate master lease arrangements. In the first quarter of 2024, the Company amended one of the separate master lease arrangements to add two stand-alone skilled nursing operations operated by the Company's independent subsidiaries. The amended master lease increased the lease liabilities and right-of-use assets by $30,980 to reflect the new lease obligations and extended the term to 20 years. Under the master leases, a default at a single facility could subject one or more of the other facilities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in the Company's outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

The components of operating lease expense are as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
Rent - cost of services[1]	$ 53,272	$ 49,760	$ 105,148	$ 96,397
General and administrative expense	181	125	334	249
Depreciation and amortization[2]	303	298	606	596
Variable lease costs[3]	5,649	5,154	11,419	9,986
	$ 59,405	**$ 55,337**	**$ 117,507**	**$ 107,228**

(1) Rent - cost of services includes deferred rent expense adjustments of $190 and $385 for the three and six months ended June 30, 2024, respectively, and $218 and $481 for the three and six months ended June 30, 2023, respectively. Additionally, rent - cost of services includes other variable lease costs such as CPI increases and short-term leases of $3,300 and $6,357 for the three and six months ended June 30, 2024, respectively, and $2,398 and $4,458 for the three and six months ended June 30, 2023, respectively.

(2) Depreciation and amortization is related to the amortization of favorable and direct lease costs.

(3) Variable lease costs, including property taxes and insurance, are classified in cost of services in the Company's condensed consolidated statements of income.

Future minimum lease payments for all third-party leases as of June 30, 2024 are as follows:

Year	Amount
2024 (remainder)	$ 100,614
2025	201,246
2026	201,024
2027	200,353
2028	199,265
2029	195,553
Thereafter	1,691,806
TOTAL LEASE PAYMENTS	**2,789,861**
Less: present value adjustment	(980,435)
PRESENT VALUE OF TOTAL LEASE LIABILITIES	**1,809,426**
Less: current lease liabilities	(89,176)
LONG-TERM OPERATING LEASE LIABILITIES	**$ 1,720,250**

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at the lease commencement date. As of June 30, 2024, the weighted average remaining lease term is 14.9 years and the weighted average discount rate used to determine the operating lease liabilities is 6.4%.

Lessor Activities

The Company leases its owned real estate properties to third-party operators, of which 29 senior living operations are operated by Pennant. All of these properties are triple-net leases, whereby the respective tenants are responsible for all costs at the properties including: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The initial terms range from 14 to 16 years.

During the first quarter of 2023, the Company entered into a sublease agreement for three stand-alone skilled nursing operations with a third-party operator with an initial lease term of 18 years.

Total rental income from all third-party sources for the three and six months ended June 30, 2024 and 2023 is as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
Pennant[1]	$ 3,824	$ 3,742	$ 7,644	$ 7,484
Other third-party[2]	1,887	1,502	3,754	2,683
TOTAL	**$ 5,711**	**$ 5,244**	**$ 11,398**	**$ 10,167**

(1) Pennant rental income includes variable rent such as property taxes of $314 and $632 during the three and six months ended June 30, 2024 and $325 and $650 for the three and six months ended June 30, 2023, respectively.

(2) Other third-party includes rental revenue associated with the Company's subleases to third parties of $1,089 and $2,169 for the three and six months ended June 30, 2024, and $1,063 and $1,771 for the three and six months ended June 30, 2023, respectively.

Future annual rental income for all third-party leases as of June 30, 2024 were as follows:

Year	Amount[1]
2024 (remainder)	$ 10,844
2025	21,427
2026	21,216
2027	21,216
2028	21,216
2029	21,216
Thereafter	109,635
TOTAL	**$ 226,770**

(1) Annual rental income includes base rents and variable rental income pursuant to existing leases as of June 30, 2024.

18. DEFINED CONTRIBUTION PLANS

The Company has a 401(k) defined contribution plan (the 401(k) Plan), whereby eligible employees may contribute up to 90% of their annual basic earnings, subject to applicable annual Internal Revenue Code limits. Additionally, the 401(k) Plan provides for discretionary matching contributions (as defined in the 401(k) Plan) by the Company.

The Company has a non-qualified deferred compensation plan (DCP), whereby certain highly compensated employees who are otherwise ineligible to participate in the Company's 401(k) plan, may defer the receipt of a portion of their base compensation and, for certain employees, up to 100% of their eligible bonuses. Additionally, the DCP allows for the employee deferrals to be deposited into a rabbi trust and the funds are generally invested in individual variable life insurance contracts owned by the Company that are specifically designed to fund savings plans of this nature. The Company paid for related administrative costs, which were not significant during the three and six months ended June 30, 2024 and 2023.

As of June 30, 2024 and December 31, 2023, the Company accrued $55,041 and $49,201, respectively, as long term deferred compensation in other long term liabilities on the consolidated balance sheet. Cash surrender value of the contracts is based on investment funds that shadow the investment allocations specified by participants in the deferred compensation plan. Refer to Note 5, *Fair Value Measurements* for more information on the funds.

For the three and six months ended June 30, 2024, the Company recorded gains related to its DCP of $527 and $2,921, respectively, which are included in other income, and recorded offsetting expenses of $628 and $3,116, which are allocated between cost of services and general and administrative expenses.

For the three and six months ended June 30, 2023, the Company recorded gains related to its DCP of $1,250 and $2,489, respectively, which are included in other income, and recorded offsetting expenses of $1,332 and $2,612, respectively, which are allocated between cost of services and general and administrative expenses.

19. SELF INSURANCE LIABILITIES

The Company is partially self-insured for general and professional liability claims up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. The combined self-insured retention for the Company's independent subsidiaries in California is $750 per claim, subject to an additional one-time deductible of $1,500. For the independent subsidiaries not in California, the self-insured claim is $650 per claim, subject to an additional one-time, deductible of $1,400. For all independent subsidiaries, except those located in Colorado, the third-party coverage above these limits is $1,000 per claim, $3,000 per operation, with a $10,000 blanket aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits is $1,000 per claim and $3,000 per operation, which is independent of the aforementioned blanket aggregate limits that apply outside of Colorado.

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

The Company’s policy is to accrue amounts equal to the actuarial estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued general liability and professional malpractice liabilities on an undiscounted basis, net of anticipated insurance recoveries, were $123,278 and $105,729 as of June 30, 2024 and December 31, 2023, respectively.

The Company’s independent subsidiaries are self-insured for workers’ compensation liabilities in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed $625 per occurrence. In Texas, the independent subsidiaries have elected non-subscriber status for workers’ compensation claims and the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 per occurrence. The Company’s independent subsidiaries in all other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $350 per occurrence. In the state of Washington, the Company is self-insured and has purchased individual specific excess insurance coverage that insures individual claims that exceed $500 per occurrence. For all of the self-insured plans and retention, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers’ compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $31,585 and $29,454 as of June 30, 2024 and December 31, 2023, respectively.

In addition, the Company has recorded an asset and corresponding liability of $15,626 and $15,913 as of June 30, 2024 and December 31, 2023, 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 12, *Restricted and Other Assets.*

The Company self-funds medical (including prescription drugs) and dental healthcare benefits for the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $525 for each covered person for fiscal year 2024. As of June 30, 2024 and December 31, 2023, the Company’s accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $14,702 and $14,814, 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.

20. COMMITMENTS AND CONTINGENCIES

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 obligations or other liabilities and other claims arising from the Company's use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of facilities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer to the Company's independent subsidiary, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with the Company's officers, directors and others, under which the Company may be required to indemnify such persons for liabilities based on the nature of their relationship to the Company. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's consolidated balance sheets for any of the periods presented.

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

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

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

The Company and its independent subsidiaries are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that services provided to patients by the Company's independent subsidiaries have resulted in injury or death, and claims related to employment and commercial matters. For example, in a four-week medical negligence trial in the State of Arizona, the jury returned a verdict against one of the Company's independent subsidiaries in late November 2023. The Company is in the process of appealing the jury verdict. The Company has in the past appealed similar decisions and has, in some circumstances, received decisions in its favor. Although the Company intends to vigorously defend against these claims and in general these types of claims and cases, there can be no assurance that the outcomes of these matters will not have a material adverse effect on operational results and financial condition. Additionally, in certain states in which the Company has or has had independent subsidiaries, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law and/or public policy prohibitions. There can be no assurance that the Company or its independent subsidiaries will not be liable for punitive damages awarded in litigation arising in states for which punitive damage insurance coverage is not available.

The skilled nursing and post-acute care industry is heavily regulated. As such, the Company and its independent subsidiaries are continuously subject to state and federal regulatory scrutiny, supervision and control in the ordinary course of business. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine. In addition to being subject to direct regulatory oversight from state and federal agencies, the skilled nursing and post-acute care industry is also subject to regulatory requirements which, if noncompliance is identified, could result in civil, administrative or criminal fines, penalties or restitutionary relief, and reimbursement; authorities could also seek the suspension or exclusion of the provider or individual from participation in their programs. The Company believes that there has been, and will continue to be, an increase in governmental investigations of post-acute providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse determinations in civil legal proceedings or governmental investigations, whether currently asserted or arising in the future, could have a material adverse effect on the Company's financial position, results of operations, and cash flows. Additionally, such proceedings and/or investigation can be a distraction to the business.

For example, in 2020, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis launched a nation-wide investigation into the COVID-19 pandemic, which included the impact of the coronavirus on residents and employees in nursing homes. In June 2020, the Company and its independent subsidiaries received a document and information request from the House Select Subcommittee. The Company and its independent subsidiaries cooperated in responding to this inquiry. In July 2022 and thereafter, the Company and its independent subsidiaries received follow up requests for additional documents and information. The Company and its independent subsidiaries responded to these requests and cooperated with the House Select Subcommittee in connection with its investigation. On December 9, 2022, the House Select Subcommittee issued its final report summarizing its investigation and related recommendations designed "to strengthen the nation's ability to prevent and respond to public health and economic emergencies." According to the information provided by the House Select Subcommittee, the issuance of this report was the House Select Subcommittee's final official act in connection with their assigned responsibilities.

Also, the Company, on behalf of its independent subsidiaries, received a Civil Investigative Demand (CID) from the U.S. Department of Justice (DOJ) in January of 2024 indicating that the DOJ is investigating the Company to determine whether it has caused the submission of claims to Medicare and Texas Medicaid for services which were unnecessary or otherwise not consistent with existing reimbursement requirements. The CID covers the period from January 1, 2016, to the present. As a general matter, the Company's independent subsidiaries maintain policies and procedures to promote compliance with all applicable Medicare and Medicaid requirements, including but not limited to those relating to the presentation of claims for reimbursement for services provided. The Company is fully cooperating with the DOJ in response to the CID. However, the Company cannot predict the outcome of the investigation or its potential impact on the consolidated financial statements.

In addition to the potential lawsuits and claims described above, the Company and its independent subsidiaries are also subject to potential lawsuits under the FCA and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare or Medicaid) or other payor. A violation may provide the basis for exclusion from federally funded healthcare programs. Such exclusions could have a correlative negative impact on the Company’s financial performance. In addition, and pursuant to the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Due to these whistleblower incentives, qui tam lawsuits have become more frequent.

For example, on May 31, 2018, the Company, on behalf of its independent subsidiaries, received a CID from the DOJ stating that it was investigating to determine whether there had been a violation of the False Claims Act (FCA) and/or the Anti-Kickback Statute (AKS) with respect to the relationships between certain of the Company’s independent subsidiaries and persons who serve or have served as medical directors. The Company fully cooperated with the DOJ and promptly responded to its requests for information. In April 2020, the Company was advised that the DOJ declined to intervene in any subsequent action filed in connection with the subject matter of this investigation. Despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its previously issued CID, the involved qui tam relator moved forward with the complaint in December 2020. From that time until December 2023, and notwithstanding the Company's success in early pre-trial motions, the Company continued to incur legal defense costs and fees, including significant amounts as part of discovery in the fourth quarter of 2023. In early January 2024, the Company entered into mediation with the involved parties and on January 19, 2024, the parties agreed to settle the civil case for $48,000, subject to the review of the DOJ and other relevant government entities. The settlement does not include admissions on the part of the Company or its independent subsidiaries and the Company maintains that it has and continues to comply with all applicable State and Federal statutes (including but not limited to the FCA and the AKS). The settlement documents are in the process of being finalized and, following payment of the settlement funds, the qui tam complaint will be dismissed and the matter will be resolved.

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

Under the Fraud Enforcement and Recovery Act of 2009 (FERA), health care providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government can argue, therefore, that an FCA violation can occur without any affirmative fraudulent action or statement, as long as the action or statement is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

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

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

The Company and its independent subsidiaries are also subject to requests for information and investigations by other state and federal governmental entities (e.g., Offices of the Attorney General and Offices of the Inspector General). The Company cannot predict or provide any assurance as to the possible outcome of any inquiry, investigation or litigation. If any such inquiry, investigation or litigation were to proceed, and the Company and its independent subsidiaries are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the FCA, or similar state and federal statutes and related regulations, or if the Company or its independent subsidiaries are alleged or found to be liable on theories of general or professional negligence or wage and hour violations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged violations and may also include the assumption of specific procedural and financial obligations by the Company or its independent subsidiaries under a Corporate Integrity Agreement and/or other such arrangement.

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.

Medicare Revenue Recoupments — The Company's independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments as a result of Recovery Audit Contractors (RAC), Program Safeguard Contractors, and Medicaid Integrity Contractors programs (collectively referred to as Reviews). For several months during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) suspended its Targeted Probe and Educate (TPE) Program. Beginning in August 2020, CMS resumed TPE Program activity. If an operation fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. The Company anticipates that these Reviews could increase in frequency in the future. As of June 30, 2024 and through the filing date of this report, 11 of the Company's independent subsidiaries had Reviews scheduled or in process.

In June 2023, CMS announced a new nationwide audit, the “SNF 5-Claim Probe & Educate Review,” in which the Medicare Administrative Contractors (MACs) will review five claims from each SNF to check for compliance. In implementing this SNF 5-Claim Probe & Educate Review, CMS acknowledged that the increase in observed improper payments from 2021 to 2022 may have arisen from a "misunderstanding" by SNFs about how to appropriately bill for claims of service after October 1, 2019. All facilities that are not undergoing TPE reviews, or have not recently passed a TPE review, will be subject to the nationwide audit. MACs will complete only one round of probe-and-educate for each SNF, rather than three rounds that typically occur in the TPE. Additionally, CMS's education for each SNF will be individualized and based on observed claim review errors, with rationales for denial explained to the SNF on a claim-by-claim basis. This program applies only to claims submitted after October 1, 2019, and will exclude claims containing a COVID-19 diagnosis.

Concentrations

Credit Risk — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary.

The Company's receivables from Medicare and Medicaid payor programs accounted for 53.0% and 53.4% of its total accounts receivable as of June 30, 2024 and December 31, 2023, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 71.2% and 71.4% of the Company's revenue for the three and six months ended June 30, 2024, respectively, and 73.1% and 73.2% for the three and six months ended June 30, 2023, respectively.

21. COMMON STOCK REPURCHASE PROGRAM

On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which the Company may repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months from September 1, 2024. Under this program, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. The share repurchase program does not obligate the Company to acquire any specific number of shares.

On August 29, 2023, the Board of Directors approved a stock repurchase program pursuant to which the Company may repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months from September 1, 2023. Under this program, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. The share repurchase program does not obligate the Company to acquire any specific number of shares. The Company did not purchase any shares pursuant to this stock repurchase program during the six months ended June 30, 2024.

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

The following discussion should be read in conjunction with the condensed consolidated financial statements and accompanying notes, which appear elsewhere in this Quarterly Report on Form 10-Q. We urge you to carefully review and consider the various disclosures made by us in this Quarterly Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Annual Report on Form 10-K for the year ended December 31, 2023 (Annual Report), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Form 10-Q and Form 8-K, for additional information. The section entitled "Risk Factors" contained in Part II, Item 1A of this Quarterly Report on Form 10-Q, and similar discussions in our other SEC filings, also describe some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Quarterly Report on Form 10-Q and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

This Quarterly Report on Form 10-Q contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to our expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, and plans and objectives of management. Forward-looking statements can often be identified by words such as "anticipates," "expects," "intends," "plans," "predicts," "believes," "seeks," "estimates," "may," "will," "should," "would," "could," "potential," "continue," "ongoing," similar expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Our actual results could differ materially from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section "Risk Factors" contained in Part II, Item 1A of this Quarterly Report on Form 10-Q. These forward-looking statements speak only as of the date of this Quarterly Report on Form 10-Q, and are based on our current expectations, estimates and projections about our industry and business, management's beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law.

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

Overview

We are a provider of health care services across the post-acute care continuum. We engage in the operation, ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare related properties and ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. Our independent subsidiaries, each of which strive to be the operation of choice in the communities they serve, provide a broad spectrum of services. As of June 30, 2024, we offered skilled nursing, long term acute care, senior living and rehabilitative care services through 312 skilled nursing and senior living facilities. Our real estate portfolio includes 120 owned real estate properties, which includes 90 facilities operated and managed by us, 30 operations leased to and operated by third-party operators and the Service Center location. Of the 30 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that we own and operate.

The following table summarizes our independent subsidiaries and operational skilled nursing beds and senior living units by ownership status as of June 30, 2024:

	Owned and Operated	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total for Facilities Operated
Number of facilities	90	12	210	312
Percentage of total	28.8 %	3.8 %	67.4 %	100.0 %
Operational skilled nursing beds	8,585	1,265	21,963	31,813
Percentage of total	27.0 %	4.0 %	69.0 %	100.0 %
Senior living units	2,009	178	1,140	3,327
Percentage of total	60.4 %	5.4 %	34.2 %	100.0 %

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

Recent Activities

We believe we exist to dignify and transform post-acute care. We set out a strategy to achieve our goal of ensuring our patients are receiving the best possible care through our ability to acquire, integrate and improve our operations. Our results serve as a strong indicator that our strategy is working and our transformation is underway. Our dedication to our cultural and operational fundamentals continues to deliver strong results. Refer to *Results of Operations* for further discussion.

Operational Expansions — During the six months ended June 30, 2024, we expanded our operations and real estate portfolio through a combination of long-term leases and real estate purchases, with the addition of 13 stand-alone skilled nursing operations and two campus operations. Of these additions, Standard Bearer acquired the real estate of seven of the operations, all of which were leased back to our independent subsidiaries. These new operations added a total of 1,369 operational skilled nursing beds and 202 operational senior living units to be operated by our independent subsidiaries. We also invested in new ancillary services that are complementary to our existing businesses.

Common Stock Repurchase Program — On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2024.

Expansion into a New State — In 2024, we expanded our operations into the state of Tennessee with the addition of three stand-alone skilled nursing operations. These expansions are part of our strategic vision to further strengthen our growing national presence in both existing and new attractive markets.

Facility Information

The following table sets forth the location of our operated and owned facilities by type as well as the number of beds and units located at operated and owned facilities as of June 30, 2024:

	TX	CA	AZ	UT	CO	WA	ID	SC	NE	IA	KS	NV	WI	TN	Total
Number of operated facilities															
Skilled nursing operations	78	67	31	20	22	15	11	9	4	5	2	3	2	3	272
Senior living operations	1	—	1	2	5	1	—	—	1	—	—	—	—	—	11
Campuses[1]	5	3	6	1	1	—	1	—	2	2	8	—	—	—	29
Number of owned and operated facilities															
Skilled nursing properties	18	10	10	9	5	4	5	5	1	1	1	—	2	—	71
Senior living communities	1	—	—	—	3	—	—	—	1	—	—	—	—	—	5
Campuses[1]	3	1	5	—	—	—	—	—	—	—	5	—	—	—	14
Number of operated beds/units															
Operational skilled nursing beds	10,074	6,666	4,633	2,071	2,359	1,378	1,002	1,126	413	450	709	483	100	349	31,813
Senior living units	604	197	898	163	723	98	21	—	341	31	251	—	—	—	3,327
Number of owned and operated beds/units															
Owned skilled nursing beds	2,377	1,185	1,694	764	467	391	470	544	88	82	423	—	100	—	8,585
Owned Senior living units	538	42	501	—	459	—	—	—	302	—	167	—	—	—	2,009
Real estate properties leased to third party[2]															
Skilled nursing and senior living properties	6	2	1	—	—	1	—	—	—	—	—	1	19	—	30

(1) Campuses represent facilities that offer both skilled nursing and senior living services.
(2) Excludes three subleases to third parties in California.

Key Performance Indicators

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

Skilled Services

- ***Routine revenue*** — Routine revenue is generated by the contracted daily rate charged for all contractually inclusive skilled nursing services. The inclusion of therapy and other ancillary treatments varies by payor source and by contract. Services provided outside of the routine contractual agreement are recorded separately as ancillary revenue, including Medicare Part B therapy services, and are not included in the routine revenue definition.
- ***Skilled revenue*** — The amount of routine revenue generated from patients in the skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs. The other skilled patients who are included in this population represent very high acuity patients who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care. Skilled revenue excludes any revenue generated from our senior living services.

- ***Skilled mix*** — The amount of our skilled revenue as a percentage of our total skilled nursing routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving skilled nursing services at the skilled nursing facilities divided by the total number of days patients from all payor sources are receiving skilled nursing services at the skilled nursing facilities for any given period.
- ***Average daily rates*** — The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period. These rates exclude additional state relief funding, which includes the American Rescue Plan Act (ARPA), the Family First Coronavirus Response Act (FFCRA) and other state specific relief programs.
- ***Occupancy percentage (operational beds)*** — The total number of patients occupying a bed in a skilled nursing facility as a percentage of the beds in a facility which are available for occupancy during the measurement period.
- ***Number of facilities and operational beds*** — The total number of skilled nursing facilities that we own or operate and the total number of operational beds associated with these facilities.

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
Skilled Mix:	**2024**	**2023**	**2024**	**2023**
Days	29.9 %	30.8 %	30.4 %	31.5 %
Revenue	48.2 %	50.7 %	49.0 %	51.7 %

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
Occupancy for skilled services:	**2024**	**2023**	**2024**	**2023**
Operational beds at end of period	31,813	29,919	31,813	29,919
Available patient days	2,869,623	2,722,599	5,684,342	5,350,130
Actual patient days	2,299,068	2,124,862	4,554,599	4,172,567
Occupancy percentage (based on operational beds)	80.1 %	78.0 %	80.1 %	78.0 %

Segments

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

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

Revenue Sources

The following tables set forth our total service revenue by payor source generated by our skilled services segment and our "All Other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Three Months Ended June 30,					
	Skilled Services		All Other [4]		Total Service Revenue	
	2024	2023	2024	2023	2024	2023
Medicaid[1]	$ 403,127	$ 352,380	$ 8,633	$ 7,401	$ 411,760	$ 359,781
Medicare	258,869	248,081	—	—	258,869	248,081
Medicaid-skilled	62,969	62,015	—	—	62,969	62,015
Subtotal	**724,965**	**662,476**	**8,633**	**7,401**	**733,598**	**669,877**
Managed care	191,022	161,101	—	—	191,022	161,101
Private and other[3]	75,298	60,623	30,656	24,500	105,954	85,123
TOTAL SERVICE REVENUE	**$ 991,285**	**$ 884,200**	**$ 39,289**	**$ 31,901**	**$ 1,030,574**	**$ 916,101**

	Three Months Ended June 30,					
	Skilled Services		All Other [4]		Total Service Revenue	
	2024	2023	2024	2023	2024	2023
Medicaid[1][2]	40.7 %	39.9 %	22.0 %	23.2 %	40.0 %	39.3 %
Medicare	26.1	28.1	—	—	25.1	27.1
Medicaid-skilled	6.3	7.0	—	—	6.1	6.7
Subtotal	**73.1**	**75.0**	**22.0**	**23.2**	**71.2**	**73.1**
Managed care	19.3	18.2	—	—	18.5	17.6
Private and other[3]	7.6	6.8	78.0	76.8	10.3	9.3
TOTAL SERVICE REVENUE	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

(1) Medicaid payor includes revenue for senior living operations.

(2) Medicaid payor includes revenue related to state relief funding during the three months ended June 30, 2023.

(3) Private and other in our "all other" category includes revenue from senior living operations and all revenue generated in our other ancillary operations.

(4) All Other incorporates intercompany eliminations.

	Six Months Ended June 30,					
	Skilled Services		All Other [4]		Total Service Revenue	
	2024	2023	2024	2023	2024	2023
Medicaid[1]	$ 785,245	$ 685,825	$ 16,678	$ 14,220	$ 801,923	$ 700,045
Medicare	524,452	495,804	—	—	524,452	495,804
Medicaid-skilled	126,278	119,942	—	—	126,278	119,942
Subtotal	**1,435,975**	**1,301,571**	**16,678**	**14,220**	**1,452,653**	**1,315,791**
Managed care	379,126	317,764	—	—	379,126	317,764
Private and other[3]	145,786	115,788	57,494	48,676	203,280	164,464
TOTAL SERVICE REVENUE	**$ 1,960,887**	**$ 1,735,123**	**$ 74,172**	**$ 62,896**	**$ 2,035,059**	**$ 1,798,019**

	Six Months Ended June 30,					
	Skilled Services		All Other [4]		Total Service Revenue	
	2024	2023	2024	2023	2024	2023
Medicaid[1][2]	40.0 %	39.5 %	22.5 %	22.6 %	39.4 %	38.9 %
Medicare	26.7	28.6	—	—	25.8	27.6
Medicaid-skilled	6.5	6.9	—	—	6.2	6.7
Subtotal	**73.2**	**75.0**	**22.5**	**22.6**	**71.4**	**73.2**
Managed care	19.3	18.3	—	—	18.6	17.7
Private and other[3]	7.5	6.7	77.5	77.4	10.0	9.1
TOTAL SERVICE REVENUE	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

(1) Medicaid payor includes revenue for senior living operations.

(2) Medicaid payor includes revenue related to state relief funding during the six months ended June 30, 2023.

(3) Private and other in our "all other" category includes revenue from senior living operations and all revenue generated in our other ancillary operations.

(4) All Other incorporates intercompany eliminations.

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

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

Standard Bearer — We generate rental revenue primarily by leasing post-acute care properties that we acquired to healthcare operators under triple-net lease arrangements, whereby the tenants are solely responsible for the costs related to the property, including property taxes, insurance and maintenance and repair costs, subject to certain exceptions. As of June 30, 2024, our real estate portfolio within Standard Bearer is comprised of 115 real estate properties. Of these properties, 86 are leased to our independent subsidiaries and 30 are leased to facilities wholly-owned and managed by third-party operators. Of those 30 operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates. During the three and six months ended June 30, 2024, we generated rental revenues of $23.4 million and $45.6 million, respectively, of which $19.2 million and $37.2 million, respectively, was derived from our independent subsidiaries and therefore eliminated in consolidation.

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

Critical Accounting Estimates

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

See Item 7., *Management's Discussion and Analysis of Financial Condition and Results of Operations*, in our Annual Report for further discussion of critical accounting estimates. There were no material changes to our critical accounting policies with which the estimates are developed since December 31, 2023.

