ADCARE HEALTH SYSTEMS, INC
Form 10-K
March 31, 2014

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

ý ANNUAL REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2013

o TRANSITION REPORT UNDER SECTION 13 OR 15(d) OF THE EXCHANGE ACT

For the transition period from to

Commission file number 001-33135

AdCare Health Systems, Inc.
(Exact name of registrant as specified in its charter)

Georgia	31-1332119
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
1145 Hembree Road, Roswell, GA	30076-1122
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number including area code (678) 869-5116

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

Title of each class	Name of each exchange on which registered
Common Stock, no par value	NYSE MKT
Preferred Stock, no par value	NYSE MKT

Securities registered under Section 12(g) of the Exchange Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No ý

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Exchange Act. Yes o No ý

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

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

Indicate by check mark if disclosure of delinquent filers in response to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨

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

Large accelerated filer o	Accelerated filer o	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company ý

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No ý

The aggregate market value of AdCare Health Systems, Inc., common stock held by non-affiliates as of June 28, 2013, the last business day of the registrant's most recently completed second fiscal quarter, was $58,698,778. The number of shares of AdCare Health Systems, Inc., common stock, no par value, outstanding as of March 26, 2014 was 17,498,962.

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Special Note Regarding Forward Looking Statements

Certain statements contained in this Annual Report on Form 10-K for the year ended December 31, 2013 (this "Annual Report") in Part II, Item 7., "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere are "forward-looking statements" within the meaning of, and subject to the protections of, Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

Forward-looking statements include statements with respect to our beliefs, plans, objectives, goals, expectations, anticipations, assumptions, estimates, intentions and future performance and involve known and unknown risks, uncertainties and other factors, many of which may be beyond our control and which may cause the actual results, performance, or achievements of AdCare Health Systems, Inc. to be materially different from future results, performance or achievements expressed or implied by such forward-looking statements.

All statements other than statements of historical fact are statements that could be forward-looking statements. You can identify these forward-looking statements through our use of words such as "may," "will," "anticipate," "assume," "should," "indicate," "would," "believe," "contemplate," "expect," "estimate," "continue," "plan," "point to," "project," "predict," "could," "intend," "target," "potential" and other similar words and expressions. These forward-looking statements may not be realized due to a variety of factors, including, without limitation, those described in Part I, Item 1A., "Risk Factors," and elsewhere in this Annual Report and those described from time to time in our future reports filed with the Securities and Exchange Commission (the "SEC") under the Exchange Act.

All written or oral forward-looking statements that are made by or are attributable to us are expressly qualified in their entirety by this cautionary notice. Our forward-looking statements apply only as of the date of this Annual Report. We have no obligation and do not undertake to update, revise or correct any of the forward-looking statements after the date of this Annual Report, or after the respective dates on which such statements otherwise are made, whether as a result of new information, future events or otherwise.

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PART I.

Item 1. Business

Overview

AdCare Health Systems, Inc. ("AdCare") through its subsidiaries (together, the "Company" or "we"), own and manage skilled nursing facilities and assisted living facilities in the states of Alabama, Arkansas, Georgia, Missouri, North Carolina, Ohio, Oklahoma, and South Carolina. The Company, through wholly owned separate operating subsidiaries, as of December 31, 2013, operates or manages 46 facilities comprised of 43 skilled nursing facilities, two assisted living facilities and one independent living/senior housing facility totaling approximately 4,700 beds. The Company's facilities provide a range of health care services to patients and residents, including, but not limited to, skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term residents and short-stay patients. As of December 31, 2013, of the total 46 facilities, the Company owned and operated 26 facilities, leased and operated nine facilities, and managed 11 facilities for third parties.

The skilled nursing and assisted living facilities provide services to individuals needing long-term care in a nursing home or assisted living setting and provide management of those facilities. Through our subsidiaries, we provide a full complement of administrative services as well as consultative services that permit our local facility leadership teams to better focus on the delivery of healthcare services. We also provide these services to unaffiliated third party long-term care operators and/or owners with whom we enter into management contracts. We currently provide these services to two unaffiliated facility owners. Each of our facilities is led by highly dedicated individuals who are responsible for the key operational decisions at their facilities. Facility leaders and staff are trained and motivated to pursue superior clinical outcomes, high patient and family satisfaction, operating efficiencies and financial performance at their facilities. In addition, our facility leaders are enabled and motivated to share real-time operating data and otherwise benchmark clinical and operational performance against their peers in other facilities in order to improve clinical care, maximize patient satisfaction and augment operational efficiencies, promoting the sharing of best practices.

Much of our historical growth can be attributed to our expertise in acquiring under-performing facilities and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. We intend to continue to grow our revenue and earnings by:

- focusing on efficiencies in our operations and internal growth;
- increasing the proportion of sub-acute patients within our skilled nursing facilities;
- expanding clinical programs within our existing facilities;
- continuing to acquire additional facilities in existing and new markets; and
- evaluating and potentially targeting the acquisition of complementary businesses which provide services to skilled nursing facilities.

Our principal executive offices are located at 1145 Hembree Road, Roswell, GA 30076, and our telephone number is (678) 869-5116. We maintain a website at www.adcarehealth.com.

Company History

AdCare is a Georgia corporation. We were incorporated in Ohio on August 14, 1991, under the name Passport Retirement, Inc. In 1995, we acquired substantially all of the assets and liabilities of AdCare Health Systems, Inc. and changed our name to AdCare Health Systems, Inc. On December 12, 2013, AdCare changed its state of incorporation from the State of Ohio to the State of Georgia.

Acquisitions and Dispositions

We have embarked on a strategy to grow our business through acquisitions and leases of senior care facilities and businesses providing services to those facilities. During the year ended December 31, 2013, the Company incurred acquisition costs totaling approximately $0.6 million. Acquisition costs are recorded in “Other Income (Expense)” section of the Consolidated Statements of Operations included in Part II, Item 8., "Financial Statements and Supplementary Data." During the year ended December 31, 2013, the Company disposed of two skilled nursing facilities and one variable interest entity was held for sale at December 31, 2013 as described further below.

