ENSIGN GROUP, INC
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You should rely only on the information contained in this prospectus. We have not authorized any other person to provide you with different or additional information. If anyone provides you different or inconsistent information, you should not rely on it. We and the selling stockholders (solely to the extent the over-allotment option is exercised) are offering to sell and seeking offers to buy shares of our common stock only in jurisdictions where offers or sales are permitted. The information in this prospectus is only accurate as of the date of this prospectus, regardless of the time of delivery of this prospectus or any sale of our common stock.

For investors outside the United States: Neither we nor any of the selling stockholders, nor any of the underwriters for the offering of our common stock, have done anything that would permit this offering or possession or distribution of this prospectus in any jurisdiction where action for that purpose is required, other than in the United States. You are required to inform yourselves about, and to observe any restrictions relating to, this offering and the distribution of this prospectus.

PROSPECTUS SUMMARY

This summary highlights selected information contained in greater detail elsewhere in this prospectus and does not contain all of the information that you should consider before investing in our common stock. You should read the entire prospectus carefully, especially the risks of investing in our common stock, which we discuss under "Risk Factors" and our consolidated financial statements and related notes. In this prospectus, the terms "Ensign," "we," "us" and "our" refer to The Ensign Group, Inc. and its separate, wholly-owned independent subsidiaries, unless otherwise stated.

The Ensign Group, Inc.

We are a provider of skilled nursing and rehabilitative care services through the operation of facilities located in California, Arizona, Texas, Washington, Utah and Idaho. As of September 30, 2007, we owned or leased 61 facilities. All of our facilities are skilled nursing facilities, except for four facilities that offer both skilled nursing and assisted living arrangements in a campus setting, and three stand-alone assisted living facilities. At our facilities, each of which strives to be the facility of choice in the community it serves, we provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. Our facilities have a collective capacity of over 7,400 skilled nursing, assisted living and independent living beds. As of September 30, 2007, we owned 23 of our facilities and operated an additional 38 facilities under long-term lease arrangements with options to purchase 12 of those 38 facilities. We also have entered into agreements to purchase four of the 38 facilities that we operate under long-term lease arrangements, which are pending subject to certain closing conditions. For the year ended December 31, 2006 and the six months ended June 30, 2007, our skilled nursing services, including our integrated rehabilitative therapy services, generated approximately 97% of our revenue.

We have increased our revenue from $102.1 million in 2002 to $358.6 million in 2006. Over the same period, we have increased our net income from $3.6 million in 2002 to $22.5 million in 2006. We believe that much of our historical growth can be attributed to our expertise in acquiring underperforming facilities and transforming them into what we believe are market leaders in clinical quality, staff competency, employee loyalty and financial performance.

We were formed with the goal of establishing a new standard of quality care within the skilled nursing industry. Our organizational structure is centered around local leadership, with key operational decisions made at the facility level. Facility leaders and staff are trained and incentivized to pursue superior clinical outcomes, operating efficiencies and financial performance at their individual facility. In addition, our facility leaders are incentivized and enabled to share real-time operating data and to assist other facility leaders on ways to improve clinical care, maximize patient satisfaction and augment operational efficiencies, resulting in a high level of interdependence and sharing of best practices.

Competitive Strengths

We believe our success in acquiring, integrating and improving our facilities is a direct result of the following key competitive strengths:

- experienced and dedicated employees;
- reputation for quality care;
- unique incentive programs;
- staff and leadership development;
- innovative "Service Center" approach, which provides centralized services for our facilities;

community-focused approach;

attractive asset base; and

investment in information technology.

Growth Strategy

Much of our historical growth can be attributed to our expertise in acquiring underperforming facilities and transforming them into successful stand-alone facilities with strengths in clinical quality, staff competency, employee loyalty and financial performance. We believe our competitive strengths position us well for future revenue and earnings growth. Key elements of our growth strategy include the following:

continue to grow our talent base and develop future leaders;

increase our mix of high acuity patients;

focus on organic growth and internal operating efficiencies;

continue to acquire additional facilities, in existing and new markets; and

expand and renovate our existing facilities, and potentially begin constructing new facilities.

Our Industry

The senior living and long-term care industries consist of three primary living arrangement alternatives, with varying degrees of healthcare offerings depending upon the type of living arrangement and the health status of the patient or resident. The three primary living arrangement alternatives include independent living facilities, assisted living facilities and skilled nursing facilities. These alternatives are sometimes combined on a single campus, creating continuing care retirement communities. We predominantly focus on skilled nursing facilities, which provide both short-term, post-acute rehabilitative care for patients and long-term custodial care for residents who require skilled nursing and therapy care on an inpatient basis. We estimate the skilled nursing market in the United States represented approximately $100 billion in revenue in 2006.

Some of the major trends that have impacted the long-term care industry include the following:

shift of patient care to lower cost alternatives by federal and state governments as a result of increasing healthcare costs;

fragmentation in the senior living industry, and in particular in the skilled nursing market, providing significant acquisition and consolidation opportunities; and

increased demand for skilled nursing services resulting from increasing life expectancies and the aging population, as well as the modest decrease in the number of skilled nursing facilities in the United States over the past five years.

Acquisitions in 2006 and 2007

Since January 1, 2006, we have added an aggregate of 15 facilities located in Texas, Washington, Utah, Idaho, Arizona and California that we had not operated previously, 11 of which we purchased and four of which we acquired under long-term lease arrangements. Three of the long-term lease arrangements include purchase options. Thirteen of these acquisitions were skilled nursing facilities, one was an assisted living facility and one was a campus that offers both skilled nursing and assisted living services. These facilities contributed 1,668 beds to our operations, increasing our total capacity by 29%. With these acquisitions, we entered two new markets, Utah and Idaho. In Texas, we increased our

capacity by 684 beds, or approximately 146%, and more than doubled the number of our facilities in that state.

In 2006, we purchased eight facilities for an aggregate purchase price of $31.1 million, of which $29.0 million was paid in cash, and $2.1 million was financed with the assumption of a loan on one of the facilities. In 2006, we also purchased the underlying assets of three facilities that we were operating under long-term lease arrangements for an aggregate purchase price of $11.1 million, which ultimately was financed under our loan agreement with General Electric Capital Corporation.

In the first six months of 2007, we acquired three additional long-term care facilities for an aggregate purchase price of $9.4 million in cash, which included two skilled nursing facilities in Texas and one skilled nursing facility in Utah. In July 2007, we exercised an option to purchase one of our leased skilled nursing facilities for $3.3 million in cash. In addition, in July 2007, we entered into an operating lease agreement for a long-term care facility in Utah that is licensed for both skilled nursing and assisted living services. We did not make any material payments to the prior facility operator and we did not acquire any assets or assume any liabilities, other than our rights and obligations under a new operating lease and operations transfer agreement, as part of this transaction. We also simultaneously entered into a separate contract with the property owner to purchase the underlying property for $3.0 million, pending the property owner's resolution of certain boundary line issues with neighboring property owners. We expect that we will purchase the property under the contract if and when these title issues are resolved. Regardless of whether the title issues are resolved, we have the option to purchase the property for $3.0 million under the operating lease. In August 2007, we entered into an agreement that we expect will close on or before December 14, 2007, to purchase two skilled nursing facilities in California and one assisted living facility in Arizona, which also provides independent living services, for an aggregate purchase price of approximately $13.0 million. We currently operate these three facilities under master lease agreements. The lease agreements for the two skilled nursing facilities contain purchase options which are not currently exercisable. Upon the expected closing of these purchase agreements, we will own 27 of our facilities and operate 34 of our facilities under long-term lease arrangements with options to purchase nine of those 34 facilities.

Risks Relating to our Company

Investing in our common stock involves risks. As part of your evaluation of our company, you should consider the risks associated with our industry, our business, and this offering. See "Risk Factors" beginning on page 11 of this prospectus for a discussion of these risks, including, among others:

- the impact of federal and state changes to reimbursement and other aspects of Medicaid and Medicare, from which we derive a significant portion of our revenue;
- continuing cost containment pressures on Medicare and Medicaid spending;
- the costs of complying with extensive and complex federal and state government laws and regulations;
- potential preclusion from participating in federal or state healthcare programs, including Medicare and Medicaid;
- changes in the acuity mix of patients in our facilities as well as payor mix and payment methodologies;
- increased competition for, or a shortage of, nurses and other skilled personnel;
- litigation that could result in significant legal costs and large settlement amounts or damage awards;

difficulties in completing future facility acquisitions and efficiently integrating our acquisitions;

our dependence upon receiving funds from multiple independent operating subsidiaries; and

the high ownership concentration of our common stock among affiliates of ours, which may prevent other stockholders from influencing significant corporate decisions.

Corporate Information

The Ensign Group, Inc. is a holding company. All of our facilities are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of "we," "us" and "our" throughout this prospectus is not meant to imply that our facilities are operated by the same entity. In addition, one of our wholly-owned subsidiaries, which we call our Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to each operating subsidiary through contractual relationships between the Service Center and such subsidiaries. We were incorporated in 1999 in Delaware. Our corporate address is 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691, and our telephone number is (949) 487-9500. Our corporate website is located at *www.ensigngroup.net.* The information contained in, or that can be accessed through, our website does not constitute a part of this prospectus.

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

Except as otherwise indicated, the market data and industry statistics in this prospectus are based upon independent industry publications and other publicly available information. While we believe these publications to be reliable and appropriate, we have not independently verified such data and statistics, and we do not make any representation as to the accuracy of such information.

The Offering

Common stock offered by Ensign	4,000,000 shares
Common stock to be outstanding after this offering	20,446,380 shares
Common stock offered by the selling stockholders pursuant to the over-allotment option	600,000 shares
Use of proceeds	We expect to use the net proceeds from the sale of the shares of common stock we are offering to acquire additional facilities, to upgrade existing facilities, pay down debt and for working capital and other general corporate purposes. See "Use of Proceeds." We will not receive any proceeds from the sale of shares of common stock offered by the selling stockholders pursuant to the exercise by the underwriters of their over-allotment option.
Dividend policy	We have paid annual cash dividends since 2002 and quarterly cash dividends for each quarter since the first quarter of 2004. For each of the first and second quarters of 2007, we have paid cash dividends to our stockholders of $0.04 per share, for an aggregate dividend of approximately $1,316,000. We also declared cash dividends of $0.04 per share as of September 30, 2007, for an aggregate dividend of $658,000, which is payable on or before October 31, 2007. For 2006, we paid cash dividends to our stockholders of $0.03 per share for each of the first three quarters, and $0.04 per share for the fourth quarter, for an aggregate dividend of approximately $2,132,000. For 2005, we paid cash dividends to our stockholders of $0.02 per share for each of the first three quarters, and $0.03 per share for the fourth quarter, for an aggregate dividend of approximately $1,502,000. For 2004, we paid cash dividends to our stockholders of $0.01 per share for each of the first two quarters, and $0.015 per share for each of the third and fourth quarters, for an aggregate dividend of approximately $835,000. For 2002 and 2003, we paid annual cash dividends to our stockholders of an aggregate of approximately $240,000 and $408,000, respectively. We do not have a formal dividend policy, but we currently intend to continue to pay regular quarterly dividends to the holders of our common stock. However, the future payment of dividends is subject to the discretion of our board of directors and will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, restrictions imposed by financing arrangements, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. The loan and security agreement governing our revolving line of credit with General Electric Capital Corporation restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement.

Risk factors	See "Risk Factors" and the other information included in this prospectus for a discussion of factors you should consider carefully before investing in shares of our common stock.
NASDAQ Global Select Market symbol	ENSG

The number of shares of common stock to be outstanding after this offering is based on 16,446,380 shares outstanding as of June 30, 2007, which assumes the conversion of all of our outstanding preferred stock into 2,741,180 shares of common stock upon the completion of this offering, and does not include, as of such date:

- 1,129,500 shares of common stock issuable upon the exercise of outstanding options at a weighted average exercise price of $6.21 per share;
- 4,000,000 shares of common stock offered by this prospectus; and
- 1,000,000 shares of common stock, subject to certain automatic annual increases, reserved for future grant or issuance under our 2007 Omnibus Incentive Plan.

Unless otherwise indicated, all information in this prospectus assumes:

- the underwriters will not exercise their over-allotment option to purchase up to 600,000 additional shares of common stock from the selling stockholders;
- no exercise of outstanding options;
- an initial public offering price of $16.00 per share; and
- the effectiveness of our amended and restated certificate of incorporation and amended and restated bylaws upon completion of this offering.

Recent Financial Information

We are currently in the process of finalizing our unaudited consolidated financial statements for the three months ended September 30, 2007, and therefore, our final results are not yet available. Management's estimates of certain selected consolidated financial data, set forth below, are subject to finalization and completion of our quarterly review procedures and completion of the financial reporting process, which could result in adjustments. Our unaudited consolidated financial statements for the three months ended September 30, 2007, have not yet been reviewed by our independent registered public accounting firm.

We expect revenues for the three months ended September 30, 2007 to be between $102.0 million and $105.0 million, compared to revenues of $92.3 million for the three months ended September 30, 2006. This increase was primarily attributable to revenue generated by facilities acquired during 2006 and 2007. This growth was hindered in part by generally lower occupancy rates, and lower skilled mix and quality mix at such facilities, as well as operational challenges at two of our existing facilities. Historically, we have generally experienced lower occupancy rates, and lower skilled mix and quality mix in recently-acquired facilities, and we expect this trend to continue.

We expect income before income tax to be between $6.7 million and $7.3 million for the three months ended September 30, 2007, compared to income before income tax of $9.9 million for the three months ended September 30, 2006. The decline in income before income tax in the three months ended September 30, 2007 was due in part to factors described above, as well as the result of higher provision for insurance related to an increase in actuarially determined estimates, increasing professional fees and wages as we prepare to become a public company, increased depreciation expense related to the recently-acquired facilities, and higher stock-based compensation expense.

Summary Consolidated Financial Data

The following tables summarize our consolidated financial data for the periods presented and should be read together with "Selected Consolidated Financial Data," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial data and related notes appearing elsewhere in this prospectus. The summary consolidated statement of income data for the years ended December 31, 2004, 2005 and 2006 and the consolidated balance sheet data as of December 31, 2005 and 2006 included in this prospectus have been derived from our audited consolidated financial statements included herein. Our summary consolidated balance sheet data as of December 31, 2004 has been derived from our audited consolidated financial statements that are not included in this prospectus. Our summary consolidated statement of income data for the six months ended June 30, 2006 and 2007 and the consolidated balance sheet data as of June 30, 2007 are derived from our unaudited consolidated financial statements included herein. Our historical results are not necessarily indicative of the results that may be expected in the future.

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
	(in thousands, except share and per share data)				
Consolidated Statement of Income Data:					
Revenue	$ 244,536	$ 300,850	$ 358,574	$ 168,727	$ 198,247
Expenses:					
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	199,986	239,379	284,847	133,350	161,001
Facility rent cost of services	14,773	16,118	16,404	8,090	8,333
General and administrative expense	8,537	10,909	14,210	6,590	7,644
Depreciation and amortization	1,934	2,458	4,221	1,758	3,186
Total expenses	225,230	268,864	319,682	149,788	180,164
Income from operations	19,306	31,986	38,892	18,939	18,083
Other income (expense):					
Interest expense	(1,565)	(2,035)	(2,990)	(1,337)	(2,349)
Interest income	85	491	772	297	698
Other expense, net	(1,480)	(1,544)	(2,218)	(1,040)	(1,651)
Income before provision for income taxes	17,826	30,442	36,674	17,899	16,432
Provision for income taxes	6,723	12,054	14,125	7,081	6,600
Net income	$ 11,103	$ 18,388	$ 22,549	$ 10,818	$ 9,832
Net income per share(1):					
Basic	$ 0.83	$ 1.35	$ 1.66	$ 0.80	$ 0.72
Diluted	$ 0.63	$ 1.05	$ 1.34	$ 0.65	$ 0.58
Weighted average common shares outstanding(1):					
Basic	13,284,902	13,468,060	13,365,682	13,379,060	13,441,490
Diluted	17,519,032	17,505,040	16,823,242	16,720,378	16,891,202

(See footnotes on following pages)

	As of December 31,			As of June 30, 2007	As of June 30, 2007 Pro Forma As Adjusted(2)
	2004	2005	2006		
	(in thousands, except per share data)				
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 14,755	$ 11,635	$ 25,491	$ 12,939	$ 71,234
Working capital	21,526	19,087	28,281	20,938	77,798
Total assets	80,255	119,390	190,531	195,609	252,469
Long-term debt, less current maturities	24,820	25,520	63,587	63,072	63,072
Redeemable, convertible preferred stock	2,725	2,725	2,725	2,725	
Stockholders' equity	17,828	32,634	51,147	59,914	119,499
Cash dividends declared per common share	$ 0.05	$ 0.09	$ 0.13	$ 0.08	$ 0.06

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
	(in thousands)				
Other Non-GAAP Financial Data:					
EBITDA(3)	$ 21,240	$ 34,444	$ 43,113	$ 20,697	$ 21,269
EBITDAR(3)	36,013	50,562	59,517	28,787	29,602

(footnotes to prior page)

(1) See Note 2 of the Notes to the Consolidated Financial Statements.

(2) Gives effect to the conversion of all of our outstanding preferred stock into 2,741,180 shares of our common stock upon the closing of this offering and the receipt of the estimated proceeds from the sale of the 4,000,000 shares offered by this prospectus at the initial public offering price of $16.00 per share, after deducting underwriting discounts and commissions and estimated offering expenses payable by us, as described in "Underwriting."

(3) EBITDA and EBITDAR are supplemental non-GAAP financial measures. GAAP means generally accepted accounting principles in the United States. Regulation G, "*Conditions for Use of Non-GAAP Financial Measures*" and other provisions of the Securities Exchange Act of 1934, as amended, define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude facility rent cost of services. These non-GAAP financial measures are used in addition to and in conjunction with results presented in accordance with GAAP. These non-GAAP financial measures should not be relied upon to the exclusion of GAAP financial measures. These non-GAAP financial measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

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

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

(See footnotes continued on the following page)

(footnotes to prior pages)

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

We use EBITDA and EBITDAR:

as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;

to design incentive compensation and goal setting;

to allocate resources to enhance the financial performance of our business;

to evaluate the effectiveness of our operational strategies; and

to compare our operating performance to that of our competitors.