Industry Trends

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

- ***Shift of Patient Care to Lower Cost Alternatives*** — The growth of the senior population in the U.S. continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher acuity patients than in the past.
- ***Significant Acquisition and Consolidation Opportunities*** — The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. Due to the increasing demands from hospitals and insurance carriers to implement sophisticated and expensive reporting systems, we believe this fragmentation provides us with significant acquisition and consolidation opportunities.
- ***Improving Supply and Demand Balance*** — The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- ***Increased Demand Driven by Aging Populations*** — As seniors account for an increasing percentage of the total U.S. population, we believe the demand for skilled nursing and senior living services will continue to increase. According to the census projection released by the U.S. Census Bureau in early 2020, between 2016 and 2030, the number of individuals over 65 years old is projected to be one of the fastest growing segments of the United States population, growing from 15% to 21%. The Bureau expects this segment to increase nearly 50% to 73 million, as compared to the total U.S. population which is projected to increase by 10% over that time period. Furthermore, the generation currently retiring has accumulated less savings than prior generations, creating demand for more affordable senior housing and skilled nursing services. As a high-quality provider in lower cost settings, we believe we are well-positioned to benefit from this trend.
- ***Value-based Care and Reimbursement Reform*** — In response to rising healthcare spending in the United States, commercial, government and other payors are generally shifting away from fee-for-service (FFS) payment models towards value-based models, including risk-based payment models that tie financial incentives to quality, efficiency and coordination of care. We believe that patient-centered outcomes driven reimbursement models will continue to grow in prominence. Many of our operations already receive value-based payments, and as valued-based payment systems continue to increase in prominence, it is our view that our strong clinical outcomes will be increasingly rewarded.

A significant goal of U.S. federal health care reform is to transform the delivery of health care by changing reimbursement to reflect and support a focus on equity, payment for value and efficacious delivery of person-centered care. Reimbursement models and demonstrations that increase accountability and provide financial incentives to encourage efficiency, affordability and high-quality care, have been developed and implemented by government and commercial third-party payers. Special focus is placed on increasing the number of beneficiaries in care relationships with accountability for quality and total cost of care, improvements in care coordination, reducing inequities at the population level and supporting care innovation to close care gaps and increase access. The most prominent value-based models designed to accomplish these aims include Accountable Care Models (e.g., MSSP ACOs, ACO REACH) and Disease-Specific & Episode-Based Models (e.g., BPCI Advanced, GUIDE Model, CJR). These models, alongside State & Community, Statutory and Health Plan Models, are aimed at alignment across payers and care settings, leveraging effective clinical tools, outcomes-focused payment approaches and stakeholder-led policy development. Reimbursement methodology reform includes Value-Based Purchasing (VBP), in which a portion of provider reimbursement is redistributed based on relative performance, or improvement on designated economic, clinical quality and patient satisfaction metrics. These reimbursement methodologies and similar programs are likely to continue and expand, both in government and commercial health plans. Many of our operations already participate in value-based initiatives and models. With our focus on quality care and strong clinical outcomes, we are well-positioned to benefit from these outcome-based payment models.

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

Our business is affected by seasonal fluctuations in occupancy and acuity, which are most prominent when comparing the summer and winter months of the calendar year.

GOVERNMENT REGULATION

General

Healthcare is an area of extensive and frequent regulatory change. Changes in the law or new interpretations of existing laws may have a significant impact on our revenue, costs and business operations. Our independent subsidiaries that provide healthcare services are subject to federal, state and local laws relating to, among other things, licensure, quality and adequacy of care, physical plant requirements, life safety, personnel and operating policies. In addition, these same subsidiaries are subject to federal and state laws that govern billing and reimbursement, relationships with vendors, business relationships with physicians and workplace protection for healthcare staff. Such laws include (but are not limited to) the Anti-Kickback Statute (AKS), the federal False Claims Act (FCA), the Stark Law and state corporate practice of medicine statutes.

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

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

Proposed, Anticipated and Recently Issued Rulemaking and Administrative Actions

The federal government, through CMS rulemaking, Presidential executive actions or Congressional legislation, and state and local governments have recently released the following proposed rulemaking or administrative actions that may have an impact on our independent Skilled Nursing Facilities (SNFs) or Assisted Living Facilities (ALFs):

Biden-Harris Administration's Nursing Home Care Priorities — The Biden-Harris Administration is seeking reform around reimbursement, staffing levels, standards of care, increased transparency and public disclosure of ownership, and enhanced civil remedies as a means of enforcement against those facilities that do not satisfy CMS's standards. Proposed rules based on these directives have already been published in 2023, including those highlighted below and observers expect additional rules to be issued this year and in the future. The SNF PPS FY 2025 Proposed Rule also includes proposals for CMS to have greater sanctioning authority for ongoing or persistent deficiencies in Medicare-participating SNFs. If CMS adopts this proposal after notice and comment, these increased sanctioning authorities will take effect as soon as the 2025 federal fiscal year, beginning in late 2024. Final rules will follow publication of these proposed rules after a notice-and-comment period required by law.

Ownership Transparency Final Rule — On November 15, 2023, CMS published its final rule requiring SNFs to publicly disclose certain additional information regarding their ownership and managerial relationships. The final rule requires disclosures to include the identity of any person or legal entity that: (1) exercises financial, operational, or managerial control over any facility or part of a facility, or provides services to a facility that include its policies and procedures or cash management services; (2) leases or subleases real property to the facility, or owns 5% or more of the real property's total value; and (3) provides any management or administrative services (or consults regarding the same), or provides accounting or financial services to SNFs. The rule also expands ownership and control interest disclosures to include information about each member of the facilities governing body, individuals or entities serving as officers, directors, members, partners or managing employees, and a comprehensive breakdown of the organizational structure of any additional disclosable party that is not a natural person along with a description of their relationships with the facility.

Certain states have adopted laws reflecting their concerns regarding ownership transparency. For example, in July 2023, Iowa adopted laws requiring disclosure of ownership information not previously required for licensure to promote transparency. Additionally, in March 2024, the California Department of Health Care Access and Information of the California Health and Human Services Agency issued its notice of approval of regulatory action establishing policies and procedures that implement financial and ownership transparency requirements for California-licensed SNFs that are required by California law passed in 2021.

Federal Legislation — On March 9, 2023, the Home and Community-Based Services (HCBS) Access Act (Access Act) was introduced to expand access to and resources available for HCBS. The Access Act ensures that Medicaid funding is made available to individuals who provide direct home- and community-based care to adults over the age of 60 or people who have disabilities. This bill also provides financial resources for the training of these direct care providers, who are intended to provide services to the elderly or disabled that range from advocacy and community integration to transportation and daily assistance tasks ranging from bathing and laundry to meal preparation and housekeeping. As of the date of filing, no further action has been taken on the HCBS Access Act since its introduction and referral to the House of Representatives committees.

On October 24, 2023, the HCBS Relief Act was introduced to provide additional funds to states to stabilize their HCBS service delivery networks, recruit and retain HCBS direct care workers, and meet long-term service and support needs of people eligible for Medicaid home and community-based services. Under the HCBS Relief Act, states would receive a temporary 10% increase in the applicable Federal Medical Assistance Percentage (FMAP) under Medicaid for certain approved home and community-based services that are provided during fiscal year (FY) 2024 through FY 2025. To qualify for the enhanced rate, a state must commit to initiatives aimed at improving the provision of services. This includes offering additional advantages to home health aides and assisting individuals in transition from nursing facilities back to their homes. As of the date of this filing, no action has been taken on the HCBS Relief Act since its introduction and referral to the Senate Committee on Finance.

State Legislation — Many states in which our independent subsidiaries operate have introduced or passed legislation that would create or change laws and regulations related to our business and industry.

In the past, California had discussed issuing proposed regulations on direct care spending requirements that may have affected our business and SNFs operating within that state. These proposals have included requirements for healthcare facilities certified by CMS, including SNFs, to report all annual revenues to the State of California and certify that a stated percentage of all non-Medicare revenues should be used for direct patient-related services, including staffing and operational costs.

On October 13, 2023, the California Governor signed into law a bill that impacts the minimum wages of healthcare workers. Effective June 1, 2024, the law raised the minimum wage for California healthcare employees and set a new wage threshold for those who are considered exempt healthcare employees. The bill only becomes effective for SNFs if a patient care minimum spending requirement bill is also passed. We anticipate that a minimum spending bill will be proposed in the future.

On April 24, 2024, the California Department of Health Care Access and Information (HCAI) announced that the Office of Health Care Affordability's Board approved a statewide healthcare spending target of 3%, which represents a long-term reduction of current levels of statewide healthcare spending. The spending target will be phased in over time, initially starting at 3.5% for 2025 and 2026, the target will be lowered to 3.2% for 2027 and 2028 before ultimately reaching 3% for 2029 and beyond.

Final Rule Fiscal Year 2024 Skilled Nursing Facility Prospective Payment System (SNF PPS) — On July 31, 2023, CMS published its final rule updating the Medicare payment rates within the SNF PPS for FY 2024 (SNF PPS FY 2024 Final Rule). The SNF PPS FY 2024 Final Rule modifies the SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing (VBP) Program. The SNF PPS FY 2024 Final Rule finalized the rates to be paid in the 2024 fiscal year, which started on October 1, 2023.

The SNF PPS FY 2024 Final Rule increases the Medicare payment rate aggregate net market basket by 4.0%. The increase includes a 6.4% net market basket update to the payment rates of 3.0%, plus a 3.6% market basket forecast error adjustment, less a 0.2% productivity adjustment, as well as a negative 2.3% in the FY 2024 SNF PPS rates due to the second phase of the Patient Driven Payment Model (PDPM) parity adjustment recalibration. The net effect of these changes was an overall 4.0% increase in payments to SNFs in FY 2024. This final rule also updates the SNF QRP for FY 2024 and future years, including the adoption of two new quality reporting measures, modification of one measure and removal of three measures resulting in public reporting of four QRP measures. Additionally, the SNF PPS FY 2024 Final Rule makes changes to the SNF VBP Program. Specifically, this final rule adopts four new measures: the nursing staff turnover measure, the discharge function score measure, the long stay hospitalization measure per 1,000 resident days and the percent of residents experiencing one or more falls with a major injury (long stay); the existing SNF 30-day all-cause readmission measure (SNFRM) is replaced with the SNF within stay potentially preventable readmissions (SNF WS PPR) measure beginning in FY 2028.

SNF PPS FY 2024 Final Rule adopted the Nursing Staff Turnover (NST) measure for the SNF VBP program beginning with the FY 2026 program year. This is a structural measure that has been collected and publicly reported on Care Compare, and the measure assesses the stability of the staffing within a SNF using nursing staff turnover. The NST measure uses facility-reported, electronic data from CMS' Payroll-Based Journal (PBJ) system to calculate annual turnover rates for nursing staff, including RNs, LPNs, and nurse assistants. Facilities would begin reporting this measure in FY 2024, with payment effects beginning in FY 2026.

The NST measure looks at six consecutive quarters of data. It starts with a baseline quarter and the first two quarters of the performance period to identify eligible employees. Then, it uses the next four quarters to find the number of employment cycles that ended in turnover. Finally, the data from the sixth quarter is validated to identify gaps in days worked that began in the last 60 days of the fifth quarter used for the measure. The measure score is then calculated by comparing the total number of eligible employees with 60-day gaps in working during the specified periods.

Proposed Rule Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System (SNF PPS) — On March 28, 2024, CMS released the proposed rule for the SNF PPS for FY 2025, which, if approved, will result in a 4.1% increase based on the proposed SNF market basket of 2.8%, plus a 1.7% market basket forecast error adjustment, and a negative 0.4% productivity adjustment. This increase does not include the SNF VBP reductions for certain SNFs subject to the net reduction in payments under the SNF VBP; those adjustments are estimated to total $196.5 million in FY 2025. CMS also plans to revise the SNF market basket base year from the 2018 base year to the current 2022 base year and to update the payment rates used under the SNF PPS based on the FY 2025 market basket increase factor, which is adjusted by both the productivity adjustment and forecast error correction. Within this proposed rule, CMS also proposes to update the SNF PPS wage index using core-based statistical areas (CBSAs) to reflect more accurate regional wage costs.

The proposed rule also includes significant enhancements to its enforcement capabilities within nursing homes, aiming to reinforce the safety and quality of care. The proposed rule seeks to broaden CMS's ability to levy financial penalties as a means to ensure sustained remediation of health and safety infractions, thereby motivating facilities to quickly comply with CMS regulations. The proposed rule aims to eliminate the restrictions of per instance (PI) for isolated violations or per day (PD) for ongoing non-compliance restrictions, allowing for more flexible imposition of both PD and PI penalties, which would not exceed statutory daily limits. This change is intended to provide CMS with enhanced tools to address violations more effectively and reflect the severity of the impact on residents' health and safety. CMS sought public feedback regarding this proposed flexibility to enforce its standards in nursing homes and SNFs through a comment period that closed on May 28, 2024. More than half of the public comments CMS received addressed the proposed rule's expansion of financial penalties that could be assessed against SNFs for non-compliance.

CMS Minimum Staffing Standards Final Rule — On April 22, 2024, CMS issued its final rule establishing minimum staffing standards for skilled nursing facilities (Staffing Rule). The Staffing Rule contains three primary staffing requirements and provides for a staggered and phase implementation over the next several years following the Staffing Rule's publication.

The initial phase, effective 90 days from the Staffing Rule's publication, which is August 8, 2024, requires facility self-assessment, which enhances the current assessment that all SNFs must perform and document annually and on an as-needed basis. The Staffing Rule's requirement for enhanced self-assessments requires the following: 1) facilities must use evidence-based methods when planning for resident care, including accommodation of behavioral health needs; 2) facilities to use their self-assessment to assess the specific needs of each resident, with adjustments made for changes in the resident population; 3) facilities include the input of staff, including leadership, management, nurse staff and other direct care providers who render other services to residents; and 4) the facility's staffing plan maximizes recruitment and retention of staff in a manner consistent with the President's April 2023 Executive Order on increasing access to high-quality care and supporting caregivers.

The second phase, effective within two years of the Staffing Rule's publication, which is May 2026 for non-rural facilities, requires that all SNFs have a registered nurse (RN) available to provide direct resident care onsite 24 hours per day, seven days per weeks (24/7). The rule states that administrative nurses may satisfy this requirement, provided that the nurse is available to provide direct resident care. In addition to the 24/7 RN, the Staffing Rule requires facilities to provide a minimum of 3.48 hours per resident per day (HPRD) of direct nursing care to residents.

The third phase, effective within three years of the Staffing Rule's publication, which is May 2027 for non-rural facilities, requires that the HPRD are satisfied through RNs providing 0.55 HPRD, nurse aides (NAs) providing 2.45 HPRD, and any combination of RNs, licensed practical nurses (LPNs), licensed vocational nurses (LVNs), or NAs to account for the final 0.48 HPRD.

The Staffing Rule finalized the hardship exemption for the HPRD requirements. A facility can qualify for a temporary hardship exemption from the new minimum staffing ratios and 24/7 RN onsite staffing requirement (the self-assessment standards must still be satisfied) if it is located in an area where the supply of RN, NA, or total nursing staff is insufficient to meet the needs of that area. This exemption is based on the provider-to-population ratio for the nursing workforce, which must be at least 20% below the national average as calculated by CMS. Additionally, the Staffing Rule provides a one year extension of deadlines to rural facilities on Phases 2 and 3.

The Staffing Rule also enhances transparency for the use of Medicaid payments for facility services, referenced as Medicaid Institutional Payment Transparency Reporting provisions (MIPTR). The MIPTR provisions within the Staffing Rule require States to report to CMS the percentage of Medicaid payments for nursing facility services spent on direct care workers and support staff, regardless of whether such payments are made under a fee-for-service or managed care model.

Prior to the issuance of the Staffing Rule, there have been two bills under the names Protecting America's Seniors' Access to Care Act and Protecting Rural Seniors' Access to Care Act (one in the House and a companion bill in the Senate), that were intended to block the rule from taking effect. The Senate bill has garnered broad bipartisan support and is endorsed by over 90 organizations. These bills reason that the minimum staffing standard would endanger rural nursing facilities, subjecting them to potential fines and closures for failure to comply and might require them to discharge residents or limit the number of residents they accept in an effort to meet the requirements of the bill. It is uncertain if any of these bills or other legislative action will pass as well as their potential impact on the Staffing Rule.

The Staffing Rule has been met with further opposition and proposed legislation to halt its implementation. On May 23, 2024, the American Health Care Association (AHCA) filed a lawsuit in the Northern District of Texas against HHS and CMS, alleging that the Staffing Rule exceeds the scope of CMS's statutory authority and violates the Administrative Procedure Act. On May 10, 2024, a measure was introduced in the House of Representatives under the Congressional Review Act to overturn the Staffing Rule. Related to the pending proposed legislation regarding the Staffing Rule, on April 19, 2024, the Long-Term Care Workforce Support Act was introduced in both the Senate and House of Representatives in an effort to increase the direct care workforce and improve pay, by increasing the federal match for Medicaid by up to 10% for each state across 10 years. The recent Supreme Court decision in *Loper Bright Enterprises v. Raimondo* ("Chevron" decision) gives courts greater authority to challenge federal agencies' statutory interpretations. As such, the Staffing Rule may see increase legal challenges under the new doctrine. (For further discussion of the Chevron case and its implications see "United States Supreme Court Decisions" section below.)

Medicare

Medicare presently accounts for approximately 26.7% of our skilled nursing services revenue year-to-date, being our second-largest revenue payor. The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins.

Patient-Driven Payment Model (PDPM) — The SNF PPS Rule included a case mix model called PDPM that focuses on the patient's condition (clinically relevant factors) and resulting care needs to determine Medicare reimbursement. PDPM utilizes clinically relevant factors for determining Medicare payment by using diagnosis codes and other patient characteristics as the basis for patient classification. PDPM makes effective use of five case-mix adjusted payment components: physician therapy, occupational therapy, speech language pathology, nursing and social services and non-therapy ancillary services. It also uses a sixth non-case mix component to cover utilization of SNFs' resources that do not vary depending on resident characteristics. PDPM is intended to achieve a more value-based, unified post-acute care payment system. For example, PDPM adjusts Medicare payments based on each aspect of a resident's care. Under the SNF PPS PDPM system, the payment to SNFs and nursing homes is based heavily on the patient's condition rather than the specific services provided by each SNF.

Skilled Nursing Facility - Quality Reporting Program (SNF QRP) — The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) provided data reporting requirements for certain Post-Acute-Care (PAC) providers. If a SNF does not submit required quality data as required by the IMPACT Act, its payment rates are reduced by 2.0% for each such fiscal year, which may result in payment rates for a fiscal year being less than the preceding fiscal year.

The SNF QRP standardized patient assessment data elements. The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities and all non-critical access hospital swing-bed rural hospitals. These data elements are the subject of frequent change and adjustment. CMS's rulemaking often identifies new data elements to be reported.

CMS revised the calculation of its five-star ratings for the Nursing Home Compare website. Under this methodology, points are assigned to a SNF based on its performance across six measures: (1) case-mix adjusted total nurse staffing levels (including registered nurses, licensed practical nurses, and nursing aides), measured by hours per resident per day; (2) case-mix adjusted registered nurse staffing levels, measured by hours per resident per day; (3) case-mix adjusted total nurse staffing levels (including registered nurses, licensed practical nurses, and nursing aides), measured by hours per resident day on the weekend; (4) total nurse turnover, defined as the percentage of nursing staff that left the nursing home over a 12-month period; (5) registered nurse turnover, defined as the percentage of registered nursing staff that left the nursing home over a 12-month period; and (6) administrator turnover, defined as the percentage of administrators that left the nursing home over a 12-month period. These six measures will be measured on a quarterly basis.

These six new measures were included in the five-star rating in October 2022. In addition, CMS also implemented a planned increase to the quality measure reporting thresholds, increasing each threshold by one-half of the average improvement of quality measure scores since CMS last set quality measure thresholds. Going forward, CMS plans to implement similar rating threshold increases every six months.

CMS has continued to refine the QRP including various measurements such as the adoption of a process measure for influenza vaccination coverage among healthcare personnel within SNFs and a Discharge Function Score (DC Function) measure, which determines the functional condition of residents by examining the proportion of SNF residents who achieve or surpass a projected discharge functionality score. The assessment includes consideration of mobility and self-care, utilizing data from the Minimum Data Set (MDS). The DC Function will replace the current process and is scheduled to go into effect for the FY 2025 SNF QRP. The SNF PPS FY 2024 Final Rule also modified the SNF QRP's Healthcare Professional (HCP) Covid Vaccine Measure. The measure will track the proportion of healthcare staff vaccinated for COVID-19 and have kept their vaccination status current per the CDC recommendations. The SNF PPS FY 2024 Final Rule also removed the Application of Functional Assessment/Care Plan measures from the SNF QRP.

CMS will adopt two measures for the SNF QRP starting in FY 2026. First, CMS will raise the Data Completion Thresholds for the MDS. SNFs must report required quality measure data and standardized resident assessment data gathered using the MDS for at least 90% of the assessments they submit to CMS. SNFs who fail to meet this requirement will be subject to a 2% reduction on their applicable fiscal year payment starting in FY 2026. Second, CMS will adopt the Patient/Resident COVID-19 Vaccine metric. This metric highlights the number of patient stays in which SNF patients received the COVID-19 vaccine.

CMS's SNF PPS FY 2025 Proposed Rule includes several updates to the SNF QRP aimed at enhancing the integration of social determinants of health (SDOH) into patient assessments and ensuring the accuracy of reported data. Starting in fiscal year 2027, CMS plans to introduce four new SDOH items related to living situation, food security, and utility access, and modify an existing item on transportation availability in the MDS. Additionally, CMS proposes that SNFs participating in the SNF QRP undergo a data validation process similar to that already implemented in the SNF VBP Program.

Medicare Annual Payment Rule — CMS is required to calculate an annual Medicare market-basket update to the payment rates. The SNF PPS FY 2025 Proposed Rule, issued on March 28, 2024 would increase the Medicare payment rates to SNFs in fiscal year 2025 by 4.1%, which is based on a market basket of 2.8% plus a 1.7% market basket forecast error adjustment, and a negative 0.4% productivity adjustment.

On July 31, 2023, CMS issued the SNF PPS FY 2024 Final Rule that increased Medicare payment rates by 4.0% to SNFs in fiscal year 2024. This increase results from the 6.4% net market basket update to the payment rates, which is based on a 3.0% SNF market basket increase plus a 3.6% market basket forecast error adjustment, less a 0.2% productivity adjustment and a negative 2.3% adjustment as a result of the recalibrated parity adjustment.

On July 29, 2022, CMS issued a final rule for fiscal year 2023 that increased the Medicare payment rates to aggregate net market basket by 2.7%. The increase results from the 5.1% update to the market basket, which is based on a 3.9% current year market basket increase plus a 1.5% market basket error adjustment, less a 0.3% productivity adjustment and a negative 2.3% adjustment as a result of the recalibrated parity adjustment. The recalibrated parity adjustment is being phased in at a rate of 2.3% per year on both the SNF PPS FY 2024 and FY 2023 Final Rules.

Sequestration of Medicare Rates —The Budget Control Act of 2011 requires a mandatory, across the board reduction in federal spending, called sequestration. Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013 incur a 2.0% reduction in Medicare payments through at least 2023, unless Congress takes further action. Under the CAA 2023, a further 4% cut to Medicare spending that would have been required under the Statutory Pay-As-You-Go Act of 2010 (PAYGO) was waived for fiscal years 2023 and 2024. Instead, the CAA 2023 deferred any further Medicare sequestration under PAYGO until fiscal year 2025. The CAA 2023 also offset planned Medicare sequestrations that would have been as high as 4.0% and instead maintained fee schedule cuts of approximately 2%.

Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program — The SNF-VBP Program rewards SNFs with incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure. CMS annually adjusts its payment rules for SNFs using the SNF-VBP Program. The program also introduced quality measures to assess how health information is shared and adopted a number of standardized patient assessment data elements that assess factors such as cognitive function and mental status, special services and social determinants of health. CMS uses regulations to specify how it measures the performance for SNFs as well as the data that SNFs are to report to CMS. The deadlines for baseline period quality measure quarterly reporting and performance periods and standards began in the 2023 program year. The final rule for the fiscal year 2023 SNF PPS also provided for SNF-VBP program expansion beyond the use of its single, all-cause hospital readmission measure to determine payment, with the inclusion of measures in fiscal year 2026 for SNF healthcare associated infections requiring hospitalization (SNF HAI) and total nursing hours per resident day measures and in fiscal year 2027, the discharge to community post-acute care measure for SNFs, which assess the rate of successful discharges to the community from a SNF setting.

The SNF PPS FY 2024 Final Rule elected to replace the SNFRM measure with the SNF within-stay (WS) potentially preventable readmission (PPR) measure beginning in the FY 2028 program year. The PPR measure assesses the risk-standardized rate of unplanned and potentially avoidable readmissions during SNF stays for Medicare fee-for-service beneficiaries. The new SNF WS PPR measure refines the original Skilled Nursing Facility 30-Day Potentially Preventable Readmission (SNFPPR) measure, which followed the requirements of the Protecting Access to Medicare Act (PAMA) of 2014. The refinement in the SNF WS PPR measure shifts the observation window from a fixed 30-day post-hospital discharge to the duration of the SNF stay. Moreover, the time gap allowed between the prior inpatient discharge and the SNF admission has been extended from one day to 30 days. These changes, based on feedback from expert panels and a 2015 partnership, better align the measure with the IMPACT Act's provisions and enhance the reliability of tracking preventable readmissions. Additionally, the SNF WS PPR measure's calculations use two years of Medicare claims data to generate a provider-specific risk-standardized readmission rate.

The SNF PPS FY 2025 Proposed Rule proposed several operational and administrative updates to the SNF VBP. The proposed rule seeks the adoption of a policy to retain and remove measurements to ensure the VBP Program's evaluation metrics remain relevant and effective for assessing care quality. Additionally, CMS plans to update the case-mix methodology for the Total Nurse Staffing measure and revise the review and correction policy to allow SNFs to review and correct Payroll-Based Journal (PBJ) data from FY 2026 and MDS data from FY 2027. CMS has provided guidance related to the proposed changes and the changes already made in SNF PPS FY 2024 Final Rule CMS, with a focus on how CMS will now calculate performance scores and collect data on the new quality measures related to nursing staff turnover, infection prevention and control, and nursing care hours.

Part B Rehabilitation Requirements — Some of our revenue is paid by the Medicare Part B program under a fee schedule. Part B services are limited with a payment cap by combined speech-language pathology services (SLP), physical therapy (PT) services and a separate annual cap for occupational therapy (OT) services. The Bipartisan Budget Act of 2018 (BBA) establishes coding modifier requirements to obtain payments beyond certain payment thresholds, discussed below and reaffirms the specific $3,000 claim audit threshold requirements for Medicare Administrative Contractors. For PT and SLP combined the threshold for coding modifier requirements was $2,330 for CY 2024 with the same threshold for OT services. The KX modifier is added to medical claims to indicate the providing clinician attests that the services corresponding to that claim were medically necessary and that the justification for those services is contained within the patient's medical records. This modifier is intended for use where the services will exceed the threshold for those services set by the BBA and updated by annual fee schedule rules, yet are still appropriate and medically necessary, and thus should be compensated by Medicare.