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Acquisitions

On February 15, 2013, the Company entered into a Purchase and Sale Agreement with Avalon Health Care, LLC ("Avalon") to acquire certain land, buildings, improvements, furniture, vehicles, contracts, fixtures and equipment comprising: (i) a 180-bed skilled nursing facility known as Bethany Health and Rehab; and (ii) a 240-bed skilled nursing facility known as Trevecca Health and Rehab, both located in Nashville, Tennessee. The Company deposited $0.4 million of earnest money escrow deposits in February 2013. On June 1, 2013, the Purchase and Sale Agreement was terminated. On August 1, 2013, the Company entered into a settlement agreement regarding the return of the $0.4 million previously deposited earnest money escrow deposits whereby $0.3 million was distributed to the Company and $0.1 million was distributed to Avalon.

The following tables provide summary information regarding our facility composition (excluding discontinued operations) for the periods indicated:

	December 31,	
	2013	2012
Cumulative number of facilities	46	46
Cumulative number of operational beds	4,677	4,677

		Number of Facilities			
State	Number of Operational Beds/Units	Owned	Leased	Managed for Third Parties	Total
Alabama	304	2	—	—	2
Arkansas	1,041	10	—	—	10
Georgia	1,379	4	7	—	11
Missouri	80	—	1	—	1
North Carolina	106	1	—	—	1
Ohio	705	4	1	3	8
Oklahoma	882	3	—	8	11
South Carolina	180	2	—	—	2
Total	4,677	26	9	11	46
Facility Type					
Skilled Nursing	4,482	24	9	10	43
Assisted Living	112	2	—	—	2
Independent Living	83	—	—	1	1
Total	4,677	26	9	11	46

We are currently evaluating acquisition opportunities and continue to seek new opportunities to further implement our growth strategy. No assurances are made that we will be able to complete any such acquisitions on terms acceptable to us, if at all.

Dispositions

As part of the Company's strategy to focus on the growth of skilled nursing facilities, the Company decided in the fourth quarter of 2011 to exit the home health business. In the fourth quarter of 2012, the Company continued this strategy and entered into an agreement to sell six assisted living facilities located in Ohio. The Company also entered into a sublease arrangement in the fourth quarter of 2012 to exit the operations of a skilled nursing facility in Jeffersonville, Georgia. During the second quarter of 2013, the Company executed two sublease arrangements to exit the skilled nursing business in Tybee Island, Georgia. A sales listing agreement was executed for the 105-unit assisted living facility located in Hoover, Alabama, which is a consolidated variable interest entity, during the fourth quarter of 2013. The results of operations and cash flows for the six Ohio assisted living facilities, the Jeffersonville, Georgia skilled nursing facility, the two skilled nursing facilities in Tybee Island, Georgia, and the assisted living variable interest entity are reported as discontinued operations. Current assets and liabilities of the disposal groups are classified as such in the Consolidated Balance Sheets at December 31, 2013 and 2012 included in Part II, Item 8,

"Financial Statements and Supplementary Data."

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Growth Strategy

Our objective is to be the provider of choice for health care and related services to the elderly in the communities in which we operate. We intend to grow our business through the initiatives discussed below. We expect to continue to increase occupancy rates and revenue per occupied unit at our facilities. We believe that our current operations serve as the foundation on which we can build a large fully-integrated senior living company. We will target attractive geographic markets by using our existing infrastructure and operating model, to provide a broad range of high quality care in a cost-efficient manner.

Organic Growth. We intend to focus on improving our operating margins within all of our facilities. We continually seek to maintain and improve by:

- increasing the proportion of higher revenue sub-acute health care services delivered at the Company's skilled nursing facilities;
- using data to identify providers in need of our services, understand their priorities and address their requirements;
- attracting new residents through on-site marketing programs focused on residents and family members;
- actively seeking referrals from professional community outreach sources, including area religious organizations, senior social service programs, civic and business networks, as well as the medical community; and
- continually refurbishing and renovating our facilities.

Pursue Strategic Acquisitions. We believe that our current infrastructure and extensive contacts within the industry will continue to provide us with the opportunity to evaluate numerous acquisition opportunities. We believe there is a significant opportunity for growth with a private to public arbitrage and opportunity to increase our operating margins by evaluating and potentially targeting the acquisition of complementary businesses which provide services to skilled nursing facilities.

Fragmentation in the Industry Provides Acquisition and Consolidation Opportunities. The senior living industry is highly fragmented and we believe that this provides significant acquisition and consolidation opportunities. We believe that the limited capital resources available to many small, private operators impedes their growth and exit prospects. We believe that we are well positioned to approach strategic small private operators and offer to them exit strategies which are not currently available as well as the ability to grow their business.

Emphasize Employee Training and Retention. We devote special attention to the hiring, screening, training, supervising and retention of our employees and caregivers. We have adopted comprehensive recruiting and screening programs for management positions that utilize corporate office team interviews and background and reference checks. We believe our commitment to, and emphasis on, quality hiring practices, employee training and retention differentiates us from many of our competitors.

Positioned for Growth. Our strategy typically begins with the acquisition of an independently owned, often times family operated, skilled nursing facility. We then utilize our proven clinical management and marketing programs to increase the proportion of more clinically complex sub-acute patients. These patients generate higher revenue per patient day. In many situations these patients are also more profitable. Additionally we are able to leverage our enhanced purchasing power and increase operating profit by providing more cost effective supplies and ancillary services. These management practices also assist in providing quality care to our patients and residents.

Operating Strategy

Our operating philosophy is to provide affordable, quality care to our patients and residents. We execute this strategy by empowering and supporting our local leadership teams at the facilities. These facility teams are supported by seasoned regional staff that provide consultative assistance from both a clinical and operations perspective. Additionally, we provide centralized back office administrative services to the facilities such as accounting, payroll and accounts payable processing, purchasing, and IT support. Centralizing these non-patient centric activities is more efficient and cost effective and frees up facility staff to focus on patient care.

Increase Revenues and Profitability at Existing Facilities. Our strategy includes increasing facility revenues and profitability levels through increasing occupancy levels, increasing the percentage of sub-acute patients, maximizing reimbursement rates as appropriate, providing additional services to our current residents, and containing costs. Ongoing initiatives to promote higher occupancy levels and appropriate payor and case mixes at our senior living facilities include corporate programs to promote specialized care and therapy services, as well as initiatives to improve

customer service and develop safety programs to improve worker compensation insurance rates.