We typically use EBITDA and EBITDAR to compare the operating performance of each skilled nursing and assisted living facility. EBITDA and EBITDAR are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, and, with respect to EBITDAR, facility rent cost of services, which may vary from period to period depending upon various factors, including the method used to finance facilities, the amount of debt that we have incurred, whether a facility is owned or leased, the date of acquisition of a facility or business, or the tax law of the state in which a business unit operates. As a result, we believe that the use of EBITDA and EBITDAR provides a meaningful and consistent comparison of our business performance between periods and between facilities by eliminating certain items required by GAAP.

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

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

they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;

they do not reflect changes in, or cash requirements for, our working capital needs;

they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;

they do not reflect any income tax payments we may be required to make;

although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and EBITDA and EBITDAR do not reflect any cash requirements for such replacements; and

other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

(See footnotes continued on the following page)

(footnotes to prior pages)

We compensate for these limitations by using them only to supplement net income as calculated 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 and notes thereto in their entirety and not to rely on any single financial measure. Because these non-GAAP financial measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. For information about our financial results as reported in accordance with GAAP, see our consolidated financial statements and related notes included elsewhere in this prospectus.

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

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
			(in thousands)		
Consolidated Statement of Income Data:					
Net income	$ 11,103	$ 18,388	$ 22,549	$ 10,818	$ 9,832
Interest expense, net	1,480	1,544	2,218	1,040	1,651
Provision for income taxes	6,723	12,054	14,125	7,081	6,600
Depreciation and amortization	1,934	2,458	4,221	1,758	3,186
EBITDA	21,240	34,444	43,113	20,697	21,269
Facility rent cost of services	14,773	16,118	16,404	8,090	8,333
EBITDAR	$ 36,013	$ 50,562	$ 59,517	$ 28,787	$ 29,602

RISK FACTORS

Investing in our common stock involves a high degree of risk. You should consider carefully the following risk factors, as well as the other information in this prospectus, including our consolidated financial statements and the related notes, before deciding whether to invest in shares of our common stock. The risks described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe are immaterial may also impair our business operations. If any of the following risks actually occurs, our business, financial condition and results of operations would be materially adversely affected. In this case, the trading price of our common stock would likely decline and you might lose all or part of your investment in our common stock.

Risks Related to Our Industry

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

For the years ended December 31, 2005 and 2006 and the six months ended June 30, 2006 and 2007, we derived approximately 44%, 42%, 42% and 44% of our revenue, respectively, from the Medicaid program. For the years ended December 31, 2005 and 2006 and for the six months ended June 30, 2006 and 2007, we derived approximately 32%, 33%, 33% and 30% of our revenue, respectively, from the Medicare program. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations could be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 ("DRA"), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 ("BBA") caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our residents.

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting base rates or basis of payment, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates and frequency at which these programs reimburse us for our services. Implementation of these and other measures to reduce or delay reimbursement could result in substantial reductions in our revenue and profitability. Payors may disallow our requests for reimbursement based on 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 reasonably 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. These and other changes to the reimbursement and other aspects of Medicaid could adversely affect our revenue.

Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending.

Medicaid, which is largely administered by the states, is a significant payor for our skilled nursing services. Rapidly increasing Medicaid spending, combined with slow state revenue growth, has led many states to institute measures aimed at controlling spending growth. Because state legislatures control the amount of state funding for Medicaid programs, cuts or delays in approval of such funding by legislatures could reduce the amount of, or cause a delay in, payment from Medicaid to skilled nursing

facilities. We expect continuing cost containment pressures on Medicaid outlays for skilled nursing facilities.

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements such as provider taxes. Under provider tax arrangements, states collect taxes or fees from healthcare providers and then return the revenue to these providers as Medicaid expenditures. Congress, however, has placed restrictions on states' use of provider tax and donation programs as a source of state matching funds. Under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, the federal medical assistance percentage available to a state was reduced by the total amount of healthcare related taxes that the state imposed, unless certain requirements are met. The federal medical assistance percentage is not reduced if the state taxes are broad-based and not applied specifically to Medicaid reimbursed services. In addition, the healthcare providers receiving Medicaid reimbursement must be at risk for the amount of tax assessed and must not be guaranteed to receive reimbursement through the applicable state Medicaid program for the tax assessed. Lower Medicaid reimbursement rates would adversely affect our revenue, financial condition and results of operations.

If Medicare reimbursement rates decline, our revenue, financial condition and results of operations could be adversely affected.

Over the past several years, the federal government has periodically changed various aspects of Medicare reimbursements for skilled nursing facilities. Medicare Part A covers inpatient hospital services, skilled nursing care and some home healthcare. Medicare Part B covers physician and other health practitioner services, some supplies and a variety of medical services not covered under Medicare Part A.

Medicare coverage of skilled nursing services is available only if the patient is hospitalized for at least three consecutive days, the need for such services is related to the reason for the hospitalization, and the patient is admitted to the facility within 30 days following discharge from a Medicare participating hospital. Medicare coverage of skilled nursing services is limited to 100 days per benefit period after discharge from a Medicare participating hospital or critical access hospital. The patient must pay coinsurance amounts for the twenty-first day and each of the remaining days of covered care per benefit period.

Medicare payments for skilled nursing services are paid on a case-mix adjusted per diem prospective payment system ("PPS") for all routine, ancillary and capital-related costs. The prospective payment for skilled nursing services is based solely on the adjusted federal per diem rate. Although Medicare payment rates under the skilled nursing facility PPS increased temporarily for federal fiscal years 2003 and 2004, new payment rates for federal fiscal year 2005 took effect for discharges beginning October 1, 2004. A regulation by the Centers for Medicaid and Medicare Services ("CMS") sets forth a schedule of prospective payment rates applicable to Medicare Part A skilled nursing services that took effect on October 1, 2007, and included a full market basket increase of 3.3%. There can be no assurance that the skilled nursing facility PPS rates will be sufficient to cover our actual costs of providing skilled nursing facility services.

Skilled nursing facilities are also required to perform consolidated billing for items and services furnished to patients and residents during a Part A covered stay and therapy services furnished during Part A and Part B covered stays. The consolidated billing requirement essentially confers on the skilled nursing facility itself the Medicare billing responsibility for the entire package of care that its residents receive in these situations. The BBA also affected skilled nursing facility payments by requiring that post-hospitalization skilled nursing services be "bundled" into the hospital's Diagnostic Related Group ("DRG") payment in certain circumstances. Where this rule applies, the hospital and the skilled nursing facility must, in effect, divide the payment which otherwise would have been paid to the

hospital alone for the patient's treatment, and no additional funds are paid by Medicare for skilled nursing care of the patient. At present, this provision applies to a limited number of DRGs, but already is apparently having a negative effect on skilled nursing facility utilization and payments, either because hospitals are finding it difficult to place patients in skilled nursing facilities which will not be paid as before or because hospitals are reluctant to discharge the patients to skilled nursing facilities and lose part of their payment. This bundling requirement could be extended to more DRGs in the future, which would accentuate the negative impact on skilled nursing facility utilization and payments.

Skilled nursing facility prospective payment rates, as they may change from time to time, may be insufficient to cover our actual costs of providing skilled nursing services to Medicare patients. In addition, we may not be fully reimbursed for all services for which each facility bills through consolidated billing. If Medicare reimbursement rates decline, it could adversely affect our revenue, financial condition and results of operations.

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Private pay sources also reserve the right to conduct audits. An adverse review, audit or investigation could result in:

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

We believe that billing and reimbursement errors and disagreements are common in our industry. We are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the processes related to patient diagnosis and care, recordkeeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce.

In 2004, our Medicare fiscal intermediary began to conduct selected reviews of claims previously submitted by and paid to some of our facilities. While we have always been subject to post-payment audits and reviews, more intensive "probe reviews" are relatively new and appear to be a permanent procedure with our fiscal intermediary.

In some cases, probe reviews can also result in a facility being temporarily placed on prepayment review of reimbursement claims, requiring additional documentation and adding steps and time to the reimbursement process for the affected facility. Payment delays resulting from the prepayment review process could have an adverse effect on our cash flow, and such adverse effect could be material if multiple facilities were placed on prepayment review simultaneously.

Failure to meet claim filing and documentation requirements during the initial review could subject a facility to an even more intensive "targeted review," where a corrective action plan addressing perceived deficiencies must be prepared by the facility and approved by the fiscal intermediary. During a targeted review, additional claims are reviewed post-payment to ensure that the prescribed corrective

actions are being followed. Failure to make corrections or to otherwise meet the claim documentation and submission requirements could eventually result in Medicare decertification.

Separately, the federal government has also introduced a pilot program that utilizes independent contractors (other than the fiscal intermediaries) to identify and recoup Medicare overpayments. These contractors are paid a contingent fee based on recoupments. This pilot program could be extended or expanded based on the recommendation of CMS and the decision of Congress. Should this occur, we anticipate that the number of overpayment reviews will increase in the future, and that the reviewers could be more aggressive in making claims for recoupment. If future Medicare reviews result in significant refund payments to the federal government, it would have an adverse effect on our financial results.

The reduction in overall Medicaid and Medicare spending pursuant to the Deficit Reduction Act of 2005 and the increased costs to comply with the Deficit Reduction Act of 2005 could adversely affect our revenue, financial condition or results of operations.

The DRA provides for a reduction in overall Medicaid and Medicare spending by approximately $11.0 billion over five years. Under the DRA, individuals who transferred assets for less than fair market value during a five year look-back period will be ineligible for Medicaid for so long as they would have been able to fund their cost of care absent the transfer or until the transfer would no longer have been made during the look-back period. This period is referred to as the penalty period. The DRA also changes the calculation for determining when the penalty period begins, and prohibits states from ignoring small asset transfers and other asset transfer mechanisms. In addition, the legislation reduces Medicare skilled nursing facility bad debt payments by 30% for those individuals who are not dually eligible for Medicaid and Medicare. If any of our existing Medicaid patients become ineligible under the DRA during their stay, it would be difficult for us to collect from them or transfer them, and our revenue could decrease without a corresponding decrease in expenses related to the care of those patients. The loss of revenue associated with potential reductions in skilled nursing facility payments could adversely affect our revenue, financial condition or results of operations. The DRA also requires entities which receive at least $5.0 million in annual Medicaid dollars each year to provide education to their employees concerning false claims laws and protections for whistleblowers. The DRA also requires those entities to provide contractors and vendors with similar information. As a result, we have and will continue to expend resources to meet these requirements. Further, the requirement that we provide education to employees and contractors regarding false claims laws and other fraud and abuse laws may result in increased investigations into these matters.

On February 5, 2007, the Bush Administration released its fiscal year 2008 budget proposal, which, if enacted, would reduce Medicare spending by approximately $5.3 billion in fiscal year 2008 and $75.9 billion over five years. In particular, the budget proposal is expected to freeze payments in fiscal year 2008 for skilled nursing facilities, and the payment update would be 0.65% less than the routine inflation update (or market basket increase) annually thereafter. The budget also would move toward site-neutral post-hospital payments to limit what the Administration characterizes as inappropriate incentives for five conditions commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities. All bad debt reimbursement for unpaid beneficiary cost-sharing would be eliminated over four years. In addition, a budget mechanism would be established to automatically reduce Medicare spending if the portion of Medicare expenditures funded through general revenue is projected to exceed 45% within the next seven years. The budget also includes a series of proposals having an impact on Medicaid, including legislative and administrative changes that would reduce Medicaid payments by almost $26 billion over five years. Many of the proposed policy changes would require congressional approval to implement.

Annual caps that limit the amounts that can be paid for outpatient therapy services rendered to any Medicare beneficiary may reduce our future revenue and profitability or cause us to incur losses.

Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The BBA requires a combined cap for physical therapy and speech-language pathology and a separate cap for occupational therapy. Due to a series of moratoria enacted subsequent to the BBA, the caps were only in effect in 1999 and for a few months in 2003. With the expiration of the most recent moratorium, the caps were reinstated on January 1, 2006 at $1,740 for physical therapy and speech therapy, and $1,740 for occupational therapy. Each of these caps increased to $1,780 on January 1, 2007.

The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006 for patients with certain conditions or multiple complexities whose therapy services are reimbursed under Medicare Part B. The majority of the residents in our skilled nursing facilities and patients served by our rehabilitation therapy programs whose therapy is reimbursed under Medicare Part B have qualified for the exceptions to these reimbursement caps. The Tax Relief and Health Care Act of 2006 extended the exceptions through the end of 2007. Unless further extended, these exceptions will expire on December 31, 2007.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond December 31, 2007, which would have an even greater adverse effect on our revenue.

We are subject to extensive and complex federal and state government laws and regulations which could change at any time and increase our cost of doing business and subject us to enforcement actions.

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:

facility and professional licensure, certificates of need, permits and other government approvals;

adequacy and quality of healthcare services;

qualifications of healthcare and support personnel;

quality of medical equipment;

confidentiality, maintenance and security issues associated with medical records and claims processing;

relationships with physicians and other referral sources and recipients;

constraints on protective contractual provisions with patients and third-party payors;

operating policies and procedures;

certification of additional facilities by the Medicare program; and

payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to

frequent change. We believe that such regulations may increase in the future and we cannot predict the ultimate content,

timing or impact on us of any healthcare reform legislation. Changes in existing laws or regulations, or the enactment of new laws or regulations, could negatively impact our business. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties and other detrimental consequences, including denial of reimbursement, imposition of fines, temporary suspension of admission of new patients, suspension or decertification from the Medicaid and Medicare programs, restrictions on our ability to acquire new facilities or expand or operate existing facilities, the loss of our licenses to operate and the loss of our ability to participate in federal and state reimbursement programs.

We are subject to federal and state laws, such as the Federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, and the federal "Stark" laws, that govern financial and other arrangements among healthcare providers, their owners, vendors and referral sources, and that are intended to prevent healthcare fraud and abuse. Among other things, these laws prohibit kickbacks, bribes and rebates, as well as other direct and indirect payments or fee-splitting arrangements that are designed to induce the referral of patients to a particular provider for medical products or services payable by any federal healthcare program, and prohibit presenting a false or misleading claim for payment under a federal or state program. They also prohibit some physician self-referrals. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. Changes in these laws could increase our cost of doing business. 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 corporate integrity, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

We are also required to comply with state and federal laws governing the transmission, privacy and security of health information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to comply with certain standards for the use of individually identifiable health information within our company, and the disclosure and electronic transmission of such information to third parties, such as payors, business associates and patients. These include standards for common electronic healthcare transactions and information, such as claim submission, plan eligibility determination, payment information submission and the use of electronic signatures; unique identifiers for providers, employers and health plans; and the security and privacy of individually identifiable health information. In addition, some states have enacted comparable or, in some cases, more stringent privacy and security laws. If we fail to comply with these state and federal laws, we could be subject to criminal penalties and civil sanctions and be forced to modify our policies and procedures.

We are unable to predict the future course of federal, state and local regulation or legislation, including Medicaid and Medicare statutes and regulations. Changes in the regulatory framework, our failure to obtain or renew required regulatory approvals or licenses or to comply with applicable regulatory requirements, the suspension or revocation of our licenses or our disqualification from participation in federal and state reimbursement programs, or the imposition of other harsh enforcement sanctions could increase our cost of doing business and expose us to potential sanctions. Furthermore, if we were to lose licenses or certifications for any of our facilities as a result of regulatory action or otherwise, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness and lease obligations.

Any changes in the interpretation and enforcement of the laws or regulations governing our business could cause us to modify our operations, increase our cost of doing business and subject us to potential regulatory action.

The interpretation and enforcement of federal and state laws and regulations governing our operations, including, but not limited to, laws and regulations relating to Medicaid and Medicare, the

Federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, the federal Stark laws, and HIPAA, are subject to frequent change. Governmental authorities may interpret these laws in a manner inconsistent with our interpretation and application. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations and reduce, forego or refund reimbursements to the government, or incur other significant penalties. We could also be compelled to divert personnel and other resources to responding to an investigation or other enforcement action under these laws or regulations, or to ongoing compliance with a corporate integrity agreement, deferred prosecution agreement, court order or similar agreement. The diversion of these resources, including our management team, clinical and compliance staff, and others, would take away from the time and energy these individuals devote to routine operations. Furthermore, federal, state and local officials are increasingly focusing their efforts on enforcement of these laws, particularly with respect to providers who share common ownership or control with other providers. The increased enforcement of these requirements could affect our ability to expand into new markets, to expand our services and facilities in existing markets and, if any of our presently licensed facilities were to operate outside of its licensing authority, may subject us to penalties, including closure of the facility. Changes in the interpretation and enforcement of existing laws or regulations could increase our cost of doing business.

We are unable to predict the intensity of federal and state enforcement actions or the areas in which regulators may choose to focus their investigations at any given time. Changes in government agency interpretation of applicable regulatory requirements, or changes in enforcement methodologies, including increases in the scope and severity of deficiencies determined by survey or inspection officials, could increase our cost of doing business. Furthermore, should we lose licenses or certifications for any of our facilities as a result of changing regulatory interpretations, enforcement actions or otherwise, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness and lease obligations.

Increased civil and criminal enforcement efforts of government agencies against skilled nursing facilities could harm our business, and could preclude us from participating in federal healthcare programs.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, skilled nursing facilities. The focus of these investigations includes, among other things:

cost reporting and billing practices;

quality of care;

financial relationships with referral sources; and

medical necessity of services provided.

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

Federal law provides that practitioners, providers and related persons may not participate in most federal healthcare programs, including the Medicaid and Medicare programs, if the individual or entity has been convicted of a criminal offense related to the delivery of a product or service under these programs or if the individual or entity has been convicted under state or federal law of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a healthcare product

or service. Other individuals or entities may be, but are not required to be, excluded from such programs under certain circumstances, including, but not limited to, the following:

- conviction related to fraud;
- conviction relating to obstruction of an investigation;
- conviction relating to a controlled substance;
- licensure revocation or suspension;
- exclusion or suspension from state or other federal healthcare programs;
- filing claims for excessive charges or unnecessary services or failure to furnish medically necessary services;
- ownership or control of an entity by an individual who has been excluded from the Medicaid or Medicare programs, against whom a civil monetary penalty related to the Medicaid or Medicare programs has been assessed or who has been convicted of a criminal offense under federal healthcare programs; and
- the transfer of ownership or control interest in an entity to an immediate family or household member in anticipation of, or following, a conviction, assessment or exclusion from the Medicare or Medicaid programs.