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

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

Through the end of coverage year 2024, certain of our Part B services provided through telehealth will still qualify for Medicare reimbursement based on flexibility first provided under the Emergency Waivers, which added physical therapy, occupational therapy and speech-language pathology to the list of approved telehealth Providers for the Medicare Part B programs provided by a SNF. During the PHE, CMS added certain PT and OT services to the list of Medicare-covered telehealth services on a temporary basis, some of which were made permanent for use and new codes were added for PT, OT, or SLP telehealth services—including some "sometimes therapy" codes that were not subject to MPPR. The CAA 2023 extended certain, but not all, telehealth flexibilities until December 31, 2024, allowing certain telehealth flexibilities to continue after the PHE's expiration.

On March 9, 2024, President Biden signed the Consolidated Appropriations Act, 2024, which included a 2.93% update to the CY 2024 Physician Fee Schedule (PFS) Conversion Factor (CF) for dates of service March 9, 2024 through December 31, 2024. This replaces the 1.25% update provided by the Consolidated Appropriations Act, 2023.

On November 2, 2023, CMS published the CY 2024 Physician Fee Schedule (2024 PFS Final Rule), which changes Medicare payments under the PFS and other Medicare Part B components. The CY 2024 PFS Final Rule contains a conversion factor of $32.74, which is a decrease of $1.15 from the CY 2023 PFS conversion factor of $33.89. This CY 2024 conversion factor is 3.4% lower than the CY 2023 conversion factor.

The CY 2024 PFS Final Rule contains provisions to make payments when physicians and certain non-physician practitioners, such as physician assistants, nurse practitioners, physical therapists, occupational therapists and clinical psychologists, involve caregivers in implementing an individualized plan of treatment or therapy. These provisions incentivize the training of caregivers and provide additional funds to offset the costs of training these caregivers through participation in licensed healthcare providers' course of care for patients and residents. For PT and SLP combined, the threshold for coding modifier requirements increases to $2,330 for CY 2024 with the same threshold for OT services. The KX modifier is added to medical claims to indicate the providing clinician attests that the services corresponding to that claim were medically necessary and that the justification for those services is contained within the patient's medical records.

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The CY 2024 PFS Final Rule will allow for general supervision of therapy assistants by PTs and OTs for remote therapeutic monitoring (RTM) services. This change may affect the rate of reimbursement for PT and OT services in the future and may affect the desirability and utilization of physical therapy assistants and occupational therapy assistants for certain patient services. Additionally, the CY 2024 PFS Final rule adds certain health and well-being coaching services that Medicare will reimburse on a temporary basis for 2024. The final rule also adds risk assessments for social determinants of health to the list of telehealth services Medicare will reimburse on a permanent basis.

Programs of All-Inclusive Care for the Elderly

The requirements under the Programs of All-Inclusive Care for the Elderly (PACE) provide greater operational flexibility and update information under the Medicare and Medicaid programs, including leniency in compliance with program requirements during and after a 3-year trial period and relieving restrictions placed on the team that assesses and provides for the needs of each PACE participant. Further, non-physician primary care providers can provide certain services in place of primary care physicians. On February 1, 2023, CMS issued its final rule, which takes effect on April 3, 2023, requiring the collection of data by Medicare Advantage organizations and their service providers and the submission of data to CMS for risk adjustment data validation (RADV) audits. The purpose of these RADV audits is to maintain the accuracy of risk-adjusted payments made to Medicare Advantage organizations.

On January 26, 2024, CMS issued a memorandum to PACE organizations informing them that they will be subject to new prescription drug event (PDE) reporting requirements to receive manufacturer discounts for drugs provided through Medicare Part D as provided for in the Inflation Reduction Act of 2022 (IRA). On March 8, 2024, CMS issued a further memorandum to PACE organizations providing the additional PDE information that they must submit beginning January 1, 2025.

Decisions Regarding Skilled Nursing Facility Payment

Reimbursement rates and rules are subject to frequent change that historically, have had a significant effect on our revenue. The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. We are not able to predict the outcome of the legislative process. We also cannot predict the extent to which proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and existing new legislation will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue and could adversely affect our business, financial condition and results of operations.

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

Patient Protection and Affordable Care Act

Various healthcare reform provisions became law upon enactment of the ACA. The reforms contained in the ACA have affected our independent 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.

The IRA, which continued and expanded certain provisions of the ACA, extended the premium subsidies paid by the federal government, until the end of 2024, resulting in subsidies being available to offset or reduce the costs of private health insurance policies for qualifying individuals. This may aid older patients in obtaining or keeping their health insurance in order to pay for long-term care services. The CAA 2023 revised the funds available to fund Medicare in 2023 and deferred the PAYGO sequestration of Medicare expenses.

The 2024 presidential election may significantly alter the current regulatory framework and impact our business and the health care industry, including any further extensions or expansions of certain ACA provisions, included, but not limited to recent rulemaking activity regarding ACA Section 1557's anti-discrimination provisions. We continually monitor these developments so we can respond to the changing regulatory environment impacting our business.

Requirements of Participation

CMS has requirements that providers, including SNFs, must meet in order to participate in the Medicare and Medicaid Programs. Some of these requirements can be burdensome and costly. One such requirement of participation in the Medicare and Medicaid programs involves limitations around the use of pre-dispute, binding arbitration agreements by SNFs. CMS has issued guidance and direction around arbitration that must be satisfied for any agreement to be enforceable and which may result in adverse consequences for our business if not followed. Congress has routinely introduced, but not passed, legislation addressing the issue of arbitration agreements used by SNFs. While legislative action is possible in the future, federal regulations and state/federal laws remain our primary source of authority over the use of pre-dispute binding arbitration agreements.

In 2022, CMS announced updated guidance for Phase 2 and 3 of the Requirements of Participation. CMS distributed these updates to surveyors and state agencies in order to, among other things, enhance responses to resident complaints and reported incidents. This guidance focuses on the following topics: (1) resident abuse and neglect (including reporting of abuse); (2) admission, transfer and discharge; (3) mental health and substance abuse disorders; (4) nurse staffing and reporting of payroll to evaluate staffing sufficiency; (5) residents' rights (including visitation); (6) potential inaccurate diagnoses or assessments; (7) prescription and use of pharmaceuticals, including psychotropics and drugs that act like psychotropics; (8) infection prevention and control; (9) arbitration of disputes between facilities and residents; (10) psychosocial outcomes and related severity; and (11) the timeliness and completion of state investigations to improve consistency in the application of standards among various states.

In 2022, CMS updated the Medicare Requirements of Participation for SNFs, which includes the modification of requirements associated with a facility's physical environment to minimize unnecessary renovation expenses in order to avoid closure of SNFs due to the related expense. CMS "grandfathered" certain facilities and will allow SNFs that were participating in Medicare before July 5, 2016 and that previously used the Fire Safety Evaluation System (FSES) to continue using the 2001 FSES mandatory values when determining compliance with applicable standards. CMS also updated the Requirements of Participation to revise existing qualification requirements for directors of food and nutrition services in SNFs, while "grandfathering" in directors with two or more years of experience and certain minimum training in food safety so they may continue in that role without satisfying further educational requirements.

In 2023, CMS revised the survey resources that CMS and state surveyors use in evaluating SNFs' compliance with federal Requirements for Participation. This revision incorporated the recent changes to CMS' focused infection control survey item, which CMS had removed in favor of standard infection control survey measures. These changes were made to the most recent revision of long-term care facility survey documents that CMS had last revised in October of 2022. These updates provided more information for state surveyors to utilize when evaluating SNFs' compliance with the Medicare Requirements of Participation, as well as included guidance for facilities on operationalizing compliance with these requirements based on how surveyors would measure and evaluate facility performance.

Civil and Criminal Fraud and Abuse Laws and Enforcement

Various complex federal and state laws exist which govern a wide array of referrals, relationships and arrangements, and prohibit fraud by healthcare providers. Governmental agencies are devoting increasing attention and resources to such anti-fraud efforts. The Balanced Budget Act of 1997 expanded the penalties for healthcare fraud. Additionally, the government or those acting on its behalf may bring an action under the FCA, alleging that a healthcare provider has defrauded the government by submitting a claim for items or services not rendered as claimed, which may include coding errors, billing for services not provided and submitting false or erroneous cost reports. The FCA clarifies that if an item or service is provided in violation of the AKS, the claim submitted for those items or services is a false claim that may be prosecuted under the FCA as a false claim. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. The Biden-Harris Administration has also signaled an increasing focus on nursing home performance and the reimbursement nursing homes receive from federal healthcare payment programs. Many states also have a false claim prohibition that mirrors or closely tracks the federal FCA.

Federal law also provides that the OIG has the authority to exclude individuals and entities from federally funded health care programs on a number of grounds, including, but not limited to, certain types of criminal offenses, licensure revocations or suspensions and exclusion from state or other federal healthcare programs. CMS can recover overpayments from health care providers up to six years following the year in which payment was made.

In 2021, the OIG released the result of an audit finding that Medicare overpaid millions of dollars for chronic care management (CCM) services. The OIG's 2021 report found that in calendar years 2017 and 2018, Medicare overpaid millions of dollars in CCM claims. In 2022, the OIG released an audit revealing that CMS had not collected $226 million, or 45%, of identified overpayments within that period, potentially affecting SNFs. These investigatory actions by OIG demonstrate its increased scrutiny into post-hospital SNF care provided to beneficiaries and may encourage additional oversight or stricter compliance standards. In 2023, representatives of the DOJ speaking at certain industry events, including the American Health Law Association's Fraud and Compliance Forum, have indicated that its healthcare enforcement trends would emphasize opioid prescribing, Medicare Advantage and managed care plan fraud, and COVID-19 related fraud, including under various relief programs available during and in conjunction with the pandemic. In November of 2023, OIG added to its work plan an audit of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, for which OIG expects to issue a report in FY 2025. In addition, the OIG identified the following areas as its "key goals" for oversight: (1) protecting residents from fraud, abuse, neglect, and promoting quality of care; (2) promoting emergency preparedness and emergency response efforts: (3) strengthening frontline oversight; and (4) supporting federal monitoring of nursing homes to mitigate risks to residents.

In February of 2024, the OIG added to its work plan a study regarding the use of the National Background Check Program (NBCP) in conducting background checks of prospective long-term care provider employees. The purpose of this study will be to prepare a report regarding the cost of background checks, number of applicants who received background checks, and disqualification of employees during and after NBCP participation. This report will also include information regarding the cost of background checks and any unintended consequences experienced as a result of using this program. In April of 2024, the OIG updated its work plan to study and determine whether and how states used Medicaid supplemental payments for use in satisfying the state's obligations to pay nursing facilities any amounts due under the state's nursing facility upper payment limit.

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

Federal Healthcare Reform

Five-Star Quality Reporting Metrics — The Quality Payment Program (QPP) was created under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015. This program was based on the Merit-based Incentive Payment System (MIPS) or the use of Alternative Payment Models (APM), which relied on quality data CMS gathered and evaluated using the Five-Star Quality Rating system, which includes a rating of one to five in various categories. These categories include (but are not limited to) the results of surveys conducted by state inspectors, other health inspection outcomes, staffing, spending, readmissions and stay durations; the data collected and its weighting in determining a rating on a scale of one to five stars is subject to periodic and ongoing revision, re-balancing and adjustment by CMS to reflect market conditions and CMS's priorities in patient care. Since 2020, CMS's measurement of the data reported by providers, including SNFs, has become more competitive and resulted in a reduction of four- and five-star rankings available under CMS's Five-Star Quality Rating system.

The Five-Star Quality reporting system for nursing homes is displayed on CMS's consumer-based Nursing Home Compare website, along with a consumer alert icon next to nursing homes that have been cited for incidents of abuse, neglect, or exploitation on the Nursing Home Compare website. The Nursing Home Compare website is updated monthly with CMS's refresh of survey inspection results on that website. Additionally, in 2022, the Nursing Home Compare website began publishing the ownership information for Medicare-enrolled nursing facilities based on disclosures made to CMS from 2016 through 2022 due to mergers, acquisitions, or other changes in ownership, to allow for the identification of common ownership of nursing facilities. In addition, the Five Star Quality Ratings incorporated staffing data such as staff tenure and SNF weekend staffing beginning with the October 2022 refresh of the Nursing Home Compare website.

In April of 2024, CMS updated its Nursing Home Five-Star Quality Rating System's Technical Users' Guide in several respects. First, CMS froze four of the quality measures from any changes: (1) percentage of residents who made improvements in function (short stay); (2) percentage of residents whose need for help with activities of daily living has increased (long stay); (3) percentage of residents whose ability to move independently worsened (long stay); and (4) percentage of high-risk residents with pressure ulcers (long stay). All of these measures will be frozen until January 2025, while the short-stay functional improvement measure is replaced in October of 2024 with a new cross-setting function measure used in the SNF QRP. Also in April of 2024, CMS is updating the staffing level case-mix adjustment methodology and freezing three staffing level measures until July of 2024: (1) adjusted RN staffing (HPRD); (2) adjusted total nurse staffing (HPRD); and (3) adjusted total nurse staffing on weekends (HPRD). These frozen measures will not affect staff turnover measures. Additionally, beginning in April of 2024, CMS will revise the staffing rating methodology to give the lowest possible score for staffing turnover measures to providers who fail to submit staffing data or submit erroneous data.

Based on the Nursing Home Five-Star Quality Rating System's Technical Users' Guide update in 2023, CMS revised the nursing-home level exclusion criteria used on the administrator turnover measure, adding information regarding the staff turnover measure and an updated ratings table, which identifies the points needed for each nursing facility to obtain certain star ratings. Under these guidelines, only 10% of nursing facilities can receive a five-star rating in the state where it operates, with the bottom 20% receiving a one-star rating and the remaining 70% receiving a distribution of two-, three-, and four-star ratings.

In September 2023, CMS announced a freeze on four of the quality measures used in the Nursing Home Five-Star Quality Rating System From April 2024 until July 2024 CMS will freeze the staffing level measures for all SNFs. Beginning with the July 2024 refresh, CMS will change the staffing case-mix adjustment methodology to a model based on PDPM

State Legislation Concerning Nursing Home Supervision — California passed into law a bill which changes the limitations, or "caps," on non-economic damages that can be awarded in medical negligence cases filed against healthcare providers (including skilled nursing and long-term care facilities). Beginning on January 1, 2023, non-economic damages (i.e., pain and suffering) available to plaintiffs suing healthcare providers in medical malpractice and professional negligence cases increased from $0.25 million to $0.35 million, and will then increase over the following ten years up to a $0.75 million cap. Once the limit reaches $0.75 million, a 2% annual inflationary adjustment will attach beginning on January 1, 2034. In wrongful death cases that arise from claims of medical malpractice and professional negligence, the cap on non-economic damages increased from $0.25 million to $0.50 million on January 1, 2023, and increase every year thereafter for ten years until the cap on non-economic damages in such cases is $1.0 million; thereafter, this cap will also be subject to an annual 2% increase. The caps are separate as to each claim, meaning that there is one cap for negligence and one cap for wrongful death. The new limits on non-economic damages apply prospectively to lawsuits filed on and after January 1, 2023.

In 2022, California's Governor signed into law the Skilled Nursing Facility Ownership and Management Reform Act of 2022. This law increases the oversight authority of the California Department of Public Health, and changes several provisions regarding SNF licensing in the State of California. This includes eliminating previous regulatory provisions that permitted SNFs to operate in advance of receiving their formal license from the State. This law also requires SNF license applicants to disclose additional information in connection with a license application and evaluates more data regarding the applicant's prior operations, including prior citations, CMS sanctions and legal proceedings against the applicant or other facilities owned or managed by the applicant before issuing a license.

United States Supreme Court Decisions – On June 28, 2024, the United States Supreme Court issued its opinion in Loper Bright Enterprises v. Raimondo, deciding to vacate and remand decisions by the United States Courts of Appeals that relied on the Supreme Court's own 1984 precedent in Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., which sometimes required courts to defer to "permissible" agency interpretations of the statutes those agencies administered and enforced—a legal doctrine known as the "Chevron doctrine." In Loper, the Supreme Court had to decide whether it should overrule or clarify the Chevron doctrine based on its application more than 40 years after its creation, and the Supreme Court chose to overrule it.

The Chevron doctrine required courts to use a two-step process to interpret statutes administered by federal agencies. After determining that the Chevron doctrine may apply to a dispute before it, a federal court must assess whether Congress has directly spoken to the precise question at issue. If (and only if) the congressional intent of the statute is clear, that is the end of the inquiry as to the statute's meaning. If the court determines that the statute is silent or ambiguous regarding the issue at hand, then the Chevron doctrine requires the court to defer to the agency's interpretation if it "is based on a permissible construction of the statute."

The Supreme Court's Loper decision found that the Chevron doctrine is incompatible with the federal Administrative Procedure Act's requirement for courts to exercise their independent judgment in deciding whether a federal agency has acted within its statutory authority. It further held that courts may not defer to an agency interpretation of a statute merely because the statute is ambiguous, as it is the responsibility of the court, rather than an agency that administers or acts under a statute, to discern the statute's meaning. The Supreme Court reasoned that allowing agencies to interpret the laws they enforce or act under, rather than reserving that activity for the courts, was an impermissible delegation of an activity reserved to the courts.

While the decisions at issue in Loper pertained to fishing regulations promulgated by the Department of Commerce, the Chevron doctrine's significance to the highly regulated field of healthcare is profound. The Chevron doctrine is frequently implicated in litigation over healthcare regulation, ranging from rules concerning staffing requirements and the validity of arbitration provisions, to requirements for healthcare workers to be vaccinated. As such, the Loper decision likely will have significant and lasting consequences for the promulgation and enforcement of federal regulations by HHS and CMS, and may bear on the depth and detail of future legislation that is passed and enacted as statutes by Congress so that such laws can be enforced without administrative rulemaking or agency enforcement mechanisms.

Monitoring Compliance in Our Facilities

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

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

In addition, CMS has increased its focus on facilities with a history of serious or sustained quality of care problems through the special focus facility (SFF) initiative. SFFs receive heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility "graduates" from the program once it demonstrates significant improvements in quality of care that are continued over a defined period of time.

In October 2022, CMS issued a Memorandum identifying the changes it intends to make in connection with the oversight of those facilities that fall under the SFF Program, including increased penalties for SFFs that fail to improve their performance upon further inspection by CMS, increasing the standards SFFs must meet to graduate from the SFF program, maintaining heightened oversight of any SFF for a period of three years after it graduates and increasing the technical assistance CMS provides to SFFs.

Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice, leaving operators with the task of deciding whether to continue accepting patients after the potential denial of payment date--risking the retroactive denial of revenue. Some of our independent subsidiaries have been or will be in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of revenue associated with patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, could include various remedies up to and including decertification.

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state surveyors. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards and to identify multi-facility providers with patterns of noncompliance. CMS is also increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey facilities more consistently.

Regulations Regarding Financial Arrangements

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

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

Violations of the Social Security Act can result in inflation-adjusted criminal penalties of more than $0.1 million and ten years imprisonment. It can also result in inflation-adjusted civil monetary penalties of more than $0.1 million per violation and an assessment of up to three times the total amount of remuneration offered, paid, solicited, or received. It may also result in an individual's or organization's exclusion from future participation in federal healthcare programs. State Medicaid programs are required to enact an anti-kickback statute. Many states in which our independent subsidiaries operate have adopted or are considering similar legislative proposals, some of which extend beyond that state's Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients regardless of the source of payment for the care.

Additionally, the "Stark Law" of the Social Security Act provides that a physician may not refer a Medicare or Medicaid patient for a “designated health service” to an entity with which the physician or an immediate family member has a financial relationship unless the financial arrangement meets an exception under the Stark Law or its regulations. Designated health services include, in relevant part, inpatient and outpatient hospital services, PT, OT, SLP, durable medical equipment, prosthetics, orthotics and supplies, diagnostic imaging, and home health services. Under the Stark Law, a “financial relationship” is defined as an ownership or investment interest or a compensation arrangement. If such a financial relationship exists and does not meet a Stark Law exception, the entity is disallowed from seeking payment under the Medicare or Medicaid programs or from collecting from the patient or other payor. Statutory and regulatory exceptions and exemptions to this exist and have specific rules that must be followed to qualify for such exception or exemption. Any funds collected for an item or service resulting from a referral that violates the Stark Law are not eligible for payment by federal healthcare programs and must be repaid. Violations of the Stark Law may result in the imposition of civil monetary penalties, including, treble damages. Individuals and organizations may also be excluded from participation in federal healthcare programs for Stark Law violations. Many states have enacted healthcare provider referral laws that go beyond physician self-referrals or apply to a greater range of services than just the designated health services under the Stark Law.

Regulations Regarding Patient Record Confidentiality

Health care providers are also subject to laws and regulations enacted to protect the confidentiality of patient health information and patients' right to access such information. For example, HHS has issued rules pursuant to HIPAA, including the Health Information Technology for Economic and Clinical Health (HITECH) Act which governs our use and disclosure of protected health information of patients. We and our independent subsidiaries have established policies and procedures to comply with HIPAA privacy and security requirements and our independent subsidiaries have adopted and implemented HIPAA compliance plans, which we believe comply with the HIPAA privacy and security regulations, which impose significant costs for ongoing compliance activities.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our independent subsidiaries are also subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA.

On January 17, 2024, CMS published the CMS Interoperability and Prior Authorization Final Rule (Interoperability Final Rule), which affects the data standards and application programming interfaces (APIs) used by entities that are payors for our services, including but not limited to Medicare Advantage organizations, Medicaid fee-for-service providers, and managed care organizations. This new rule requires these payor entities to adopt new patient access APIs beginning January 1, 2026, and to complete implementation of both patient and provider access APIs by January 1, 2027, to facilitate the sharing of payor information with payors and providers. While the purpose of this final rule is predominantly oriented to sharing information in the clinical setting and expediting the exchange of prior authorization data, this new rule may have implications for our business and how information is shared among our independent subsidiaries that participate in these programs, the payors, residents, and residents’ families involved in their care.

Antitrust Laws

We are also subject to federal and state antitrust laws. Enforcement of the antitrust laws against healthcare providers is common, and antitrust liability may arise in a wide variety of circumstances, including third party contracting, physician relations, joint venture, merger, affiliation and acquisition activities. On February 3, 2023, the DOJ’s Antitrust Division withdrew its support for three policies that had been jointly created by the DOJ and the Federal Trade Commission (FTC) in 1993, 1996, and 2011, announcing instead, without providing further alternative guidance, that the DOJ would take a case-by-case enforcement approach to evaluate conduct in the healthcare industry, citing that the previous policies were outdated and overly permissive. Similarly, on July 14, 2023, the FTC withdrew two antitrust policy statements related to enforcement in healthcare markets. Moving forward, the FTC will evaluate mergers and conduct in healthcare markets on a case-by-case basis using principles of antitrust enforcement and competition policy.

On July 19, 2023, the DOJ and FTC released a draft joint statement of antitrust policy that outlines 13 guidelines to be used when determining if a merger is unlawfully anticompetitive under antitrust laws. These guidelines cover various aspects of antitrust enforcement relevant to SNF and senior living facilities, such as market concentration, competition between firms, risk of coordination, elimination of potential entrants, control of products or services, vertical mergers, dominant positions, trends toward concentration, series of multiple acquisitions, multi-sided platforms, competing buyers, partial ownership or minority interests and overall impact on competition. The draft joint statement also includes detailed sections on the application of the guidelines, defining relevant markets and approaches to rebuttal evidence. These proposed statements are not exhaustive and the DOJ and FTC may focus on one or multiple guidelines depending on the specific circumstances of each merger. These proposed general statements of antitrust policy, once finalized, may be a prelude to a new joint statement of healthcare antitrust policy of the DOJ and FTC, with the agencies’ finalized general statements providing insight into whether healthcare-specific statements will be issued. This development and potential new guidance regarding DOJ and FTC antitrust policy increases risk and uncertainty regarding transactions that may be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

Americans with Disabilities Act

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

Civil Rights

On January 25, 2024, the Office for Civil Rights (OCR) for HHS issued guidance to hospitals and long-term care facilities, emphasizing their obligation under CMS regulations to ensure non-discriminatory visitation policies, especially during public health emergencies. This guidance, part of the U.S. National Strategy to Counter Antisemitism, clarifies that these facilities cannot discriminate based on religion or other classes or characteristics protected against discrimination under federal civil rights laws. The guidance includes examples where non-compliance occurred, such as unequal treatment based on religious affiliation or dietary restrictions, and stricter screening processes for certain religious groups. OCR offers assistance to facilities to obtain compliance with these standards and encourages residents and other affected individuals to file complaints with OCR for potential administrative or civil action in cases of civil rights violations.

Real Estate Investment Trust (REIT) Qualification

We elected for Standard Bearer to be taxed as a REIT for U.S. federal income tax purposes. Standard Bearer's qualification as a REIT will depend upon its ability to meet, on a continuing basis, various complex requirements under the Internal Revenue Code, relating to, among other things, the sources of its gross income, the composition and value of its assets, distribution levels to its shareholders and the concentration of ownership of its capital stock. We believe that Standard Bearer is organized in conformity with the requirements for qualification and taxation as a REIT under the Code and that its manner of operation has and will enable it to continue to meet the requirements for qualification and taxation as a REIT.

REGULATIONS SPECIFIC TO SENIOR LIVING COMMUNITIES AND ANCILLARY SERVICES

As previously mentioned, senior living services revenue (approximately 2.1% of total revenue) is primarily derived from private pay residents, with a small portion of senior living revenue derived from Medicaid funds. Thus, some of the regulations discussed above applicable to Medicaid providers, also apply to senior living.

A majority of states provide, or are approved to provide, Medicaid payments for personal care and medical services to some residents in licensed senior living communities. As rates paid to senior living community operators are generally lower than rates paid to SNF operators, some states use Medicaid funding of senior living services as a means of lowering the cost of services for residents who may not need the higher level of health services provided in SNFs. States that administer Medicaid programs for services in senior living communities are responsible for monitoring the participating communities and, as a result of the growth of senior living in recent years, these states have adopted licensing standards applicable to senior living communities.

CMS has continued to commence a series of actions to increase its oversight of state quality assurance programs for senior living communities and has provided guidance and technical assistance to states to improve their ability to monitor and improve the quality of services paid through Medicaid waiver programs. CMS is encouraging state Medicaid programs to expand their use of home and community-based services as alternatives to facility-based services, pursuant to provisions of the ACA, and other authorities, through the use of several programs.

The types of laws and statutes affecting the regulatory landscape of the post-acute industry continue to expand and the pressure to enforce those laws by federal and state authorities continues to grow as well. In order to operate our businesses, we and our independent subsidiaries must comply with federal, state and local laws from healthcare including provisions regarding patient safety, staffing, and prescription drugs to environmental issues. Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

RESULTS OF OPERATIONS

Since the first quarter of 2024, Same Facilities skilled nursing occupancy has surpassed pre-pandemic occupancy. Our focus on rebuilding census resulted in Same Facilities occupancy of 80.8% during the three months ended June 30, 2024, an increase of 2.2% compared to the same period in 2023, demonstrating our ability to gain additional market share even at our more mature operations. Further, our Transitioning Facilities occupancy increased by 3.1% to 75.7% compared to the same period in 2023, highlighting our ability to increase occupancy during the transition period and to transform the underperforming operations that we have acquired.

Throughout most of our history, our business has been affected by seasonal fluctuations including occupancy and acuity. For skilled nursing occupancy and skilled mix, we typically experience stronger occupancy and acuity during the first and fourth quarters and softening in the second and third quarters. Additionally, we historically have acquired operations with lower occupancy and skilled mix. As these operations become "operations of choice" in each of their respective healthcare markets, we typically see both occupancy and skilled mix increase.