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Offer Services Based on Level of Care. We are continually expanding our range of products and services to meet the evolving needs of our patients and residents. We have developed a variety of special clinical programs and care offerings in response to particular geographic markets.

Improve Operating Efficiencies. We actively monitor and manage our operating costs. By having an established portfolio of properties, we believe that we have a platform to achieve operating efficiencies through economies of scale in the purchase of bulk items, such as food, and in the spreading of fixed costs, such as corporate overhead, over a larger revenue base and the ability to provide more effective management supervision and financial controls.

Increase Occupancy Through Emphasis on Marketing Efforts. We emphasize strong corporate support for the marketing of our various local facilities. At a local level, our sales and marketing efforts are designed to promote higher occupancy levels and optimal payor mix. Management believes that the long-term care industry is fundamentally a local industry in which both patients and residents and the referral sources for them are based in the immediate local geographic area of the facility.

Improve Collaboration with Community Partners. Changes in healthcare have created the need for providers to create more efficient delivery models. We endeavor to work closely with our community partners to develop specific post-acute program tracts, care transition algorithms and programs to reduce hospital readmissions.

Promote an Internally-Developed Marketing Program. We focus on the identification and provision of services needed by the community. We assist each facility administrator in analysis of local demographics and competition with a view toward complementary service development. Our belief is that this locally based marketing approach, coupled with strong corporate monitoring and support, provides us an advantage over regional competitors.

Operate the Facility Based Management Model. We hire an administrator/manager and director of nursing for each of our skilled nursing facilities and provide them with autonomy, responsibility and accountability. We believe this allows us to attract and retain higher quality administrators and directors of nursing. This leadership team manages the day-to-day operations of each facility, including oversight of the quality of care, delivery of resident services, and monitoring of the financial performance and marketing functions. We actively recruit personnel to maintain adequate staffing levels at our existing facilities and provide financial and budgeting assistance for our administrators, directors of nursing and department managers.

Industry Trends

The skilled nursing industry has evolved to meet the growing demand for post-acute and custodial healthcare services generated by an aging population, increasing life expectancies and the trend toward shifting of patient care to lower cost settings. The growth of the senior population in the United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings, such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher acuity patients than in the past.The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us. Additionally, based on a decrease in the number of skilled nursing facilities over the past few years, we expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.

We also anticipate that, as life expectancy continues to increase in the United States, the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

Medicaid and Medicare Reimbursement

Rising healthcare costs due to a variety of factors, including an aging population and increasing life expectancies, has generated growing demand for post-acute healthcare services in recent years. In an effort to mitigate the cost of providing

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healthcare benefits, third-party payors, including Medicaid, Medicare, managed care providers, insurance companies and others, have increasingly encouraged the treatment of patients in lower-cost care settings. As a result, in recent years skilled nursing facilities, which typically have significantly lower cost structures than acute care hospitals and certain other post-acute care settings, have generally been serving larger populations of higher-acuity patients than in the past. However, Medicaid and Medicare reimbursement rates are subject to change from time to time and reduction in rates could materially and adversely impact our revenue.

Revenue derived directly or indirectly from Medicare reimbursement has historically comprised a substantial portion of our consolidated 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. In October 2010, the number of RUG categories was expanded from 53 to 66 as part of the implementation of the RUGs IV system and the introduction of a revised and substantially expanded patient assessment tool called the Minimum Data Set, version 3.0.

On July 29, 2011, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule providing for, among other things, a net 11.1% reduction in PPS payments to skilled nursing facilities for CMS's fiscal year 2012 (which began October 1, 2011) as compared to PPS payments in CMS's fiscal year 2011 (which ended September 30, 2011). The 11.1% reduction was on a net basis, after the application of a 2.7% market basket increase, and reduced by a 1.0% multi-factor productivity ("MFP") adjustment required by the Patient Protection and Affordable Care Act of 2010 ("PPACA"). The final CMS rule also adjusted the method by which group therapy is counted for reimbursement purposes and changed the timing in which patients who are receiving therapy must be reassessed for purposes of determining their RUG category.

The Middle Class Tax Relief and Job Creation Act of 2012 was signed into law on February 22, 2012, extending the Medicare Part B outpatient therapy cap exceptions process through December 31, 2012. The statutory Medicare Part B outpatient therapy cap for occupational therapy ("OT") was $1,880 for 2012, and the combined cap for physical therapy ("PT") and speech-language pathology services ("SLP") was also $1,880 for 2012. This is the annual per beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. All therapy services rendered above the $3,700 amount are subject to manual medical review and may be denied unless pre-approved by the provider's Medicare Administrative Contractor. The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning October 1, 2012, some therapy providers may submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the $3,700 threshold) to avoid denial of claims for services above the threshold amount. The $3,700 figure is the defined threshold that triggers the provision for an exception request. Prior to October 1, 2012, there was no provision for an exception request when the threshold was exceeded.

On July 27, 2012, CMS issued a final rule providing for, among other things, a net 1.8% increase in PPS payments to skilled nursing facilities for CMS's fiscal year 2013 (which began on October 1, 2012) as compared to PPS payments to skilled nursing facilities in CMS's fiscal year 2012 (which ended September 30, 2012). The 1.8% increase was on a net basis, reflecting the application of a 2.5% market basket increase, less a 0.7% MFP adjustment mandated by PPACA. This increase is offset by the 2% sequestration reduction, discussed below, which became effective April 1, 2013.

On January 1, 2013 the American Taxpayer Relief Act of 2012 (the "ATRA") extended the therapy cap exception process for one year. The ATRA also made additional changes to the Multiple Procedure Payment Reduction previously implemented in 2010. The existing discount to multiple therapy procedures performed in an outpatient environment during a single day was 25%. Effective April 1, 2013, ATRA increased the discount rate by an additional 25% to 50%. The ATRA additionally delayed the sequestration reductions of 2% to all Medicare payments until April 1, 2013.

On July 31, 2013, CMS issued a final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase is attributable to a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by a 0.5% MFP adjustment as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. For fiscal year 2012 (most recent available fiscal year), the projected market basket percentage change exceeds the actual market basket percentage change by 0.51%. The 2014 Medicare payment rates for skilled nursing facilities were effective on October 1, 2013.