The Office of Inspector General ("OIG"), among other priorities, is responsible for identifying and eliminating fraud, abuse and waste in certain federal healthcare programs. The OIG has implemented a nationwide program of audits, inspections and investigations and from time to time issues "fraud alerts" to segments of the healthcare industry on particular practices that are vulnerable to abuse. The fraud alerts inform healthcare providers of potentially abusive practices or transactions that are subject to criminal activity and reportable to the OIG. An increasing level of resources has been devoted to the investigation of allegations of fraud and abuse in the Medicaid and Medicare programs, and federal and state regulatory authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act and Medicaid and Medicare programs. Although we have created a corporate compliance program that we believe is consistent with the OIG guidelines, the OIG may modify its guidelines or interpret its guidelines in a manner inconsistent with our interpretation or the OIG may ultimately determine that our corporate compliance program is insufficient.

In some circumstances, if one facility is convicted of abusive or fraudulent behavior, then other facilities under common control or ownership may be decertified from participating in Medicaid or Medicare programs. Federal regulations prohibit any corporation or facility from participating in federal contracts if it or its principals have been barred, suspended or declared ineligible from participating in federal contracts. In addition, some state regulations provide that all facilities under common control or ownership licensed within a state may be de-licensed if one or more of the facilities are de-licensed. If any of our facilities were decertified or excluded from participating in Medicaid or Medicare programs, our revenue would be adversely affected.

Increased survey and enforcement efforts by governmental agencies on facilities could result in increased scrutiny by state and federal survey agencies.

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to identify multi-facility providers with patterns of noncompliance. In addition, the Department of Health and Human Services has adopted a rule that

requires CMS to charge user fees to healthcare facilities cited during regular certification, recertification or substantiated complaint surveys for deficiencies, which require a revisit to assure that corrections have been made. CMS is also increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey facilities more consistently.

In addition, CMS has adopted, and is considering additional regulations expanding, federal and state authority to impose civil money penalties in instances of noncompliance. When a facility is found to be deficient under state licensing and Medicaid and Medicare standards, sanctions may be threatened or imposed such as denial of payment for new Medicaid and Medicare admissions, civil monetary penalties, focused state and federal oversight and even loss of eligibility for Medicaid and Medicare participation or state licensure. Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients' care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance.

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, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility's existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously-certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators. In addition, in 2003, CMS established a program for identifying "special focus facilities," which are facilities identified in consultation with state health officials as needing special enforcement attention. These facilities are not immediately notified of their status as special focus facilities, but are placed under heightened scrutiny by federal and state officials. Such heightened scrutiny includes more frequent regulatory surveys and potentially heavier sanctions for noncompliance, among other things.

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

Some states require healthcare providers, including skilled nursing facilities, to obtain prior approval, known as a certificate of need, for:

the purchase, construction or expansion of healthcare facilities;

capital expenditures exceeding a prescribed amount; or

changes in services or bed capacity.

In addition, other states that do not require certificates of need have effectively barred the expansion of existing facilities and the development of new ones by placing partial or complete moratoria on the number of new Medicaid beds they will certify in certain areas or in the entire state. Other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. 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, 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.

Overbuilding in certain markets, increased competition and increased operating costs may adversely affect our ability to generate and increase our revenue and profits and to pursue our growth strategy.

The skilled nursing and long-term care industries are highly competitive and may become more competitive in the future. We compete with numerous other companies that provide long-term and rehabilitative care alternatives such as home healthcare agencies, life care at home, facility-based service programs, retirement communities, convalescent centers and other independent living, assisted living and skilled nursing providers, including not-for-profit entities. We have experienced and expect to continue to experience increased competition in our efforts to acquire and operate skilled nursing facilities. Consequently, we may encounter increased competition that could limit our ability to attract new patients, raise patient fees or expand our business.

In addition, if overbuilding in the skilled nursing industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

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

Our operations are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act which governs such matters as minimum wages, overtime and other working conditions, the Americans with Disabilities Act ("ADA") and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission, regulations of the Office of Civil Rights, regulations of state Attorneys General, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Because labor represents such a large portion of our operating costs, changes in federal and state employment-related laws and regulations could increase our cost of doing business.

The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our facilities are required to comply with the ADA. The ADA has separate compliance requirements for "public accommodations" and "commercial properties," but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if

implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law. While we are insured for these types of claims, we could experience damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

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 on certain bases in any of our practices if it would cause such individuals to face barriers in gaining residency in any of our facilities. Additionally, the Fair Housing Act and other similar state laws require that we advertise our services in such a way that we promote diversity and not limit it. We may be required, among other things, to change our marketing techniques to comply with these requirements.

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

We are subject to environmental and occupational health and safety regulations, which may subject us to sanctions, penalties and increased costs.

We are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. The types of regulatory requirements to which we are subject include, but are not limited to:

- air and water quality control requirements;
- occupational health and safety requirements (such as standards regarding blood-borne pathogens and ergonomics) and waste management requirements;
- specific regulatory requirements applicable to asbestos, mold, lead-based paint and underground storage tanks; and
- requirements for providing notice to employees and members of the public about hazardous materials and wastes.

If we fail to comply with these and other standards, we may be subject to sanctions and penalties. In addition, complying with these and other standards may increase our cost of doing business.

Risks Related to Our Business

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 facilities as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of our patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially increase or decrease the rate of program payments to us for our services. For the years ended December 31, 2004, 2005 and 2006 and the six months ended June 30, 2006 and 2007, 75.0%, 75.7%, 75.0%, 74.8% and 74.2%, respectively, of our revenue was provided by government payors that reimburse us at predetermined rates. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of our patients 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 payors attempt to control healthcare costs by contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services, we may lose patients if we choose not to renew our contracts with these insurers at lower rates.

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

We operate one or more skilled nursing facilities in the states of California, Arizona, Texas, Washington, Utah and Idaho. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities operating in that state. In California, the California Department of Health Services ("DHS"), enforces legislation that requires each skilled nursing facility to provide a minimum of 3.2 nursing hours per patient day. DHS enforces this requirement primarily through on-site reviews conducted during periodic licensing and certification surveys and in response to complaints. If a facility is determined to be out of compliance with this minimum staffing requirement, DHS may issue a notice of deficiency, or a citation, depending on the impact on patient care. A citation carries with it the imposition of monetary fines that can range from $100 to $100,000 per citation. The issuance of either a notice of deficiency or a citation requires the

facility to prepare and implement an acceptable plan of correction. If we are unable to satisfy the minimum staffing requirements required by DHS, we could be subject to significant monetary fines. In addition, if DHS were to issue regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.

Washington requires that at least one registered nurse directly supervise resident care for a minimum of 16 hours per day, seven days per week, and that one registered nurse or licensed practical nurse directly supervise resident care during the remaining eight hours per day, seven days per week. State regulators may inspect skilled nursing facilities at any time to verify compliance with these requirements. If deficiencies are found, regulators may issue a citation and require the facility to prepare and execute a plan of correction. Failure to satisfactorily complete a plan of correction can result in civil fines of between $50 and $3,000 per day or between $1,000 and $3,000 per instance. Failure to correct deficiencies can also result in the suspension, revocation or nonrenewal of the skilled nursing facility's license. In addition, deficiencies can result in the suspension of resident admissions and/or the termination of Medicaid participation. If we are unable to satisfy the minimum staffing requirements in Washington, we could be subject to monetary fines and potential loss of license.

In Idaho, skilled nursing facilities with 59 or fewer residents must provide an average of 2.4 nursing hours per resident per day, including the supervising nurse's hours. Skilled nursing facilities with 60 or more residents must provide an average of 2.4 nursing hours per resident per day, excluding the supervising nurse's hours. A facility complies with these requirements if the total nursing hours for the previous seven days equal or exceed the minimum staffing ratio for the period, averaged on a daily basis, if the facility has received prior approval to calculate nursing hours in this manner. State regulators may inspect at any time to verify compliance with these requirements. If any deficiencies are found and not timely or adequately corrected, regulators can revoke the facility's skilled nursing facility license. If we are unable to satisfy the minimum staffing requirements in Idaho, we could be subject to potential loss of our license.

Texas requires that a facility maintain a ratio of one licensed nursing staff person for each 20 residents for every 24 hour period, or a minimum of 0.4 licensed-care hours per resident day. State regulators may inspect a facility at any time to verify compliance with these requirements. Uncorrected deficiencies can result in the civil fines of between $100 and $10,000 per day per deficiency. Failure to correct deficiencies can further result in the revocation of the facility's skilled nursing facility license. In addition, deficiencies can result in the suspension of patient admissions and/or the termination of Medicaid participation. If we are unable to satisfy the minimum staffing requirements in Texas, we could be subject to monetary fines and potential loss of our license.

Arizona requires that at least one nurse must be present and responsible for providing direct care to not more than 64 residents. State regulators may impose civil fines for a facility's failure to comply with the laws and regulations governing skilled nursing facilities. Violations can result in civil fines in an amount not to exceed $500 per violation. Each day that a violation occurs constitutes a separate violation. In addition, such noncompliance can result in the suspension or revocation of the facility's license. If we are unable to satisfy the minimum staffing requirements in Arizona, we could be subject to fines and/or revocation of license.

Utah has no state-specific minimum staffing requirement beyond those required by federal regulations. Federal law requires that a facility have sufficient nursing staff to provide nursing and related services. Sufficient staff means, unless waived under certain circumstances, a licensed nurse to function as the charge nurse, and the services of a registered nurse for at least eight consecutive hours per day, seven days per week.

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.

We have hired personnel, including skilled nurses and therapists, from outside the United States. If immigration laws are changed, or if new and more restrictive government regulations proposed by the Department of Homeland Security are enacted, our access to qualified and skilled personnel may be limited. Increased competition for or a shortage of nurses or other trained personnel, or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge to our patients. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility. An increase in costs associated with, or a shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

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 our patients and residents and the services we provide. We and others in our industry are subject to a large and increasing number of claims and lawsuits, including professional liability claims, alleging that our services have resulted in personal injury, elder abuse, wrongful death or other related claims. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards. Plaintiffs tend to sue every healthcare provider who may have been involved in the patient's care and, accordingly, we respond to multiple lawsuits and claims every year.

In addition, plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers and other long-term care companies, and have employed a wide variety of advertising and publicity strategies. Among other things, these strategies include establishing their own Internet websites, paying for premium advertising space on other websites, paying Internet search engines to optimize their plaintiff solicitation advertising so that that it appears in advantageous positions on Internet search results, including results from searches for our company and facilities, using newspaper, magazine and television ads targeted at customers of the healthcare industry generally, as well as at customers of specific providers, including us. From time to time, law firms claiming to specialize in long-term care litigation have named us, our facilities and other specific healthcare providers and facilities in their advertising and solicitation materials. These advertising and solicitation activities could result in more claims and litigation, which could increase our liability exposure and legal expenses, divert the time and attention of our personnel from day-to-day business operations, and materially and adversely affect our financial condition and results of operations.

Certain lawsuits filed on behalf of patients of long-term care facilities for alleged negligence and/or alleged abuses have resulted in large damage awards against other companies, both in and related to our industry. In addition, there has been an increase in the number of class action suits filed against long-term and rehabilitative care companies. A class action suit was previously filed against us alleging, among other things, violations of certain California Health and Safety Code provisions and a violation of the California Consumer Legal Remedies Act at certain of our facilities. We settled this class action suit and this settlement was approved by the affected class and the Court in April 2007. However, we could be subject to similar actions in the future.

In addition to the class action, professional liability and other types of lawsuits and claims described above, we are also subject to potential lawsuits under the Federal False Claims Act and comparable state laws governing submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. These lawsuits, which may be initiated by the government or by a private party asserting direct knowledge of the claimed fraud or misconduct, can result in the imposition on a

company of significant monetary damages, fines and attorney fees (a portion of which may be awarded to the private parties who successfully identify the subject practices), as well as significant legal expenses and other costs to the company in connection with defending against such claims. Insurance is not available to cover such losses. Penalties for Federal False Claims Act violations include fines ranging from $5,500 to $11,000 for each false claim, plus up to three times the amount of damages sustained by the federal government. A violation may also provide the basis for exclusion from federally-funded healthcare programs. If one of our facilities or key employees were excluded from such participation, such exclusion could have a correlative negative impact on our financial performance. In addition, some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations.

In addition, the DRA created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. The DRA sets forth standards for state false claims acts to meet, including: (a) liability to the state for false or fraudulent claims with respect to any expenditure described in the Medicaid program; (b) provisions at least as effective as federal provisions in rewarding and facilitating whistleblower actions; (c) requirements for filing actions under seal for sixty days with review by the state's attorney general; and (d) civil penalties no less than authorized under the federal statutes. As such, we could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in existing and future markets in which we do business. Any of this potential litigation could result in significant legal costs and large settlement amounts or damage awards.

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. In one case, one of our landlords has filed suit alleging we are in default under one of our facility leases and is claiming damages arising from the alleged default. If we are unsuccessful in defending the litigation, we could be required to pay significant damages, which we believe have been adequately reserved for, and/or submit to other remedies available to the landlord under the lease agreement or applicable laws, which could have a material adverse effect on our financial condition and results of operations.

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

As Medicare and Medicaid certified providers, our operating subsidiaries undergo periodic audits and "probe reviews" by government agents, which can result in recoupments of prior revenue of the government, cause further reimbursements to be delayed or held and could result in civil or criminal sanctions.

Our facilities undergo regular claims submission audits by government reimbursement programs in the normal course of their business, and such audits can result in adjustments to their past billings and reimbursements from such programs. In addition to such audits, several of our facilities have recently participated in more intensive "probe reviews" as described above, conducted by our Medicare fiscal intermediary. Some of these probe reviews identified patient miscoding, documentation deficiencies and other errors in recordkeeping and Medicare billing. If the government or court were to conclude that such errors and deficiencies constituted criminal violations, or were to conclude that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or if it were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable levels, we and certain of our officers might face potential criminal charges and/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of

operations and financial condition. Such amounts could include claims for treble damages and penalties of up to $11,000 per false claim submitted to a federal healthcare program.

In addition, we and/or some of our key personnel could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare. In any event, it is likely that a governmental investigation alone, regardless of its outcome, would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings.

We believe that the U.S. Department of Justice is conducting an investigation into the billing and reimbursement processes of some of our operating subsidiaries, which could adversely affect our operations and financial condition.

In March 2007, we and certain of our officers received a series of notices from our bank indicating that the United States Attorney for the Central District of California had issued a subpoena to our bank requesting documents related to financial transactions involving us, ten of our operating subsidiaries, an outside investor group, and certain of our current and former officers. The U.S. Attorney voluntarily rescinded the subpoena before the bank delivered any documents. Subsequently, in June 2007, the U.S. Attorney sent a letter to one of our current employees requesting a meeting. The letter indicated that the U.S. Attorney and the U.S. Department of Health and Human Services Office of Inspector General were conducting an investigation of claims submitted to the Medicare program for rehabilitation services provided at our skilled nursing facilities. Although both we and the employee offered to cooperate, the U.S. Attorney later withdrew its meeting request. We have not been formally charged with any wrongdoing, served with any related subpoenas or requests, or directly notified of any concerns or investigations by the U.S. Attorney or any government agency. While we believe that the assertion of criminal charges, civil claims, administrative sanctions or whistleblower actions would be unwarranted, the U.S. Attorney's office has declined to discuss or provide us with any further information with respect to this matter and we cannot predict the outcome of any investigation or any possible related proceedings. To the extent the U.S. Attorney's office elects to pursue this matter, or if the investigation has been instigated by a *qui tam* relator who elects to pursue the matter, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

We are conducting an internal investigation into the billing and reimbursement processes of some of our operating subsidiaries, which could adversely affect our operations and financial condition.

We initiated an internal investigation in November 2006 when we became aware of an allegation of possible reimbursement irregularities at one or more of our facilities. We retained outside counsel to assist us in looking into these matters. This investigation is currently ongoing, and no conclusion regarding the allegation has yet been reached. At this time, we do not know what might be the ultimate outcome or findings of this investigation. If our internal investigation results in findings of significant billing and reimbursement noncompliance, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

We may be unable to complete future facility acquisitions at attractive prices or at all, which may adversely affect our revenue.

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

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

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

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

In 2006, we acquired ten skilled nursing facilities and one assisted living facility with a total of 1,160 beds. In 2007, we have acquired three skilled nursing facilities and one campus that offers both skilled nursing and assisted living services, with a total of 508 beds. 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 any future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such facilities quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our facility acquisitions, and our business may suffer.

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

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those facilities, against whom we may have little or no recourse. Many facilities we have historically acquired were underperforming financially and had clinical and regulatory issues. Even though we believe we have improved operations and patient care at facilities that we have acquired, we still may face post-acquisition regulatory issues, including, without limitation, payment recoupment related to our predecessors' prior noncompliance and/or our own inability to quickly bring non-compliant facilities into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us

to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities that we may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, or may not meet a risk profile that our investors find acceptable. In addition, we might encounter unanticipated difficulties and expenditures relating to any of the acquired facilities, including contingent liabilities. For example, when we acquire a facility, we generally assume the facility's existing Medicare provider number for purposes of billing Medicare for services. If CMS later determined that the prior owner of the facility had received overpayments from Medicare for the period of time during which it operated the facility, or had incurred fees in connection with the operation of the facility, CMS could hold us liable for repayment of the overpayments or fines. If the prior operator is defunct or otherwise unable to reimburse us, we may be unable to recover these funds. We may be unable to improve every facility that we acquire. In addition, operation of these facilities may divert management time and attention from other operations and priorities, negatively impact cash flows, result in adverse or unanticipated accounting charges, or otherwise damage other areas of our company if they are not timely and adequately improved.

We are subject to reviews relating to Medicare overpayments, which could result in recoupment to the federal government of Medicare revenue.