Our total revenue for the three months ended June 30, 2024 increased $114.9 million, or 12.5%, compared to the three months ended June 30, 2023, while our diluted GAAP earnings per share grew by 8.9%, from $1.12 to $1.22, compared to the three months ended June 30, 2023. Throughout the quarter, we continued to make progress on targeted initiatives related to increasing occupancy in our facilities, attracting and developing our people and acquiring underperforming skilled nursing operations and integrating them with our proven cultural and operational principles. We continue to experience healthy growth in both revenue and overall results.

During the six months ended June 30, 2024, we added fifteen new operations. We continue to work diligently with existing and recently acquired operations so that each can reach its full clinical and financial potential.

Our strength remains in our operating model, which empowers each operator to form their own market-specific strategy and adjust to the needs of their local medical communities, including methods for attracting new healthcare professionals into our workforce and retaining and developing existing staff. Despite continued labor pressures, there are positive trends on both turnover and agency usage across our operations.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	**2023**	**2024**	**2023**
REVENUE:				
Service revenue	99.4 %	99.4 %	99.4 %	99.4 %
Rental revenue	0.6	0.6	0.6	0.6
TOTAL REVENUE	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**
Expenses:				
Cost of services	79.2	78.4	79.1	78.5
Rent—cost of services	5.1	5.4	5.1	5.3
General and administrative expense	5.4	5.8	5.6	5.8
Depreciation and amortization	2.0	1.9	2.0	2.0
TOTAL EXPENSES	**91.7**	**91.5**	**91.8**	**91.6**
Income from operations	8.3	8.5	8.2	8.4
Other income (expense):				
Interest expense	(0.2)	(0.2)	(0.2)	(0.2)
Interest income	0.7	0.4	0.7	0.4
Other income	0.1	0.1	0.2	0.2
Other income, net	**0.6**	**0.3**	**0.7**	**0.4**
Income before provision for income taxes	8.9	8.8	8.9	8.8
Provision for income taxes	2.0	1.9	2.1	2.0
NET INCOME	**6.9**	**6.9**	**6.8**	**6.8**
Less: net income attributable to noncontrolling interests	—	—	—	—
Net income attributable to The Ensign Group, Inc.	**6.9 %**	**6.9 %**	**6.8 %**	**6.8 %**

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
SEGMENT INCOME[1]	*(In thousands)*			
Skilled services	$ 122,185	$ 117,008	$ 248,994	$ 230,353
Standard Bearer[2]	7,360	7,133	14,618	14,352
NON-GAAP FINANCIAL MEASURES:				
PERFORMANCE METRICS				
Adjusted EBT	102,111	88,471	202,789	174,815
EBITDA	107,334	97,033	211,968	190,462
Adjusted EBITDA	117,207	104,451	232,882	205,795
FFO for Standard Bearer	14,526	13,266	28,613	26,451
VALUATION METRICS				
Adjusted EBITDAR	$ 170,479		$ 338,030	

(1) Segment income represents operating results of the reportable segments excluding gain and loss on sale of assets, real estate insurance recoveries and losses, impairment charges and provision for income taxes. Included in segment income for Standard Bearer are expenses for intercompany management fees between Standard Bearer and the Service Center and intercompany interest expense. Segment income is reconciled to the Condensed Consolidated Statement of Income in Note 8, *Business Segments* in Notes to Interim Financial Statements of this Quarterly Report on Form 10-Q.
(2) Standard Bearer segment income includes rental revenue and expenses from our independent subsidiaries.

The following discussion includes references to Adjusted EBT, EBITDA, Adjusted EBITDA, Adjusted EBITDAR and Funds from Operations (FFO) which are non-GAAP financial measures (collectively, the Non-GAAP Financial Measures). Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Securities Exchange Act of 1934, as amended (the Exchange Act), define and prescribe the conditions for use of certain non-GAAP financial information. These Non-GAAP Financial Measures are used in addition to and in conjunction with results presented in accordance with GAAP. These Non-GAAP Financial Measures should not be relied upon to the exclusion of GAAP financial measures. These Non-GAAP Financial Measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

We believe the presentation of certain Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

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

We use the Non-GAAP Financial Measures:

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

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

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of certain Non-GAAP Financial Measures.

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

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

We compensate for these limitations by using them only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business. Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' Non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table below, along with our Interim Financial Statements and related notes included elsewhere in this document.

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

PERFORMANCE MEASURES

Adjusted EBT

We adjust income before provision for income taxes (Adjusted EBT) when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance. We believe that the presentation of Adjusted EBT, when combined with income before provision for income taxes and GAAP net income attributable to The Ensign Group, Inc., is beneficial to an investor's complete understanding of our operating performance. We use this performance measure as an indicator of business performance, as well as for operational planning, decision-making purposes and to determine compensation in our executive compensation plan.

Adjusted EBT is income before provision for income taxes adjusted for non-core business items, which for the reported periods includes, to the extent applicable:

- stock-based compensation expense;
- litigation;
- impairment of long-lived assets;
- acquisition related costs;
- costs incurred related to system implementations;
- business interruption recoveries and
- depreciation and amortization of patient base intangible assets.

EBITDA

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

We calculate EBITDA as net income, adjusted for net losses attributable to noncontrolling interest, before (a) interest income, (b) provision for income taxes, (c) depreciation and amortization, and (d) interest expense. EBITDA in the prior period has been recast to conform to the current period presentation.

Adjusted EBITDA

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

Adjusted EBITDA is EBITDA adjusted for the same non-core business items as listed in Adjusted EBT, except for depreciation and amortization of patient base intangible assets.

Funds from Operations (FFO)

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

VALUATION MEASURE

Adjusted EBITDAR

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

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

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

The table below reconciles income before provision for income taxes to Adjusted EBT for the periods presented:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
Consolidated statements of income data:		*(In thousands)*		
Income before provision for income taxes	$ 92,064	$ 81,053	$ 181,662	$ 159,435
Stock-based compensation expense	8,985	8,881	17,223	15,454
Litigation[(a)]	(1,634)	(885)	(870)	(818)
Business interruption recoveries	—	(750)	—	(750)
Impairment of long-lived assets	—	—	1,849	—
Acquisition related costs[(b)]	165	112	279	572
Costs incurred related to system implementations	2,357	60	2,433	875
Depreciation and amortization - patient base[(c)]	174	—	213	47
ADJUSTED EBT	**$ 102,111**	**$ 88,471**	**$ 202,789**	**$ 174,815**

(a) Litigation relates to specific proceedings arising outside of the ordinary course of business and legal adjustments associated with a favorable overturned verdict.
(b) Costs incurred to acquire operations that are not capitalizable.
(c) Included in depreciation and amortization are amortization expenses related to patient base intangible assets at newly acquired skilled nursing and senior living facilities.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	2023	2024	2023
Consolidated statements of income data:		*(In thousands)*		
Net income	$ 71,181	$ 64,090	$ 140,141	$ 124,059
Less: Net income attributable to noncontrolling interests	174	97	299	214
Interest income	7,084	3,542	13,544	7,526
Add: Provision for income taxes	20,883	16,963	41,521	35,376
Depreciation and amortization	20,488	17,596	40,145	34,708
Interest expense	2,040	2,023	4,004	4,059
EBITDA	**$ 107,334**	**$ 97,033**	**$ 211,968**	**$ 190,462**
Adjustments to EBITDA:				
Stock-based compensation expense	8,985	8,881	17,223	15,454
Litigation[(a)]	(1,634)	(885)	(870)	(818)
Impairment of long-lived assets	—	—	1,849	—
Business interruption recoveries	—	(750)	—	(750)
Acquisition related costs[(b)]	165	112	279	572
Costs incurred related to system implementations	2,357	60	2,433	875
ADJUSTED EBITDA	**$ 117,207**	**$ 104,451**	**$ 232,882**	**$ 205,795**
Rent—cost of services	53,272	49,760	105,148	96,397
ADJUSTED EBITDAR	**$ 170,479**		**$ 338,030**	

(a) Litigation relates to specific proceedings arising outside of the ordinary course of business and legal adjustments associated with a favorable overturned verdict.
(b) Costs incurred to acquire operations that are not capitalizable.

Three Months Ended June 30, 2024 Compared to the Three Months Ended June 30, 2023

The following tables set forth details of operating results for our revenue and earnings, and their respective components, by our reportable segment for the periods indicated.

	Three Months Ended June 30, 2024				
	Skilled services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 991,285	$ 23,354	$ 47,339	$ (25,693)	$ 1,036,285
Total expenses, including other income, net	869,100	15,994	84,820	(25,693)	944,221
Segment income (loss)	122,185	7,360	(37,481)	—	92,064
Income before provision for income taxes					**$ 92,064**

	Three Months Ended June 30, 2023				
	Skilled services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 884,200	$ 19,914	$ 38,354	$ (21,123)	$ 921,345
Total expenses, including other income, net	767,192	12,781	81,342	(21,123)	840,192
Segment income (loss)	117,008	7,133	(42,988)	—	$ 81,153
Loss on insurance recoveries from real estate	—	—	—	—	(100)
Income before provision for income taxes					**$ 81,053**

Our total revenue increased by $114.9 million, or 12.5%, compared to the three months ended June 30, 2023. The increase in revenue was primarily driven by an increase in occupancy of 2.2% and 3.1% from our skilled services in Same Facilities and Transitioning Facilities, respectively, coupled with increasing daily revenue rates and the impact of acquisitions. Additionally, our skilled services in Recently Acquired Facilities increased total revenue by $52.6 million, when compared to the same period in 2023.

Skilled Services

REVENUE

The following tables present the skilled services revenue and key performance metrics by category during the three months ended June 30, 2024 and 2023:

	Three Months Ended June 30,			
	2024	2023	Change	% Change
TOTAL FACILITY RESULTS:	*(Dollars in thousands)*			
Skilled services revenue	$ 991,285	$ 884,200	$ 107,085	12.1 %
Number of facilities at period end	272	253	19	7.5 %
Number of campuses at period end[(1)]	29	26	3	11.5 %
Actual patient days	2,299,068	2,124,862	174,206	8.2 %
Occupancy percentage — Operational beds	80.1 %	78.0 %	2.1 %	2.7 %
Skilled mix by nursing days	29.9 %	30.8 %	(0.9)%	(2.9)%
Skilled mix by nursing revenue	48.2 %	50.7 %	(2.5)%	(4.9)%

	Three Months Ended June 30,			
	2024	2023	Change	% Change
SAME FACILITY RESULTS:[2]	*(Dollars in thousands)*			
Skilled services revenue	$ 745,469	$ 697,935	$ 47,534	6.8 %
Number of facilities at period end	194	194	—	— %
Number of campuses at period end[1]	25	25	—	— %
Actual patient days	1,705,703	1,663,531	42,172	2.5 %
Occupancy percentage — Operational beds	80.8 %	78.6 %	2.2 %	2.8 %
Skilled mix by nursing days	31.5 %	32.0 %	(0.5)%	(1.6)%
Skilled mix by nursing revenue	49.4 %	51.5 %	(2.1)%	(4.1)%

	Three Months Ended June 30,			
	2024	2023	Change	% Change
TRANSITIONING FACILITY RESULTS:[3]	*(Dollars in thousands)*			
Skilled services revenue	$ 123,496	$ 116,553	$ 6,943	6.0 %
Number of facilities at period end	40	40	—	— %
Number of campuses at period end[1]	1	1	—	— %
Actual patient days	329,061	323,165	5,896	1.8 %
Occupancy percentage — Operational beds	75.7 %	72.6 %	3.1 %	4.3 %
Skilled mix by nursing days	21.7 %	20.8 %	0.9 %	4.3 %
Skilled mix by nursing revenue	38.3 %	38.8 %	(0.5)%	(1.3)%

	Three Months Ended June 30,			
	2024	2023	Change	% Change
RECENTLY ACQUIRED FACILITY RESULTS:[4]	*(Dollars in thousands)*			
Skilled services revenue	$ 122,320	$ 69,712	$ 52,608	NM
Number of facilities at period end	38	19	19	NM
Number of campuses at period end[1]	3	—	3	NM
Actual patient days	264,304	138,166	126,138	NM
Occupancy percentage — Operational beds	81.5 %	86.1 %	NM	NM
Skilled mix by nursing days	29.9 %	38.9 %	NM	NM
Skilled mix by nursing revenue	50.4 %	62.3 %	NM	NM

(1) Campus represents a facility that offers both skilled nursing and senior living services. Revenue and expenses related to skilled nursing and senior living services have been allocated and recorded in the respective operating segment.
(2) Same Facility results represent all facilities purchased prior to January 1, 2021.
(3) Transitioning Facility results represent all facilities purchased from January 1, 2021 to December 31, 2022.
(4) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2023.

Skilled services revenue increased by $107.1 million, or 12.1%, compared to the three months ended June 30, 2023. The increases in skilled services revenue were across all payer types, including increases in Medicaid revenue of $51.7 million, or 12.5%, Medicare revenue of $10.8 million, or 4.3%, managed care revenue of $29.9 million, or 18.6% and private revenue of $14.7 million, or 24.2%.

The increase in skilled services revenue was primarily driven by strong occupancy performance across our skilled services operations. Our consolidated occupancy increased by 2.1% to 80.1%, during the three months ended June 30, 2024 compared to the same period in 2023. In addition, in the second quarter of 2024, we experienced an increase in skilled days, driven by steady growth in our managed care and our Medicaid patients.

Revenue in our Same Facilities increased by $47.5 million, or 6.8%, compared to the same period in 2023, due to increased occupancy and revenue per patient day. Our Same Facilities occupancy continues to surpass pre-pandemic levels. Our diligent efforts to strengthen our partnerships with various managed care organizations, hospitals and local communities, increased our managed care revenue by 12.2%, mainly due to an increase in managed care days of 5.7% and managed care revenue per patient day of 3.9%. We continued to see a shift in our patient population from Medicare to managed care as Medicare Advantage enrollment accounted for a larger portion of the overall population. In addition, Medicaid revenue increased by $24.8 million or 7.6%, mainly from the increase in Medicaid days and revenue per patient day.

Revenue generated by our Transitioning Facilities increased by $6.9 million, or 6.0%, primarily due to improved occupancy growth and an increase in revenue per patient day. Our Managed Care revenue increased by 36.5% and private and other revenue increased by 17.4%, demonstrating our ability to focus on increasing occupancy across payer types. Included in the three months ended June 30, 2023 is the revenue related to a facility not operating at full capacity starting in first quarter of 2024 due to flooding.

Skilled services revenue generated by Recently Acquired Facilities increased by $52.6 million compared to the three months ended June 30, 2023. The increase was primarily due to 22 operational expansions between July 1, 2023 and June 30, 2024 across ten states.

Historically, we have generally experienced lower occupancy rates and lower skilled mix at Recently Acquired Facilities and therefore, we anticipate lower overall occupancy during years of growth. Included in our metrics for Recently Acquired Facilities are 17 facilities we acquired in California in 2023 that were more mature and accordingly, had higher occupancy rates, higher skilled mix days and higher skilled mix revenue than our typical acquisitions. In the future, if we acquire additional turnaround or start-up operations, we expect to see lower occupancy rates and skilled mix and these metrics are expected to vary from period to period based upon the type of facilities and operations that we acquire.

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

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
SKILLED NURSING AVERAGE DAILY REVENUE RATES:								
Medicare	$ 750.50	$ 711.27	$ 699.67	$ 666.81	$ 847.86	$ 863.55	$ 760.63	$ 724.65
Managed care	548.68	527.96	518.97	511.87	577.58	616.58	548.28	531.37
Other skilled	617.55	595.87	494.40	506.32	621.86	531.80	607.13	583.35
Total skilled revenue	631.46	609.68	595.72	589.26	733.52	762.71	639.39	620.17
Medicaid	300.18	272.88	269.12	244.31	304.59	286.19	295.73	268.64
Private and other payors	277.77	261.15	249.55	238.46	323.77	345.65	278.32	261.47
Total skilled nursing revenue	$ 402.18	$ 379.46	$ 337.56	$ 315.27	$ 434.66	$ 476.45	$ 396.63	$ 376.00

(1) The rates are based on contractually agreed-upon amounts or rates, excluding the estimates of variable consideration under the revenue recognition standard, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606 and state relief funding during the three months ended June 30, 2023.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 5.5% and 4.9%, respectively, compared to the three months ended June 30, 2023. The increase is attributable to the 4.0% net market basket increase that became effective in October 2023 and a shift to higher acuity patients.

Our average Medicaid rates increased 10.1% due to state reimbursement increases, our participation in supplemental Medicaid payment programs and quality improvement programs in various states, and change in Medicaid mix. For example, we continue to have an increase in Medicaid days in states with higher rates, such as California.

Payor Sources as a Percentage of Skilled Nursing Services. We use our skilled mix as measures of the quality of reimbursements we receive at our affiliated skilled nursing facilities over various periods.

The following tables set forth our percentage of skilled nursing patient revenue and days by payor source:

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING REVENUE								
Medicare	20.4 %	22.9 %	20.0 %	22.2 %	32.5 %	44.2 %	21.8 %	24.6 %
Managed care	20.1	19.8	13.7	11.0	13.1	13.6	18.4	18.2
Other skilled	8.9	8.8	4.6	5.6	4.8	4.5	8.0	7.9
Skilled Mix	**49.4**	**51.5**	**38.3**	**38.8**	**50.4**	**62.3**	**48.2**	**50.7**
Private and other payors	7.1	7.5	8.9	9.0	7.7	5.9	7.4	7.6
Medicaid	43.5	41.0	52.8	52.2	41.9	31.8	44.4	41.7
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING DAYS								
Medicare	10.9 %	12.2 %	9.6 %	10.5 %	16.7 %	24.4 %	11.4 %	12.8 %
Managed care	14.7	14.3	8.9	6.8	9.9	10.5	13.3	12.9
Other skilled	5.9	5.5	3.2	3.5	3.3	4.0	5.2	5.1
Skilled Mix	**31.5**	**32.0**	**21.7**	**20.8**	**29.9**	**38.9**	**29.9**	**30.8**
Private and other payors	10.2	11.0	12.0	11.8	10.3	8.1	10.5	10.9
Medicaid	58.3	57.0	66.3	67.4	59.8	53.0	59.6	58.3
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

Cost of Services

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

	Three Months Ended June 30,		Change	
	2024	2023	$	%
Cost of service	$ 791,613	$ 697,148	$ 94,465	13.6 %
Revenue percentage	79.9 %	78.8 %		1.1 %

Cost of services related to our skilled services segment increased by $94.5 million, or 13.6% from the same period in 2023. Cost of services as a percentage of revenue increased to 79.9% from 78.8% due to the increase in labor cost as a result of new acquisitions with higher expenses in the turnaround stage, as well as an increase related to general and professional liability reserves. We continue to make progress in reducing contracted labor by driving up retention and hiring. Our cost of services as a percentage of revenue varies depending on the volume of acquisitions during the period, which typically have higher costs during the transition period.

Standard Bearer

	Three Months Ended June 30,		Change	
	2024	2023	$	%
	(Dollars in thousands)			
Rental revenue generated from third-party tenants	$ 4,198	$ 3,786	$ 412	10.9 %
Rental revenue generated from Ensign's independent subsidiaries	19,156	16,128	3,028	18.8
TOTAL RENTAL REVENUE	**$ 23,354**	**$ 19,914**	**$ 3,440**	**17.3 %**
Segment income	7,360	7,133	227	3.2
Depreciation and amortization	7,166	6,133	1,033	16.8
FFO	**$ 14,526**	**$ 13,266**	**$ 1,260**	**9.5 %**

Rental revenue — Our rental revenue, including revenue generated from our independent subsidiaries, increased by $3.4 million, or 17.3%, to $23.4 million, compared to the three months ended June 30, 2023. The increase in revenue is primarily attributable to 12 real estate purchases, as well as annual rent increases since the three months ended June 30, 2023.

FFO — Our FFO increased by $1.3 million, or 9.5%, to $14.5 million, compared to the three months ended June 30, 2023. The increase in rental revenue of $3.4 million is offset by increases in interest expense of $2.1 million associated with the intercompany agreements as we continue to grow our real estate portfolio.

All Other Revenue

Our other revenue increased by $9.0 million, or 23.4%, to $47.3 million, compared to the three months ended June 30, 2023. Other revenue includes senior living revenue of $21.9 million, revenue from other ancillary services of $22.4 million and rental income of $3.0 million. The increase in other revenue is primarily attributable to our other ancillary services.

Consolidated Financial Expenses

Rent-cost of services — Our rent-cost of services as a percentage of total revenue decreased by 0.3% to 5.1%, as our operational expansions included a mix of both leases and purchases of real estate.

General and administrative expense — General and administrative expense increased $2.8 million or 5.2%, to $56.2 million. This increase was primarily driven by additional headcount due to acquisition activities and system implementation costs. General and administrative expense as a percentage of revenue decreased by 0.4% to 5.4%.

Depreciation and amortization — Depreciation and amortization expense increased $2.9 million, or 16.4%, to $20.5 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations and capital expenditures. Depreciation and amortization increased by 0.1%, to 2.0%, as a percentage of revenue.

Other income, net — Other income primarily includes interest income from our investments, interest expense related to our debt and deferred compensation gains and losses. Other income, net as a percentage of revenue increased by 0.3% due to the increase in interest income from our investments.

Provision for income taxes — Our effective tax rate was 22.7% for the three months ended June 30, 2024, compared to 20.9% for the same period in 2023. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, partially offset by non-deductible expenses including non-deductible compensation. See Note 14, *Income Taxes*, in the Notes to the Interim Financial Statements for further discussion.

Six Months Ended June 30, 2024 Compared to the Six Months Ended June 30, 2023

The following tables set forth details of operating results for our revenue and earnings, and their respective components, by our reportable segment for the periods indicated.

	Six Months Ended June 30, 2024				
	Skilled Services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 1,960,887	$ 45,555	$ 89,911	$ (49,896)	$ 2,046,457
Total expenses, including other income, net	1,711,893	30,937	170,012	(49,896)	1,862,946
Segment income (loss)	248,994	14,618	(80,101)	—	183,511
Impairment of long-lived assets					(1,849)
Income before provision for income taxes					**$ 181,662**

	Six Months Ended June 30, 2023				
	Skilled Services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 1,735,123	$ 39,631	$ 75,450	$ (42,018)	$ 1,808,186
Total expenses, including other income, net	1,504,770	25,279	160,620	(42,018)	1,648,651
Segment income (loss)	230,353	14,352	(85,170)	—	159,535
Loss on insurance recoveries from real estate					(100)
Income before provision for income taxes					**$ 159,435**

Our total revenue increased $238.3 million, or 13.2%, compared to the six months ended June 30, 2023. The increase in revenue was primarily driven by an increase in occupancy of 2.2% and 2.6% from our skilled services in Same Facilities and Transitioning Facilities, respectively, coupled with increasing daily revenue rates and the impact of acquisitions. Additionally, our skilled services in Recently Acquired Facilities increased total revenue by $114.8 million, when compared to the same period in 2023.

Skilled Services Segment

Revenue

The following tables present the skilled services revenue and key performance metrics by category during the six months ended June 30, 2024 and 2023:

	Six Months Ended June 30,			
	2024	2023	Change	% Change
TOTAL FACILITY RESULTS:		*(Dollars in thousands)*		
Skilled services revenue	$ 1,960,887	1,735,123	$ 225,764	13.0 %
Number of facilities at period end	272	253	19	7.5 %
Number of campuses at period end[(1)]	29	26	3	11.5 %
Actual patient days	4,554,599	4,172,567	382,032	9.2 %
Occupancy percentage — Operational beds	80.1 %	78.0 %	2.1 %	2.7 %
Skilled mix by nursing days	30.4 %	31.5 %	(1.1)%	(3.5)%
Skilled mix by nursing revenue	49.0 %	51.7 %	(2.7)%	(5.2)%

	Six Months Ended June 30,			
	2024	2023	Change	% Change
SAME FACILITY RESULTS:[2]	*(Dollars in thousands)*			
Skilled services revenue	$ 1,488,722	$ 1,393,741	$ 94,981	6.8 %
Number of facilities at period end	194	194	—	— %
Number of campuses at period end[1]	25	25	—	— %
Actual patient days	3,416,043	3,313,436	102,607	3.1 %
Occupancy percentage — Operational beds	80.9 %	78.7 %	2.2 %	2.8 %
Skilled mix by nursing days	31.9 %	32.8 %	(0.9)%	(2.7)%
Skilled mix by nursing revenue	50.2 %	52.5 %	(2.3)%	(4.4)%

	Six Months Ended June 30,			
	2024	2023	Change	% Change
TRANSITIONING FACILITY RESULTS:[3]	*(Dollars in thousands)*			
Skilled services revenue	$ 247,120	$ 231,144	$ 15,976	6.9 %
Number of facilities at period end	40	40	—	— %
Number of campuses at period end[1]	1	1	—	— %
Actual patient days	657,532	639,117	18,415	2.9 %
Occupancy percentage — Operational beds	74.8 %	72.2 %	2.6 %	3.6 %
Skilled mix by nursing days	21.7 %	21.8 %	(0.1)%	(0.5)%
Skilled mix by nursing revenue	38.1 %	40.4 %	(2.3)%	(5.7)%

	Six Months Ended June 30,			
	2024	2023	Change	% Change
RECENTLY ACQUIRED FACILITY RESULTS:[4]	*(Dollars in thousands)*			
Skilled services revenue	$ 225,045	$ 110,238	$ 114,807	NM
Number of facilities at period end	38	19	19	NM
Number of campuses at period end[1]	3	—	3	NM
Actual patient days	481,024	220,014	261,010	NM
Occupancy percentage — Operational beds	82.5 %	85.9 %	NM	NM
Skilled mix by nursing days	31.8 %	40.4 %	NM	NM
Skilled mix by nursing revenue	53.0 %	64.0 %	NM	NM

(1) Campus represents a facility that offers both skilled nursing and senior living services. Revenue and expenses related to skilled nursing and senior living services have been allocated and recorded in the respective operating segment.
(2) Same Facility results represent all facilities purchased prior to January 1, 2021.
(3) Transitioning Facility results represent all facilities purchased from January 1, 2021 to December 31, 2022.
(4) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2023.

Skilled services revenue increased $225.8 million, or 13.0%, compared to the six months ended June 30, 2023. The increases in skilled services revenue were across all payer types including increases in Medicaid revenue of $105.8 million, or 13.1%, Medicare revenue of $28.6 million, or 5.8%, managed care revenue of $61.4 million, or 19.3%, and private revenue of $30.0 million, or 25.9%.

The increase in skilled services revenue was primarily driven by strong occupancy performance across our skilled services operations. Our consolidated occupancy increased by 2.1% to 80.1% during the six months ended June 30, 2024 compared to the same period in 2023. In addition, we continue to increase our skilled days, mainly in the steady growth in our managed care and our long-term care Medicaid patients.