Should future changes in PPS include further reduced rates or increased standards for reaching certain reimbursement levels (including as a result of automatic cuts tied to federal deficit cut efforts or otherwise), our Medicare revenues derived

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from our skilled nursing facilities could be reduced, with a corresponding adverse impact on our financial condition and results of operation.

We also derive a substantial portion of our consolidated revenue from Medicaid reimbursement, primarily through our skilled nursing business. Medicaid programs are administered by the applicable states and financed by both state and federal funds. Medicaid spending nationally has increased significantly in recent years, becoming an increasingly significant component of state budgets. This increase, combined with slower state revenue growth and other state budget demands, has led the federal government to institute measures aimed at controlling the growth of Medicaid spending (and in some instances reducing it).

Historically, adjustments to reimbursement under Medicaid and Medicare have had a significant effect on our revenue and results of operations. Recently enacted, pending and proposed legislation and administrative rulemaking at the federal and state levels could have similar effects on our business. Efforts to impose reduced reimbursement rates, greater discounts and more stringent cost controls by government and other payors are expected to continue for the foreseeable future and could adversely affect our business, financial condition and results of operations. Additionally, any delay or default by the federal or state governments in making Medicare and/or Medicaid reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

Regulatory Matters. Laws and regulations governing Federal Medicare and state Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from certain governmental programs. The Company believes that it is in compliance in all material respects with all applicable laws and regulations.

A significant portion of the Company's revenue is derived from Medicaid and Medicare, for which reimbursement rates are subject to regulatory changes and government funding restrictions. Any significant future change to reimbursement rates could have a material effect on the Company's operations.

Recently, the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") issued its Work Plan for Fiscal Year 2014 ("2014 Work Plan"). The 2014 Work Plan outlines the areas of special concern to the OIG and describes those enforcement initiatives the OIG will pursue in FY 2014 in connection with its oversight of the CMS and other agencies of HHS. A new focus for the Work Plan this year will be Medicare Part A billing by skilled nursing facilities. The OIG will examine the differences of skilled nursing facility billing practices between selected years. The OIG has found that more and more skilled nursing facilities billed the highest level of therapy while the general beneficiary characteristics have remained fairly constant. Additionally, the OIG found a $1.5 billion error in inappropriate Medicare payments in 2009 due to the mistakes in the claims submitted by skilled nursing facilities. Another target the OIG will review relates to questionable billing patterns associated with nursing homes and Medicare providers for Part B services that are provided and not paid for under Part A (for example, stays during which benefits are exhausted or the 3-day prior-inpatient-stay requirement is not met). There will be a series of studies that will inspect various services across the board. The reason behind this investigation comes from the inquiry of Congress to examine Part B billing for fraud and abuse during residents' non-Part A stay.

Health Reform Legislation. Although the federal government has delayed the employer mandate provision of the PPACA, October 1, 2013 was the deadline for employers to provide a notice of health care coverage options to their employees. Generally, the notice informs the employee of the new health insurance marketplace, a description of services, how to contact the marketplace and other additional required information. Employers covered by the Fair Labor Standards Act ("FLSA") must distribute the required notice to all employees, regardless of plan enrollment status or whether the employees are full or part time. By October 1, 2013, all employers covered by the FLSA were required to provide current employees with the notice. Starting October 1, 2013, each new hire must also receive the notice within 14 days of the employee's start date.

On December 26, 2013, President Obama signed into law the Pathway for SGR (Medicare Sustainable Growth Rate) Reform Act of 2013. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014, as was scheduled, and provides for a 0.5 percent increase for services through March 31, 2014.

HIPAA. On January 25, 2013, the HHS promulgated new HIPAA privacy, security, and enforcement regulations, which increase significantly the penalties and enforcement practices of HHS regarding HIPAA violations. The new HIPAA regulations are effective as of March 26, 2013, and compliance was required by September 23, 2013.

Revenue Sources

Total Revenue by Payor Sources. We derive revenue primarily from the Medicaid and Medicare programs, private pay patients and managed care payors. Medicaid typically covers patients that require standard custodial services and provides

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reimbursement rates that are generally lower than rates earned from other sources. We monitor our patient mix, which is the percentage of non-Medicaid revenue from each of our facilities, to measure the level received from each payor across each of our business units. We intend to continue our focus on enhanced care offerings for high acuity patients.

Medicaid. Medicaid is a state-administered program financed by state funds and matching federal funds. Medicaid programs are administered by the states and their political subdivisions. Medicaid programs generally provide health benefits for qualifying individuals and may supplement Medicare benefits for financially needy persons aged 65 and older. Medicaid reimbursement formulas are established by each state with the approval of the federal government in accordance with federal guidelines. Seniors who enter skilled nursing facilities as private pay clients can become eligible for Medicaid once they have substantially depleted their assets. Medicaid is the largest source of funding for nursing home facilities.

Medicare. Medicare is a federal program that provides healthcare benefits to individuals who are 65 years of age or older or are disabled. To achieve and maintain Medicare certification, a skilled nursing facility must meet the CMS, "Conditions of Participation," on an ongoing basis, as determined in periodic facility inspections or surveys conducted primarily by the state licensing agency in the state where the facility is located. Medicare pays for inpatient skilled nursing facility healthcare services under the prospective payment system. The prospective payment for each beneficiary is based upon the medical condition of, and care needed by, the beneficiary. Medicare skilled nursing facility coverage is limited to 100 days per episode of illness for those beneficiaries who require daily care following discharge from an acute care hospital.

Managed Care and Private Insurance. Managed care patients consist of individuals who are insured by a third-party entity, typically a senior health maintenance organization ("HMO") plan, or who are Medicare beneficiaries who have assigned their Medicare benefits to a senior HMO plan. Another type of insurance, long-term care insurance, is also becoming more widely available to consumers, but is not expected to contribute significantly to industry revenues in the near term.

Private and Other Payors. Private and other payors consist primarily of individuals, family members or other third parties who directly pay for the services we provide.

Billing and Reimbursement. Our revenue from government payors, including Medicare and state Medicaid agencies, is subject to retroactive adjustments in the form of claimed overpayments and underpayments based on rate adjustments and asserted billing and reimbursement errors. We believe billing and reimbursement errors, disagreements, overpayments and underpayments are common in our industry, and we are regularly engaged with government payors and their fiscal intermediaries in reviews, audits and appeals of our claims for reimbursement due to the subjectivity 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.