We are subject to reviews relating to Medicare services, billings and potential overpayments. Recent probe reviews, as described above, resulted in Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments of approximately $75,000 during the six months ended June 30, 2007, $253,000 in 2006 and $215,000 in 2005, a portion of which is currently under appeal. We anticipate that these probe reviews will increase in frequency in the future. In addition, four of our facilities are currently on prepayment review, and others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. We have no facilities that are currently undergoing targeted review.

Separately, the federal government has also introduced a pilot program that utilizes independent contractors (other than the fiscal intermediaries) to identify and recoup Medicare overpayments. These contractors are paid a contingent fee on recoupments. This pilot program could be extended or expanded based on the recommendation of CMS and the decision of Congress. Should this occur, we anticipate that the number of overpayment reviews will increase in the future, and that the reviewers could be more aggressive in making claims for recoupment. One of our facilities has been subjected to review under this pilot program, resulting in a recoupment to the federal government of approximately $12,000. If future Medicare reviews result in revenue recoupment to the federal government, it would have an adverse effect on our financial results.

Potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.

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 facilities. We have acquired at least one facility that we believe either already was or had been identified prior to the time of acquisition as a candidate for special focus facility status, as described above, and other facilities may be identified for such status in the future. 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. In the past, some of our facilities have been in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of the revenue associated with the Medicare and Medicaid patients admitted after the denial of payment date. Additional

sanctions could ensue and, if imposed, these sanctions, entailing various remedies up to and including decertification, would further negatively affect our financial condition and results of operations.

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other enforcement actions. The diversion of these resources, including our management team, clinical and compliance staff, and others take away from the time and energy that these individuals could otherwise spend on routine operations. As noted, from time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. The focus of these deficiency reports tends to vary from year to year. Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility, which could result in the imposition of fines, imposition of a provisional or conditional license, 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. We currently have no facilities whereby the provisional license status is the result of inspection deficiencies. Furthermore, in some states citations in one facility impact other facilities in the state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew existing licenses at other facilities, which may also trigger defaults or cross-defaults under our leases and our credit arrangements, or adversely affect our ability to operate or obtain financing in the future. If state or federal regulators were to determine, formally or otherwise, that one facility's regulatory history ought to impact another of our existing or prospective facilities, this could also increase costs, result in increased scrutiny by state and federal survey agencies, and even impact our expansion plans. Therefore, our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations as a whole.

We may not be successful in generating internal growth at our facilities by expanding occupancy at these facilities. We also may be unable to improve patient mix at our facilities.

Overall occupancy across all of our facilities was approximately 81% and 78% at December 31, 2006 and June 30, 2007, respectively, leaving opportunities for internal growth without the acquisition or construction of new facilities. Because a large portion of our costs are fixed, a decline in our occupancy could adversely impact our financial performance. In addition, our profitability is impacted heavily by our patient mix. We generally generate greater profitability from non-Medicaid patients. If we are unable to maintain or increase the proportion of non-Medicaid patients in our facilities, our financial performance could be adversely affected.

Termination of our patient admission agreements and the resulting vacancies in our facilities could cause revenue at our facilities to decline.

Most state regulations governing skilled nursing and assisted living facilities require written patient admission agreements with each patient. Several of these regulations also require that each patient have the right to terminate the patient agreement for any reason and without prior notice. Consistent with these regulations, all of our skilled nursing patient agreements allow patients to terminate their agreements without notice, and all of our assisted living resident agreements allow residents to terminate their agreements upon thirty days' notice. Patients and residents terminate their agreements from time to time for a variety of reasons, causing some fluctuations in our overall occupancy as patients and residents are admitted and discharged in normal course. If an unusual number of patients or residents elected to terminate their agreements within a short time, occupancy levels at our facilities

could decline. As a result, beds may be unoccupied for a period of time, which would have a negative impact on our revenue, financial condition and results of operations.

We face significant competition from other healthcare providers and may not be successful in attracting patients and residents to our facilities.

The skilled nursing and assisted living industries are highly competitive, and we expect that these industries may become increasingly competitive in the future. Our skilled nursing facilities compete primarily on a local and regional basis with many long-term care providers, from national and regional multi-facility providers that have substantially greater financial resources to small providers who operate a single nursing facility. We also compete with other skilled nursing and assisted living facilities, and with inpatient rehabilitation facilities, long-term acute care hospitals, home healthcare and other similar services and care alternatives. Increased competition could limit our ability to attract and retain patients, attract and retain skilled personnel, maintain or increase private pay and managed care rates or expand our business. Our ability to compete successfully varies from location to location depending upon a number of factors, including:

our ability to attract and retain qualified facility leaders, nursing staff and other employees;

the number of competitors in the local market;

the types of services available;

our local reputation for quality care of patients;

the commitment and expertise of our staff;

our local service offerings; and

the cost of care in each locality and the physical appearance, location, age and condition of our facilities.

We may not be successful in attracting patients to our facilities, particularly Medicare, managed care, and private pay patients who generally come to us at higher reimbursement rates. Some of our competitors have greater financial and other resources than us, may have greater brand recognition and may be more established in their respective communities than we are. Competing skilled nursing companies may also offer newer facilities or different programs or services than we do and may thereby attract current or potential patients. Other competitors may accept a lower margin, and, therefore, present significant price competition for managed care and private pay patients. In addition, some of our competitors operate on a not-for-profit basis or as charitable organizations and have the ability to finance capital expenditures on a tax-exempt basis or through the receipt of charitable contributions, neither of which are available to us.

Competition for the acquisition of strategic assets from buyers with lower costs of capital than us or that have lower return expectations than we do could limit our ability to compete for strategic acquisitions and therefore to grow our business effectively.

Several real estate investment trusts ("REITs"), other real estate investment companies, institutional lenders who have not traditionally taken ownership interests in operating businesses or real estate, as well as several skilled nursing and assisted living facility providers, have similar asset acquisition objectives as we do, along with greater financial resources and lower costs of capital than we are able to obtain. This may increase competition for acquisitions that would be suitable to us, making it more difficult for us to compete and successfully implement our growth strategy. Significant competition exists among potential acquirers in the skilled nursing and assisted living industries, including with REITs, and we may not be able to successfully implement our growth strategy or complete acquisitions, which could limit our ability to grow our business effectively.

If we do not achieve and maintain competitive quality of care ratings from CMS and private organizations engaged in similar monitoring activities, or if the frequency of CMS surveys and enforcement sanctions increases, our business may be negatively affected.

CMS, as well as certain private organizations engaged in similar monitoring activities, provides comparative data available to the public on its web site, rating every skilled nursing facility operating in each state based upon quality-of-care indicators. These quality-of-care indicators include such measures as percentages of patients with infections, bedsores and unplanned weight loss. In addition, CMS has undertaken an initiative to increase Medicaid and Medicare survey and enforcement activities, to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to require state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified. For example, one of our facilities is now surveyed every six months instead of every 12 to 15 months as a result of historical survey results that may date back to prior operators. We have found a correlation between negative Medicaid and Medicare surveys and the incidence of professional liability litigation. In 2006, we experienced a higher than normal number of negative survey findings in some of our facilities. If we are unable to achieve quality-of-care ratings that are comparable or superior to those of our competitors, our ability to attract and retain patients could be adversely affected.

Significant legal actions and liability claims against us in excess of insurance limits or outside of our insurance coverage could subject us to increased insurance costs, litigation reserves, operating costs and substantial uninsured liabilities.

We maintain liability insurance policies in amounts and with coverage limits and deductibles we believe are appropriate based on the nature and risks of our business, historical experience, industry standards and the price and availability of coverage in the insurance market. At any given time, we may have multiple current professional liability cases and/or other types of claims pending, which is common in our industry. In the past year, we have not paid or settled any claims in excess of the policy limits of our insurance coverages. We may face claims which exceed our insurance limits or are not covered by our policies.

We also face potential exposure to other types of liability claims, including, without limitation, directors' and officers liability, employment practices and/or employment benefits liability, premises liability, and vehicle or other accident claims. Given the litigious environment in which all businesses operate, it is impossible to fully catalogue all of the potential types of liability claims that might be asserted against us. As a result of the litigation and potential litigation described above, as well as factors completely external to our company and endemic to the skilled nursing industry, during the past several years the overall cost of both general and professional liability insurance to the industry has dramatically increased, while the availability of affordable and favorable insurance coverage has dramatically decreased. If federal and state medical liability insurance reforms to limit future liability awards are not adopted and enforced, we expect that our insurance and liability costs may continue to increase.

In some states, the law prohibits or limits insurance coverage for the risk of punitive damages arising from professional liability and general liability claims or litigation. Coverage for punitive damages is also excluded under some insurance policies. As a result, we may be liable for punitive damage awards in these states that either are not covered or are in excess of our insurance policy limits. Claims against us, regardless of their merit or eventual outcome, also could inhibit our ability to attract patients or expand our business, and could require our management to devote time to matters unrelated to the day-to-day operation of our business.

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

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

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

If any of these potential circumstances were to occur, our insurance carriers may require us to significantly increase our self-insured retention levels or pay substantially higher premiums for the same or reduced coverage for insurance, including workers compensation, property and casualty, automobile, employment practices liability, directors and officers liability, employee healthcare and general and professional liability coverages.

With few exceptions, workers' compensation and employee health insurance costs have also increased markedly in recent years. To partially offset these increases, we have increased the amounts of our self-insured retention ("SIR") and deductibles in connection with general and professional liability claims. We have also have implemented a self-insurance program for workers compensation in California, and elected non-subscriber status for workers compensation in Texas. If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected.

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

Since 2001, we have maintained insurance through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd., to insure our SIR and deductibles as part of a continually evolving overall risk management strategy. In addition, from 2001 to 2002, we used Standardbearer to reinsure a "fronted" professional liability policy, and we may elect to do so again in the future. We establish the premiums to be paid to Standardbearer, and the loss reserves set by that subsidiary based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted. Further, because our SIR under our general and professional liability and workers compensation programs apply 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.

Our self-insured liabilities are based upon estimates, and while our management believes that the estimates of loss are appropriate, the ultimate liability may be in excess of, or less than, recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that we could experience changes in estimated losses which could be material to net income. We believe that we have recorded reserves for general liability, professional liability, worker's compensation and healthcare benefits, at a level which has substantially mitigated the potential negative impact of adverse developments and/or volatility. In addition, if coverage becomes too difficult or costly to obtain from insurance carriers, we would have to self-insure a greater portion of our risks.

In May 2006, we began self-insuring our employee health benefits. With respect to our health benefits self-insurance, we do not yet have a meaningful loss history by which to set reserves or premiums, and have consequently employed general industry data that is not specific to our own company to set reserves and premiums. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.

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

Our facilities located in California and Arizona account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, 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 approximately half of our facilities are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as earthquakes or mudslides. In addition, to the extent we acquire additional facilities in Texas, we become more susceptible to revenue loss, cost increase or damage caused by hurricanes or flooding. Any significant loss due to a natural disaster may not be covered by insurance or may exceed our insurance limits and may also lead to an increase in the cost of insurance.

The actions of a national labor union that has been pursuing a negative publicity campaign criticizing our business may adversely affect our revenue and our profitability.

Unlike many other companies in our industry, we continue to assert our right to inform our employees about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staffs at our facilities that have been approached to unionize have uniformly rejected union organizing efforts. Because a majority of certain categories of service and maintenance employees at one of our facilities voted to accept union representation, we have recognized the union and been engaged in collective bargaining with that union since 2005. If employees of other facilities 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, and strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

The unwillingness on the part of both our management and staff to accede to union demands for "neutrality" and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union and its local chapter based in Oakland, California. Since 2002, this union has prosecuted a negative retaliatory publicity action, also known as a "corporate campaign," against us and has filed, promoted or participated in multiple legal actions against us. The union's campaign asserts, among other allegations, poor treatment of patients, inferior medical services

provided by our employees, poor treatment of our employees, and health code violations by us. In addition, the union has publicly mischaracterized actions taken by the California Department of Health Services against us and our facilities. In numerous cases, the union's allegations have created the false impression that violations and other events that occurred at facilities prior to our acquisition of those facilities were caused by us. Since a large component of our business involves acquiring underperforming and distressed facilities, and improving the quality of operations at these facilities, we may therefore be associated with the past poor performance of these facilities.

This union, along with other similar agencies and organizations, has demanded focused regulatory oversight and public boycotts of some of our facilities. It has also attempted to pressure hospitals, doctors, insurers and other healthcare providers and professionals to cease doing business with or referring patients to us. If this union or another union is successful in convincing our patients, their families or our referral sources to reduce or cease doing business with us, our revenue may be reduced and our profitability could be adversely affected. Additionally, if we are unable to attract and retain qualified staff due to negative public relations efforts by this or other union organizations, our quality of service and our revenue and profits could decline. Our strategy for responding to union allegations involves clear public disclosure of the union's identity, activities and agenda, and rebuttals to its negative campaign. Our ability to respond to unions, however, may be limited by some state laws, which purport to make it illegal for any recipient of state funds to promote or deter union organizing. For example, such a state law passed by the California Legislature was successfully challenged on the grounds that it was preempted by the National Labor Relations Act, only to have the challenge overturned by the Ninth Circuit in 2006. The case is now before the United States Supreme Court. If the Supreme Court upholds the Ninth Circuit's ruling, our ability to oppose unionization efforts could be hindered, and our business could be negatively affected.

A number of our facilities are operated under master lease arrangements or leases that contain cross-default provisions, and in some cases the breach of a single facility lease could subject multiple facilities to the same risk.

We occupy approximately 15% of our facilities under agreements that are structured as master leases. Under a master lease, we may lease a large number of geographically dispersed properties through an indivisible lease. 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. Failure to comply with Medicare or Medicaid provider requirements is a default under several of our master lease 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, which would have a negative impact on our capital structure and our ability to generate future revenue, and could interfere with our ability to pursue our growth strategy. Moreover, our equity interests in four of our subsidiaries, including three of our operating companies, which operate three facilities held under a master lease arrangement with one of our landlords, have been pledged to the landlord as additional security for the obligations under the master lease arrangement. In addition, we occupy approximately 25% of our facilities under individual facility leases that are held by the same or related landlords, the largest of which covers nine of our facilities and represented 2.6% and 10.4% of our net income for the year ended December 31, 2006 and the six months ended June 30, 2007, respectively. These leases typically contain cross-default provisions that could cause a default at one facility to trigger a technical default with respect to one or more other locations, potentially subjecting us to the various remedies available to the landlords under each of the related leases.

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 operations and cause us to lose facilities or experience foreclosures.

At June 30, 2007, we had $64.0 million of outstanding indebtedness under our Third Amended and Restated Loan Agreement (the "Term Loan"), our Amended and Restated Loan and Security Agreement, as amended (the "Revolver") and mortgage notes, plus $165.4 million of operating lease obligations. We intend to continue financing our facilities 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. The Revolver was set to mature in March 2007, but has been extended until November 19, 2007. We are currently in the process of amending our Revolver to both extend the maturity date and increase the amount of credit available to us thereunder, but we cannot assure you that we will be able to extend and increase the Revolver in a timely fashion or at all. If we are unable to do so, we intend to use proceeds of this offering and/or seek alternative sources of working capital financing to replace the Revolver, which may negatively impact our cash flow.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, 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 Loan, mortgage 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 operations, 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.

Our existing credit facilities and mortgage loans contain restrictive covenants and any default under such facilities or loans could result in a freeze on additional advances, the acceleration of indebtedness, the termination of leases, or cross-defaults, any of which would negatively impact our liquidity and inhibit our ability to grow our business and increase revenue.

Our outstanding credit facilities and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage and project yield. The debt service coverage ratios are generally calculated as revenue less operating costs, including an implied management fee and a reserve for capital expenditures, divided by the outstanding principal and accrued interest under the debt. These restrictions may interfere with our ability to obtain additional advances under existing credit facilities or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue. At times in the past we have failed to timely deliver audited financial statements to our lender as required under our loan covenants. In each such case, we obtained waivers from our lender. In addition, in December 2000, we were unable to make balloon payments due under two mortgages on one of our facilities, but we were able to negotiate extensions with both lenders, and paid off both loans in January 2001 as required by the terms of the extensions. If we fail to comply with any of our loan requirements, or if we experience any defaults, then the related indebtedness could become immediately due and payable prior to its stated maturity date. We may not be able to pay this debt if it becomes immediately due and payable.

If we decide to expand our presence in the assisted living industry, we would become subject to risks in a market in which we have limited experience.

The majority of our facilities have historically been skilled nursing facilities. If we decide to expand our presence in the assisted living industry, our existing overall business model would change and we would become subject to risks in a market in which we have limited experience. Although assisted living operations generally have lower costs and higher margins than skilled nursing, they typically generate lower overall revenue than skilled nursing operations. In addition, assisted living revenue is derived primarily from private payors as opposed to government reimbursement. In most states, skilled nursing and assisted living are regulated by different agencies, and we have less experience with the agencies that regulate assisted living. In general, we believe that assisted living is a more competitive industry than skilled nursing. If we decided to expand our presence in the assisted living industry, we would have to change our existing business model, which could have an adverse affect on our business.

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

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

We may need additional capital to fund our operations 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.

Continued expansion of our business through the acquisition of existing facilities, expansion of our existing facilities and construction of new facilities may require additional capital, particularly if we were to accelerate our acquisition and expansion plans. Financing may not be available to us or may be available to us only on terms that are not favorable. In addition, some of our outstanding indebtedness and long-term leases restrict, among other things, our ability to incur additional debt. If we are unable to raise additional funds or obtain additional funds on terms acceptable to us, we may have to delay or abandon some or all of our growth strategies. Further, if additional funds are raised through the issuance of additional equity securities, the percentage ownership of our stockholders would be diluted. Any newly issued equity securities may have rights, preferences or privileges senior to those of our common stock.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our 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. For example, in August 2007, we experienced a four week reimbursement delay in California due to a budget impasse in the California legislature that was resolved in September 2007. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. Our working capital management procedures may not successfully ameliorate the effects of any delays in our receipt of payments or reimbursements. Accordingly, such delays could have an adverse effect on our liquidity and financial condition.