Revenue in our Same Facilities increased $95.0 million, or 6.8%, compared to the same period in 2023, due to increased occupancy from long-term care patients and revenue per patient day and strong skilled days. Our diligent efforts to strengthen our partnerships with various managed care organizations, hospitals and local communities, increased our managed care revenue by 12.8%, mainly due to increases in managed care days of 5.2% and revenue per patient day of 5.0%. We continued to see a shift in our patient population from Medicare to managed care as Medicare Advantage enrollment accounts for a larger portion of the overall population. In addition, Medicaid revenue increased by $49.1 million or 7.6%, mainly from the increases in Medicaid days and revenue per patient day.

Revenue generated by our Transitioning Facilities increased $16.0 million, or 6.9%, primarily due to improved occupancy growth and an increase in revenue per patient day. Managed Care and private revenue increased by 37.6% and 25.8%, respectively, demonstrating our ability to focus on increasing occupancy across payer types.

Skilled services revenue generated by Recently Acquired Facilities increased by approximately $114.8 million compared to the six months ended June 30, 2023. The increases were primarily due to 22 operational expansions between July 1, 2023 and June 30, 2024 across ten states. In addition, we acquired 17 operations in February 2023 that contributed to the year over year increase.

Historically, we have generally experienced lower occupancy rates and lower skilled mix at Recently Acquired Facilities and therefore, we anticipate lower overall occupancy during years of growth. Included in our metrics for Recently Acquired Facilities are 17 facilities we acquired in California in 2023 that were more mature and accordingly, had higher occupancy rates, higher skilled mix days and higher skilled mix revenue than our typical acquisitions. In the future, if we acquire additional turnaround or start-up operations, we expect to see lower occupancy rates and skilled mix and these metrics are expected to vary from period to period based upon the type of the facilities and operations that we acquire.

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

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
SKILLED NURSING AVERAGE DAILY REVENUE RATES								
Medicare	$ 747.66	$ 711.25	$ 696.25	$ 666.23	$ 852.62	$ 858.19	$ 759.21	$ 720.06
Managed care	548.52	522.43	523.54	512.50	586.47	606.49	549.10	525.35
Other skilled	619.01	597.65	494.77	498.79	603.84	524.67	606.98	584.16
Total skilled revenue	631.63	608.89	594.02	589.49	743.85	754.00	640.09	616.65
Medicaid	296.64	270.02	269.31	243.89	302.48	278.36	292.81	265.79
Private and other payors	280.87	262.14	254.55	237.16	332.78	347.26	281.69	261.44
Total skilled nursing revenue	$ 402.00	$ 380.36	$ 337.89	$ 318.63	$ 445.75	$ 476.32	$ 397.34	$ 375.96

(1) The rates are based on contractually agreed-upon amounts or rates, excluding the estimates of variable consideration under the revenue recognition standard, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606 and state relief funding during the six months ended June 30, 2023.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 5.1% and 4.5%, respectively, compared to the six months ended June 30, 2023. The increase is attributable to the 4.0% net market basket increase that became effective in October 2023 and a shift toward higher acuity patients.

Our average Medicaid rates increased 10.2% due to state reimbursement increases, our participation in supplemental Medicaid payment programs and quality improvement programs in various states, and change in Medicaid mix. For example, we continue to have an increase in Medicaid days in states with higher rates, such as California.

Payor Sources as a Percentage of Skilled Nursing Services — We use our skilled mix as a measure of the quality of reimbursements we receive at our independent skilled nursing facilities over various periods.

The following tables set forth our percentage of skilled nursing patient revenue and days by payor source:

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING REVENUE								
Medicare	20.9 %	24.1 %	19.3 %	23.5 %	35.6 %	45.2 %	22.5 %	25.4 %
Managed care	20.2	20.0	14.1	11.5	13.4	14.2	18.7	18.5
Other skilled	9.1	8.4	4.7	5.4	4.0	4.6	7.8	7.8
Skilled mix	**50.2**	**52.5**	**38.1**	**40.4**	**53.0**	**64.0**	**49.0**	**51.7**
Private and other payors	7.1	7.4	9.0	8.6	7.4	5.9	7.4	7.4
Medicaid	42.7	40.1	52.9	51.0	39.6	30.1	43.6	40.9
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING DAYS								
Medicare	11.3 %	12.9 %	9.4 %	11.2 %	18.6 %	25.1 %	11.8 %	13.3 %
Managed care	14.8	14.5	9.1	7.2	10.2	11.2	13.5	13.2
Other skilled	5.8	5.4	3.2	3.4	3.0	4.1	5.1	5.0
Skilled mix	**31.9**	**32.8**	**21.7**	**21.8**	**31.8**	**40.4**	**30.4**	**31.5**
Private and other payors	10.3	10.7	11.9	11.5	9.9	8.1	10.5	10.7
Medicaid	57.8	56.5	66.4	66.7	58.3	51.5	59.1	57.8
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

Cost of Services

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

	Six Months Ended June 30,		Change	
	2024	2023	$	%
Cost of service	$ 1,559,590	$ 1,367,817	$ 191,773	14.0 %
Revenue percentage	79.5 %	78.8 %		0.7 %

Cost of services related to our skilled services segment increased by $191.8 million, or 14.0%, from the same period in 2023. Cost of services as a percentage of revenue increased to 79.5% from 78.8%, due to an increase in labor cost as a result of new acquisitions with higher expenses in the turnaround stage, as well as an increase related to general and professional liability reserves. In addition, included in cost of services during the six months ended June 30, 2024 is the expense related to the deferred compensation investment program of $1.6 million compared to a gain of $1.3 million during the six months ended June 30, 2023. We continue to make progress in reducing contracted labor by driving up retention and hiring. Our cost of services as a percentage of revenue varies depending on the volume of acquisitions during the period, which typically have higher costs during the transition period.

Standard Bearer

	Six Months Ended June 30,		Change	
	2024	2023	$	%
	(Dollars in thousands)			
Rental revenue generated from third-party tenants	$ 8,393	$ 7,572	$ 821	10.8 %
Rental revenue generated from Ensign's independent subsidiaries	37,162	32,059	5,103	15.9
TOTAL RENTAL REVENUE	**$ 45,555**	**$ 39,631**	**$ 5,924**	**14.9 %**
Segment income	14,618	14,352	266	1.9
Depreciation and amortization	13,995	12,099	1,896	15.7
FFO	**$ 28,613**	**$ 26,451**	**$ 2,162**	**8.2 %**

Rental revenue — Our rental revenue, including revenue generated from our independent subsidiaries, increased by $5.9 million, or 14.9%, to $45.6 million, compared to the six months ended June 30, 2023. The increase in revenue is primarily attributable to 12 real estate purchases as well as annual rent increases since the six months ended June 30, 2023.

FFO — Our FFO increased by $2.2 million, or 8.2%, to $28.6 million, compared to the six months ended June 30, 2023. The increase in rental revenue of $5.9 million is offset by increases in interest expense of $3.6 million associated with the intercompany debt arrangements between Standard Bearer and us, as we continue to grow our real estate portfolio.

All Other Revenue

Our other revenue increased by $14.5 million, or 19.2%, to $89.9 million, compared to the six months ended June 30, 2023. Other revenue for 2024 includes senior living revenue of $42.2 million, revenue from other ancillary services of $41.8 million and rental income of $5.9 million. The increase in other revenue is primarily attributable to our other ancillary services.

Consolidated Financial Expenses

Rent-cost of services — Our rent-cost of services as a percentage of total revenue decreased by 0.2% to 5.1%, as our operational expansions included a mix of both leases and purchases of real estate.

General and administrative expense — General and administrative expense increased by $8.0 million or 7.6%, to $113.4 million. This increase was primarily driven by additional headcount due to acquisition activity and system implementation costs. General and administrative expense as a percentage of revenue decreased by 0.2% to 5.6%.

Depreciation and amortization — Depreciation and amortization expense increased by $5.4 million, or 15.7%, to $40.1 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations and capital expenditures. Depreciation and amortization expense remained consistent at 2.0%, as a percentage of revenue.

Other income, net — Other income primarily includes interest income from our investments, interest expense related to our debt and deferred compensation gains and losses. Other income, net as a percentage of revenue increased by 0.3% mainly due to an increase in interest income from our investments.

Provision for income taxes — Our effective tax rate was 22.9% for the six months ended June 30, 2024, compared to 22.2% for the same period in 2023. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, partially offset by non-deductible expenses, including non-deductible compensation. See Note 14, *Income Taxes*, in the Interim Financial Statements for further discussion.

Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flows from operations and long-term debt secured by our real property and our Credit Facility. Our liquidity as of June 30, 2024 is impacted by cash generated from strong operational performance offset by investments made for our operational expansions and ancillary businesses as well as capital expenditures to improve the quality of care at our existing operations.

Historically, we have primarily financed the majority of our acquisitions through mortgages on our properties, our Credit Facility and cash generated from operations. Cash paid to fund acquisitions was $66.0 million for the six months ended June 30, 2024 compared to $1.6 million cash paid for the six months ended June 30, 2023. Total capital expenditures for property and equipment were $64.6 million and $51.6 million for the six months ended June 30, 2024 and 2023, respectively. We currently have approximately $110.0 million budgeted for renovation projects in 2024. We believe our current cash balances, our cash flow from operations and the amounts available for borrowing under our Credit Facility will be sufficient to cover our operating needs for at least the next 12 months.

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

Our cash and cash equivalents as of June 30, 2024 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2024, we held investments of approximately $136.9 million. We believe our investments that were in an unrealized loss position as of June 30, 2024 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so.

As mentioned above, our primary source of cash is from our ongoing operations. Our positive cash flows have supported our business and have allowed us to pay regular dividends to our stockholders. We currently anticipate that existing cash and total investments as of June 30, 2024, along with projected operating cash flows and available financing, will support our normal business operations for the foreseeable future.

On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2024. On August 29, 2023, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2023. We did not purchase any shares pursuant to this stock repurchase program during the six months ended June 30, 2024.

Under these repurchase programs, we are authorized to repurchase our issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. The stock repurchase programs do not obligate us to acquire any specific number of shares.

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

	Six Months Ended June 30,	
	2024	**2023**
NET CASH PROVIDED BY/(USED IN):	*(In thousands)*	
Operating activities	$ 112,249	$ 168,082
Investing activities	(144,564)	(62,435)
Financing activities	25	(1,943)
Net (decrease) increase in cash and cash equivalents	**(32,290)**	**103,704**
Cash and cash equivalents beginning of period	509,626	316,270
Cash and cash equivalents at end of period	**$ 477,336**	**$ 419,974**

Operating Activities

Cash provided by operating activities is net income adjusted for certain non-cash items and changes in operating assets and liabilities. The $55.8 million decrease in cash provided by operating activities for the six months ended June 30, 2024 compared to the same period in 2023 was due primarily to the timing of income tax payments. In 2023, the U.S. Internal Revenue Service and California provided disaster-area tax relief for the deferral of federal and California estimated tax payments until the fourth quarter of 2023. As of the second quarter of 2023, the Company deferred approximately $50.0 million of 2023 federal and California estimated tax payments that were paid in the fourth quarter of 2023. In the second quarter of 2024, we paid $56.1 million in income tax payments. The remaining change in cash provided by operating activities is due to the timing of accounts receivable collections as well as timing of payments and wages and benefits offset by an increase in operational performance.

Investing Activities

Investing cash flows consist primarily of capital expenditures, investment activities, insurance proceeds and cash used for acquisitions. The $82.1 million increase in cash used in investing activities for the six months ended June 30, 2024 compared to the same period in 2023 was primarily due to cash used for operational expansions and capital expenditures.

Financing Activities

Financing cash flows consist primarily of payment of dividends to stockholders, issuance and repayment of short-term and long-term debt, payment for share repurchases and sale of subsidiary shares. The $2.0 million increase in cash provided by financing activities for the six months ended June 30, 2024 compared to the same period in 2023, was primarily due to stock option exercises.

Credit Facility with a Lending Consortium Arranged by Truist

We maintain a revolving credit facility with Truist Securities (Truist) (the Credit Facility) with availability up to $600.0 million in aggregate principal amount. The maturity date of the Credit Facility is April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the Credit Facility). In addition, there is a commitment fee on the unused portion of the commitments that ranges from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

Mortgage Loans and Promissory Note

As of June 30, 2024, 23 of our subsidiaries have mortgage loans insured with HUD for an aggregate amount of $148.6 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates at a range of 3.1% to 4.2%, including fixed interest rates at a range of 2.4% to 3.3% per annum. In addition to the interest rate, we incur other fees for HUD placement, including but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0%, and is reduced by 3.0% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

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

Operating Leases

As of June 30, 2024, 222 of our facilities are under long-term lease arrangements, of which 98 of the operations are under nine triple-net Master Leases and one stand-alone lease with CareTrust REIT, Inc. (CareTrust). The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%. At our option, we can extend the Master Leases for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If we elect to renew the term of a Master Lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the Master Lease. Additionally, four of the 99 facilities leased from CareTrust include an option to purchase that we can exercise starting on December 1, 2024.

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

Eighty-two of our independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases from CareTrust, are operated under 13 separate master lease arrangements. Under these master leases, a default at a single facility could subject one or more of the other independent subsidiaries covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of our leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in our outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

Inflation

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

Labor, supply expenses and capital expenditures make up a substantial portion of our cost of services. Those expenses can be subject to increase in periods of rising inflation and when labor shortages occur in the marketplace. To date, we have generally been able to implement cost control measures or obtain increases in reimbursement sufficient to offset increases in these expenses. There can be no assurance that we will be able to anticipate fully or otherwise respond to any future inflationary pressures.

Item 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

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

We have a Credit Facility with Truist of up to $600.0 million in aggregate principal amount. We have no outstanding borrowings under our Credit Facility as of June 30, 2024 and through the filing date of this report. In addition, we have outstanding indebtedness under mortgage loans insured with HUD and a promissory note payable to a third party of $150.4 million, all of which are at fixed interest rates.

Our cash and cash equivalents as of June 30, 2024 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2024, we held investments of approximately $136.9 million. We believe our investments that were in an unrealized loss position as of June 30, 2024 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so. Our market risk exposure is interest rate sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal, while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10.0% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of June 30, 2024 and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Item 4. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act as of the end of the period covered by this Quarterly Report on Form 10-Q. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures are effective.

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended June 30, 2024, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II.

Item 1. LEGAL PROCEEDINGS

Indemnities — From time to time, we enter into certain types of contracts that contingently require us to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which we may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from our use of the applicable premises, (ii) operations transfer agreements, in which we agree to indemnify past operators of facilities we acquire against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer to our independent subsidiary, (iii) certain lending agreements, under which we may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with our officers, directors and others, under which we may be required to indemnify such persons for liabilities based on the nature of their relationship to us. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on our balance sheets for any of the periods presented.

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

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

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

We and our independent subsidiaries are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that services provided to patients by our independent subsidiaries have resulted in injury or death, and claims related to employment and commercial matters. For example, in a four-week medical negligence trial in the State of Arizona, the jury returned a verdict against one of our independent subsidiaries in late November 2023. We are in the process of appealing the jury verdict. We have in the past appealed similar decisions and have, in some circumstances, received decisions in our favor. Although we intend to vigorously defend against these claims and in general these types of claims and cases, there can be no assurance that the outcomes of these matters will not have a material adverse effect on operational results and financial condition. Additionally, in certain states in which we have or have had independent subsidiaries, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law and/or public policy prohibitions. There can be no assurance that we and or our independent subsidiaries will not be liable for punitive damages awarded in litigation arising in states for which punitive damage insurance coverage is not available.

The skilled nursing and post-acute care industry is heavily regulated. As such, we and our independent subsidiaries are continuously subject to state and federal regulatory scrutiny, supervision and control in the ordinary course of business. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine. In addition to being subject to direct regulatory oversight from state and federal agencies, the skilled nursing and post-acute care industry is also subject to regulatory requirements which, if noncompliance is identified, could result in civil, administrative or criminal fines, penalties or restitutionary relief, and reimbursement; authorities could also seek the suspension or exclusion of the provider or individual from participation in their programs. We believe that there has been, and will continue to be, an increase in governmental investigations of post-acute providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse determinations in civil legal proceedings or governmental investigations, whether currently asserted or arising in the future, could have a material adverse effect on our financial position, results of operations, and cash flows. Additionally, such proceedings and/or investigation can be a distraction to the business.

For example, in 2020, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis launched a nation-wide investigation into the COVID-19 pandemic, which included the impact of the coronavirus on residents and employees in nursing homes. In June 2020, we and our independent subsidiaries received a document and information request from the House Select Subcommittee. We and our independent subsidiaries cooperated in responding to this inquiry. In July 2022 and thereafter, we and our independent subsidiaries received follow up requests for additional documents and information. We and our independent subsidiaries responded to these requests and cooperated with the House Select Subcommittee in connection with its investigation. On December 9, 2022, the House Select Subcommittee issued its final report summarizing its investigation and related recommendations designed "to strengthen the nation's ability to prevent and respond to public health and economic emergencies." According to the information provided by the House Select Subcommittee, the issuance of this report was the House Select Subcommittee's final official act in connection with their assigned responsibilities. Also, we, on behalf of our independent subsidiaries, received a Civil Investigative Demand (CID) from the U.S. Department of Justice (DOJ) in January of 2024 indicating that the DOJ is investigating the Company to determine whether we have caused the submission of claims to Medicare and Texas Medicaid for services which were unnecessary or otherwise not consistent with existing reimbursement requirements. The CID covers the period from January 1, 2016 to the present. As a general matter, our independent subsidiaries maintain policies and procedures to promote compliance with all applicable Medicare and Medicaid requirements, including, but not limited to those relating to the presentation of claims for reimbursement for services provided. We are fully cooperating with the DOJ in response to the CID. However, we cannot predict the outcome of the investigation or its potential impact to the consolidated financial statements.

In addition to the potential lawsuits and claims described above, we and our independent subsidiaries are also subject to potential lawsuits under the FCA and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare or Medicaid) or other payor. A violation may provide the basis for exclusion from federally funded healthcare programs. Such exclusions could have a correlative negative impact on our financial performance. In addition, and pursuant to the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Due to these whistleblower incentives, qui tam lawsuits have become more frequent.

For example, on May 31, 2018, we, on behalf of our independent subsidiaries, received a CID from the DOJ stating that it was investigating to determine whether there had been a violation of the False Claims Act (FCA) and/or the Anti-Kickback Statute (AKS) with respect to the relationships between certain of our independent subsidiaries and persons who serve or have served as medical directors. We fully cooperated with the DOJ and promptly responded to its requests for information. In April 2020, we were advised that the DOJ declined to intervene in any subsequent action filed in connection with the subject matter of this investigation. Despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its previously issued CID, the involved qui tam relator moved forward with the complaint in December 2020. From that time until December 2023, and notwithstanding our success in early pre-trial motions, we continued to incur legal defense costs and fees, including significant amounts as part of discovery in the fourth quarter of 2023. In early January 2024, we entered into mediation with the involved parties and on January 19, 2024, the parties agreed to settle the civil case for $48.0 million, subject to the review of the DOJ and other relevant government entities. The settlement does not include admissions on the part of the Company or our independent subsidiaries, and we maintain that we have and continue to comply with all applicable State and Federal statutes (including but not limited to the FCA and the AKS). The settlement documents are in the process of being finalized and, following payment of the settlement funds, the qui tam complaint will be dismissed and the matter will be resolved.

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

Under the Fraud Enforcement and Recovery Act of 2009 (FERA), health care providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government can argue, therefore, that an FCA violation can occur without any affirmative fraudulent action or statement, as long as the action or statement is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

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

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

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

Medicare Revenue Recoupments — We and our independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments resulting from reviews conducted via RAC, Program Safeguard Contractors, and Medicaid Integrity Contractors (collectively referred to as Reviews). For several months during the COVID-19 pandemic, CMS suspended its Targeted Probe and Educate (TPE) Program. Beginning in August 2020, CMS resumed TPE Program activity. If an operation fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. We anticipate that these Reviews could increase in frequency in the future. As of June 30, 2024 and through the filing date of this report, 11 of the our independent subsidiaries had Reviews scheduled or in process.

In June 2023, CMS announced a new nationwide audit, the “SNF 5-Claim Probe & Educate Review,” in which the Medicare Administrative Contractors will review five claims from each SNF to check for compliance. In implementing this SNF 5-Claim Probe & Educate Review, CMS acknowledged that the increase in observed improper payments from 2021 to 2022 may have arisen from a “misunderstanding” by SNFs about how to appropriately bill for claims of service after October 1, 2019. All facilities that are not undergoing TPE reviews, or have not recently passed a TPE review, will be subject to the nationwide audit. MACs will complete only one round of probe-and-educate for each SNF, rather than the three rounds that typically occur in the TPE Program. Additionally, CMS’s education for each SNF will be individualized and based on observed claim review errors, with rationales for denial explained to the SNF on a claim-by-claim basis. This program will apply only to claims submitted after October 1, 2019, and will exclude claims containing a COVID-19 diagnosis.

Item 1A. RISK FACTORS

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

Risks Related to our Business and Industry

- The rules of Medicare and Medicaid, including reductions of reimbursement rates, changes to spending requirements, data reporting, measurement and evaluation standards could have a material, adverse effect on our revenues, financial condition and results of operations.
- Reforms to the U.S. healthcare system, including new regulations under the ACA, new transparency and disclosure requirements, potential federal and state standards for minimum nurse staffing levels, continue to impose new requirements upon us that could materially impact our business.
- Changes in the U.S. political environment may result in significant changes to the regulatory framework, enforcement, and reimbursements in our industry.
- We are subject to various government reviews, audits and investigations that could adversely affect our business, including an obligation to refund amounts previously paid to us, potential criminal charges, loss of licensure, the imposition of fines and sanctions.
- We are subject to extensive and complex laws and government regulations. If we are not operating in compliance with these laws and regulations or if these laws and regulations change, we could be required to make significant expenditures or change our operations in order to bring our facilities and operations into compliance.
- Public and government calls for increased enforcement efforts toward SNFs, potential rulemaking that may result in enhanced enforcement and penalties, and new guidance for surveyors regarding the review of SNFs and enforcement of their Requirements of Participation, could result in increased scrutiny by state and federal survey agencies, including sanctions that could negatively affect our financial condition and results of operations.
- CMS's changes to the SFF program and its look-back period may create greater risk of our facilities being subject to this program and subject to potential fines and sanctions, even after graduating from the SFF program.
- Federal minimum staffing mandates may adversely affect our labor costs, ability to maintain desired levels of patient or resident capacity, and profitability.
- Future cost containment initiatives undertaken by payors may limit our revenue and profitability.
- Changes in Medicare reimbursements for physician and non-physician services could impact reimbursement for medical professionals.
- We may be subject to increased investigation and enforcement activities related to HIPAA violations.
- Security breaches and other cyber-security incidents could violate security laws and subject us to significant liability.
- If our independent subsidiaries are not fully reimbursed for all services for which each facility bills through consolidated billing, our revenue, financial condition and results of operations could be adversely affected.
- Increased competition for, or a shortage of, nurses and other skilled personnel, could increase our staffing and labor costs and subject us to monetary fines resulting from a failure to maintain minimum staffing requirements, or may affect reimbursement.
- Annual caps, uncertainty regarding reimbursement and other cost-reductions for outpatient therapy services may reduce our future revenue and profitability or cause us to incur losses.
- Increased scrutiny of our activities and billing practices by the OIG or other regulatory authorities may result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.
- State efforts to regulate or deregulate the healthcare services industry or the construction or expansion of healthcare facilities could impair our ability to expand our operations, or could result in increased competition.
- Newly enacted legislation in the States where our independent subsidiaries are located may impact the volume and severity of cases filed and the overall cost of those cases from a defense and indemnity standpoint.
- Changes to federal and state employment-related laws and regulations could increase our cost of doing business.
- Required regulatory approvals could delay or prohibit transfers of our healthcare operations, which could result in periods in which we are unable to receive reimbursement for such properties.
- Compliance with federal and state fair housing, fire, safety, staffing, and other regulations may require us to incur unexpected expenses, which could be costly to us.
- Our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our independent subsidiaries as well as payor mix and payment methodologies.
- We are subject to litigation that could result in significant legal costs and large settlement amounts or damage awards. Similarly, a change in the enforceability of arbitration provisions between SNFs and senior living facilities and residents and patients may affect the risks we face from claims and potential litigation.

- If our regular internal investigations into the care delivery, recordkeeping and billing processes of our independent subsidiaries detect instances of noncompliance, efforts to correct such non-compliance could materially decrease our revenue.
- We may be unable to complete future facility or business acquisitions at attractive prices or at all, or may elect to dispose of underperforming or non-strategic independent subsidiaries, either of which could decrease our revenue.
- We may not be able to successfully integrate acquired facilities and businesses into our operations, or we may be exposed to costs, liabilities and regulatory issues that may adversely affect our operations.
- In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations.
- If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar monitoring activities, our business may be negatively affected.
- If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected, and our self-insurance programs may expose us to significant and unexpected costs and losses.
- The geographic concentration of our independent subsidiaries could leave us vulnerable to economic downturn, regulatory changes or acts of nature in those areas.
- The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.
- The risks associated with leased property where our independent subsidiaries operate could adversely affect our business, financial position or results of operations.
- Failure to generate sufficient cash flow to cover required payments or meet operating covenants under our long-term debt, mortgages and long-term operating leases could result in defaults under such agreements and cross-defaults under other debt, mortgage or operating lease arrangements, which could harm our independent subsidiaries and cause us to lose facilities or experience foreclosures.
- A continued housing slowdown or housing downturn could decrease demand for senior living services.
- As we continue to acquire and lease real estate assets, we may not be successful in identifying and consummating these transactions.
- As we expand our presence in other relevant healthcare industries, we would become subject to risks in a market in which we have limited experience.
- If our referral sources fail to view us as an attractive skilled nursing provider, or if our referral sources otherwise refer fewer patients, our patient base may decrease.
- We may need additional capital to fund our independent subsidiaries and finance our growth, and we may not be able to obtain it on terms acceptable to us, or at all, which may limit our ability to grow.
- The condition of the financial markets could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business.
- Delays in reimbursement may cause liquidity problems.
- The utilization and expansion of managed care organizations may contribute to delays or reductions in our reimbursement, including Managed Medicaid.
- Compliance with the regulations of the Department of Housing and Urban Development may require us to make unanticipated expenditures which could increase our costs.
- Failure to safeguard our patient trust funds may subject us to citations, fines and penalties.
- We are a holding company with no operations and rely upon our multiple independent subsidiaries.
- Certain directors who serve on our Board of Directors also serve as directors of Pennant, and ownership of shares of Pennant common stock by our directors and executive officers may create, or appear to create, conflicts of interest.
- Standard Bearer's failure to qualify as a REIT may cause it to be subject to U.S. federal income tax. Additionally, legislative or other actions affecting REITs could have a negative effect on Standard Bearer.

Risks Related to Ownership of our Common Stock

- We may not be able to pay or maintain dividends and the failure to do so would adversely affect our stock price.
- Our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law contain provisions that could discourage transactions resulting in a change in control, which may negatively affect the market price of our common stock.

Risks Related to Our Business and Industry

The rules of Medicare and Medicaid, including reductions of reimbursement rates, changes to spending requirements, data reporting, measurement and evaluation standards could have a material, adverse effect on our revenues, financial condition and results of operations.