Management fees. Management fee revenue is received under various contractual agreements with both third-party and related party companies.

We employ accounting, reimbursement and compliance specialists who train, mentor and assist our clerical, clinical and rehabilitation staffs in the preparation of claims and supporting documentation, regularly monitor billing and reimbursement practices within our facilities, and assist with the appeal of overpayment and recoupment claims generated by governmental, fiscal intermediary and other auditors and reviewers. In addition, due to the potentially serious consequences that could arise from any impropriety in our billing and reimbursement processes, we investigate all allegations of impropriety or irregularity relative thereto.

Whether information about our billing and reimbursement processes is obtained from external sources or activities, such as Medicaid and Medicare audits or probe reviews, or our regular day-to-day monitoring and training activities, we collect and utilize such information to improve our billing and reimbursement functions and the various processes related thereto. We continually strive to improve the efficiency and accuracy of all of our operational and business functions, including our billing and reimbursement processes. The table below sets forth our annual revenue by payor source during the years ended December 31, 2013 and 2012.

	Year Ended December 31,	
Annual Revenue by Payor (000's)	2013	2012

Medicaid	$117,260	$104,598
Medicare	67,499	57,029
Other	35,991	30,294
Management fees	2,097	2,156
Total	$222,847	$194,077

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Competition

Our ability to compete successfully varies from location to location and depends on a number of factors, including the number of competing facilities in the local market, the types of services available, our local reputation for quality care of patients, the commitment and expertise of our staff and physicians, our local service offerings and treatment programs, the cost of care in each locality, and the physical appearance, location, age and condition of our facilities.

We are in a competitive, yet fragmented, industry. While there are several national and regional companies that provide skilled nursing services, we anticipate that our primary source of competition will be the smaller regional and local development and management companies. There is limited, if any, price competition with respect to Medicaid and Medicare patients, since revenues for services to such patients are strictly controlled and are based on fixed rates and cost reimbursement principles. Although the degree of success with which our facilities compete varies from location to location, management believes that its facilities generally compete effectively with respect to these factors.

Our competitors include assisted living communities and other retirement facilities and communities, home health care agencies, nursing homes and convalescent centers, some of which operate on a not-for-profit or charitable basis. Our skilled nursing and assisted living facilities compete with both national and local competitors. We also compete with other health care companies for facility acquisitions and management contracts. We give no assurance that additional facilities or management contracts can be acquired on favorable terms.

We seek to compete effectively in each market by establishing a reputation within the local community for quality of care, attractive and comfortable facilities, and providing specialized healthcare with an ability to care for high-acuity patients. We believe that the average cost to a third-party payor for the treatment of our typical high-acuity patient is lower if that patient is treated in one of our skilled nursing facilities than if that same patient were to be treated in an inpatient rehabilitation facility or long-term acutecare hospital. We face direct competition from alternative facilities in our markets for residents. The skilled nursing facilities operated by us compete with other facilities in their respective markets, including rehabilitation hospitals and other "skilled" and personal care residential facilities. Some of these providers are not-for-profit organizations with access to sources of funds not available to our centers. In addition, our facilities also face competition for employees.

Increased competition could limit our ability to expand our business. We believe that the most important competitive factors in the long-term care business are a nursing center's local reputation with the local community and other healthcare providers, such as acute care hospitals, physicians, religious groups, other community organizations, managed care organizations, and a patient's family and friends; physical plant condition; the ability to identify and meet particular care needs in the community; the availability of qualified personnel to provide the requisite care; and the rates charged for services.

Increased competition could limit our ability to attract and retain patients, maintain or increase rates or to expand our business. Many of our competitors have greater financial and other resources than we have, may have greater brand recognition and may be more established in their respective communities than we are. Competing companies may also offer newer facilities or different programs or services than we do and may as a result be more attractive to our current patients, to potential patients and to referral sources. Some of our competitors may accept lower profit margins than we do, which could present significant price competition, particularly for managed care and private pay patients.

Government Regulation

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, certificates of need, quality of patient care and Medicaid and Medicare fraud and abuse. Over the last several years, government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations as well as laws and regulations governing quality of care issues in the skilled nursing profession in general. Violations of these laws and regulations could result in exclusion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations is subject to ongoing government review and interpretation, as well as regulatory actions in which government agencies seek to impose fines and penalties.

Licensure and Certification. Certain states administer a certificate of need program, which applies to the incurrence of capital expenditures, the offering of certain new institutional health services, the cessation of certain services and the acquisition of major medical equipment. Such legislation also stipulates requirements for such programs, including that each program be consistent with the respective state health plan in effect pursuant to such legislation and provide for penalties to enforce program requirements. To the extent that certificates of need or other similar approvals are required for expansion of our operations, either through acquisitions, expansion or provision of new services or other changes, such expansion could be affected adversely by the failure or inability to obtain the necessary approvals, changes in the standards applicable to such approvals or possible delays and expenses associated with obtaining such approvals.

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Skilled nursing and assisted living facilities are required to be individually licensed or certified under applicable state law and as a condition of participation under the Medicare program. In addition, healthcare professionals and practitioners are required to be licensed in most states. We believe that our operating companies and personnel that provide these services have all required regulatory approvals necessary for our current operations. The failure to obtain, retain or renew any required license could adversely affect our operations, including our financial results.

Health Reform Legislation. In recent years, there have been numerous initiatives on the federal and state levels for comprehensive reforms affecting the payment for, the availability of and reimbursement for healthcare services in the United States. These initiatives have ranged from proposals to fundamentally change federal and state healthcare reimbursement programs, including the provision of comprehensive healthcare coverage to the public under governmental funded programs, to minor modifications to existing programs. PPACA, which was passed in 2010 and has implementation timing and costs and regulatory implications that are still uncertain in many respects, is among the most comprehensive and notable of these legislative efforts, and its full effects on us and others in our industry are still in many ways difficult to predict. The content or timing of any future health reform legislation, and its impact on us, is impossible to predict. If significant reforms are made to the U.S. healthcare system, those reforms may have an adverse effect on our business, financial condition and results of operations.