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

Four of our facilities are currently subject to regulatory agreements with the Department of Housing and Urban Development ("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. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection, which we are currently awaiting. If our facility fails the re-inspection, the HUD Commissioner could exercise its authority to replace us as the facility operator. In such event, we could be forced to repay the HUD mortgage on this facility to avoid being replaced as the facility operator, which would negatively impact our cash and financial condition. The balance on this mortgage as of June 30, 2007 was approximately $6.7 million. In addition, we would be required to pay a prepayment penalty of approximately $0.3 million if this mortgage was repaid on June 30, 2007. This alternative is not available to us if any of our other three HUD-insured facilities were determined by HUD to be operationally deficient because they are leased facilities. 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.

Upkeep of healthcare properties is capital intensive, requiring us to continually direct financial resources to the maintenance and enhancement of our facilities and equipment.

Our ability to maintain and enhance our facilities 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 facilities and equipment. Some of our competitors may operate facilities that are not as old as ours, or may appear more modernized than our facilities, and therefore may be more attractive to prospective patients. We are sometimes more aggressive than our competitors in capital spending to address issues that arise in connection with aging facilities. If we are unable to direct the necessary financial and human resources to the maintenance of, upgrades to and modernization of our facilities and equipment, our business may suffer.

Failure to comply with existing environmental laws could result in increased expenditures, litigation and potential loss to our business and in our asset value.

Our operations are subject to regulations under various federal, state and local environmental laws, primarily those relating to the handling, storage, transportation, treatment and disposal of medical waste; the identification and warning of the presence of asbestos-containing materials in buildings, as well as the encapsulation or removal of such materials; and the presence of other substances in the indoor environment.

Our facilities generate infectious or other hazardous medical waste due to the illness or physical condition of the patients. Each of our facilities has an agreement with a waste management company for the proper disposal of all infectious medical waste, but the use of a waste management company does not immunize us from alleged violations of such laws for operations for which we are responsible even if carried out by a third party, nor does it immunize us from third-party claims for the cost to cleanup disposal sites at which such wastes have been disposed.

Some of the facilities we lease, own or may acquire may have asbestos-containing materials. Federal regulations require building owners and those exercising control over a building's management to identify and warn their employees and other employers operating in the building of potential hazards posed by workplace exposure to installed asbestos-containing materials and potential asbestos-containing materials in their buildings. Significant fines can be assessed for violation of these regulations. Building owners and those exercising control over a building's management may be subject to an increased risk of personal injury lawsuits. Federal, state and local laws and regulations also govern the removal, encapsulation, disturbance, handling and disposal of asbestos-containing materials and potential asbestos-containing materials when such materials are in poor condition or in the event of construction, remodeling, renovation or demolition of a building. Such laws may impose liability for improper handling or a release into the environment of asbestos-containing materials and potential asbestos-containing materials and may provide for fines to, and for third parties to seek recovery from, owners or operators of real properties for personal injury or improper work exposure associated with asbestos-containing materials and potential asbestos-containing materials. The presence of asbestos-containing materials, or the failure to properly dispose of or remediate such materials, also may adversely affect our ability to attract and retain patients and staff, to borrow using such property as collateral or to make improvements to such property.

The presence of mold, lead-based paint, underground storage tanks, contaminants in drinking water, radon and/or other substances at any of the facilities we lease, own or may acquire may lead to the incurrence of costs for remediation, mitigation or the implementation of an operations and maintenance plan and may result in third party litigation for personal injury or property damage. Furthermore, in some circumstances, areas affected by mold may be unusable for periods of time for repairs, and even after successful remediation, the known prior presence of extensive mold could adversely affect the ability of a facility to retain or attract patients and staff and could adversely affect a facility's market value and ultimately could lead to the temporary or permanent closure of the facility.

If we fail to comply with applicable environmental laws, we would face increased expenditures in terms of fines and remediation of the underlying problems, potential litigation relating to exposure to such materials, and a potential decrease in value to our business and in the value of our underlying assets.

We are unable to predict the future course of federal, state and local environmental regulation and legislation. Changes in the environmental regulatory framework could result in increased costs. In addition, because environmental laws vary from state to state, expansion of our operations to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our 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 facilities is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the amount of money that was misappropriated. In 2005 we became aware of two separate and unrelated instances of employees misappropriating an aggregate of approximately $380,000 in patient trust funds, some of which was recovered from the employees and some of which we were required to reimburse from our funds. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties pursuant to federal and state laws.

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

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

Risks Related to This Offering and Ownership of our Common Stock

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

Our ability to pay and maintain cash dividends is based on many factors, including our ability to make and finance acquisitions, our ability to negotiate favorable lease and other contractual terms, anticipated operating cost levels, the level of demand for our beds, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. In addition, the Revolver with General Electric Capital Corporation (the "Lender") restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement.

While we do not have a formal dividend policy, we currently intend to continue to pay regular quarterly dividends to the holders of our common stock, but future dividends will continue to be at the

discretion of our board of directors and will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, restrictions imposed by financing arrangements including pursuant to the loan and security agreement governing our revolving line of credit, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. From 2002 through 2006, we paid aggregate annual dividends equal to approximately 5% to 10% of our net income. We may not be able to pay or maintain dividends, and we may at any time elect not to pay dividends but to retain cash for other purposes. We also cannot assure you that the level of dividends will be maintained or increase over time or that increases in demand for our beds and monthly patient fees will increase our actual cash available for dividends to stockholders. It is possible that we may pay dividends in a future period that may exceed our net income for such period. The failure to pay or maintain dividends could adversely affect our stock price.

An active market for our shares of common stock may never develop which could make it difficult for you to sell your shares of common stock and could affect the value of your investment.

There has not been a public market for our common stock. An active trading market for our common stock may not develop following this offering. You may not be able to sell your shares quickly or at the market price if trading in our common stock is not active. The initial public offering price for the shares was determined by negotiations between us and representatives of the underwriters and may not be indicative of prices that will prevail in the trading market. Please see "Underwriting" for more information regarding our arrangements with the underwriters and the factors considered in setting the initial public offering price.

If the ownership of our common stock continues to be highly concentrated, it may prevent you and other stockholders from influencing significant corporate decisions and may result in conflicts of interest that could cause our stock price to decline.

Following the completion of this offering, our executive officers, directors and their affiliates will beneficially own or control approximately 62.7% of the outstanding shares of our common stock assuming the underwriters do not exercise their over-allotment option, of which Roy Christensen, our Chairman of the board of directors, Christopher Christensen, our President and Chief Executive Officer, and Gregory Stapley, our Vice President and General Counsel, will beneficially own approximately 19.1%, 19.0% and 5.8%, respectively, of the outstanding shares. Accordingly, our current executive officers, directors and their affiliates, if they act together, will have substantial control over the outcome of corporate actions requiring stockholder approval, including the election of directors, any merger, consolidation or sale of all or substantially all of our assets or any other significant corporate transactions. These stockholders may also delay or prevent a change of control of us, even if such a change of control would benefit our other stockholders. The significant concentration of stock ownership may adversely affect the trading price of our common stock due to investors' perception that conflicts of interest may exist or arise.

If securities or industry analysts do not publish research or reports about our business, if they change their recommendations regarding our stock adversely or if our operating results do not meet their expectations, our stock price and trading volume could decline.

The trading market for our common stock will be influenced by the research and reports that industry or securities analysts publish about us or our business. If one or more of these analysts cease coverage of our company or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our operating results do not meet their expectations, our stock price could decline.

The market price and trading volume of our common stock may be volatile, which could result in rapid and substantial losses for our stockholders.

Even if an active trading market develops, the market price of our common stock may be highly volatile and could be subject to wide fluctuations. In addition, the trading volume in our common stock may fluctuate and cause significant price variations to occur. If the market price of our common stock declines, you may be unable to resell your shares at or above your purchase price. We cannot assure you that the market price of our common stock will not fluctuate or decline significantly in the future. In the past, when the market price of a stock has been volatile, holders of that stock have instituted securities class action litigation against the company that issued the stock. If any of our stockholders brought a lawsuit against us, we could incur substantial costs defending or settling the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business.

Future offerings of debt or equity securities by us may adversely affect the market price of our common stock.

In the future, we may attempt to increase our capital resources by offering debt or additional equity securities, including commercial paper, medium-term notes, senior or subordinated notes, series of preferred shares or shares of our common stock. Upon liquidation, holders of our debt securities and preferred shares, and lenders with respect to other borrowings, would receive a distribution of our available assets prior to any distribution to the holders of our common stock. Additional equity offerings may dilute the economic and voting rights of our existing stockholders or reduce the market price of our common stock, or both. Because our decision to issue securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our common stock bear the risk of our future offerings reducing the market price of our common stock and diluting their share holdings in us. We also intend to continue to actively pursue acquisitions of facilities and may issue shares of stock in connection with these acquisitions.

Any shares issued in connection with our acquisitions, the exercise of outstanding stock options or otherwise would dilute the holdings of the investors who purchase our shares in this offering.

New investors in our common stock will experience immediate and substantial dilution.

The initial public offering price of our common stock is substantially higher than the net tangible book value per share of our existing common stock. As a result, purchasers of our common stock in this offering will incur immediate and substantial dilution of $10.42 in pro forma as adjusted net tangible book value per share of common stock, based on the initial public offering price of $16.00 per share.

We have broad discretion with respect to the application of the net proceeds obtained from this offering and may not use these funds in a manner which you would approve.

We will have broad discretion as to the application of the net proceeds from this offering. We intend to use the net proceeds of this offering to fund possible future acquisitions of skilled nursing facilities and businesses engaged in activities that are similar or complementary to our business, to fund expansions, improvements and upgrades at our existing facilities and the development and construction of new skilled nursing facilities, and to pay down debt and for general corporate purposes, including working capital. We may not use these funds in a manner which you would approve.

The number of shares eligible for sale following this offering may depress the market price of our common stock.

Sales of a substantial number of shares of our common stock in the public market, or the perception that substantial sales may occur, could cause the market price of our common stock to decrease. Based on the shares of our common stock outstanding as of June 30, 2007, immediately after

the completion of this offering, we will have 20,446,380 shares of common stock outstanding. In general, the shares sold in this offering will be freely transferable without restriction or additional registration under the Securities Act of 1933, as amended, or the Securities Act. In addition, all of the remaining 16,446,380 shares of common stock that will be outstanding after this offering will be available for sale in the public markets pursuant to Rule 144 or Rule 701 promulgated under the Securities Act. Assuming the underwriters do not exercise their over-allotment option, 15,932,480 shares will be subject to lock-up agreements or market stand-off provisions entered into by our directors, executive officers and certain stockholders. D.A. Davidson & Co. may, in its sole discretion, permit any director, executive officer, employee or stockholder who is subject to this lock-up to sell shares prior to the expiration of their respective lock-up agreements. Such lock-up agreements and market stand-off provisions will expire 180 days after the execution of the underwriting agreement, unless extended an additional 18 days under certain circumstances. As such, 3,237,300 of the shares of common stock subject to such lock-up agreements and market stand-off provisions will be immediately eligible for resale in the public markets and the remaining 12,695,180 shares subject to such lock-up agreements held by our directors, executive officers and other affiliates will be subject to the volume limitations under Rule 144 promulgated under the Securities Act.

After the completion of this offering, we intend to register, under one or more registration statements on Form S-8, approximately 1,129,500 shares of our common stock that are issuable under our 2001 Stock Option Deferred Stock and Restricted Stock Plan and our 2005 Stock Incentive Plan, and 1,000,000 shares of our common stock that are issuable under our 2007 Omnibus Incentive Plan. In addition, the number of shares of common stock reserved under the Omnibus Plan will automatically be increased on the first day of each fiscal year, beginning January 1, 2008, in an amount equal to the lesser of (i) 1,000,000 shares of common stock; (ii) 2% of the number of shares outstanding as of the last day of the immediately preceding fiscal year; or (iii) such lesser number as determined by our board of directors. Once we register these shares, all of such shares can be freely sold in the public markets upon issuance, subject to the lock-up agreements and market stand-off provisions described above and any applicable vesting restrictions and, for our executive officers, directors and their affiliates, subject also to the limitations of Rule 144 other than the holding period.

Failure to achieve and maintain effective internal controls in accordance with Section 404 of the Sarbanes-Oxley Act could result in a restatement of our financial statements, cause investors to lose confidence in our financial statements and our company and have a material adverse effect on our business and stock price.

We produce our consolidated financial statements in accordance with the requirements of GAAP, but our internal accounting controls may not currently meet all standards applicable to companies with publicly traded securities. Effective internal controls are necessary for us to provide reliable financial reports to help mitigate the risk of fraud and to operate successfully as a publicly traded company. As a public company, we will be required to document and test our internal control procedures in order to satisfy the requirements of Section 404 of the Sarbanes-Oxley Act of 2002, or Section 404, which will require annual management assessments of the effectiveness of our internal controls over financial reporting. This requirement will apply to us starting with our annual report for the year ended December 31, 2008.

During 2006, we identified certain accounting errors in our financial statements for the three years ended December 31, 2005. These errors primarily related to the appropriate classification of self-insurance liabilities between short-term and long-term. As a result of discovering these errors, we undertook a further review of our historical financial statements and identified similar reclassifications to deferred taxes and captive insurance subsidiary cash and cash equivalents. Following this review, our board of directors and independent registered public accounting firm concluded that an amendment of our consolidated financial statements, which included the restatement of our financial statements for the three years ended December 31, 2005, was necessary. It was not deemed that these errors were caused by a significant deficiency or material weakness in internal controls over financial reporting.

As we prepare to comply with Section 404, we may identify significant deficiencies or errors that we may not be able to remediate in time to meet our deadline for compliance with Section 404. Testing and maintaining internal controls can divert our management's attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not be able or willing to issue a favorable assessment if we conclude that our internal controls over financial reporting are not effective. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified report as required by Section 404, investors could lose confidence in our reported financial information and our company, which could result in a decline in the market price of our common stock, and cause us to fail to meet our reporting obligations in the future, which in turn could impact our ability to raise additional financing if needed in the future.

If we fail to implement the requirements of Section 404 in a timely manner, we may also be subject to sanctions or investigation by regulatory authorities such as the Securities and Exchange Commission or NASDAQ.

The requirements of being a public company, including compliance with the reporting requirements of the Securities Exchange Act of 1934, as amended, and the requirements of the Sarbanes-Oxley Act, may strain our resources, increase our costs and distract management, and we may be unable to comply with these requirements in a timely or cost-effective manner.

As a public company, we will need to comply with laws, regulations and requirements, certain corporate governance provisions of the Sarbanes-Oxley Act of 2002, related regulations of the Securities and Exchange Commission, and requirements of NASDAQ, with which we are not required to comply as a private company. As a result, we will incur significant legal, accounting and other expenses that we did not incur as a private company. Complying with these statutes, regulations and requirements will occupy a significant amount of the time of our board of directors and management, will require us to have additional finance and accounting staff, may make it more difficult to attract and retain qualified officers and members of our board of directors, particularly to serve on our audit committee, and make some activities more difficult, time consuming and costly. Among other things, we will need to:

- institute a more comprehensive compliance function;
- establish new internal policies, such as those relating to disclosure controls and procedures and insider trading;
- design, establish, evaluate and maintain a system of internal control over financial reporting in compliance with the requirements of Section 404 and the related rules and regulations of the Securities and Exchange Commission and the Public Company Accounting Oversight Board;
- prepare and distribute periodic reports in compliance with our obligations under the federal securities laws;
- involve and retain to a greater degree outside counsel and accountants in the above activities; and
- establish an investor relations function.

If we are unable to accomplish these objectives in a timely and effective fashion, our ability to comply with our financial reporting requirements and other rules that apply to reporting companies could be impaired. If our finance and accounting personnel insufficiently support us in fulfilling these public-company compliance obligations, or if we are unable to hire adequate finance and accounting personnel, we could face significant legal liability, which could have a material adverse effect on our

financial condition and results of operations. Furthermore, if we identify any issues in complying with those requirements (for example, if we or our independent registered public accountants identified a material weakness or significant deficiency in our internal control over financial reporting), we could incur additional costs rectifying those issues, and the existence of those issues could adversely affect us, our reputation or investor perceptions of us.

In addition, we also expect that being a public company subject to these rules and regulations will require us to modify our director and officer liability insurance, and we may be required to accept reduced policy limits or incur substantially higher costs to obtain the same or similar coverage. These factors could also make it more difficult for us to attract and retain qualified members of our board of directors, particularly to serve on our audit committee, and qualified executive officers.

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

In addition to the effect that the concentration of ownership by our significant stockholders may have, our amended and restated certificate of incorporation and our amended and restated bylaws will contain provisions that may enable our management 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, to be set forth in our amended and restated certificate of incorporation or amended and restated bylaws, each of which will be effective upon the completion of this offering, include:

- our board of directors will be 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 will be 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 will be limited;
- special meetings of the stockholders will be 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 will not be 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 will be filled only by majority vote of the remaining directors;
- our board of directors will be expressly authorized to make, alter or repeal our bylaws; and
- stockholders will be permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

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.

FORWARD-LOOKING STATEMENTS

Some of the statements under "Prospectus Summary," "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," "Industry," "Business," "Compensation Discussion and Analysis" and elsewhere in this prospectus may contain forward-looking statements which reflect our current views with respect to, among other things, future events and financial performance. You can identify these forward-looking statements by the use of forward-looking words such as "outlook," "believes," "expects," "potential," "continues," "may," "should," "seeks," "approximately," "predicts," "intends," "plans," "estimates," "anticipates" or the negative version of those words or other comparable words. Any forward-looking statements contained in this prospectus are based upon the historical performance of our subsidiaries and on our current plans, estimates and expectations. The inclusion of this forward-looking information should not be regarded as a representation by us, the underwriters or any other person that the future plans, estimates or expectations contemplated by us will be achieved. Such forward-looking statements are subject to various risks and uncertainties. Accordingly, there are or will be important factors that could cause our actual results to differ materially from those indicated in these statements. We believe that these factors include, but are not limited to, the following risks:

federal and state changes to reimbursement and other aspects of Medicare and Medicaid;

the effect of federal and state government laws and regulations on our business;

preclusion from participating in federal or state healthcare programs, including, Medicare and Medicaid;

state efforts to regulate or deregulate healthcare services or the construction or expansion of healthcare facilities;

overbuilding in certain markets, increased competition and increased operating costs;

any changes in the acuity mix of patients in our facilities as well as payor mix and payment methodologies;

increased competition for or a shortage of nurses and other skilled personnel;

the inability to expand occupancy or to improve patient mix at our facilities;

diversion of material time, resources and attention from our management team and staff away from our business to respond to government probe reviews and/or investigations;

competition from other healthcare providers in attracting patients and residents to our facilities;

difficulties in completing future facility acquisitions and efficiently integrating acquired facilities;

the achievement and maintenance of competitive quality of care ratings from CMS and private organizations engaged in similar monitoring activities;

the geographic concentration of our facilities;

significant legal actions and liability claims;

increases in the expense or difficulty in obtaining insurance coverage;

exposure through our self-insurance programs to significant and unexpected losses;

the departure or other loss of our management team and facility leaders;

the effect of a breach of a single facility lease on a master-lease or other leases with the same landlord;

the failure to comply with the restrictive covenants and other provisions of our long-term debt, mortgages and long-term operating leases;

our dependence upon receiving funds from multiple, independent operating subsidiaries;

our referral sources referring fewer patients to our facilities; and

the termination of our patient admission agreements and the resulting vacancies in our facilities.