We derived 25.1% and 25.8% of our service revenue from the Medicare programs for the three and six months ended June 30, 2024, respectively, and 27.1% and 27.6% for the three and six months ended June 30, 2023, respectively. In addition, many other payors may use published Medicare rates as a basis for reimbursements. Accordingly, if Medicare reimbursement rates are reduced or fail to increase as quickly as our costs, if there are changes in the rules governing the Medicare program that are disadvantageous to our business or industry, or if there are delays in Medicare payments, our business and results of operations will be adversely affected.

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

Additionally, payments can be delayed or declined due to determinations that certain costs are not reimbursable or reasonable because either adequate or additional documentation was not provided or because certain services were not covered or considered medically necessary. Additionally, revenue from these payors can be retroactively adjusted after a new examination during the claims settlement process or as a result of post-payment audits. New legislation and regulatory proposals could impose further limitations on government payments to healthcare providers.

CMS often changes the rules governing the Medicare program, including those governing reimbursement. Changes to the Medicare program that could adversely affect our business could include, but are not limited to the following:

- administrative or legislative changes to base rates or the bases for payment, including changes to the rates at which Medicare will reimburse services;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- changes in methodology for patient assessment and/or determination of payment levels;
- changes in staff requirements as a condition of payment or eligibility for Medicare reimbursement (See also, Item 2., under *Government Regulation*);
- the reduction or elimination of annual rate increases, or the end of the reduced payments deferment (See also, Item 2., under *Government Regulation*); and
- an increase in co-payments or deductibles payable by beneficiaries.

Among the changes being implemented by CMS are provisions of the IMPACT Act, which imposes a stringent timeline for implementing benchmark quality measures and data metrics across facilities that include SNFs. The enactment mandates specific actions to design a unified payment methodology for post-acute providers, which CMS implements through ongoing regulations. The costs of final implementation may be significant, with potential fines and payment reductions resulting from a failure to meet CMS's implementation requirements.

Reductions in reimbursement rates or the scope of services being reimbursed could have a material, adverse effect on our revenue, financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating costs. In addition, CMS may make future adjustments to reimbursement levels and underlying reimbursement formulae as it continues to monitor the impact of current payments system on patient outcomes and budget neutrality. The Biden-Harris Administration continues to study the nursing home industry and for HHS to issue proposed rules based on those studies, including changes to SNF facility reimbursement, including the SNF-VBP Program, may also adversely affect our reimbursement. These metrics potentially affecting our revenues and expenses in future government fiscal years include the SNF healthcare-associated infections (HAI) measurement, total nursing hours per resident day measures, and discharge to community - post acute care measure. The Interoperability Final Rule’s implementation beginning in 2026, and to be completed by January 1, 2027, may also adversely affect our reimbursement paid through Medicare, specifically including Medicare Advantage.

Loss of Medicare reimbursement, or a delay or default by the government in making Medicare payments, would also have a material adverse effect on our revenue. Non-compliance with Medicare regulations exist, and any penalty, suspension, termination, or other sanction under any state's Medicaid program could lead to reciprocal and commensurate penalties being imposed under the Medicare program, up to termination or rescission of our Medicare participation and payor agreements as noted above.

A significant portion of reimbursement for skilled nursing services comes from Medicaid. In fact, Medicaid is our largest source of revenue, accounting for 46.1% and 45.6% of our revenue for the three and six months ended June 30, 2024, respectively, and 46.0% and 45.6% for the three and six months ended June 30, 2023, respectively. Medicaid is a state-administered program financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets, which has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending. Since a significant portion of our revenue is generated from our skilled nursing independent subsidiaries in California, Texas and Arizona, any budget reductions or delays in these states could adversely affect our net patient service revenue and profitability. Due to recent fluctuations in state budgets many of the states in which we operate (including those with current budget surpluses), are seeking to contain costs on Medicaid outlays for SNFs, and any such decline could adversely affect our financial condition and results of operations.

The Medicaid program and its reimbursement rates and rules are subject to frequent change at both the federal and state level, including through changes in laws, regulations, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which our services are reimbursed by state Medicaid plans or the amount of expense we incur.

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements commonly referred to as provider taxes. Under provider tax arrangements, states collect taxes from healthcare providers and then use the revenue to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the providers' total revenue. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures could have a significant and adverse effect on states' Medicaid expenditures, and as a result could have a material and adverse effect on our business, financial condition or results of operations.

State-Level Direct Spending Requirements could negatively impact our results of operations

Certain states where the Company operates have implemented direct spending requirements requiring SNFs to spend a portion of their revenue, particularly including Medicaid-derived revenue, on expenses directly relating to care. These spending requirements could affect our operational results and place the Company at higher risk of suffering non-compliance consequences, such as penalties, pay-backs, restrict admissions and/or operational/financial penalties.

For example, Washington state incorporates the costs of direct care, indirect care, and capital expenditures for SNF services in computing the State's Medicaid payments to nursing facilities. Using periodically updated calculations that account for factors including case acuity, fair market value of capital expenditures, inflation, and facility performance, Washington sets facility compensation so that the majority of Medicaid reimbursement paid to a skilled nursing facility is used for care-related activities, with limitations on how much a facility's reimbursement may increase from year to year. Washington state first adopted this care-based payment model in 2015 and has periodically updated it since, including in 2020, 2022, and 2023; it is expected that Washington will continue to amend this law in the future. For state fiscal year 2024, Texas requires all nursing facilities must show that funds paid to SNFs by Texas's Medicaid program, including both fee-for-service and managed care reimbursement, were expanded for direct care activities, including direct care staff wages and benefits. In addition, California in the past has proposed bills that, if passed, would require nursing facilities to spend a stated percentage of revenue on direct patient-related services. While the most recent attempt by the California Assembly (Bill 1537) to impose direct spending requirements on SNFs has been placed in suspense with no action has been taken on, similar legislation in the future may seek to impose identical or analogous funding requirements for SNFs operating in California.

Reforms to the U.S. healthcare system, including new regulations under the ACA, continue to impose new requirements upon us that could materially impact our business

As discussed in greater detail in Item 2., under *Government Regulation*, the ACA has resulted in significant changes to our operations and reimbursement models for services we provide. CMS continues to issue rules to implement the ACA, including most recently, new rules regarding the implementation of the anti-discrimination provisions and proposed rules requiring the disclosure of SNF ownership, organization, management and the identity of the real property owners from which the SNF leases or subleases its operating space. With the passage of the IRA in August of 2022, Congress continues to expand and supplement the ACA, including through the continuation of federally funded insurance premium subsidies. This modification of the ACA by the IRA indicates that Congress may continue to change and expand the ACA in the future.

The efficacy of the ACA is the subject of much debate among members of Congress and the public and it has been the subject of extensive litigation before numerous courts, including the United States Supreme Court, with varying outcomes — some expanding and others limiting the ACA. If the ACA is repealed or any elements of the ACA that are beneficial to our business are materially amended or changed, such as provisions regarding the health insurance industry, reimbursement and insurance coverage by payers, our business, operating results and financial condition could be harmed. Thus, the future impact of the ACA on our business is difficult to predict and its continued uncertain future may negatively impact our business.

While it is not possible to predict whether and when any such changes will occur, specific proposals discussed leading up to the 2024 presidential election, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. The ACA continues to be a salient political topic and proposed changes to it may become the subject of campaign promises, litigation, administrative action, or legislation leading up to or following the 2024 Presidential election. In addition, even if the ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS have a significant impact on the implementation of the provisions of the ACA, and a new administration could make changes impacting the implementation and enforcement of the ACA, which could harm our business, operating results and financial condition. We have already seen this with regulatory activity promulgating rules regarding anti-discrimination under Section 1557 of the ACA and most recently proposed rulemaking requiring the disclosure of SNF ownership and service providers under Section 6101 of the ACA. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

Similarly, the Nursing Home Improvement Act proposed during the prior Congress may be re-introduced in the future and could ultimately have an impact on our business due to the proposed 2% decrease in payments to SNFs, as well as the staffing and reporting requirements contained within the bill. While it is difficult to determine whether the Nursing Home Improvement Act or an identical bill will even be reintroduced, if ultimately signed into law, this bill may negatively impact our business, with the scope and nature of its consequences unknown.

On November 15, 2023, CMS issued a final rule that, requires SNFs to disclose certain information regarding their ownership and managerial relationships, which is more invasive and comprehensive than the ownership information already disclosed through Medicare's Nursing Home Compare website. Refer to Item 2., under *Government Regulation*, for additional information. The breadth of disclosure required by this new rule may be adverse to our business interests and detrimental to our operations, revenue, and profitability and may have a chilling effect on investment due to the depth of the new reporting and transparency requirements. Similarly, California passed a comparable law requiring the disclosure of certain ownership and financial information for SNFs in 2021. On March 6, 2024, California’s regulations implementing this law took effect, which may invite further scrutiny and potential legal action, whether by the state agencies or private parties, within California based on the information disclosed as required by this law and its enabling regulations.

We cannot predict what effect future reforms to the U.S. healthcare system will have on our business, including the demand for our services or the amount of reimbursement available for those services. However, it is possible these new laws may lower reimbursement or increase the cost of doing business and adversely affect our business.

The changes in Congress due to the U.S. midterm elections in 2022, changes in representation, and actions in anticipation of the 2024 Presidential election may result in significant changes to regulatory framework, enforcements and reimbursements.

The midterm elections in 2022 resulted in a change of control in the House of Representatives and representative departures that are expected in 2024 are anticipated to further narrow the margin of Republican control over the House of Representatives. Both events could result in significant changes in, and have resulted in uncertainty with respect to, legislation, regulation, implementation or repeal of laws and rules related to government health programs, including Medicare and Medicaid. Democratic proposals for Medicare for All or significant expansion of Medicare, could significantly impact our business and the healthcare industry if implemented, although the implementation of such proposals remains unlikely under the political party currently holding a majority within the House of Representatives. Other legislation, such as the Protecting America's Seniors' Access to Care Act and Protecting America's Rural Seniors' Access Act, which seek to halt HHS and CMS from finalizing and enforcing its proposed rule for staffing requirements, indicates a bipartisan interest in restraining HHS's ability to finalize, implement and enforce regulations that may be burdensome on our independent operating subsidiaries, creating still more uncertainty and unpredictability in the legislative process.

Congress's passage of the IRA in August of 2022, which expanded upon and continued certain provisions of the ACA, indicates that additional legislative changes to the ACA may be forthcoming. Similarly, the Consolidated Appropriations Act of 2024 and its increase in the Medicare conversion factor, resulting in increased Medicare reimbursement to providers, may have political implications if popular among Medicare beneficiaries and the providers paid through that program, and may yield further, similar legislation leading up to the November 2024 election. If proposed policies specific to nursing facilities are implemented, these may result in significant regulatory changes, increased survey frequency and scope, and increased penalties for non-compliance. As both political parties have begun their Presidential and congressional campaigns in 2024, each of them may seek to introduce or pass legislation that would either expand or reduce the scope of the ACA. Based on the IRA and inflationary pressures in the economy, the ACA and affordability of healthcare generally may be a campaign issue and lead to promises, administrative action, or legislation that could adversely affect our business. As a result, future legislation may be proposed or passed that may adversely affect our business, operating results and financial condition.

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

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with the rules associated with these programs and related applicable laws and regulations, including our claims for payments submitted to those programs, which are subject to reviews by Recovery Audit Contractors, Zone Program Integrity Contractors, Program Safeguard Contractors, Unified Program Integrity Contractors, Supplemental Medical Review Contractors and Medicaid Integrity Contractors programs, (collectively referred to as Reviews). In these Reviews, third-party firms engaged by CMS conduct extensive analysis of claims data and medical and other records to identify potential improper payments under the federal and state programs. As discussed above, the Biden-Harris Administration has called for HHS and CMS to increase the level of scrutiny of SNF facilities and requested those agencies to adopt rules that would impose greater penalties upon non-compliant SNF operators. SNF PPS FY 2025 Proposed Rule proposed increased penalties that surveyors may impose on SNFs for perceived non-compliance with CMS's requirements for SNF participation in Medicare. On October 26, 2023, CMS updated the survey resources that CMS and state surveyors use in evaluating our SNFs' compliance with federal Requirements for Participation, incorporating recent changes to CMS's methods for surveying infection control procedures.

In 2022, CMS announced updated guidance for Phase 2 and 3 of the requirements of participation, discussed in greater detail in Item 2., under *Government Regulation*. The application of CMS's new guidance could result in more aggressive and stringent surveys, and potential fines, penalties, sanctions, or administrative actions taken against our independent subsidiaries. Also described in Item 2., under *Government Regulation*, the Interoperability Final Rule and its changes intended to facilitate data exchange between and among patients, providers, and payors, will be implemented beginning in 2026 and must be fully implemented by January 1, 2027. This rule and the greater access to and use of data between and among payors transmitting funds for state and federal healthcare programs, may also trigger additional scrutiny or review of facilities such as ours, and may adversely affect our reimbursement paid through state and federal programs including Medicaid.

CMS announced a new nationwide audit the "SNF 5-Claim Probe & Educate Review" in which the Medicare Administrative Contractors will review five claims from each of the facilities to check for compliance with PDPM billings, which could result in individual claim payment denials if errors are identified. All facilities that are not undergoing Targeted Probe and Educate (TPE) reviews, or have not recently passed a TPE review, will be subject to the nationwide audit.

Private payors also reserve the right to conduct audits. We believe that billing and reimbursement errors and disagreements are common in our industry, and thus we are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the process related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce. An adverse review, audit or investigation could result in:

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

Although we have always been subject to post-payment audits and reviews, more intensive "probe reviews" performed by Medicare administrative contractors in recent years appear to be a regular procedure with our fiscal intermediaries. All findings of overpayment from CMS contractors are eligible for appeal. With the exception of rare findings of overpayment related to objective errors in Medicare payment methodology or claims processing, we utilize all defenses reasonably available to us to demonstrate that the services provided meet all clinical and regulatory requirements for reimbursement.

In cases where claim and documentation review by a CMS contractor results in repeated unsatisfactory results, an operation can be subjected to protracted regulatory oversight. This CMS oversight may include education and sampling of claims, extended pre-payment review, referral of the operating business to recovery audit or integrity contractors, or extrapolation of an error rate to other reimbursement made outside of specifically reviewed claims. Ongoing failure to demonstrate improvement towards meeting all claim filing and documentation requirements could ultimately lead to Medicare decertification. As of June 30, 2024 and through the filing date of this report, 11 of our independent subsidiaries had reviews scheduled or in process, either pre- or post-payment. We anticipate that these reviews could increase in frequency in the future.

Additionally, both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, SNFs. The focus of these investigations includes, among other things, billing and cost reporting practices; quality of care provided; financial relationships with referral sources; and the medical necessity of rendered services. For example, refer to the matter discussed in Part II, Item 1. *Legal Proceedings.*

If we should agree to a settlement of claims or obligations under Medicare statutes, the FCA, or similar federal or state statutes and related regulations, our business, financial condition and results of operations and cash flows could be materially and adversely affected, and our stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations and may also include our assumption of specific procedural and financial obligations going forward under a corporate integrity agreement or other arrangement with the government.

If the government or a court were to conclude that errors and deficiencies constitute criminal violations and/or that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable levels, we and certain of our officers might face potential criminal charges and civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we or some of the key personnel of our independent subsidiaries could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare.

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

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

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

- licensure and certification;
- disclosure of ownership and affiliated parties;
- adequacy and quality of healthcare services;
- qualifications of healthcare and support personnel;
- state-specified and potential federal mandates for specific nurse staffing levels;
- quality and maintenance of medical equipment and facilities;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources and recipients;
- constraints on protective contractual provisions with patients and third-party payors;
- operating policies and procedures;
- addition of facilities and services; and
- billing for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we conduct our business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to frequent change. As noted above, the Biden-Harris Administration has called upon HHS and CMS to study and propose new rules regarding staffing requirements and reimbursement for the nursing home industry, including tying reimbursement to staffing levels, salary, benefits, and retention. CMS's recently finalized ownership transparency rule, and similar state disclosure rules such as California's (for which new regulations took effect in March of 2024), discussed in Item 2., under Government Regulation, may provide an additional basis for further investigation, administrative action and ultimately fines, penalties, or sanctions if finalized, and may dissuade parties from working with us or our independent subsidiaries due to the reporting and disclosure obligations of being an Additional Disclosable Party under that final rule.

We believe that such regulations that may adversely affect our business, operation and profitability may increase in the future and we cannot predict the ultimate content, timing or impact on us of any healthcare reform legislation. If we fail to comply with these applicable laws and regulations, or their interpretations as determined by courts or enforced by regulators, we could suffer civil or criminal penalties and other detrimental consequences, including denial of reimbursement, imposition of fines, temporary suspension of admission of new patients, suspension or decertification from the Medicaid and Medicare programs, restrictions on our ability to acquire new facilities or expand or operate existing facilities, the loss of our licenses to operate and the loss of our ability to participate in federal and state reimbursement programs. Additionally, in the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses.

As discussed in greater detail in Item 2., under *Government Regulation*, we are subject to federal and state laws intended to prevent healthcare fraud and abuse. Possible sanctions for violation of any of these laws and regulations include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations, refund payments to the government, enter into a corporate integrity agreement, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

These anti-fraud and abuse laws and regulations are complex, and we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. While we do not believe we are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing these prohibitions will not assert that we are violating the provisions of such laws and regulations. Our company is currently aware of litigation filed by an individual related to allegations that certain of our independent SNFs may have violated the FCA or the AKS with respect to the relationships between certain SNFs and persons who served as medical directors. While our independent subsidiaries maintain policies and procedures to promote compliance with the FCA, the AKS, and other applicable regulatory requirements, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on our company.

We are unable to predict the future course of federal, state and local regulation or legislation, including as it pertains to Medicare, Medicaid, or fraud and abuse laws, and how they are enforced. Changes in the regulatory framework, our failure to obtain or renew required regulatory approvals, credentials, qualifications, or licenses or to comply with applicable regulatory requirements, or the imposition of other enforcement sanctions, fines or penalties could have a material adverse effect upon our business, financial condition or results of operations. Furthermore, should we lose licenses or certifications for a number of our facilities or other businesses as a result of regulatory action or legal proceedings, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness.

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

As CMS turns its attention to enhancing enforcement activities towards SNFs, as discussed in Item 2., under *Government Regulation*, state survey agencies will have more accountability for their survey and enforcement efforts. Within the SNF PPS FY 2025 Proposed Rule, CMS seeks greater ability to impose monetary penalties upon SNFs for incident-based and day-based violations of CMS's conditions of participation. Further, the enhanced penalties against SFFs under the Biden-Harris Administration represents further federal calls for transparency, oversight and penalties for low-ranked and underperforming SNFs. These enhanced penalties and enforcement activities precedes greater focus by CMS in obtaining oversight over SFFs, and continuing that oversight even after those SFFs improve, and subjecting them to more exacting and routine oversight. The likely result may be more frequent surveys of our independent subsidiaries, with more substantial penalties, fines and consequences if they do not perform well. For low-performing facilities in the SFF program, the standards for successfully emerging from that program and not being subject to ongoing and enhanced government oversight will be higher and measured over a longer period of time, prolonging the risks of monetary penalties, fines and potential suspension or exclusion from the Medicare and Medicaid programs.

From time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. CMS's updated guidance to these surveyors incorporate recent changes to CMS's methods for surveying infection control procedures. Additionally, CMS's recently finalized rule requiring disclosure of ownership and financial relationships between nursing facilities and property owners or management entities, as well as other state rules over ownership transparency, may provide an additional basis for further investigation, administrative action, and ultimately fines, penalties, or sanctions and could dissuade individuals and businesses from doing business with us or our independent subsidiaries.

Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility. These remedial actions could result in the imposition of fines, imposition of a license to a conditional or provisional status, suspension or revocation of a license, suspension or denial of payment for new admissions, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including criminal penalties. In the past, we have experienced inspection deficiencies that have resulted in the imposition of a provisional license and could experience these results in the future.

Furthermore, in some states, citation of one independent subsidiaries could negatively impact other independent subsidiaries in the same state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew, or maintain, existing licenses at other facilities, which may also trigger defaults or cross-defaults under our leases and our credit arrangements, or adversely affect our ability to operate or obtain financing in the future. CMS's proposed rules requiring disclosure of ownership, management and the owners of real property lessors or sublessors, which are greater and more intrusive than existing disclosure requirements heighten this risk. Our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations.

From time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements. If we elect to voluntary close any operations in the future or to opt to stop accepting new patients pending completion of a state or federal survey, it could negatively impact our financial condition and results of operation.

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our independent subsidiaries. We have had independent subsidiaries placed on SFF status in the past and other independent subsidiaries may be identified for such status in the future. We currently have no facility placed on SFF status.

CMS's changes to the SFF program and its look-back period may create greater risk of our facilities being subject to this program and subject to potential fines and sanctions, even after graduating from the SFF program.

As discussed in discussed in greater detail in Item 2., under *Government Regulation*, in 2022 CMS updated the SFF program with the intent to reduce the amount of time a SNF spends as an SFF and increase the number of nursing homes that progress through the SFF program. CMS clarified certain details of the SFF program updates in 2023 and how they are to be implemented by each state survey agency (SA). As part of the revisions to the SFF program, a priority in revising the SFF program was to address "yo-yo" noncompliance of SNFs that would graduate from the SFF program only to later see their compliance and quality measures regress after graduation, potentially requiring readmission to the SFF program. Among the measures implemented to avoid this issue of "yo-yo" noncompliance was a three-year look-back period for facilities that graduate from the SFF program to ensure that the quality and compliance improvements achieved through the SFF program were sustained. Facilities that graduate from the SFF program but continue to demonstrate poor compliance as evidenced by any SA's survey, such as for actual harm, substandard quality of care, or immediate jeopardy deficiencies, may be subject to enhanced enforcement by CMS, up to and including termination from the Medicare and/or Medicaid programs.

This three-year look-back for sustained improvements by facilities that graduate the SFF program poses risk for our independent subsidiaries, specifically those that may be subject to the SFF program or that have been subject to the SFF program in the past. As of June 30, 2024, we have three facilities graduated from the SFF program within the past three years. First, for SNFs that are selected by CMS for participation in the SFF program, or which currently are in the SFF program, even graduation from the program is no longer an assurance that the SNF will be able to continue its operations. Even one survey with a significant compliance deficiency, such as actual harm or an immediate jeopardy deficiency, may result in CMS—acting solely within its discretion—terminating the SNF's Medicare or Medicaid participation, likely triggering the termination of other payor contracts and rendering the facility economically unviable. Second, for SNFs that have graduated from the SFF program, they are subject to a three-year period of enhanced scrutiny where adverse findings by a SA and a single survey's finding of poor compliance may result in CMS discretionally terminating that facility's Medicare and/or Medicaid participation, which would likely cause other payors to terminate their agreements with the facility as well. As a result, the financial and manpower resources needed for graduation from the SFF program may be for nothing if, in the three years following graduation from the SFF program, a SNF receives a poor survey result and permits CMS to impose fines and penalties up to the termination of the facility's Medicare and Medicaid participation.

As discussed above, Medicare and Medicaid represent significant sources of payment for our independent subsidiaries. Any of our facilities' loss of a Medicare or Medicaid contract would significantly harm the financial performance of that facility. Additionally, if CMS perceived there to be common upstream ownership of multiple facilities that were participants in or graduates of the SFF program, CMS may seek to take enforcement actions against those other facilities due to their common ownership based on another facility's deficiencies after graduating the SFF program, with CMS imposing penalties up to and potentially including termination of those SNFs' participation in the Medicare and/or Medicaid programs.

Federal minimum staffing mandates may adversely affect our labor costs, ability to maintain desired levels of patient or resident capacity, and profitability.

On April 22, 2024 CMS issued its final rule establishing minimum staffing standards for skilled nursing facilities (the Staffing Rule). As discussed in more detail in Item 2., under *Government Regulation*, the Staffing Rule contains three primary staffing requirements which are phased in over the next several years. Due to pending legislation in both the House of Representatives and the Senate, industry litigation filed to dispute the Staffing Rule's validity and enforceability, as well as the long phase in of the requirements, the exact effects of the Staffing Rule cannot be ascertained. However, we expect that the Staffing Rule in its current form will have adverse financial consequences upon our business.

We may be required to hire substantially more staff members, particularly nurse practitioners, registered nurses, and nursing aides than currently staffed. Additionally, the Staffing Rule would place similar pressure on our competitors and result in sudden, expanded demand for nursing staff across the SNF industry. This sudden demand across the SNF industry may exacerbate an already difficult labor market, with demand for nursing staff far outstripping the supply of qualified individuals, and the salary requirements of both current and prospective staff increasing markedly to increase the likelihood of recruiting and retaining skilled caregivers.

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

Our non-Medicare and non-Medicaid revenue and profitability are affected by continuing efforts of third-party payors to maintain or reduce costs of healthcare, such as by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. In addition, sustained unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates.

Third-party payors may not make timely payments for our services, and we may be unable to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare and non-Medicaid sources of revenue and any changes in payment levels from current or future third-party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

As discussed in greater detail in Item 2., under *Government Regulation*, MACRA revised the payment system for physician and non-physician services. The changes to the therapy caps imposed on Medicare Part B outpatient therapy from this law have been changed by the BBA, and are subject to future budgetary changes through rulemaking and legislation, resulting in ongoing uncertainty regarding payment for these Medicare Part B services. Under the CY 2024 PF Final Rule, reductions in conversion factor, payments to providers and conditions imposed in exchange for higher payments may impose operational requirements and working conditions that further detract from and reduce our financial performance. Similarly, new final rules concerning the PACE program and the information it will collect from our independent subsidiaries may adversely affect the risk-adjusted reimbursement.

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

HIPAA, as amended by the HITECH Act, requires us to adopt and maintain business procedures and systems designed to protect the privacy, security and integrity of patients' individual health information, in addition to state laws governing the privacy of patient information. We must comply with these state privacy laws to the extent that they are more protective of healthcare information or provide additional protections not afforded by HIPAA. The regulations enacting HIPAA periodically change and the last proposed change was issued in late 2022. In 2024, CMS published the Interoperability Final Rule, which affects the data standards and APIs that entities may use. Additionally, CMS issued its final rule updating the separate confidentiality requirements for Substance Use Disorder (SUD) records maintained. Changes to these regulations may require our independent subsidiaries to modify certain policies, procedures and practices regarding the disclosure of residents' information. If we fail to comply with these state and federal laws, we could be subject to criminal penalties, civil sanctions, litigation, and be forced to modify our policies and procedures, in addition to undertaking costly breach notification and remediation efforts, as well as sustaining reputational harm.

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

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

Healthcare businesses are increasingly the target of cyberattacks whereby hackers disrupt business operations or obtain protected health information, often demanding large ransoms. Already in 2024, healthcare is the most-breached sector of the economy based on publicly disclosed information. At the end of the first quarter of 2023, the healthcare sector saw a 60% increase in the average weekly number of cyberattacks over 2021. By August of 2023, industry observers note that cybersecurity breaches in the healthcare industry had become less frequent, but larger in scope and affecting more patients than the prior year. Our business is dependent on the proper functioning and availability of our computer systems and networks. We cannot assure you that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations. Additionally, we cannot control the safety and security of our information held by third-party vendors with whom we contract. The techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect, and as such we (or third-party vendors) may be unable to anticipate these techniques or implement adequate preventive measures. In addition, hardware, software or applications we (or third-party vendors) develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise the security of information systems. Unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud or other forms of deception. Additionally, the rapid ongoing evolution and increased adoption of emerging technologies such as artificial intelligence and machine learning may make it more difficult to anticipate and implement protective measures to recognize, detect and prevent the occurrence of cybersecurity breaches.