Although the federal government has delayed the employer mandate provision of the PPACA, October 1, 2013 was the deadline for employers to provide a notice of health care coverage options to their employees. Generally, the notice informs the employee of the new health insurance marketplace, a description of services, how to contact the marketplace and other additional required information. Employers covered by the Fair Labor Standards Act (“FLSA”) must distribute the required notice to all employees, regardless of plan enrollment status or whether the employees are full or part time. By October 1, 2013, all employers covered by the FLSA were required to provide current employees with the notice. Starting October 1, 2013, each new hire must also receive the notice within 14 days of the employee’s start date.

While many of the provisions of PPACA will not take effect for several years or are subject to further refinement through the promulgation of regulations, some key provisions of PPACA are presently effective:

- Enhanced CMPs and Escrow Provisions. PPACA includes expanded civil monetary penalty ("CMP") and related provisions applicable to all Medicaid and Medicare providers. CMS rules adopted to implement applicable provisions of PPACA also provide that assessed CMPs may be collected and placed in whole or in part into an escrow account pending final disposition of the applicable administrative and judicial appeals process. To the extent our businesses are assessed large CMPs that are collected and placed into an escrow account pending lengthy appeals, such actions could adversely affect our business, financial condition and results of operations.
- Nursing Home Transparency Requirements. In addition to expanded CMP provisions, PPACA imposes new transparency requirements for Medicare-participating nursing facilities. In addition to previously required disclosures regarding a facility's owners, management, and secured creditors, PPACA expanded the required disclosures to include information regarding the facility's organizational structure, additional information on officers, directors, trustees, and "managing employees" of the facility (including their names, titles, and start dates of services), and information regarding certain parties affiliated with the facility. The transparency provisions could result in the potential for greater government scrutiny and oversight of the ownership and investment structure for skilled nursing facilities, as well as more extensive disclosure of entities and individuals that comprise part of skilled nursing facilities' ownership and management structure.
- Suspension of Payments During Pending Fraud Investigations. PPACA provides the federal government with expanded authority to suspend Medicaid and Medicare payments if a provider is investigated for allegations or issues of fraud. This suspension authority creates a new mechanism for the federal government to suspend both Medicaid and Medicare payments for allegations of fraud, independent of whether a state exercises its authority to suspend Medicaid payments pending a fraud investigation. To the extent the suspension of payment provision is applied to one of our businesses for allegations of fraud, such a suspension could adversely affect our business, financial condition and results of operations.
- Overpayment Reporting and Repayment; Expanded False Claims Act Liability. PPACA enacted several important changes that expand potential liability under the federal False Claims Act. Overpayments related to services provided

to both Medicaid and Medicare beneficiaries must be reported and returned to the applicable payor within specified deadlines, or else they are considered obligations of the provider for purposes of the federal False Claims Act. This new provision substantially tightens the repayment and reporting requirements generally associated with the operations of health care providers to avoid False Claims Act exposure.

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- Home and Community Based Services. PPACA provides that states can provide home and community-based attendant services and support through the Community First Choice State plan option. States choosing to provide home and community-based services under this option must make them available to assist with activities of daily living, instrumental activities of daily living and health-related tasks under a plan of care agreed upon by the individual and his/her representative. For states that elect to make coverage of home and community-based services available through the community First Choice State plan option, the percentage of the state's Medicaid expenses paid by the federal government will increase by six percentage points. PPACA also includes additional measures related to the expansion of community and home-based services and authorizes states to expand coverage of community and home-based services to individuals who would not otherwise be eligible for them. The expansion of home and community-based services could reduce the demand for the facility-based services that we provide.
- Health Care-Acquired Conditions. PPACA provides that the Secretary of Department of Health and Human Services ("DHHS") must prohibit payments to states for any amounts expended for providing medical assistance for certain medical conditions acquired during the patient's receipt of health care services. CMS adopted a final rule to implement this provision of PPACA in the third quarter of 2011. The rule prohibits states from making payments to providers under the Medicaid program for conditions that are deemed to be reasonably preventable. It uses Medicare's list of preventable conditions in inpatient hospital settings as the base (adjusted for the differences in the Medicaid and Medicare populations) and provides states the flexibility to identify additional preventable conditions and settings for which Medicaid payments will be denied.
- Value-Based Purchasing. PPACA requires the DHHS to develop a plan to implement a value-based purchasing ("VBP") program for payments under the Medicare program for skilled nursing facilities and to submit a report containing the plan to Congress. The intent of the provision is to potentially reconfigure how Medicare pays for health care services, moving the program towards rewarding better value, outcomes, and innovations, instead of volume. According to the plan submitted to Congress in June 2012, the funding for the VBP program could come out of payment withholds from poor-performing skilled nursing facilities or by holding back a portion of the base payment rate or the annual update for all skilled nursing facilities. If a VBP program is ultimately implemented, it is uncertain what effect it would have upon skilled nursing facilities, but its funding or other provisions could negatively affect them.
- Anti-Kickback Statute Amendments. PPACA amended the Anti-Kickback Statute so that: (i) a claim that includes items or services violating the Anti-Kickback Statute also would constitute a false or fraudulent claim under the federal False Claims Act; and (ii) the intent required to violate the Anti-Kickback Statute is lowered such that a person need not have actual knowledge or specific intent to violate the Anti-Kickback Statute in order for a violation to be deemed to have occurred. These modifications of the Anti-Kickback Statute could expose us to greater risk of inadvertent violations of the statute and to related liability under the federal False Claims Act.
- Accountable Care Organizations. PPACA authorized CMS to enter into contracts with Accountable Care Organizations ("ACO"). ACOs are entities of providers and suppliers organized to deliver services to Medicare beneficiaries and eligible to receive a share of any cost savings the entity can achieve by delivering services to those beneficiaries at a cost below a set baseline and with sufficient quality of care. CMS recently finalized regulations to implement the ACO initiative. The widespread adoption of ACO payment methodologies in the Medicare program, and in other programs and payors, could impact our operations and reimbursement for our services.