A further description of these risks and other risks that may affect our business is described in the section entitled "Risk Factors" beginning on page 11 of this prospectus. These factors should not be construed as exhaustive and should be read in conjunction with the other cautionary statements that are included in this prospectus. We do not undertake any obligation to publicly update or review any forward-looking statement, whether as a result of new information, future developments or otherwise.

If one or more of these or other risks or uncertainties materialize, or if our underlying assumptions prove to be incorrect, actual results may vary materially from what we may have projected. Any forward-looking statements you read in this prospectus reflect our current views with respect to future events and are subject to these and other risks, uncertainties and assumptions relating to our operations, results of operations, financial condition, growth strategy and liquidity. You should specifically consider the factors identified in this prospectus that could cause actual results to differ before making an investment decision.

USE OF PROCEEDS

The net proceeds from our sale of 4,000,000 shares of common stock in this offering are estimated to be approximately $56,860,000 based on the initial public offering price of $16.00 per share, after deducting underwriting discounts and commissions and estimated offering expenses payable by us. The shares of common stock that may be purchased by the underwriters upon exercise of their over-allotment option are shares outstanding before this offering and not additional shares issuable by us. If the underwriters' over-allotment option is exercised in full, it is estimated that the selling stockholders' net proceeds will be approximately $8,928,000. We will not receive any of the proceeds from the sale of shares of our common stock offered by the selling stockholders pursuant to the exercise, if any, of the over-allotment option.

We currently plan to use a portion of the net proceeds from this offering to acquire additional facilities, for expansion, improvements and upgrades to our existing facilities and to pay down debt. We currently have approximately $13.5 million budgeted for significant capital refurbishments at existing facilities in 2007. We currently plan to use approximately $16.0 million of the net proceeds from this offering to purchase four facilities that we currently operate under operating lease agreements. Of this amount, we expect to use approximately $3.0 million to purchase one facility from Lone Peak Properties, LLC, in which the purchase is pending the property owner's resolution of certain boundary line issues with neighboring property owners. We expect to use the remaining $13.0 million to purchase three facilities from Health Care Properties, Inc. on or before December 14, 2007, but may choose to fund these purchases under the Revolver. As of September 30, 2007, we held options to purchase 12 of our leased facilities. We will consider exercising some or all of such options as they become exercisable and may use a portion of the net proceeds to pay the purchase price for these facilities. We anticipate paying off our $2.1 million mortgage note in 2008, which mortgage note has a fixed interest rate of 7.49% and is due on September 1, 2008, and we will also consider paying off all or a portion of our short-term debt, if any, that is incurred in connection with facility acquisitions. If we do not complete the transactions contemplated by the Commitment Letter described below in "Management's Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources," we intend to use proceeds of this offering and/or seek alternative sources of working capital financing to replace the Revolver. As of September 30, 2007, we have no amounts outstanding under the Revolver. Further, if we do not complete the transactions contemplated by the Commitment Letter, we will use approximately $8.4 million of the net proceeds from this offering to collateralize outstanding letters of credit currently secured by the available borrowing capacity of the Revolver.

We expect to use the remainder of the net proceeds from this offering for working capital and for general corporate purposes.

As of the date of this prospectus, we cannot specify with certainty all of the particular uses for the net proceeds from this offering. The amounts actually expended for the purposes indicated above will depend upon a number of factors, including the availability of suitable facilities, the related lease rates and acquisition costs, the status of the real estate market, construction and related materials costs, as well as other industry related factors. Accordingly, our management will retain broad discretion in the allocation of the net proceeds from this offering. Pending their use, we anticipate investing the net proceeds from this offering in short-term, interest-bearing, investment-grade securities.

DIVIDEND POLICY

We paid annual cash dividends for 2002 and 2003, and commenced paying quarterly dividends for the first quarter of 2004. We have paid cash dividends to our stockholders in each quarter since then. The approximate cash dividends we have paid to our stockholders since May 2003 are as follows:

Dividend Per Share	Date Paid	Aggregate Dividend Paid
		(in thousands)
$0.015	May 28, 2003	$ 240
$0.025	February 18, 2004	$ 408
$0.01	May 25, 2004	$ 164
$0.01	July 28, 2004	$ 167
$0.015	November 1, 2004	$ 252
$0.015	February 4, 2005	$ 252
$0.02	April 29, 2005	$ 338
$0.02	July 29, 2005	$ 331
$0.02	October 28, 2005	$ 333
$0.03	January 31, 2006	$ 500
$0.03	April 28, 2006	$ 490
$0.03	July 28, 2006	$ 492
$0.03	November 1, 2006	$ 493
$0.04	January 30, 2007	$ 657
$0.04	April 28, 2007	$ 658
$0.04	July 30, 2007	$ 658
$0.04	October 31, 2007(1)	$ 658

(1) Dividend declared to stockholders of record as of September 30, 2007, which is expected to be paid by October 31, 2007.

We do not have a formal dividend policy but we currently intend to continue to pay regular quarterly dividends to the holders of our common stock. From 2002 to 2006, we paid aggregate annual dividends equal to approximately 5% to 10% of our net income. However, future dividends will continue to be at the discretion of our board of directors, and we may or may not continue to pay dividends at such rate. We expect that the payment of dividends will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. The loan and security agreement governing our revolving line of credit with General Electric Capital Corporation restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement. In addition, we are a holding company with no direct operating assets, employees or revenues. As a result, we are dependent upon distributions from our independent operating subsidiaries to generate the funds necessary to meet our financial obligations and pay dividends. It is possible that in certain quarters, we may pay dividends that exceed our net income for such period as calculated in accordance with GAAP.

CAPITALIZATION

The following table summarizes our cash and cash equivalents and our capitalization at June 30, 2007:

- on an actual basis;
- on a pro forma basis to reflect (a) an amendment to our certificate of incorporation to reflect an increase in our authorized capitalization prior to the closing of the offering, and (b) the conversion of all of our outstanding preferred stock into an aggregate of 2,741,180 shares of common stock upon the closing of this offering; and
- on a pro forma as adjusted basis to reflect (a) the conversion of all of our outstanding preferred stock into an aggregate of 2,741,180 shares of common stock upon the closing of this offering; and (b) our issuance of 4,000,000 shares of common stock at the initial public offering price of $16.00 per share, after deducting underwriting discounts and commissions and estimated offering expenses payable by us.

This table should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and the related notes included elsewhere in this prospectus.

	June 30, 2007		
	Actual	Pro Forma	Pro Forma As Adjusted
	(in thousands, except share data)		
Cash and cash equivalents	$ 12,939	$ 12,939	$ 71,234
Long-term debt, including current maturities	64,002	64,002	64,002
Series A redeemable convertible preferred stock, $0.001 par value; 1,000,000 shares authorized, 685,295 shares issued and outstanding, actual; no shares issued and outstanding, pro forma or pro forma as adjusted.	2,725		
Stockholders' equity:			
Common stock, $0.001 par value; 20,000,000 shares authorized, 13,705,200 shares issued and outstanding, actual; 75,000,000 shares authorized, 16,446,380 shares issued and outstanding, pro forma; 75,000,000 shares authorized, 20,446,380 shares issued and outstanding, pro forma as adjusted	14	17	21
Additional paid-in capital	1,784	4,506	61,362
Retained earnings	62,900	62,900	62,900
Common stock in treasury, at cost, 745,000 shares	(4,784)	(4,784)	(4,784)
Total stockholders' equity	59,914	62,639	119,499
Total capitalization	$ 126,641	$ 126,641	$ 183,501

The table above excludes, as of June 30, 2007:

- 1,129,500 shares of common stock issuable upon the exercise of outstanding options at a weighted average exercise price of $6.21 per share; and

1,000,000 shares of common stock, subject to certain automatic annual increases, reserved for future grant or issuance under our 2007 Omnibus Incentive Plan.

For additional information regarding our capital structure, see "Compensation Discussion and Analysis Employee Benefit Plans," "Description of Capital Stock" and Notes 10, 11 and 12 of the Notes to the Consolidated Financial Statements.

DILUTION

If you invest in our common stock in this offering, your interest will be diluted immediately to the extent of the difference between the initial public offering price per share of our common stock and the pro forma net tangible book value per share of our common stock after completion of this offering. Our pro forma net tangible book value as of June 30, 2007 was approximately $57.2 million, or $3.48 per share of common stock (after giving effect to the conversion of all of our outstanding preferred stock into common stock). Pro forma net tangible book value per share as of June 30, 2007 represents our total tangible assets less total liabilities divided by the number of shares of our common stock outstanding as of June 30, 2007 after giving effect to the conversion of all of our outstanding preferred stock into common stock upon the closing of this offering. After giving effect to the conversion of all of our outstanding preferred stock into common stock upon the closing of this offering, and our sale of 4,000,000 shares of common stock offered by this prospectus at the initial public offering price of $16.00 per share, and the receipt and application of those net proceeds, our pro forma net tangible book value as of June 30, 2007 would have been $114.1 million, or $5.58 per share of common stock. This represents an immediate increase in pro forma net tangible book value of $2.10 per share to our existing stockholders and an immediate dilution in pro forma net tangible book value of $10.42 per share to investors purchasing common stock in this offering.

The following table illustrates this per share dilution:

Initial public offering price per share		$ 16.00
Pro forma net tangible book value per share as of June 30, 2007	$ 3.48	
Increase per share attributable to new investors	$ 2.10	
Pro forma net tangible book value per share after this offering		$ 5.58
Dilution per share to new investors		$ 10.42

The following table summarizes on a pro forma as adjusted basis as of June 30, 2007 (after giving effect to the conversion of all of our outstanding preferred stock into common stock), the difference between the number of shares of common stock purchased from us, the total consideration paid and the average price per share paid by existing stockholders and by our new investors purchasing our common stock at the initial public offering price of $16.00 per share and before deducting underwriting discounts and commissions and estimated offering expenses payable by us:

	Shares Purchased		Total Consideration		
	Number	Percent	Amount	Percent	Average Price Per Share
Existing stockholders	16,446,380	80.4%	$ 3,494,829	5.2%	$ 0.21
New investors	4,000,000	19.6	64,000,000	94.8	$ 16.00
Total	20,446,380	100.0%	$ 67,494,829	100.0%	$ 3.30

If the underwriters exercise their over-allotment option in full, the number of shares held by new investors will increase to 4,600,000, or 22.5% of the total number of shares of common stock outstanding after this offering.

The foregoing discussion and tables assume no exercise of any stock options outstanding as of June 30, 2007. To the extent that these options are exercised, new investors will experience further dilution. As of June 30, 2007, options to purchase 1,129,500 shares of our common stock were outstanding at a weighted average exercise price of $6.21 per share. Assuming all of our outstanding options are exercised, new investors will own approximately 18.5% of the total number of shares of common stock outstanding after this offering while contributing approximately 85.9% of the total consideration for such shares. Assuming all of our outstanding options are exercised, pro forma net tangible book value before this offering at June 30, 2007 would be $3.65 per share, representing an immediate increase of $0.17 per share to our existing stockholders, and, after giving effect to the sale of shares of common stock in this offering, there would be an immediate dilution of $10.39 per share to new investors in this offering.

SELECTED CONSOLIDATED FINANCIAL DATA

Our consolidated statement of income data for the years ended December 31, 2004, 2005 and 2006 and the consolidated balance sheet data as of December 31, 2005 and 2006 included in this prospectus have been derived from our audited consolidated financial statements included herein. The consolidated statement of income data for the years ended December 31, 2002 and 2003 and the consolidated balance sheet data as of December 31, 2002, 2003 and 2004 have been derived from our audited consolidated financial statements that are not included in this prospectus. The consolidated statement of income data for the six months ended June 30, 2006 and 2007 and the consolidated balance sheet data as of June 30, 2007 are derived from our unaudited consolidated financial statements included herein. Historical results are not necessarily indicative of future results. The following data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and related notes included elsewhere in this prospectus.

	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
	(in thousands, except share and per share data)						
Consolidated Statement of Income Data:							
Revenue	$ 102,103	$ 158,007	$ 244,536	$ 300,850	$ 358,574	$ 168,727	$ 198,247
Expenses:							
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	84,380	128,522	199,986	239,379	284,847	133,350	161,001
Facility rent cost of services	6,777	9,964	14,773	16,118	16,404	8,090	8,333
General and administrative expense	4,115	6,246	8,537	10,909	14,210	6,590	7,644
Depreciation and amortization	915	1,229	1,934	2,458	4,221	1,758	3,186
Total expenses	96,187	145,961	225,230	268,864	319,682	149,788	180,164
Income from operations	5,916	12,046	19,306	31,986	38,892	18,939	18,083
Other income (expense):							
Interest expense	(1,104)	(1,268)	(1,565)	(2,035)	(2,990)	(1,337)	(2,349)
Interest income	8	4	85	491	772	297	698
Other expense, net	(1,096)	(1,264)	(1,480)	(1,544)	(2,218)	(1,040)	(1,651)
Income before provision for income taxes	4,820	10,782	17,826	30,442	36,674	17,899	16,432
Provision for income taxes	1,256	4,284	6,723	12,054	14,125	7,081	6,600
Net income	$ 3,564	$ 6,498	$ 11,103	$ 18,388	$ 22,549	$ 10,818	$ 9,832
Net income per share(1):							
Basic	$ 0.27	$ 0.49	$ 0.83	$ 1.35	$ 1.66	$ 0.80	$ 0.72
Diluted	$ 0.22	$ 0.38	$ 0.63	$ 1.05	$ 1.34	$ 0.65	$ 0.58
Weighted average common shares outstanding(1):							
Basic	12,701,574	12,905,250	13,284,902	13,468,060	13,365,682	13,379,060	13,441,490

	Year Ended December 31,					Six Months Ended June 30,	
Diluted	16,571,686	16,985,350	17,519,032	17,505,040	16,823,242	16,720,378	16,891,202

(1) See Note 2 of the Notes to the Consolidated Financial Statements.

	As of December 31,					As of June 30,
	2002	2003	2004	2005	2006	2007
	(in thousands, except per share data)					
Consolidated Balance Sheet Data:						
Cash and cash equivalents	$ 1,545	$ 745	$ 14,755	$ 11,635	$ 25,491	$ 12,939
Working capital	1,402	10,191	21,526	19,087	28,281	20,938
Total assets	32,246	62,538	80,255	119,390	190,531	195,609
Long-term debt, less current maturities	12,019	16,239	24,820	25,520	63,587	63,072
Redeemable, convertible preferred stock	2,689	2,722	2,725	2,725	2,725	2,725
Stockholders' equity	1,393	7,343	17,828	32,634	51,147	59,914
Cash dividends declared per common share	$ 0.015	$ 0.025	$ 0.05	$ 0.09	$ 0.13	$ 0.08

	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
Other Non-GAAP Financial Data:							
EBITDA(1)	$ 6,831	$ 13,275	$ 21,240	$ 34,444	$ 43,113	$ 20,697	$ 21,269
EBITDAR(1)	13,608	23,239	36,013	50,562	59,517	28,787	29,602

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

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

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

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

We use EBITDA and EBITDAR:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;

to design incentive compensation and goal setting;

to allocate resources to enhance the financial performance of our business;

to evaluate the effectiveness of our operational strategies; and

to compare our operating performance to that of our competitors.

(See footnotes continued on the following page)

(footnotes to prior page)

We typically use EBITDA and EBITDAR to compare the operating performance of each skilled nursing and assisted living facility. EBITDA and EBITDAR are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, and, with respect to EBITDAR, facility rent cost of services, which may vary from period-to-period depending upon various factors, including the method used to finance facilities, the amount of debt that we have incurred, whether a facility is owned or leased, the date of acquisition of a facility or business, or the tax law of the state in which a business unit operates. As a result, we believe that the use of EBITDA and EBITDAR provide a meaningful and consistent comparison of our business between periods by eliminating certain items required by GAAP.

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

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

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

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

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

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

	Year Ended December 31,				Six Months Ended June 30,	
2002	2003	2004	2005	2006	2006	2007
			(in thousands)			
Consolidated Statement of Income Data:						

	Year Ended December 31,					Six Months Ended June 30,	
Net income	$ 3,564	$ 6,498	$ 11,103	$ 18,388	$ 22,549	$ 10,818	$ 9,832
Interest expense, net	1,096	1,264	1,480	1,544	2,218	1,040	1,651
Provision for income taxes	1,256	4,284	6,723	12,054	14,125	7,081	6,600
Depreciation and amortization	915	1,229	1,934	2,458	4,221	1,758	3,186
EBITDA	6,831	13,275	21,240	34,444	43,113	20,697	21,269
Facility rent cost of services	6,777	9,964	14,773	16,118	16,404	8,090	8,333
EBITDAR	$ 13,608	$ 23,239	$ 36,013	$ 50,562	$ 59,517	$ 28,787	$ 29,602

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion together with the consolidated financial statements and the notes thereto included elsewhere in this prospectus. This discussion contains forward-looking statements that are based upon management's current expectations, estimates and projections about our business and operations. The cautionary statements made in this prospectus should be read as applying to all related forward-looking statements wherever they appear in this prospectus. Forward-looking statements are not guarantees of future performance and involve significant risks and uncertainties. Our actual results may vary from those currently anticipated and expressed in such forward-looking statements as a result of a number of factors, including those we discuss under "Risk Factors" and elsewhere in this prospectus. You should read "Risk Factors" and "Forward-Looking Statements."