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

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

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.

SNFs are required to perform consolidated billing for certain items and services furnished to patients and residents. The consolidated billing requirement requires the SNF to effectively bill for the entire package of care that its patients receive in these situations. Post-hospitalization skilled nursing services must be “bundled” into the hospital's diagnostic related group (DRG) payment in certain circumstances, in which case the hospital and SNF must effectively divide the payment that otherwise would have been made to the hospital. Although this practice is uncommon, it adversely affects SNF utilization and payments, whether due to the practical difficulty of this apportionment or hospitals being reluctant to lose revenue by discharging patients to a SNF. If more payments are required to be bundled in the future, this trend may continue, with our SNFs not receiving full reimbursement for all the services they provide, and have a further adverse effect on SNF utilization and revenue.

Increased competition for, or a shortage of, nurses and other skilled personnel could increase our staffing and labor costs and subject us to monetary fines.

Our success depends upon our ability to retain and attract nurses and other skilled personnel, such as Certified Nurse Assistants, social workers and speech, physical and occupational therapists, as well as skilled management personnel responsible for day-to-day facility operation. Each facility has a facility leader responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Depending upon the size of the facility, each facility leader is supported by facility staff who are directly responsible for day-to-day care of the patients, marketing and community outreach programs. Other key positions supporting each facility may include individuals responsible for physical, occupational and speech therapy, food service and maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

Our independent SNFs are located in the states of Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. All states follow the current federal regulation relative to staffing, which establishes that SNFs are required to staff to meet the needs of the residents present in the facility. In addition, several states have established minimum staffing requirements for facilities operating in those states.

Failure to comply with these requirements can, among other things, jeopardize a facility's compliance with the conditions of participation under relevant state and federal healthcare programs. If a facility is determined to be out of compliance with these requirements, it may be subject to a notice of deficiency, a citation, or a significant fine or litigation risk, with penalties including the suspension of patient admissions and the termination of Medicaid participation, or the suspension, revocation or non-renewal of the SNF's license.

Nonetheless, for the federal government or any state government to materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly. The broader labor market where we compete is in a state of disequilibrium where the needs of businesses such as ours outstrip the supply of available and willing workers. There is additional upward pressure on wages from different industries and more generally due to the current rate of inflation. Some of these industries compete with us for labor and others that do not, which makes it difficult to make significant hourly wage and salary increases due to the fixed nature of our reimbursement under insurance contracts as well as Medicare and Medicaid, in addition to our increasing variable costs. Due to the limited supply of qualified applicants who seek or are willing to accept employment, these broader concerns, may increase our labor costs or lead to potential staffing shortages, reduced operations to comply with applicable laws and regulations, or difficulty complying with those laws and regulations at current operational levels.

Federal laws and regulations, such as the Staffing Rule, may increase our costs of maintaining qualified nursing and skilled personnel, or make it more difficult for us to attract or retain qualified nurses and skilled staff members. Proposed legislation, such as the previously proposed Nursing Home Improvement Act and the proposed HCBS Access Act, may make it more expensive to compete for, hire, and retain nursing staff, if passed into law in substantially the same form as previously introduced to Congress. The Biden-Harris Administration's desire to increase staffing level requirements for the nursing home industry and to tie reimbursement to the salary, benefits, and retention of staff also may increase our labor costs. CMS has published guidance to surveyors addressing topics that specifically include nurse staffing and collection of payroll data to evaluate appropriate staffing levels, which may lead to future regulation that increase our staffing requirements and labor costs or lower revenues.

Similar state-level requirements in the states where our independent SNFs operate, whether such requirements are passed by statute, regulation, or executive order, may result in a shortage or inability to obtain nurses and skilled staff. Prior concerns about the COVID-19 vaccination IFR may be abated by the Omnibus Final Rule’s withdrawal of that IFR. The withdrawal of the COVID-19 vaccination IFR may allow for nursing and other personnel unwilling to receive the COVID-19 vaccination to re-enter the workforce for Medicare-certified facilities and increase the pool of hirable talent.

Increased competition for, or a shortage of, nurses or other trained personnel, or general ongoing inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility, and may adversely affect those facilities' quality ratings based on data reported to CMS. In addition, state laws regarding minimum wage increases, such as California's minimum wage increases for both health care and fast-food workers, may intensify competition for unskilled labor in both skilled and unskilled settings. For skilled workers within the skilled care market where we operate, the costs of skilled labor, which are already greater than unskilled labor, could increase further. Similarly, the increased minimum wage of unskilled labor will not only increase the cost of unskilled labor, but may also have effects that dissuade workers from training to join the skilled workforce to earn higher wage growth, resulting in a smaller pool of available skilled workers and further increased competition—and higher wages—for them. If we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations could be harmed.

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

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

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

As discussed in greater detail in Item 2., under *Government Regulation*, Civil and Criminal Fraud and Abuse Laws and Enforcement, the OIG regularly conducts investigations regarding certain payment or compliance issues within the healthcare industry. The OIG identified SNF compliance as an issue of concern in its 2021 and 2022 semi-annual reports to Congress, and its January 2023 study regarding SNF emergency preparedness identified the need for further oversight and addition of SNF emergency readiness to the OIG's fall 2023 work plan. In November of 2023, OIG added to its work plan an audit of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, for which OIG expects to issue a report in FY 2025. Nursing homes were also a topic of discussion in the OIG's 2023 semiannual report to Congress, which emphasized the continued protection and oversight of care that nursing facilities provide to residents. Among other things, the OIG recommended attention to the rate of reimbursement for professional services rendered within facilities. The OIG's reports to Congress have also recommended a reduction in the use of psychotropic drugs in nursing homes and urged CMS to evaluate the appropriateness of psychotropic drug use among residents, including the use of data to identify nursing homes with higher rates of use for potential further scrutiny and action. Based on this information, SNFs in particular are potential targets for more robust scrutiny and examination by regulators. Recent publications and statements by the Biden-Harris Administration have also called for greater scrutiny of SNF facilities.

To respond to the local community needs and the shifting of higher acuity patients from the acute care setting to the SNF setting, over time our overall patient mix has consistently shifted to higher acuity and higher-resource utilization patients in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording activities of daily living services, among other things. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

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

Some states require healthcare providers, including SNFs, to obtain prior approval, known as a certificate of need, for: (1) the purchase, construction or expansion of healthcare facilities; (2) capital expenditures exceeding a prescribed amount; or (3) changes in services or bed capacity.

Other states that do not require certificates of need have effectively barred the expansion of existing facilities and the establishment of new ones by placing partial or complete moratoria on the number of new Medicaid beds those states will certify in certain areas or throughout the entire state. Still other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. In addition, some states require the approval of the state Attorney General for acquisition of a facility being operated by a non-profit organization.

Our ability to acquire or construct new facilities or expand or provide new services at existing facilities would be adversely affected if we are unable to obtain the necessary approvals, if there are changes in the standards applicable to those approvals, or if we experience delays and increased expenses associated with obtaining those approvals. We may not be able to obtain licensure, certificate of need approval, Medicaid certification, state Attorney General approval or other necessary approvals for future expansion projects. Conversely, the elimination or reduction of state regulations that limit the construction, expansion or renovation of new or existing facilities could result in increased competition to us or result in overbuilding of facilities in some of our markets. If overbuilding in the skilled nursing industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

Newly enacted and proposed legislation in the States where our independent subsidiaries are located may affect our operations in terms of individual litigation and the broader regulatory environment.

A bill in the State of California was recently signed into law which increases the cap of non-economic damages awarded to plaintiffs who are successful in medical malpractice litigation. The cap increases from $0.25 million to $0.35 million beginning on January 1, 2023, then increases over the following 10 years until the cap reaches a maximum of $0.75 million, with further adjustments for inflation. In wrongful death cases, the cap increases from $0.25 million to $0.5 million on January 1, 2023, with incremental increases over the following 10 years until the cap reaches a maximum of $1.0 million, with adjustments for inflation. Due to California's influence on other states, other jurisdictions where we operate may enact similar laws. Similar to the potential incentive of increased damages caps, the Supreme Court’s recent decision in certain case may increase public interest in potential claims against SNFs and senior living facilities, particularly pertaining to specific civil rights claims against governmental actors rather than general liability claims against privately owned SNFs such as those operated by our independent subsidiaries. While there may be additional claims and litigation that arise from the Supreme Court's decision that have an adverse impact on our cash flow, it is not expected that the decision will have a significant impact on our business.

Another example, California’s adoption of the Skilled Nursing Facility Ownership and Management Reform Act of 2022, discussed in Item 2., *Government Regulation*, imposes new requirements for obtaining licenses to operate SNFs. These new requirements may delay or limit the ability to obtain new SNF licenses within that state, whether through acquisition of existing facilities or opening a new facility. This new law's obligations may increase the costs of obtaining licensure, make applications more time-consuming and complex, and may result in civil penalties and other sanctions against our independent subsidiaries in the event they are not compliant with these new licensure application requirements. As a result, this new law may delay or impede growth within California. As with the bill that increases the cap of non-economic damages for medical malpractice litigation, California’s influence on other states may result in this legislation becoming a model for other states and having similar, potentially adverse effects within those jurisdictions as well.

In late 2023, California passed and its governor signed into law SB-525, which would increase the minimum wage for healthcare workers upon passage of a companion bill imposing minimum spending requirements upon SNFs. As discussed in Item 2., Government Regulation, these proposed bills would create new and costly obligations on our independent subsidiaries if they became law and if enacted, would adversely affect our business, operations, and profitability.

As another example, Texas passed a bill which partially restored Medicaid state relief funding for SNFs through August 31, 2023, while it also considered legislation that contained direct care spending requirements and ownership, similar to proposed federal rulemaking discussed in Item 2., *Government Regulation*. While this bill provided financial relief to our independent subsidiaries in Texas, other proposed bills may impose the same regulatory requirements and limitations inherent in both the proposed legislation in other states and the federally proposed rule requiring disclosure of such information in applications and change-of-ownership disclosures, which may adversely affect our business, operations, and profitability.

Changes to federal and state employment-related laws and regulations could increase our cost of doing business.

Our independent subsidiaries are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act that governs such matters as minimum wages, overtime and other working conditions, the ADA and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the EEOC, regulations of the Office of Civil Rights, regulations of state attorney generals, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Changes to federal and state regulations and laws are discussed in more detail in Item 2., under *Government Regulation.*

The Biden-Harris Administration has requested HHS and CMS study and issue proposed rules regarding care-based careers, including improving access to training, increasing the attractiveness of compensation in care-based positions, and improving the retention and career progression of care workers. The administration has sought proposed rules that tie some of these issues, such as wages and retention, to Medicare reimbursement for facilities. Other pending legislation, such as the HCBS Access Act, indicate a legislative priority of providing funding for care-based careers that may affect our pool of desired workers. Rising operating costs due to labor shortages, greater compensation and incentives required to attract and retain qualified personnel and higher-than-usual inflation on items including energy, utilities, food and other goods used in our facilities and the costs for transporting these items could increase our cost and decrease our profits.

The compliance costs associated with these laws and evolving regulations could be substantial. By way of example, all of our independent subsidiaries are required to comply with the ADA, which has separate compliance requirements for “public accommodations” and “commercial properties,” but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law. While we are insured for these types of claims, we could be subject to damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

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

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

Compliance with federal and state fair housing, fire, safety and other regulations may require us to make unanticipated expenditures, which could be costly to us.

We must comply with the federal Fair Housing Act and similar state laws, which prohibit us from discriminating against individuals if it would cause such individuals to face barriers in gaining residency in any of our independent subsidiaries. Additionally, the Fair Housing Act and other similar state laws require that we advertise our services in such a way that we promote diversity and not limit it. We may be required, among other things, to change our marketing techniques to comply with these requirements.

In addition, our independent subsidiaries are required to operate in compliance with applicable fire and safety regulations, building codes and other land use regulations and food licensing or certification requirements as they may be adopted by governmental agencies and bodies from time to time. Like other healthcare facilities, our independent SNFs are subject to periodic surveys or inspections by governmental authorities to assess and assure compliance with regulatory requirements. Surveys occur on a regular (often annual or biannual) schedule, and special surveys may result from a specific complaint filed by a patient, a family member or one of our competitors. We may be required to make substantial capital expenditures to comply with these requirements. In some cases, we may be unable to comply with new regulations prior to their effective date exposing us to potential fines or regulatory action.

We depend largely upon reimbursement from third-party payors, and our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our independent subsidiaries as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of the patients of our independent subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability. We generally receive higher reimbursement rates for high acuity patients, and payors reimburse us at different rates. For the three and six months ended June 30, 2024, 71.2% and 71.4%, of our revenue was provided by government payors that reimburse us at predetermined rates, respectively. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of the patients of our independent subsidiaries for whom we receive Medicaid reimbursement, our results of operations may be adversely affected.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs may adversely affect our business. These tactics include contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services and we did not wish to accept such reductions, we may lose patients if we choose not to renew our contracts with these insurers at lower rates. Additionally, trade publications within the healthcare industry have reported on the trend of payors using the No Surprises Act as a means to force re-negotiation of reimbursement rates for providers and facilities, leading to litigation between these providers and/or facilities against payors and it may adversely affect us as well.

As discussed under Item 2., *Government Regulation*, the Biden-Harris Administration has requested HHS and CMS conduct studies to evaluate potential staffing, data reporting, employee compensation and retention, and resident experience regulations that may result in a reduction of our revenue from Medicare and Medicaid. CMS first requested information regarding these priorities in 2022 and subsequently published further requests for information from the public in the Federal Register to aid in studies and anticipated rulemaking. CMS's final rule regarding nursing home ownership disclosure represented a product of these efforts and imposes additional regulatory requirements for participation in those programs.

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

The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents of our independent subsidiaries and the services we provide. The industry has experienced an increased trend in the number and severity of litigation claims, due in part to the number of large verdicts, including large punitive damage awards. These claims are filed based upon a wide variety of claims and theories, including deficiencies under conditions of participation under certain state and federal healthcare programs. Plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers, employing a wide variety of advertising and solicitation activities to generate more claims. The increased caps on damages awarded in such actions, as discussed above, may trigger a larger number of these lawsuits against our independent subsidiaries in California and other states that adopt similar legislation. The defense of lawsuits has in the past, and may in the future, result in significant legal costs, regardless of the outcome. Additionally, increases to the frequency and/or severity of losses from such claims and suits may result in increased liability insurance premiums or a decline in available insurance coverage levels, which could materially and adversely affect our business, financial condition and results of operations. In addition to carrying third-party liability insurance, our captive insurance subsidiary provides professional liability and general liability insurance to various independent subsidiaries. See the risk factor titled "*Our self-insurance programs may expose us to significant and unexpected costs and losses.*"

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

We are subject to potential lawsuits under the FCA and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare or Medicaid) or other payor. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Due to these whistleblower incentives, qui tam lawsuits have become more frequent. For example, despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its previously issued CID, the involved qui tam relator moved forward with the complaint in December 2020. Refer to Part II, Item 1. *Legal Proceedings* for additional information on this case.

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

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

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

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

Congress has repeatedly considered, without passage, a bill that would require, among other things, that agreements to arbitrate nursing home disputes be made after the dispute has arisen rather than before prospective patients move in, to prevent nursing home operators and prospective patients from mutually entering into a pre-admission pre-dispute arbitration agreement. This bill, known as the Fairness in Nursing Home Arbitration Act, was introduced in the House of Representatives in 2021; the bill and its analogue introduced in the Senate have never made it out of the committees to which they were referred for discussion. The Fairness in Nursing Home Arbitration Act was re-introduced in the House of Representatives on January 29, 2024 and was referred to the Committee on Ways and Means and the Committee on Energy and Commerce. No action has been taken since these referrals of the bill to these committees.

Our independent subsidiaries use arbitration agreements, which have generally been favored by the courts, to streamline the dispute resolution process and reduce our exposure to legal fees and excessive jury awards. CMS has identified these arbitration agreements as an area of focus and issued guidance to state surveyors regarding federal requirements for the use of arbitration agreements in nursing home care, with non-compliance potentially resulting in fines and other sanctions. If we are not able to secure pre-admission arbitration agreements, our litigation exposure and costs of defense in patient liability actions could increase, our liability insurance premiums could increase, and our business may be adversely affected.

The outcomes of any of these litigation matters are difficult to predict and litigation and other legal claims are subject to inherent uncertainties. Those uncertainties include, but are not limited to, litigation costs and attorneys' fees, unpredictable judicial or jury decisions and the differing laws and judicial proclivities regarding damage awards among the states in which we operate. A further complication is that even where the possibility of an adverse outcome is remote under traditional legal analysis, juries sometimes substitute their subjective views in place of facts and established legal principles. Unexpected outcomes in such legal proceedings, or changes in management's evaluation or predictions of the likely outcomes of such proceedings (possibly resulting in changes in established reserves) could have a material adverse effect on our business, financial condition, and results of operations.

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

As an operator of healthcare facilities, we have a program to help us comply with various requirements of federal and private healthcare programs. Our compliance program includes, among other things, (1) policies and procedures modeled after applicable laws, regulations, sub-regulatory guidance and industry practices and customs that govern the clinical, reimbursement and operational aspects of our subsidiaries; (2) training about our compliance process for all of the employees of our independent subsidiaries, our directors and officers, and training about Medicare and Medicaid laws, fraud and abuse prevention, clinical standards and practices, and claim submission and reimbursement policies and procedures for appropriate employees; and (3) internal controls that monitor, among other things, the accuracy of claims, reimbursement submissions, cost reports and source documents, provision of patient care, services, and supplies as required by applicable standards and laws, accuracy of clinical assessment and treatment documentation, and implementation of judicial and regulatory requirements (i.e., background checks, licensing and training).

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

Through these internal inquiries, we have identified potential deficiencies in the assessment of and recordkeeping for small subsets of patients. We have assisted in implementing, targeted improvements in the assessment and recordkeeping practices to make them consistent with the existing standards and policies applicable to our independent subsidiaries. We continue to monitor the measures implemented for effectiveness and perform follow-up reviews to ensure compliance. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

If additional reviews result in identification and quantification of additional amounts to be refunded, we will accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course and within the time permitted by law. Failure to refund overpayments within required time frames (as described in greater detail above) could result in FCA liability and our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

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

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

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

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

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

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

During the six months ended June 30, 2024, we expanded our operations and real estate portfolio through a combination of long-term leases and real estate purchases, with the addition of 13 stand-alone skilled nursing operations and two campus operations. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage operations we may acquire in the future. Also, the newly acquired operations may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such operations quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our acquisitions, and our business may suffer.

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

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those businesses, against whom we may have little or no recourse. Many operations we have historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved independent subsidiaries and patient care , we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant operations into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, operations that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable.

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

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

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

As discussed in Item 2., under *Government Regulation*, CMS provides comparative public data, rating every SNF operating in each state based upon quality-of-care indicators. Certain private organizations engage in similar monitoring and ranking activities. CMS's system is the Five-Star Quality Rating System which gives each nursing home a rating of between one and five stars in various categories, with five-star ratings harder to obtain over time. The ratings are available on a consumer-facing website, Nursing Home Compare. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating and the rating may not reflect the improvements we were able to make until it is recalculated. Based on CMS's guidance and regulations, we expect more data to be collected by CMS and reported on the Nursing Home Compare website in the future. Additionally, CMS's ownership transparency final rule, which requires the disclosure of SNF ownership and affiliated parties, will ultimately provide for the public disclosure of information reported to CMS under that rule. Other states, including Iowa and California, have adopted similar statutes and regulations requiring the disclosure of this information, with California's most recent regulations addressing this topic taking effect in March of 2024. The publicly available information disclosed as a result of these laws and rules may result in potential residents perceiving our highly rated facilities to be less desirable if they share ownership with lower rated facilities, even if the lower rated facility is a new acquisition or has a lower score for reasons beyond our control.

CMS continues to increase quality measure thresholds, which is regularly increased every six months, making it more difficult to achieve upward and five-star ratings. CMS increased its quality measure thresholds in 2022, making it more difficult for facilities to obtain or maintain four- and five-star ratings. Some facilities may see a decline in their overall five-star rating absent any new inspection information, and as a result the five-star ratings of our independent subsidiaries may decline even as their quality measures remain unchanged or improve. Additionally, on the Nursing Home Compare website, CMS recently began displaying a consumer alert icon next to nursing homes that have been cited on inspection reports for incidents of abuse, neglect, or exploitation. In 2022, CMS updated the scoring measures used for SNFs to include six dimensions of staffing and turnover, which may adversely affect the rating of our facilities on the Nursing Home Compare website.

In July 2023, CMS revised the nursing-home level exclusion criteria used on the administrator turnover measure, adding information regarding its calculation of the staff turnover measure and publishing an updated ratings table, which identifies the points needed for each nursing facility to obtain certain star ratings within its state. This change made it more competitive to obtain a five-star rating, and more difficult to maintain such a rating once achieved. Only 10% of nursing facilities can receive a five-star rating in the state where it operates. These changes also increase the pressure on our independent subsidiaries to obtain a smaller number of available five-star ratings, as lower ratings may make it more difficult to attract prospective residents to receive our services.

In September 2023, CMS announced that it will update the staffing level case-mix adjustment methodology and freeze four of the quality measures used in the Nursing Home Five-Star Quality Rating System beginning with the April 2024 refresh of the Nursing Home Compare website data. In April 2024, CMS announced that it is freezing four quality measures, with one short-stay measure to be replaced in October of 2024 and the other three measures to be unfrozen in January of 2025. CMS will also be freezing three of its staffing level measures until July of 2024, although these frozen measures will not affect staff turnover measures. Additionally, CMS announced that it is changing its staffing rating methodology to give the lowest possible score to and penalize providers that fail to provide staffing data or provide erroneous staffing data. These changes risk our independent operating subsidiaries' facilities being incorrectly awarded a lower star rating, or prevented from attaining a deserved higher ranking due to favorable data not being reflected in CMS's five-star ratings due to the freeze or replacement of certain measures. These lower ratings may cause potential residents to evaluate these independent operating subsidiaries' facilities as less desirable, and result in fewer admissions and thus reduced revenue.

In July 2024, CMS will change the staffing case-mix adjustment methodology to a model based on PDPM. The Nursing Home Compare website will then begin posting staffing level measures that use this methodology. CMS will revise the staffing rating thresholds to maintain the same distribution of points for staffing measures that will be affected by this freeze and replacement. Further, CMS will penalize SNFs that submit erroneous data, or fail to submit data, by awarding them the lowest possible rating on that measure. We may be significantly affected if any of our independent subsidiaries fail to submit information for the MDS in 2024, or if CMS deems their MDS submissions to be erroneous. In addition to the uncertainty created by future changes to CMS's five-star ratings that currently are unknown, the potential negative consequences of freezing unfavorable data may adversely affect our star rating and negatively impact our ability to attract residents.

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

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

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

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

If any of these potential circumstances were to occur, our insurance carriers may cancel or not renew our policies, or require us to significantly increase our self-insured retention levels or pay substantially higher premiums for the same or reduced coverage for insurance, including workers compensation, property and casualty, automobile, employment practices liability, directors and officers liability, employee healthcare and general and professional liability coverages.

In some states, the law prohibits or limits insurance coverage for the risk of punitive damages arising from professional liability and general liability claims or litigation. Other states where we operate have experienced a withdrawal of insurers from the marketplace due to prior losses, or are at risk of insurers leaving the market due to changes in the law that make it difficult for those insurers to operate within the state. Coverage for punitive damages is also excluded under some insurance policies. As a result, we may be liable for punitive damage awards in these states that either are not covered or are in excess of our insurance policy limits. Claims against us, regardless of their merit or eventual outcome, could also inhibit our ability to attract patients or expand our business and could require our management to devote time to matters unrelated to the day-to-day operation of our business.

With few exceptions, workers compensation and employee health insurance costs have also increased markedly in recent years and are expected to increase in the future. To partially offset these increases, we have increased the amounts of our self-insured retention and deductibles in connection with general and professional liability claims. We also have implemented a self-insurance program for workers compensation in all states, and elected non-subscriber status for workers compensation in Texas. Due to the nature of our business and the residents we serve, including the risk of claims from residents as well as potential governmental action, it may be difficult to complete the underwriting process and obtain insurance at commercially reasonable rates. If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, or if the coverage levels we can economically obtain decline, our business may be adversely affected.

Our self-insurance programs may expose us to significant and unexpected costs and losses.

We maintain general and professional liability insurance and workers compensation insurance through a wholly-owned captive insurance subsidiary to insure our self-insurance reimbursements and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted.

Further, because our self-insurance reimbursements under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.

We also self-insure our employee health benefits. With respect to our health benefits self-insurance, our reserves and premiums are computed based on a mix of company specific and general industry data that is not specific to our own company. Even with a combination of limited company-specific loss data and general industry data, our loss reserves are based on actuarial estimates that may not correlate to actual loss experience in the future. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.

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

Our independent subsidiaries located in Arizona, California, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies and real estate markets, changes in governmental rules, presence and participation of insurers, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since over 22% of our independent subsidiaries are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as electrical power shortages, fires, earthquakes or mudslides, or increased liabilities that may arise from regulations as discussed within Item 2., under *Government Regulation*.

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

The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.

We continue to maintain our right to inform the employees of our independent subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. Historically, the staff at our independent subsidiaries that have been approached to unionize have uniformly rejected union organizing efforts. Forthcoming proposed rules from CMS, which, based on the Biden-Harris Administration's executive orders discussed under *Government Regulation* in Item 2., as well as potential legislation such as the HCBS Access Act aimed toward providing more resources to those considering care-based careers, may increase the likelihood of employee unionization due to increased emphasis on care-based careers in SNF facilities. If employees decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

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

As of June 30, 2024, we leased 222 of our 312 independent subsidiaries. Most of our leases are triple-net leases, which means that, in addition to rent, we are required to pay for the costs related to the property (including property taxes, insurance, and maintenance and repair costs). We are responsible for paying these costs notwithstanding the fact that some of the benefits associated with paying these costs accrue to the landlords as owners of the associated facilities.

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

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

Our Credit Facility has a borrowing capacity of up to $600.0 million in aggregate principal amount. As of June 30, 2024 and through the filing date of this report, we had no outstanding borrowings under our Credit Facility. Twenty-three of our subsidiaries have mortgage loans insured with the Department of Housing and Urban Development (HUD) for an aggregate amount of $148.6 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The terms of the mortgage loans range from 25- to 35-years.

We also have one outstanding promissory note with an aggregate principal amount of approximately $1.8 million as of June 30, 2024. The term of the note is 12 years. Because this promissory note is insured with HUD, our borrower subsidiary under the note is subject to HUD oversight and periodic inspections.

In addition, we had $2.8 billion of future operating lease obligations as of June 30, 2024. We intend to continue financing our independent subsidiaries through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, our outstanding Credit Facility and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage, project yield, net leverage ratios, minimum interest coverage ratios and minimum asset coverage ratios. These restrictions may interfere with our ability to obtain additional advances under our Credit Facility or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue.