On June 28, 2012, the United States Supreme Court ruled that the enactment of PPACA did not violate the Constitution of the United States. This ruling permits the implementation of most of the provisions of PPACA to proceed. The provisions of PPACA discussed above are examples of recently enacted federal health reform provisions that we believe may have a material impact on the long-term care profession generally and on our business. However, the foregoing discussion is not intended to constitute, nor does it constitute, an exhaustive review and discussion of PPACA. It is possible that other provisions of PPACA may be interpreted, clarified, or applied to our businesses in ways that could have a material impact on our business, financial condition and results of operations. Similar federal and/or state legislation that may be adopted in the future could have similar effects.

In addition, we incur considerable administrative costs in monitoring the changes made within the various reimbursement programs in which we participate, determining the appropriate actions to be taken in response to those

changes, and implementing the required actions to meet the new requirements and minimize the repercussions of the changes to our organization, reimbursement rates and costs.

Medicaid and Medicare. Medicare is a federally-funded and administered health insurance program for the aged and for certain chronically disabled individuals. Part A of the Medicare program covers inpatient hospital services and certain services furnished by other institutional providers such as skilled nursing facilities. Part B of the Medicare program covers the services

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of doctors, suppliers of medical items, various types of outpatient services and certain ancillary services of the type provided by long-term and acute care facilities. Medicare payments under Part A and Part B are subject to certain caps and limitations, as provided in Medicare regulations. Medicare benefits are not available for intermediate and custodial levels of nursing center care or for assisted living center arrangements.

Medicaid is a medical assistance program for the indigent, operated by individual states with financial participation by the federal government. Criteria for medical indigence and available Medicaid benefits and rates of payment vary somewhat from state to state, subject to certain federal requirements. Basic long-term care services are provided to Medicaid beneficiaries, including nursing, dietary, housekeeping and laundry, restorative health care services, room and board and medications. Federal law requires that a state Medicaid program must provide for a public process for determination of Medicaid rates of payment for nursing center services. Under this process, proposed rates, the methodologies underlying the establishment of such rates and the justification for the proposed rates are published. This public process gives providers, beneficiaries and concerned state patients a reasonable opportunity for review and comment. Certain of the states in which we now operate are actively seeking ways to reduce Medicaid spending for nursing center care by such methods as capitated payments and substantial reductions in reimbursement rates.

As a component of CMS administration of the government's reimbursement programs, a new ratings system was implemented in December 2008 to assist the public in choosing a skilled care provider. The system is an attempt to simplify all the data for each nursing center to a "Star" ranking. The overall Star rating is determined by three components (three years survey results, quality measure calculations, and staffing data), with each of the components receiving star rankings as well. We will continue to strive to achieve high rankings for our facilities, as well as assuring that our rankings are correct and appropriately reflect our quality results.

Health Insurance Portability and Accountability Act of 1996 Compliance. There are numerous legislative and regulatory requirements at the federal and state levels addressing patient privacy and security of health information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") contains provisions that require us to adopt and maintain business procedures designed to protect the privacy, security and integrity of patients' individual health information. States also have laws that apply to the privacy of healthcare information. We must comply with these state privacy laws to the extent that they are more protective of healthcare information or provide additional protections not afforded by HIPAA. HIPAA's security standards were designed to protect electronic information against reasonably anticipated threats or hazards to the security or integrity of the information and to protect the information against unauthorized use or disclosure. These standards have had and are expected to continue to have a significant impact on the health care industry because they impose extensive requirements and restrictions on the use and disclosure of identifiable patient information. In addition, HIPAA established uniform standards governing the conduct of certain electronic healthcare transactions and protecting the privacy and security of individually identifiable health information. The Health Information Technology for Clinical Health Act of 2009 expanded the requirements and noncompliance penalties under HIPAA and requires correspondingly intensive compliance efforts by companies such as ours, including self-disclosures of breaches of unsecured health information to affected patients, federal officials, and, in some cases, the media.

On January 25, 2013, the DHHS promulgated new HIPAA privacy, security, and enforcement regulations, which increase significantly the penalties and enforcement practices of the Department regarding HIPAA violations. We implemented or upgraded computer and information systems as we believe necessary to comply with the new regulations. We believe that we are in substantial compliance with applicable state and federal regulations relating to privacy and security of patient information. However, if we fail to comply with the applicable regulations, we could be subject to significant penalties.

On January 25, 2013, the DHHS promulgated new HIPAA privacy, security, and enforcement regulations, which increase significantly the penalties and enforcement practices of DHHS regarding HIPAA violations. The new HIPAA regulations are effective as of March 26, 2013, and compliance was required by September 23, 2013.

Employees

As of December 31, 2013, excluding discontinued operations, we had approximately 3,368 total employees of which 2,629 were full-time employees.

Item 1A. Risk Factors

The following are certain risk factors that could affect our business, operations and financial condition. These risk factors should be considered in connection with evaluating the forward-looking statements contained in this Annual Report because these factors could cause the actual results and conditions to differ materially from those projected in forward-looking statements. This section does not describe all risks applicable to our business, and we intend it only as a summary of certain

material factors. If any of the following risks actually occur, our business, financial condition or results of operations could be negatively affected. In that case, the trading price of our common stock and our Series A Preferred Stock could decline.

Health care reform may affect our profitability and may require us to change the way our business is conducted.

Health care is an area of extensive and frequent regulatory change. The manner and the extent to which health care is regulated at the federal and state level is evolving. Changes in the laws or new interpretations of existing laws may have a significant effect on our methods and costs of doing business. Our success will depend partially on our ability to satisfy the applicable regulations and requirements and to procure and maintain required licenses. Our operations could also be adversely affected by, among other things, regulatory developments such as mandatory increases in the scope and quality of care given to the residents and revisions in licensing and certification standards. We are and will continue to be subject to varying degrees of regulation and licensing by health or social service agencies. We believe that our operations do not presently violate any existing federal or state laws, but we make no assurances that federal, state, or local laws or regulatory procedures which might adversely affect our business, financial condition, results of operations or prospects will not be expanded or imposed. A failure to comply with applicable requirements could cause us to be fined or could cause the cessation of our business, which would have a material adverse effect on our Company.