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 61 facilities located in California, Arizona, Texas, Washington, Utah and Idaho. All of these facilities are skilled nursing facilities, other than three stand-alone assisted living facilities in Arizona and Texas and four campuses that offer both skilled nursing and assisted living services in California, Arizona and Utah. Our facilities provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. We encourage and empower our facility leaders and staff to make their facility the "facility of choice" in the community it serves. This means that our facility leaders and staff are generally free to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then work to create a superior service offering and reputation for that particular community or market to encourage prospective customers and referral sources to choose or recommend the facility. As of September 30, 2007, we owned 23 of our facilities and operated an additional 38 facilities under long-term lease arrangements, and had options to purchase 12 of those 38 facilities. We also have agreements to purchase four of the 38 facilities that we operate under long-term lease arrangements. The lease agreements on three of these four facilities contain options to purchase the underlying property, but they are not currently exercisable. Assuming the expected closing of these purchase agreements, we will own 27 of our facilities, operate 34 facilities under long-term lease arrangements and hold options to purchase nine of our leased facilities. The following table summarizes our facilities and licensed and independent living beds by ownership status as of September 30, 2007:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	23	12	26	61
Percent of total	37.7%	19.7%	42.6%	100%
Skilled nursing, assisted living and independent living beds(1)(2)	2,954	1,350	3,144	7,448
Percent of total	39.7%	18.1%	42.2%	100%

(1) Includes 671 beds in our 460 assisted living units and 84 independent living units. All of the independent living units are located at one of our assisted living facilities.

(2) All bed counts are licensed beds except for independent living beds, and may not reflect the number of beds actually available for patient use.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. All of our facilities are operated by separate, wholly-owned, independent subsidiaries, which have their own management, employees and assets. In addition, one of our wholly-owned independent

subsidiaries, which we call our Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other services to each operating subsidiary through contractual relationships between such subsidiaries.

Facility Acquisition History

In 2003, we increased our total bed capacity by approximately 76% through the acquisition of 17 facilities in California and Arizona. We purchased the assets of a long-term care facility located in Arizona for approximately $2.7 million, of which $0.3 million was paid in cash and the balance of approximately $2.4 million was financed through debt secured primarily by the underlying real property. We also entered into operating lease agreements whereby we assumed the operations of 16 facilities located in Southern California and Arizona. No material amounts were paid to the prior facility operators and we did not acquire any assets or assume any liabilities, other than our rights and obligations under the new operating leases and operations transfer agreements, as part of these transactions.

In 2004, we increased our total bed capacity by approximately 5% through acquisition of two facilities in California and Arizona. We purchased the assets of a long-term care facility located in Arizona for approximately $6.0 million paid in cash. In addition, we entered into an operating lease agreement whereby we assumed the operations of a skilled nursing facility located in Southern California. No material amount was paid to the prior facility operator, and we did not acquire any assets or assume any liabilities, other than our rights and obligations under a new operating lease and operations transfer agreement, as part of this transaction.

In 2005, we increased our total bed capacity by approximately 7% from the prior year by acquiring three skilled nursing facilities in California. One of these facilities was acquired through a new operating lease agreement whereby we assumed the operations of a skilled nursing facility. No material amount was paid to the prior facility operator, and we did not acquire any assets or assume any liabilities, other than our rights and obligations under a new operating lease and operations transfer agreement. The other two facilities were purchased for aggregate cash consideration of approximately $14.9 million.

Since January 1, 2006, we have added an aggregate of 15 facilities located in Texas, Washington, Utah, Idaho, Arizona and California that we had not operated previously, 11 of which we purchased and four of which we acquired under long-term lease arrangements. Three of the long-term lease arrangements include purchase options. Thirteen of these acquisitions were skilled nursing facilities, one was an assisted living facility and one was a campus that offers both skilled nursing and assisted living services. These facilities contributed 1,668 beds to our operations, increasing our total capacity by 29%. With these acquisitions, we entered two new markets, Utah and Idaho. In Texas, we increased our capacity by 684 beds, or approximately 146%, and more than doubled the number of our facilities in that state.

In 2006, we purchased eight facilities for an aggregate purchase price of $31.1 million, of which $29.0 million was paid in cash, and $2.1 million was financed with the assumption of a loan on one of the facilities. We also entered into operating lease agreements whereby we assumed the operations of three skilled nursing facilities located in Utah, Idaho and Arizona. No material amounts were paid to the prior facility operators and we did not acquire any assets or assume any liabilities, other than our rights and obligations under the new operating leases and operations transfer agreements. In addition, in 2006, we purchased the underlying assets of three facilities that we were operating under long-term lease arrangements for an aggregate purchase price of $11.1 million, which ultimately was financed using our Third Amended and Restated Loan Agreement (the "Term Loan").

In the first six months of 2007, we acquired three additional long-term care facilities for an aggregate purchase price of $9.4 million in cash, which included two skilled nursing facilities in Texas

and one skilled nursing facility in Utah. In July 2007, we exercised an option to purchase one of our leased skilled nursing facilities for $3.3 million in cash. In addition, in July 2007, we entered into an operating lease agreement for a long-term care facility in Utah that is licensed for both skilled nursing and assisted living services. Since the facility was not profitable at the time, the prior operator voluntarily relinquished its leasehold to its affiliated landlord for no material consideration. We did not make any material payments to the prior facility operator and we did not acquire any assets or assume any liabilities, other than our rights and obligations under a new operating lease and operations transfer agreement, as part of this transaction. We also simultaneously entered into a separate contract with the property owner to purchase the underlying property for $3.0 million, pending the property owner's resolution of certain boundary line issues with neighboring property owners. We expect that we will purchase the property under the contract if and when these title issues are resolved. Regardless of whether the title issues are resolved, we have the option to purchase the property for $3.0 million under the operating lease. In August 2007, we entered into an agreement that we expect will close on or before December 14, 2007, to purchase two skilled nursing facilities in California and one assisted living facility in Arizona, which also provides independent living services, for an aggregate purchase price of approximately $13.0 million. We currently operate these three facilities under master lease agreements. The lease agreements for the two skilled nursing facilities contain purchase options which are not currently exercisable. Upon the expected closing of these purchase agreements, we will own 27 of our facilities and operate 34 of our facilities under long-term lease arrangements with options to purchase nine of those 34 facilities.

The following table sets forth the location and number of licensed and independent living beds located at our facilities as of September 30, 2007:

	CA	AZ	TX	UT	WA	ID	Total
Number of facilities	31	12	10	4	3	1	61
Skilled nursing, assisted living and independent living beds(1)(2)	3,529	1,952	1,154	442	283	88	7,448

(1) Includes 671 beds in our 460 assisted living units and 84 independent living units.

(2) All bed counts are licensed beds except for independent living beds, and may not reflect the number of beds actually available for patient use.

Key Performance Indicators

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

Routine revenue: Routine revenue is generated by the contracted daily rate charged for all contractually inclusive 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 our skilled nursing facilities who are receiving care under Medicare or managed care reimbursement, referred to as "Medicare and managed care patients." Skilled revenue excludes any revenue generated from our assisted living services.

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

Quality mix: The amount of routine non-Medicaid revenue as a percentage of our total routine revenue. Quality mix (in days) represents the number of days our non-Medicaid patients are receiving services at our skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at our skilled nursing facilities for any given period. Our quality mix revenue excludes assisted living revenue, which represented 2.6%, 2.5% and 2.6% of our total revenue for the year ended December 31, 2006 and the six months ended June 30, 2006 and 2007, respectively.

Average daily rates: The routine revenue by payor source for a period at our skilled nursing facilities divided by actual patient days for that revenue source for that given period.

Occupancy percentage: The total number of residents occupying a bed in a skilled nursing, assisted living or independent living facility as a percentage of the number of licensed and independent living beds in the facility.

Number of facilities and licensed beds: The total number of skilled nursing, assisted living and independent living facilities that we own or operate and the total number of licensed and independent living beds associated with these facilities. Independent living beds do not have a licensing requirement.

Skilled and Quality Mix. Like most skilled nursing providers, we measure both patient days and revenue by payor. Medicare and managed care 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 skilled mix and quality mix for the periods indicated as a percentage of our total routine revenue (less revenue from assisted living services) and as a percentage of total patient days:

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
Skilled Mix:					
Days	19.4%	22.4%	24.3%	24.7%	23.1%
Revenue	39.6%	42.9%	45.6%	46.2%	43.5%
Quality Mix:					
Days	33.5%	36.0%	37.4%	37.9%	36.2%
Revenue	51.5%	53.5%	55.5%	56.2%	53.7%

Occupancy. We define occupancy as the actual patient days (one patient day equals one patient or resident occupying one bed for one day) during any measurement period as a percentage of the number of available patient days for that period. Available patient days are determined by multiplying the number of licensed and independent living beds in service during the measurement period by the number of calendar days in the measurement period. During any measurement period, the number of licensed and independent living beds in a skilled nursing, assisted living or independent living facility that are actually available to us may be less than the actual licensed and independent living bed capacity due to, among other things, temporary bed suspensions as a result of low occupancy levels, the voluntary or other imposition of quarantines or bed holds, or the dedication of bed space to other uses.

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

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
Occupancy:					
Licensed and independent living beds at end of period(1)	5,417	5,796	6,940	6,115	7,342
Available patient days	1,918,678	2,034,270	2,281,735	1,069,194	1,303,752
Actual patient days	1,557,008	1,668,566	1,849,932	878,189	1,013,624
Occupancy percentage	81.2%	82.0%	81.1%	82.1%	77.7%

(1) The number of licensed beds is calculated using the historical number of beds licensed at each facility. All bed counts are licensed beds except for independent living beds, and may not reflect the number of beds actually available for patient use.

Revenue Sources

Our total revenue represents revenue derived primarily from providing services to patients and residents of skilled nursing facilities, and to a lesser extent from assisted living facilities and ancillary services. We receive service revenue from Medicaid, Medicare, private payors and other third-party payors, and managed care sources. The sources and amounts of our revenue are determined by a number of factors, including licensed bed capacity and occupancy rates of our healthcare facilities, the mix of patients at our facilities and the rates of reimbursement among payors. Payment for ancillary services varies based upon the service provided and the type of payor. The following table sets forth our total revenue by payor source and as a percentage of total revenue for the periods indicated:

	Year Ended December 31,						Six Months Ended June 30,			
	2004		2005		2006		2006		2007	
	$	%	$	%	$	%	$	%	$	%
	(in thousands, except percentages)									
Revenue:										
Medicare	$ 72,301	29.6%	$ 96,208	32.0%	$ 117,511	32.8%	$ 56,105	33.3%	$ 59,696	30.1%
Managed care	25,172	10.3	33,484	11.1	44,487	12.4	21,088	12.5	25,707	13.0
Private and other(1)	35,942	14.7	39,831	13.2	45,312	12.6	21,449	12.7	25,496	12.8
Medicaid	111,121	45.4	131,327	43.7	151,264	42.2	70,085	41.5	87,348	44.1
Total revenue	$ 244,536	100.0%	$ 300,850	100.0%	$ 358,574	100.0%	$ 168,727	100.0%	$ 198,247	100.0%

(1) Includes revenue from assisted living facilities.

Primary Components of Expense

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately below). Our cost of services represents the costs of operating our facilities and primarily consists of payroll and related benefits, supplies, purchased services, and ancillary expenses such as the cost of pharmacy and therapy services provided to residents. Cost of services also includes the cost of general and professional liability insurance and other general cost of services with respect to our facilities.

Facility Rent Cost of Services. Facility rent cost of services consists solely of base minimum rent amounts payable under lease agreements to third-party owners of the facilities that we operate but do not own and does not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements.

General and Administrative Expense. General and administrative expense consists primarily of payroll and related benefits and travel expenses for our administrative Service Center personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees), costs relating to our information systems, stock-based compensation and rent for our Service Center office.

We expect our general and administrative expense to increase in the future as a result of becoming a public company. Our anticipated additional expenses include:

- increased salaries, bonuses and benefits necessary to attract and retain qualified accounting professionals as we seek to expand the size and enhance the skills of our accounting and finance staff;
- increased professional fees as we complete the process of complying with Section 404 of the Sarbanes-Oxley Act, including incurring additional audit fees in connection with our independent registered public accounting firm's audit of our assessment of our internal controls over financial reporting;
- increased costs associated with creating and developing an internal audit function, which we have not had historically;
- increased legal costs associated with complying with reporting requirements under the federal securities laws; and
- the incurrence of miscellaneous costs, such as stock exchange fees, investor relations fees, filing expenses, training expenses and increased directors' and officers' liability insurance.

Depreciation and Amortization. Property and equipment are recorded at their original historical cost. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets. The following is a summary of the depreciable lives of our depreciable assets:

Buildings and improvements	15 to 30 years
Leasehold improvements	Shorter of the lease term or estimated useful life, generally 5 to 15 years
Furniture and equipment	3 to 10 years

Critical Accounting Policies

Our discussion and analysis of our financial condition and results of operations are based upon our consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these financial statements and related disclosures requires us to make judgments, estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. On an ongoing basis we review our judgments and estimates, including those related to doubtful accounts, income taxes and loss contingencies. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. Actual results may differ from these estimates under different assumptions or conditions. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty and actual results could differ materially from the amounts reported. The following summarizes our critical accounting policies, defined as those policies that we believe: (a) are the most important to the portrayal of our financial condition and results of operations; and (b) require management's most subjective or complex judgments, often as a result of the need to make estimates about the effects of matters that are inherently uncertain.

Revenue Recognition

We follow the provisions of Staff Accounting Bulletin ("SAB") 104, *"Revenue Recognition in Financial Statements"* ("SAB 104"), for revenue recognition. Under SAB 104, four conditions must be met before revenue can be recognized: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii) the price is fixed or determinable; and (iv) collection is reasonably assured.

Our revenue is derived primarily from providing healthcare services to residents and is recognized on the date services are provided at amounts billable to individual residents. For residents under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on predetermined contractually agreed upon amounts on a per patient, daily basis.

Revenue from reimbursements under the Medicare and Medicaid programs accounted for approximately 75%, 76%, 75%, 75% and 74% of our revenue for the years ended December 31, 2004, 2005 and 2006 and the six months ended June 30, 2006 and 2007, respectively. We record our revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. Our revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlements. We recorded retroactive adjustments that increased revenues by $0.2 million, $0.2 million and $0.8 million for the years ended December 31, 2005 and 2006 and for the six months ended June 30, 2007, respectively. The adjustment for 2005 does not include the 2004 retroactive adjustment to record a California state Medicaid rate increase. Because of the complexity of the laws and regulations governing Medicare and state Medicaid assistance programs, our estimates may potentially change by a material amount. We record our revenue from private pay patients as services are performed. If, for the six months ended June 30, 2007, we were to experience a decrease of 1% in our revenue, our revenue would decline by approximately $2.0 million.

Allowance for Doubtful Accounts

Accounts receivable are comprised of amounts due from patients and residents, Medicare and Medicaid payor programs, third-party insurance payors, and other nursing facilities and customers. We value our receivables based on the net amount we expect to receive from these payors. In evaluating the collectibility of our accounts receivable, management considers a number of factors including changes in collection patterns, accounts receivable aging trends by payor category and the status of ongoing disputes with third party payors. The percentages applied to our aged receivable balances are based on our historical experience and time limits, if any, for managed care, Medicare and Medicaid. We periodically refine our procedures for estimating the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances. Our receivables from Medicare and Medicaid payor programs accounted for approximately 63%, 70%, 65% and 62% of our total accounts receivable as of December 31, 2004, 2005 and 2006 and June 30, 2007, respectively, and represent our only significant concentration of credit risk.

Self-Insurance

We are partially self-insured for general and professional liability, up to a base amount per claim (self-insurance retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party coverage with coverage limits per occurrence, per location and on an aggregate basis for our company. For claims made in 2006, the self-insured retention was $0.4 million per claim with a $0.9 million deductible. The third party coverage above these limits for all years is $1.0 million per occurrence, $3.0 million per facility with a $6.0 million company aggregate. The insurers' maximum aggregate loss limits are generally above our actuarially determined probable

losses; therefore, we believe the likelihood of losses exceeding the insurers' maximum aggregate loss is remote.

The self-insured retention and deductible limits are self-insured through a wholly-owned insurance captive, the related assets and liability of which are included in the accompanying consolidated financial statements. We are subject to certain statutory requirements as we operate a captive insurance subsidiary. These requirements include, but are not limited to, maintaining minimum statutory capital. Our policy is to accrue amounts equal to the estimated costs to settle open claims as well as an estimate of the costs of claims that have been incurred but not reported. We have developed information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and have evaluated the estimate for claim loss exposure on an annual basis through 2006 and on a quarterly basis beginning with the first quarter in 2007. Accrued self-insured general liability and professional malpractice liabilities recorded on an undiscounted basis in the accompanying consolidated balance sheets were $12.0 million, $16.0 million and $18.4 million as of December 31, 2005 and 2006 and June 30, 2007, respectively.

We are self-insured for workers compensation liability in California, and in Texas, we have elected non-subscriber status for workers compensation claims. We have third-party guaranteed cost coverage in the other states in which we operate. In California and Texas, we accrue 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. We use actuarial valuations to estimate the liability based on historical experience and industry information. Accrued self-insured workers compensation liabilities recorded on an undiscounted basis in the accompanying consolidated balance sheets were $3.2 million, $4.5 million and $4.3 million as of December 31, 2005 and 2006 and June 30, 2007, respectively.

During 2003 and 2004, we were insured for workers compensation in California and Arizona by a third-party carrier under a policy where the retrospective premium is adjusted annually based on incurred developed losses and allocated expenses. Based on a comparison of the computed retrospective premium to the actual payments funded, amounts will be due to the insurer or insured. The funded accrual in excess of the estimated liabilities are included in prepaid expenses and other current assets in the accompanying consolidated balance sheets and totaled $1.7 million, $0.9 million and $0.8 million as of December 31, 2005 and 2006 and June 30, 2007, respectively.