From time to time, the financial performance of one or more of our mortgaged facilities may not comply with the required operating covenants under the terms of the mortgage. Any non-payment, noncompliance or other default under our financing arrangements could, subject to cure provisions, cause the lender to foreclose upon the facility or facilities securing such indebtedness or, in the case of a lease, cause the lessor to terminate the lease, each with a consequent loss of revenue and asset value to us or a loss of property. Furthermore, in many cases, indebtedness is secured by both a mortgage on one or more facilities, and a guaranty by us. In the event of a default under one of these scenarios, the lender could avoid judicial procedures required to foreclose on real property by declaring all amounts outstanding under the guaranty immediately due and payable, and requiring us to fulfill our obligations to make such payments. If any of these scenarios were to occur, our financial condition would be adversely affected. For tax purposes, a foreclosure on any of our properties would be treated as a sale of the property for a price equal to the outstanding balance of the debt secured by the mortgage. If the outstanding balance of the debt secured by the mortgage exceeds our tax basis in the property, we would recognize taxable income on foreclosure, but would not receive any cash proceeds, which would negatively impact our earnings and cash position. Further, because our mortgages and operating leases generally contain cross-default and cross-collateralization provisions, a default by us related to one facility could affect a significant number of other facilities and their corresponding financing arrangements and operating leases.

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

A housing downturn could decrease demand for senior living services.

Seniors often use the proceeds of home sales to fund their admission to senior living facilities. A downturn in the housing markets, including reductions in sales prices caused by increasing mortgage interest rates, economic uncertainty, recession, or a reduction in activity in the market for residential real estate, could adversely affect seniors' ability to afford our resident fees and entrance fees. If national or local housing markets enter a persistent decline, our occupancy rates, revenues, results of operations and cash flow could be negatively impacted.

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

We lease 30 of our properties to third-party operators. In the future, we might expand our leasing property portfolio to additional tenants. We have very limited control over the success or failure of our tenants' and operators' businesses and, at any time, a tenant or operator may experience a downturn in its business that weakens its financial condition. If that happens, the tenant or operator may fail to make its payments to us when due. Although our lease agreements give us the right to exercise certain remedies in the event of default on the obligations owing to us, we may determine not to do so if we believe that enforcement of our rights would be more detrimental to our business than seeking alternative approaches.

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

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

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

The majority of our independent subsidiaries have historically been SNFs. As we expand our presence in other relevant healthcare industries, our existing overall business model will continue to change and expose our company to risks in markets in which we have limited experience, such as the Eliminating Kickbacks in Recovery Act and other state laws that are not as well-developed in regulation and decisional authority as their federal equivalents. We expect that we will have to adjust certain elements of our existing business model, which could have an adverse effect on our business.

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

We rely significantly on appropriate referrals from hospitals, physicians, and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our independent subsidiaries. Our referral sources are not obligated to refer business to us and may refer business to other healthcare providers. We believe many of our referral sources refer business to us as a result of the quality of our patient care and our efforts to establish and build a relationship with our referral sources. If we lose, or fail to maintain, existing relationships with our referral resources, fail to develop new relationships, or if we are perceived by our referral sources as not providing high quality patient care, our occupancy rate and the quality of our patient mix could suffer. In addition, if any of our referral sources have a reduction in patients whom they can refer due to a decrease in their business, our occupancy rate and the quality of our patient mix could suffer.

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

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

The condition of the financial markets, including volatility and deterioration in the capital and credit markets, could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business, as well as negatively impact or impair the value of our current portfolio of cash, cash equivalents and investments, including U.S. Treasury securities and U.S.-backed investments.

Our cash, cash equivalents and investments are held in a variety of interest-bearing instruments, including U.S. treasury securities. As a result of the uncertain domestic and global political, economic, credit and financial market conditions, including the significant increases in the federal funds rate since 2021, an increase in the Consumer Price Index of 7% in 2022, expected Consumer Price Index increases above historical norms for 2023, investments in these types of financial instruments pose risks arising from liquidity and credit concerns. Given that future deterioration in the U.S. and global credit and financial markets is a possibility, no assurance can be made that losses or significant deterioration in the fair value of our cash, cash equivalents, or investments will not occur. Uncertainty surrounding the trading market for U.S. government securities or impairment of the U.S. government's ability to satisfy its obligations under such treasury securities could impact the liquidity or valuation of our current portfolio of cash, cash equivalents, and investments, a substantial portion of which were invested in U.S. treasury securities. Further, continued domestic and international political uncertainty, along with credit, and financial market uncertainty, may make it difficult for us to liquidate our investments prior to their maturity without incurring a loss, which would have a material adverse effect on our consolidated financial position, results of operations or cash flows.

We may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. U.S. capital markets can be volatile. We cannot assure you that additional capital will be available or available on terms acceptable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our billing information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews.

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

The continued use and growth of managed care organizations (MCOs) may contribute to delays or reductions in our reimbursement, including Managed Medicaid.

In forty-one states, including some of the largest where we operate, state Medicaid benefits are administered through MCOs. Typically, these MCOs manage commercial health and federal Medicare Advantage benefits under a managed care contract. Nationally, MCOs cover approximately 57 million and 30 million Medicaid and Medicare Advantage beneficiaries, respectively. MCOs may be more aggressive than state Medicaid and federal Medicare agencies in denying claims or seeking recoupment of payments so that their services under these managed contracts are profitable. The additional steps created by the use of MCOs in disbursement of funds creates more risk of delayed, reduced, or recouped payments for our independent subsidiaries, and additional avenues for risks that include fines and other sanctions, including suspension or exclusion from participation in various governmental programs.

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

Twenty-three of our independent subsidiaries are currently subject to regulatory agreements with HUD that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. Compliance with HUD's requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

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

Each of our independent subsidiaries is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the amount of money that was misappropriated. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties pursuant to federal and state laws.

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

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

If the separation of Pennant fails to qualify as generally tax-free for U.S. federal income tax purposes, we and our stockholders could be subject to significant tax liabilities.

The spin-off in 2019 is intended to qualify for tax-free treatment to us and our stockholders for U.S. federal income tax purposes. Accordingly, completion of the transaction was conditioned upon, among other things, our receipt of opinions from outside tax advisors that the distributions would qualify as a transaction that is intended to be tax-free to both us and our stockholders for U.S. federal income tax purposes under Sections 355 and 368(a)(1)(D) of the Internal Revenue Code. The opinions were based on and relied on, among other things, certain facts and assumptions, as well as certain representations, statements and undertakings, including those relating to the past and future conduct. If any of these facts, assumptions, representations, statements or undertakings is, or becomes, inaccurate or incomplete, or if any of the parties' breach any of their respective covenants relating to the transactions, the tax opinions may be invalid. Moreover, the opinions are not binding on the IRS or any courts. Accordingly, notwithstanding receipt of the opinion, the IRS could determine that the distribution and certain related transactions should be treated as taxable transactions for U.S. federal income tax purposes.

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

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

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

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

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

If Standard Bearer fails to qualify or remain qualified as a REIT, it will be subject to U.S. federal income tax as a regular corporation and could face substantial tax liability.

Standard Bearer currently operates, and intends to continue to operate, in a manner that allows it to qualify to be taxed as a REIT for U.S. federal income tax purposes. Standard Bearer has elected to be taxed as a REIT for U.S. federal income tax purposes.

If Standard Bearer fails to qualify to be taxed as a REIT in any year, it would be subject to U.S. federal income tax, including any applicable alternative minimum tax, on our taxable income at regular corporate rates, and dividends paid to its shareholders would not be deductible by it in computing its taxable income. Any resulting corporate liability could be substantial and would reduce the amount of cash available for distribution to its shareholders. Unless it was entitled to relief under certain Code provisions, it also would be disqualified from re-electing to be taxed as a REIT for the four taxable years following the year in which it failed to qualify to be taxed as a REIT.

Legislative or other actions affecting REITs could have a negative effect on Standard Bearer.

The rules dealing with U.S. federal income taxation are constantly under review by persons involved in the legislative process and by the IRS and the U.S. Department of the Treasury (Treasury). Changes to the tax laws or interpretations thereof, with or without retroactive application, could materially and adversely affect Standard Bearer's investors or Standard Bearer. We cannot predict how changes in the tax laws, including any tax reform called for by the current presidential administration, might affect Standard Bearer or its investors. New legislation, Treasury regulations, administrative interpretations or court decisions could significantly and negatively affect its ability to qualify to be taxed as a REIT or the U.S. federal income tax consequences to Standard Bearer or its investors of such qualification. For instance, the Tax Cuts and Jobs Act (TCJA) significantly changed the U.S. federal income tax laws applicable to businesses and their owners, including REITs and their shareholders. Technical corrections or other amendments to the TCJA or administrative guidance interpreting the TCJA may be forthcoming at any time. We cannot predict the long-term effect of the TCJA or any future law changes on REITs or their shareholders. Changes to the U.S. federal tax laws and interpretations thereof, whether under the TCJA or otherwise, could adversely affect an investment in our stock. Additionally, REIT's that are related to our operation will likely be subject to the disclosure requirements of CMS's ownership transparency final rule (and analogous state rules), and may subject these REITs to additional public scrutiny.

No prediction can be made regarding whether new legislation or regulation (including new tax measures) will be enacted by legislative bodies or governmental agencies, nor can we predict what consequences would result from this legislation or regulation. Accordingly, no assurance can be given that the currently anticipated tax treatment of an investment will not be modified by legislative, judicial or administrative changes, possibly with retroactive effect.

Standard Bearer could fail to qualify to be taxed as a REIT if income it receives from our tenants is not treated as qualifying income.

Under applicable provisions of the Code, Standard Bearer will not be treated as a REIT unless it satisfies various requirements, including requirements relating to the sources of its gross income. Rents received or accrued by it from its tenants will not be treated as qualifying rent for purposes of these requirements if the leases are not respected as true leases for U.S. federal income tax purposes and are instead treated as service contracts, joint ventures or other arrangements. If the leases are not respected as true leases for U.S. federal income tax purposes, Standard Bearer will likely fail to qualify to be taxed as a REIT.

Even if Standard Bearer remains qualified as a REIT, it may face other tax liabilities that reduce its cash flow.

Even if Standard Bearer remain qualified for taxation as a REIT, it may be subject to certain U.S. federal, state, and local taxes on its income and assets, including taxes on any undistributed income and state or local income, property and transfer taxes. For example, Standard Bearer may hold some of its assets or conduct certain of its activities through one or more taxable REIT subsidiaries (each, a TRS) or other subsidiary corporations that will be subject to U.S. federal, state, and local corporate-level income taxes as regular C corporations. In addition, it may incur a 100% excise tax on transactions with a TRS if they are not conducted on an arm's-length basis. Any of these taxes would decrease cash available for distribution to its shareholders.

Risks Related to Ownership of our Common Stock

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

Our ability to pay and maintain cash dividends is based on many factors, including our ability to make and finance acquisitions, our ability to negotiate favorable lease and other contractual terms, anticipated operating cost levels, the level of demand for occupancy at our facilities, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. The Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under the agreement. The failure to pay or maintain dividends could adversely affect our stock price.

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

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

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

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

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

Item 5. OTHER INFORMATION

Rule 10b5-1 Plan Elections

Barry R. Port, Chief Executive Officer and Director, entered into a Rule 10b5-1 trading arrangement on May 6, 2024. Mr. Port's 10b5-1 Plan provides for the potential exercise of vested stock options and the associated sale of up to 16,517 shares of the Company's common stock between August 5, 2024 and August 31, 2026.

Daren J. Shaw, a member of our Board of Directors, entered into a Rule 10b5-1 trading arrangement on May 6, 2024. Mr. Shaw's 10b5-1 Plan provides for the potential sale of up to 8,000 shares of the Company's common stock between August 15, 2024 and May 30, 2025.

Swati B. Abbott, a member of our Board of Directors, entered into a Rule 10b5-1 trading arrangement on June 11, 2024. Ms. Abbott's 10b5-1 Plan provides for the potential sale of up to 1,000 shares of the Company's common stock between September 13, 2024 and June 13, 2025.

These Rule 10b5-1 trading arrangements were entered into during open trading windows and are intended to satisfy the affirmative defense conditions of Rule 10b5-1 (c) under the Securities Exchange Act of 1934, as amended, and the Company's policies regarding transactions in Company securities.

Announcement of Lead Independent Director

On May 16, 2024, the Board of Directors approved and adopted the Lead Independent Director guidelines and also approved the appointment of Barry M. Smith as its lead independent director.

Mr. Smith has served as a member of our Board of Directors since 2014. He most recently served as Chairman and Chief Executive Officer of Magellan Health, Inc., the nation's largest provider of behavioral health services and a leading national provider of radiology benefit management services, specialty pharmacy, and prescription benefit management services, since 2013. He retired from Magellan at the end of 2019. He founded and served as Chairman, President and Chief Executive Officer of VistaCare, Inc., a national provider of hospice services, from 1996 to 2002, and he served as Chairman of VistaCare in 2003. From 1990 through 1995, Mr. Smith served as Chairman and Chief Executive Officer of Value Rx, Inc., which was then one of the country's largest pharmacy benefit management companies and, prior to that, served as vice president of operations for PCS Health Systems, also a pharmacy benefit management firm. We believe that Mr. Smith's extensive experience and leadership qualify him to serve as our Lead Independent Director.

The Lead Independent Director guidelines are available on the Investors Relations section of Ensign's website at http://investor.ensigngroup.net. Information on our website is not incorporated by reference into this report and should not be considered part of this report.

Item 6. EXHIBITS

EXHIBIT INDEX

Exhibit	Description
3.1	Fifth Amended and Restated Certificate of Incorporation of the Corporation, filed with the Delaware Secretary of State on November 15, 2007, and all Certificates of Amendment thereto filed with the Delaware Secretary of State through May 23, 2024.
3.2	Amended and Restated Bylaws of The Ensign Group, Inc. (attached as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on December 21, 2007)
3.3	Amendment to the Amended and Restated Bylaws, dated August 5, 2014 (attached as Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 001-33757) filed with the SEC on August 8, 2014)
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	Cover Page Interactive Data File - the cover page XBRL tags are embedded within the Inline XBRL document.

* Documents not filed herewith are incorporated by reference to the prior filings identified in the table above.

SIGNATURES

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

THE ENSIGN GROUP, INC.

July 25, 2024

BY: /s/ SUZANNE D. SNAPPER

Suzanne D. Snapper

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

Exhibit 3.1

[THE FOLLOWING COMPOSITE FIFTH AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE ENSIGN GROUP, INC. (THE "CORPORATION") REFLECTS THE PROVISIONS OF THE FIFTH AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE CORPORATION FILED WITH THE DELAWARE SECRETARY OF STATE ON NOVEMBER 15, 2007, AND ALL AMENDMENTS THERETO FILED WITH THE DELAWARE SECRETARY OF STATE THROUGH MAY 23, 2024, BUT IS NOT AN AMENDMENT AND/OR FURTHER RESTATEMENT THEREOF]

FIFTH AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE ENSIGN GROUP, INC.

The undersigned, Christopher R. Christensen and Gregory K. Stapley, hereby certify that:

FIRST: They are the duly elected and acting Chief Executive Officer and Secretary, respectively, of The Ensign Group, Inc., a Delaware corporation (the "Corporation").

SECOND: The Certificate of Incorporation of the Corporation was originally filed in the Office of the Secretary of the State of Delaware on May 27, 1999.

THIRD: The Amended and Restated Certificate of Incorporation of the Corporation was filed in the Office of the Secretary of the State of Delaware on August 9, 2000; the Second Amended and Restated Certificate of Incorporation of the Corporation was filed in the Office of the Secretary of the State of Delaware on April 23, 2001; the Third Amended and Restated Certificate of Incorporation of the Corporation was filed in the Office of the Secretary of the State of Delaware on April 28, 2004; the Fourth Amended and Restated Certificate of Incorporation of the Corporation was filed in the Office of the Secretary of the State of Delaware on September 26, 2005; and a Certificate of Amendment to the Fourth Amended and Restated Certificate of Incorporation was filed in the Office of the Secretary of State of Delaware on October 18, 2007.

FOURTH: The Fourth Amended and Restated Certificate of Incorporation of the Corporation is hereby amended and restated to read in its entirety as follows:

ARTICLE I

The name of the Corporation is The Ensign Group, Inc. (the "Corporation").

ARTICLE II

The address of the Corporation's registered office in the State of Delaware is 160 Greentree Drive, Suite 101, in the City of Dover, County of Kent, Delaware 19904. The name of the Corporation's registered agent at that address is National Registered Agents, Inc.

ARTICLE III

The purpose of the Corporation is to engage in any lawful act or activity for which corporations may now or hereafter be organized under the Delaware General Corporation Law ("DGCL"), as amended from time to time.

ARTICLE IV

The total number of shares of capital stock the Corporation is authorized to issue is One Hundred Fifty One Million (151,000,000) shares, consisting of One Hundred Fifty Million (150,000,000) shares of common stock, par value $0.001 per share (the "Common Stock"), and One Million (1,000,000) shares of preferred stock, par value $0.001 per share ("Preferred Stock").

A. The holders of shares of the Common Stock shall be entitled to vote on all matters to be voted on by the stockholders of the Corporation and shall be entitled to one vote for each share thereof held of record.

B. The Preferred Stock may be issued from time to time by the board of directors as shares of one or more classes or series, without further stockholder approval. Subject to the provisions hereof and the limitations prescribed by law, the board of directors is expressly authorized, by adopting resolutions providing for the issuance of shares of any particular class or series and, if and to the extent from time to time required by law, by filing with the Delaware Secretary of State a certificate setting forth the resolutions so adopted pursuant to the DGCL, to establish the number of shares to be included in each such class or series and to fix the designation and relative powers, including voting powers (which may be full, limited or non-voting powers), preferences, rights, qualifications and limitations and restrictions thereof, relating to the shares of each such class or series. The rights, privileges, preferences and restrictions of any such additional class or series may be subordinated to, pari passu with (including, without limitation, inclusion in provisions with respect to liquidation and acquisition preferences, redemption and/or approval of matters by vote), or senior to any of those of any present or future class or series of Preferred Stock or Common Stock. The board of directors is also authorized to increase or decrease the number of authorized shares of any class or series of Preferred Stock prior or subsequent to the issue of that class or series, but not below the number of shares of such class or series then outstanding. In case the number of shares of any class or series shall be so decreased, the shares constituting such decrease shall resume the status which they had prior to the adoption of the resolution originally fixing the number of shares of such class or series.

The authority of the board of directors with respect to each class or series shall include, but not be limited to, determination of the following:

(i) the distinctive class or serial designation of such class or series and the number of shares constituting such class or series;

(ii) the annual dividend rate on shares of such class or series, if any, whether dividends shall be cumulative and, if so, from which date or dates;

(iii) whether the shares of such class or series shall be redeemable and, if so, the terms and conditions of such redemption, including the date or dates upon and after which such shares shall be redeemable, and the amount per share payable in case of redemption, which amount may vary under different conditions and at different redemption dates;

(iv) the obligation, if any, of the Corporation to retire shares of such class or series pursuant to a sinking fund;

(v) whether shares of such class or series shall be convertible into, or exchangeable for, shares of stock of any other class or classes and, if so, the terms and conditions of such conversion or exchange, including the price or prices or the rate or rates of conversion or exchange and the terms of adjustment, if any;

(vi) whether the shares of such class or series shall have voting rights, in addition to any voting rights provided by law, and, if so, the terms of such voting rights;

(vii) the rights of the shares of such class or series in the event of voluntary or involuntary liquidation, dissolution or winding-up of the Corporation; and

(viii) any other relative rights, powers, preferences, qualifications, limitations or restrictions thereof relating to such class or series.

ARTICLE V

The number of directors to constitute the whole board of directors shall be such number (not less than four nor more than nine) as shall be fixed from time to time by resolution of the board of directors adopted by such vote as may be required in the bylaws. The board of directors shall be divided into three classes as nearly equal in number as may be feasible, hereby designated as Class I, Class II and Class III, with the term of office of one class expiring each year. For the purposes hereof, the initial Class I, Class II and Class III directors shall be so designated by a resolution of the board of directors. Each director shall serve for a term ending on the third annual meeting of stockholders following the annual meeting of stockholders at which such director was elected, or until his or her earlier death, resignation or removal; provided, however, that the directors first elected to Class I shall serve for a term ending on the Corporation's first annual meeting of stockholders following the effectiveness of this Fifth Amended and Restated Certificate of Incorporation, the directors first elected to Class II shall serve for a term

ending on the Corporation's second annual meeting of stockholders following the effectiveness of this Fifth Amended and Restated Certificate of Incorporation, and the directors first elected to Class III shall serve for a term ending on the Corporation's third annual meeting of stockholders following the effectiveness of this Fifth Amended and Restated Certificate of Incorporation. Subject to the rights, if any, of the holders of any Preferred Stock then outstanding, any vacancy in the board of directors, whether because of death, resignation, disqualification, an increase in the authorized number of directors, removal, or any other cause, may be filled by a vote of the majority of the remaining directors, although less than a quorum, or by a sole remaining director. When the board of directors fills a vacancy, the director chosen to fill that vacancy shall complete the term of the director he or she succeeds (or shall complete the term of the class of directors in which the new directorship was created) and shall hold office until such director's successor shall have been elected and qualified or until such director's earlier death, resignation or removal. No reduction of the authorized number of directors shall have the effect of removing any director prior to the expiration of such director's term of office. Directors shall continue in office until others are elected and qualified in their stead, or until their earlier death, resignation or removal. When the number of directors is changed, each director then serving as such shall nevertheless continue as a director of the class of which he or she is a member until the expiration of his or her current term, and any newly created directorships or any decrease in directorships shall be so assigned among the classes by a majority of the directors then in office, though less than a quorum, as to make all classes as nearly equal in number as may be feasible. Any director or the entire board of directors may be removed at any time by the affirmative vote of the holders of at least a majority of the shares then entitled to vote at an election of directors, but only for cause.

Advance notice of stockholder nominations for the election of members of the board of directors and of business to be brought by stockholders before any meeting of the stockholders of the Corporation shall be given in the manner provided in the bylaws of the Corporation.

Elections of directors need not be by written ballot unless the bylaws of the Corporation shall so provide.

ARTICLE VI

To the extent permitted by law, any action required to be taken at any annual or special meeting of stockholders of the corporation, or any action which may be taken at any annual or special meeting of such stockholders, may be taken without a meeting, without prior notice and without a vote, if: (i) a consent in writing, setting forth the action so taken shall be signed by the holders of outstanding stock having not less than the minimum number of votes that would be necessary to authorize or take such action at a meeting at which all shares entitled to vote thereon were present, and (ii) such action has been earlier approved by the board of directors. Prompt notice of the taking of the corporate action without a meeting by less than unanimous written consent shall be given to those stockholders who have not consented in writing. Special meetings of stockholders may be called only by the Chairman of the Board or the Chief Executive Officer or by the board of directors acting pursuant to a resolution adopted by a majority of the board of directors.

ARTICLE VII

In furtherance and not in limitation of the power conferred upon the board of directors by law, the board of directors shall have power to adopt, amend, alter and repeal from time to time the bylaws of the Corporation by majority vote of all directors except that any provision of the bylaws requiring, for board action, a vote of greater than a majority of the board shall not be amended, altered or repealed except by such supermajority vote. The stockholders of the Corporation may only adopt, amend or repeal bylaws with the affirmative vote of the holders of at least a majority of the voting power of all of the shares of the Common Stock outstanding and entitled to vote thereon.

ARTICLE VIII

The Corporation reserves the right to amend this Fifth Amended and Restated Certificate of Incorporation in any manner provided herein or permitted by the DGCL, and all rights and powers, if any, conferred herein on stockholders, directors and officers are subject to the reserved power. Notwithstanding the foregoing, without the affirmative vote of the holders of record of a majority of the voting power of all of the shares of the Common Stock outstanding entitled to vote thereon, the Corporation shall not alter, amend or repeal Article V, Article VI or Article VIII, of this Certificate of Incorporation or the provisions of Article IV providing for undesignated Preferred Stock.

ARTICLE IX

A. To the fullest extent permitted by the DGCL, as the same exists or as may hereafter be amended, a director or officer of the Corporation shall not be personally liable to the Corporation or its stockholders for monetary damages for breach of fiduciary duty as a director or officer, as applicable. For purposes of this Article IX, "officer" shall have the meaning provided in Section 102(b)(7) of the DGCL, as the same exists or as may hereafter be amended.

B. The Corporation shall indemnify to the fullest extent permitted by law any person made or threatened to be made a party to an action or proceeding, whether criminal, civil, administrative or investigative, by reason of the fact that he or she, his or her testator or intestate is or was a director or officer of the Corporation or any predecessor of the Corporation, or serves or served at any other enterprise as a director or officer at the request of the Corporation, or any predecessor to the Corporation.

C. Neither any amendment nor repeal of this Article IX, nor the adoption of any provision of the Corporation's Certificate of Incorporation inconsistent with this Article IX, shall eliminate or reduce the effect of this Article IX in respect of any matter occurring, or any action or proceeding accruing or arising or that, but for this Article IX, would accrue or arise, prior to such amendment, repeal or adoption of an inconsistent provision.

FIFTH: This Fifth Amended and Restated Certificate of Incorporation has been duly approved by the board of directors of the Corporation in accordance with the provisions of Sections 242 and 245 of the General Corporation Law of the State of Delaware.

SIXTH: This Fifth Amended and Restated Certificate of Incorporation has been duly approved, in accordance with Sections 228, 242 and 245 of the General Corporation Law of the State of Delaware, by the written consent of the holders of the requisite number of the shares of outstanding Common Stock and the requisite number of the shares of outstanding stock of each class of stock entitled to vote thereon as a class and the requisite number of the shares of outstanding stock of each series of Preferred Stock, and written notice of such action will be given to the holders of such shares who did not so consent, in each case in accordance with Section 228 of the General Corporation Law of the State of Delaware.

IN WITNESS WHEREOF, The Ensign Group, Inc. has caused this Fifth Amended and Restated Certificate of Incorporation to be signed by its Chief Executive Officer and Secretary on this 15th day of November, 2007.

THE ENSIGN GROUP, INC.

	/s/ Christopher R. Christensen
By:	Christopher R. Christensen, Chief Executive Officer
	/s/ Gregory K. Stapley
By:	Gregory K. Stapley, Secretary

EXHIBIT 31.1

I, Barry R. Port, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: July 25, 2024

/s/ Barry R. Port

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

EXHIBIT 31.2

I, Suzanne D. Snapper, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: July 25, 2024

/s/ Suzanne D. Snapper

Name: Suzanne D. Snapper

Title: *Chief Financial Officer, Executive Vice President and Director (principal financial officer and principal accounting officer)*

EXHIBIT 32.1

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

In connection with the Quarterly Report of The Ensign Group, Inc. (the Company) on Form 10-Q for the period ended June 30, 2024, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Barry R. Port, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m or 78o(d))); and

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

/s/ Barry R. Port

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

July 25, 2024

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

EXHIBIT 32.2

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

In connection with the Quarterly Report of The Ensign Group, Inc. (the Company) on Form 10-Q for the period ended June 30, 2024, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Suzanne D. Snapper, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m or 78o(d))); and

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

/s/ Suzanne D. Snapper

Name: Suzanne D. Snapper

Title: *Chief Financial Officer, Executive Vice President and Director (principal financial officer and principal accounting officer)*

July 25, 2024

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