Effective May 1, 2006, we began to provide self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of our employees. Prior to this, we had multiple third-party HMO and PPO plans, of which certain HMO plans are still active. We are not aware of any run-off claim liabilities from the prior plans. We are fully liable for all financial and legal aspects of these benefit plans. To protect ourselves against loss exposure with this policy, we have purchased individual stop-loss insurance coverage that insures individual claims that exceed $0.1 million to a maximum of $6.0 million on our PPO plan and unlimited on our HMO plan. We have also purchased aggregate stop loss coverage that reimburses the plan up to $5.0 million once paid claims exceed approximately $7.2 million. The aforementioned coverage only applies to claims paid during the plan year. Our accrued liability under these plans recorded on an undiscounted basis in the accompanying consolidated balance sheets was $1.0 million and $1.4 million as of December 31, 2006 and June 30, 2007, respectively.

We believe that adequate provision has been made in our financial statements for liabilities that may arise out of patient care, workers compensation, healthcare benefits and related services provided to date. The amount of our reserves is determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this process and our assumptions about emerging trends, we, with the assistance of an independent actuary, develop information about the potential 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. In addition to the actuarial estimate of retained losses, our provision for insurance includes accruals for insurance premiums and the related costs for the coverage period and our estimate of any experience-based adjustments to premiums.

Our self-insured liabilities are based upon estimates, and while our management believes that the estimates of loss are adequate, the ultimate liability may be in excess of, or less than, recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that we could experience changes in estimated losses that could be material to net income. If our actual liability exceeds our estimate of loss, our future earnings and financial condition would be adversely affected.

Impairment of Long-Lived Assets

Our management reviews the carrying value of our long-lived assets that are held and used in our operations for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operations to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, then the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. We estimate the fair value of assets based on the estimated future discounted cash flows of the asset. Our management has evaluated our long-lived assets and has not identified any impairment as of December 31, 2004, 2005, 2006 or June 30, 2007.

Intangible Assets and Goodwill

Intangible assets consist primarily of deferred financing costs, lease acquisition costs and trade names. Deferred financing costs are amortized over the term of the related debt, ranging from seven to 26 years. Lease acquisition costs are amortized over the life of the lease of the facility acquired, ranging from ten to 20 years. Trade names are amortized over 30 years.

Goodwill is accounted for under Statement of Financial Accounting Standards ("SFAS") No. 141, "*Business Combinations*" ("SFAS 141") and represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. In accordance with SFAS No. 142, "*Goodwill and Other Intangible Assets*" ("SFAS 142"), goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. We perform our annual test for impairment during the fourth quarter of each year. We did not record any impairment charges in 2004, 2005, 2006 or the six months ended June 30, 2007.

Stock-Based Compensation

As of January 1, 2006, we adopted SFAS No. 123(R), "*Share-Based Payment"* ("SFAS 123(R)"), which requires the measurement and recognition of compensation expense for all share-based payment awards made to employees and directors including employee stock options based on estimated fair values, ratably over the requisite service period of the award. Prior to the adoption of SFAS 123(R), we accounted for stock-based awards to employees and directors using the intrinsic value method in accordance with APB Opinion No. 25, "*Accounting for Stock Issued to Employees"* ("APB 25") as allowed under SFAS No. 123, "*Accounting for Stock-Based Compensation"* ("SFAS 123"). Under that method, no compensation expense was recognized by us in our financial statements in connection with the awarding of stock option grants to employees provided that, as of the grant date, all terms associated with the award were fixed and the fair value of our stock, as of the grant date, was equal to or less than the amount an employee must pay to acquire the stock.

We adopted SFAS 123(R) using the prospective transition method, which requires the application of the accounting standard as of January 1, 2006, the first day of our fiscal year ended December 31, 2006. Our consolidated financial statements as of and for the periods ended December 31, 2006, and June 30, 2006 and 2007 reflect the impact of SFAS 123(R). In accordance with the prospective transition method, our consolidated financial statements for periods prior to January 1, 2006 have not been restated to reflect, and do not include, the impact of SFAS 123(R).

Stock-based compensation expense recognized under SFAS 123(R) consists of share-based payment awards made to employees and directors including employee stock options based on estimated fair values. Stock-based compensation expense recognized in our consolidated statement of income for the year ended December 31, 2006 and our unaudited consolidated statements of income for the six months ended June 30, 2006 and 2007 does not include compensation expense for share-based payment awards granted prior to, but not yet vested as of January 1, 2006, in accordance with the pro forma provisions of SFAS 123, but does include compensation expense for the share-based payment awards granted subsequent to January 1, 2006 based on the fair value on the grant date estimated in accordance with the provisions of SFAS 123(R). As stock-based compensation expense recognized in our consolidated statement of income for the year ended December 31, 2006 and our unaudited consolidated statements of income for the six months ended June 30, 2006 and 2007 is based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. SFAS 123(R) requires forfeitures to be estimated at the time of grant and revised, if necessary, in subsequent periods if actual forfeitures differ from those estimates.

We use the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for all share-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. We develop estimates based on historical data and market information, which can change significantly over time. The Black-Scholes model required us to make several key judgments including:

The expected option term reflects the application of the simplified method set out in SAB No. 107 "*Share-Based Payment*" ("SAB 107"), which was issued in March 2005. Accordingly, we have utilized the average of the contractual term of the options and the weighted average vesting period for all options to calculate the expected option term.

Estimated volatility also reflects the application of SAB 107 interpretive guidance and, accordingly, incorporates historical volatility of similar public entities until sufficient information regarding the volatility of our share price becomes available.

The dividend yield is based on our historical pattern of dividends as well as expected dividend patterns.

The risk-free rate is based on the implied yield of U.S. Treasury notes as of the grant date with a remaining term approximately equal to the expected term.

Estimated forfeiture rate of approximately 8% per year is based on our historical forfeiture activity of unvested stock options.

For stock options granted during the year ended December 31, 2006, the assumptions for grants used in the Black-Scholes model were a weighted average risk free rate of 5.0%, an expected life of 6.5 years, a weighted average volatility of 45% and a weighted average dividend yield of 1.1%. No options were granted during the six month period ended June 30, 2007.

As of December 31, 2004, 2005 and 2006, we valued our common stock using a combination of weighted income and market valuation approaches. The income approach was based on discounted cash flows. The market approach employed both a guideline company method and merger and acquisition method.

The weighted income approach was given heavier consideration in determining final valuations, consistent with our opinion that this method produced the best indicator of the value of our stock. The assumptions and methodologies used in performing the income approach's discounted cash flow analysis included, among other things:

- Debt-free cash flows were projected for five years, which was deemed to be the appropriate valuation period;
- Earnings before interest, depreciation and amortization, less working capital investment, were used to estimate terminal value;
- The appropriate discount rate to be applied to the net free cash flows and terminal value for purposes of these valuations was based upon our perception of the rate of return expected for a similar investment with similar risks; and
- Discounts for lack of control and lack of marketability were also taken when appropriate.

Among other things, the market-approach valuations also took into account the following:

- Trends and comparable valuations with respect to the guideline companies; and
- Mergers and acquisitions within the guideline company group were reviewed, and values were derived based on observed market multiples, as adjusted for differences in size, profitability, facility age, geographic location and other factors.

As noted above, in addition to the annual year-end weighted valuations, starting in 2004, we determined fair market value as outlined below contemporaneously with the granting of stock options. These valuations considered:

- Our recent operating performance; and
- A net income multiple derived from the annual weighted valuation analysis based on the factors outlined above.

On July 26, 2006, in a manner generally consistent with historical valuation and grant practices, we granted options to purchase approximately 663,500 shares of common stock to employees. The exercise price was based on a contemporaneous fair value calculation performed as discussed above. Subsequently, a weighted valuation (also as discussed above) was performed, which produced a fair value less than the exercise price. Then, in March 2007, an additional retrospective weighted valuation was performed. This weighted valuation took into consideration the possibility of our entering the public marketplace in 2007. This re-measurement resulted in the adjusted fair value exceeding the exercise price. As a result of the finalized valuations and the adoption of SFAS 123(R), we recorded aggregate compensation expense of approximately $0.4 million and $0.5 million during the year ended December 31, 2006 and the six months ended June 30, 2007, respectively.

During 2007, until the time of our initial public offering, we plan on obtaining weighted valuations that take into consideration the possibility of our entering into the public marketplace when we determine the value of our common stock.

During the period January 1, 2006 to July 26, 2006, we granted to certain of our employees and directors, options to purchase 686,000 shares of our common stock. These options have exercise prices ranging from $7.05 to $7.50 per share. The fair value of the common stock as of January 17, 2006 and July 26, 2006 was $5.96 and $15.09 per share, respectively. We have not granted any options subsequent to July 26, 2006.

The significant factors contributing to the difference between the fair value of the stock options granted on January 17, 2006 and July 26, 2006 and the initial public offering price of $16.00, include the following:

- *Acquired Facilities*. Since March 1, 2006, we added an aggregate of 15 facilities located in Texas, Washington, Utah, Idaho, Arizona, and California that we had not previously operated. In the first quarter of 2006, we acquired one facility, and an average of three to four facilities per

quarter beginning with the second quarter of 2006 through the first quarter of 2007. In addition, in July 2007, we entered into an operating lease agreement for a long-term care facility in Utah that offers both skilled nursing and assisted living services. As a result of this growth strategy; we have increased the number of facilities we operate by 33% since March 1, 2006.

Increased Owned Properties. We increased the number of owned facilities by approximately 188% from eight facilities as of February 28, 2006 to 23 facilities, which includes previously operated facilities, as of September 30, 2007.

Increased Revenue. The increase in the number of facilities has significantly contributed to our revenue growth in the first six months of 2007. In addition, our revenue grew 19%, or $57.7 million, for the year ended December 31, 2006 as compared to the year ended December 31, 2005.

Increased Dividends. We increased our average quarterly dividends by 23% to $0.04 per share for the first three quarters in 2007 as compared to an average of $0.033 in 2006. Average quarterly dividends for 2005 were $0.023 per share. While we do not have a formal dividend policy, we currently expect to continue to pay regular quarterly dividends to our common stockholders.

Relative Performance of Similar Public Companies. The overall market valuations for certain key, publicly-traded competitors within the industry have increased since January 2006.

Elimination of Lack of Marketability. Historically, our board of directors determined the estimated market price contemporaneously to the granting of options based upon the best valuation information available to our board at the time of grant. Starting in 2004, annual year-end weighted valuations were used by our board in assessing the estimated market price. These valuations took multiple factors into account including a discount for lack of marketability. In addition to the annual year-end weighted valuations, our board of directors determined fair market value contemporaneously with the granting of stock options based on our recent operating performance and a net income multiple derived from the annual weighted valuation analysis. The exercise price was then set equal to the estimated market price as contemporaneously determined by the board, except for the July 2006 grants for which the valuation process is described above.

There are inherent uncertainties in performing such valuations and identifying comparable companies, transactions and other data that may be indicative of the fair value of our common stock. We believe that the estimates of the fair value of our common stock at each option grant date occurring prior to our initial public offering were reasonable under the circumstances.

In future periods, we expect to recognize a total of approximately $4.1 million in stock-based compensation expense for outstanding unvested options ratably over the next 3.7 weighted average years. As of December 31, 2006 and June 30, 2007, there were 148,400 and 142,000 vested, exercisable options outstanding, respectively, under our stock option plans.

Income Taxes

We account for income taxes in accordance with SFAS No. 109, "*Accounting for Income Taxes*." Under this method, deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities at tax rates expected to be in effect when such temporary differences are expected to reverse. Our temporary differences are primarily attributable to compensation accruals, straight line rent adjustments, reserves for doubtful accounts and insurance liabilities. We assess the likelihood that our deferred tax assets will be recovered from future taxable income and, if we believe that recovery is not more likely than not, we establish a valuation allowance to reduce the deferred tax assets to the amounts expected to be realized.

Our net deferred tax asset balances as of December 31, 2005 and 2006 and June 30, 2007 were approximately $8.1 million, $12.6 million and $13.9 million, respectively. We expect to fully utilize these deferred tax assets; however, their ultimate realization will depend upon the amount of future taxable income during the periods in which the temporary differences become deductible.

We make our estimates and judgments regarding deferred tax assets and the associated valuation allowance, if any, based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. However, due to the nature of certain assets and liabilities, there are risks and uncertainties associated with some of our estimates and judgments. Actual results could differ from these estimates under different assumptions or conditions.

FIN 48 requires us to maintain a liability for underpayment of income taxes and related interest and penalties, if any, for uncertain income tax positions. In considering the need for and magnitude of a liability for uncertain income tax positions, we must make certain estimates and assumptions regarding the amount of income tax benefit that will ultimately be realized. The ultimate resolution of an uncertain tax position may not be known for a number of years, during which time we may be required to adjust these reserves, in light of changing facts and circumstances.

We used an estimate of our annual income tax rate to recognize a provision for income taxes in financial statements for interim periods. However, changes in facts and circumstances could result in adjustments to our effective tax rate in future quarterly or annual periods.

Acquisition Policy

We periodically enter into agreements to acquire assets and/or businesses. The considerations involved in each of these agreements may include cash, financing, and/or long-term lease arrangements for real properties. We evaluate each transaction to determine whether the acquired interests are assets or businesses using the framework provided by Emerging Issue Task Force ("EITF") Issue No. 98-3, "*Determining Whether a Nonmonetary Transaction Involves Receipt of Productive Assets or of a Business*" ("EITF 98-3"). EITF 98-3 defines a business as a self sustaining integrated set of activities and assets conducted and managed for the purpose of providing a return to investors. A business consists of (a) input; (b) processes applied to those inputs; and (c) resulting outputs that are used to generate revenues. In order for an acquired set of activities and assets to be a business, it must contain all of the inputs and processes necessary for it to continue to conduct normal operations after the acquired entity is separated from the seller, including the ability to sustain a revenue stream by providing its outputs to customers. An acquired set of activities and assets fail the definition of a business if it excludes one or more of the above items such that it is not possible to continue normal operations and sustain a revenue stream by providing its products and/or services to customers.

Operating Leases

We account for operating leases in accordance with SFAS No. 13, "*Accounting for Leases*," and Financial Accounting Standards Board ("FASB") Technical Bulletin 85-3, "*Accounting for Operating Leases with Scheduled Rent Increases*." Accordingly, we recognize rent expense under the operating leases for our facilities and administrative offices on a straight-line basis over the original term of such leases, inclusive of predetermined rent escalations or modifications.

Industry Trends

Labor. We are a labor-intensive business. For the six months ended June 30, 2007, approximately 66.6% of our total expenses represent payroll and related benefits, and we employ a large number of healthcare professionals who are in high demand and short supply in a number of our markets. At June 30, 2007, we had approximately 5,506 full-time equivalent employees, a number of whom are highly skilled, healthcare professionals, while others are non-exempt, hourly wage employees. Periodically, market forces, which vary by region, require that we increase wages in excess of general

inflation or in excess of increases in the reimbursement rates we receive. A majority of our skilled nursing facilities are subject to state mandated minimum staffing ratios so our ability to reduce costs by decreasing staff is limited. We expect wages for healthcare professionals to continue to increase for the foreseeable future.

In addition, health benefit costs continue to escalate well above the average wage rate increases that we have incurred and the increases in other goods and services we purchase. We have a limited ability to mitigate the increases in health benefit costs due to our need to offer competitive benefits to recruit and retain qualified personnel.

Effects of Changing Prices. Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our skilled nursing facilities under a prospective payment system ("PPS") for certain inpatient covered services. Under the PPS, facilities are paid a predetermined amount per patient, per day, based on the anticipated costs of treating patients. The amount to be paid is determined by classifying each patient into a resource utilization group ("RUG") category that is based upon each patient's acuity level. As of January 1, 2006, the RUG categories were expanded from 44 to 53, with increased reimbursement rates for treating higher acuity patients. The new rules also implemented a market basket increase that increased rates by 3.1% for fiscal year 2006. At the same time, Congress terminated certain temporary add-on payments that were added in 1999 and 2000 as the nursing home industry came under financial pressure from prior Medicare cuts. While the 2006 Medicare skilled nursing facility payment rates will not decrease payments to skilled nursing facilities, the loss of revenue associated with future changes in skilled nursing facility payments could, in the future, have an adverse impact on our financial condition or results of operation.

The DRA is expected to significantly reduce net Medicare and Medicaid spending. Prior to the DRA, caps on annual reimbursements for rehabilitation therapy became effective on January 1, 2006. The DRA provides for exceptions to those caps for patients with certain conditions or multiple complexities whose therapy is reimbursed under Medicare Part B and provided in 2006. These exceptions have been extended to December 31, 2007.

On February 5, 2007, the Bush Administration released its fiscal year 2008 budget proposal, which, if enacted, would reduce Medicare spending by approximately $5.3 billion in fiscal year 2008 and $75.9 billion over five years. In particular, the budget proposal is expected to freeze payments in fiscal year 2008 for skilled nursing facilities, and the payment update would be 0.65% less than the routine inflation update (or market basket increase) annually thereafter. The budget also would move toward site-neutral post-hospital payments to limit what the Administration characterizes as inappropriate incentives for five conditions commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities. All bad debt reimbursement for unpaid beneficiary cost-sharing would be eliminated over four years. In addition, a budget mechanism would be established to automatically reduce Medicare spending if the portion of Medicare expenditures funded through general revenue is projected to exceed 45% within the next seven years. The budget also includes a series of proposals having an impact on Medicaid, including legislative and administrative changes that would reduce Medicaid payments by almost $26 billion over five years. Many of the proposed policy changes would require congressional approval to implement.

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates see Risk Factors Risks Related to Our Industry "Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare," "Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending," and "If Medicare reimbursement rates decline, our revenue, financial condition and results of operations could be adversely affected." 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.

Results of Operations

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

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
Revenue	100.0%	100.0%	100.0%	100.0%	100.0%
Expenses:					
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	81.8	79.6	79.4	79.0	81.2
Facility rent cost of services	6.0	5.4	4.6	4.8	4.2
General and administrative expense	3.5	3.6	4.0	3.9	3.9
Depreciation and amortization	0.8	0.8	1.2	1.1	1.6
Total expenses	92.1	89.4	89.2	88.8	90.9
Income from operations	7.9	10.6	10.8	11.2	9.1
Other income (expense):					
Interest expense	(0.6)	(0.7)	(0.8)	(0.8)	(1.2)
Interest income		0.2	0.2	0.2	0.4
Other expense, net					