In March 2010, the PPACA and the Health Care and Education Reconciliation Act of 2010 were signed into law. Together, these two measures make the most sweeping changes to the U.S. health care system since the creation of Medicaid and Medicare. These new laws include a large number of health care related provisions scheduled to take effect over the next four years, including expanding Medicaid eligibility, requiring most individuals to have health insurance, establishing new regulations on health plans, establishing health insurance exchanges and modifying certain payment systems to encourage more cost-effective care and a reduction of inefficiencies and waste, including new tools to address fraud and abuse. As the implementation of, and rulemaking with respect to, these measures is ongoing, we are unable to accurately predict the effect these laws or any future legislation or regulation will have on us or our operations, including future reimbursement rates and occupancy in our inpatient facilities.

Our business depends on reimbursement under federal and state programs, and federal and state legislation or other changes to reimbursement and other aspects of Medicaid and Medicare may reduce or otherwise adversely affect reimbursement amounts.

A substantial portion of our revenue is derived from third-party payors, including Medicaid and Medicare programs. Our business, financial condition, results of operations and prospects would be adversely affected in the event that reimbursement rates under these programs are reduced or rise more slowly than the rate at which our costs increase or if there are changes in the way these programs pay for services. For example, services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all, or further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could occur, each of which could adversely impact our business, financial condition, results of operations and prospects.

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting, among other things, base rates or basis of payment, retroactive rate adjustments, annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to Medicare beneficiaries, 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.

For example, on July 29, 2011, CMS announced a final rule reducing Medicare skilled nursing facility PPS payments in fiscal year 2012 by $3.87 billion, or 11.1% lower than payments for fiscal year 2011. Moreover, CMS effectively reduced our Medicare reimbursement rates by nearly 11.7% by reducing rates as well as implementing changes to the RUG classification system. Similarly, in July 2011, Ohio Medicaid implemented reductions to the reimbursement rates of 6%.

On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which requires the federal budget to include automatic spending reductions beginning in 2012, including reduction of not more than 2% to Medicare providers, but exempting reductions to certain Medicaid and Medicare benefits. With respect to Medicare, these automatic sequestration reductions went into effect on April 1, 2013. Also, on March 15, 2013, the Medicare

Payment Advisory Commission recommended that Congress eliminate the market basket update and revise the prospective payment system to result in 2014 in a 4% reduction in Medicare payments to skilled nursing facilities, with subsequent reductions to follow. We are unable to accurately predict the impact these automatic and potential reductions will have on our business, and those reductions could materially adversely affect our business, financial condition, results of operations and prospects.

Recent federal governmental proposals could limit the states' use of provider tax programs to generate revenue for their Medicaid expenditures, which could result in a reduction in our reimbursement rates under Medicaid. To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements commonly referred to as "provider

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

We cannot currently estimate the magnitude of the potential Medicaid and Medicare rate or payment reductions, the impact of the failure of these programs to increase rates to match increasing expenses or the impact on us of potential Medicaid and Medicare policy changes, but they may be material to our operations and affect our future results of operations. We are unable to accurately predict whether future Medicaid and Medicare rates and payments will be sufficient to cover our costs. Future Medicaid and Medicare rate declines or a failure of these rates or payments to cover our costs could result in our experiencing materially lower earnings or losses.

We conduct business in a heavily regulated industry, and changes in, or violations of, regulations may result in increased costs or sanctions that reduce our revenue and profitability.

As a result of our participation in the Medicaid and Medicare programs, we are subject to, in the ordinary course of business, various governmental reviews, inquiries, investigations and audits by federal and state agencies to verify our compliance with these programs and laws and regulations applicable to the operation of, and reimbursement for, skilled nursing and assisted living facilities and our other operating areas. These regulations include those relating to licensure, conduct of operations, ownership of facilities, construction of new facilities and additions to existing facilities, allowable costs, services and prices for services.

Recently, the federal government has imposed extensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies and other regulatory sanctions, including terminations from the Medicaid and Medicare programs, denials of payment for new Medicaid and Medicare admissions and civil monetary penalties. If we fail to comply, or are perceived as failing to comply, with the extensive laws and regulations applicable to our industry, then we may become ineligible to receive government program reimbursement, be required to refund amounts received from Medicare, Medicaid or private payors, suffer civil or criminal penalties, suffer damage to our reputation or be required to significantly change the way we operate our business.

We operate in multiple states and the applicable regulatory provisions in each state are subject to changes over time. We continue to monitor state regulatory provisions applicable to our business to facilitate compliance with any revised or newly issued rules and policies.

Federal and state healthcare fraud and abuse laws regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to such beneficiaries. Under these laws, individuals and organizations can be penalized for submitting claims for services that are not provided, that have been inadequately provided, billed in an incorrect manner or other than as actually provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed or coded in a manner that does not otherwise comply with applicable governmental requirements. Penalties also may be imposed for violation of anti-kickback and patient referral laws. Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate healthcare fraud and abuse, including exclusion of the provider from participation in the Medicaid and Medicare programs, fines, criminal and civil monetary penalties and suspension of payments and, in the case of individuals, imprisonment. We also are subject to potential lawsuits under a federal whistleblower statute designed to combat fraud and abuse in the health care industry. These lawsuits can involve significant monetary awards to private plaintiffs who successfully bring these suits.

We believe that we maintain and follow policies and procedures that are sufficient to ensure that our facilities will operate in substantial compliance with these anti-fraud and abuse requirements and other Medicaid and Medicare program criteria. While we believe that our business practices are consistent with Medicaid and Medicare criteria, those criteria are often vague and subject to change and interpretation.

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We are unable to accurately predict the future course of federal, state and local regulation or legislation, including Medicaid and Medicare statutes and regulations, or the intensity of federal and state enforcement actions. An adverse review, inquiry, investigation or audit 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
- harm to our reputation in various markets.

An expanded federal program is underway to recover Medicare overpayments.

The Medicare Modernization Act of 2003 established a three year demonstration project to recover overpayments and identify underpayments on Medicare claims from hospitals, skilled nursing facilities and home health agencies through a review of claims previously paid by Medicare beginning in October, 2007. Medicare contracted nationwide with third parties known as Recovery Audit Contractors ("RAC") to conduct these reviews commonly referred to as RAC Audits. Due to the success of the program, the Tax Relief and Health Care Act of 2006 made the program permanent and mandated its expansion to all 50 states in 2010. We are also subject to other audits under various government programs, including Zone Program Integrity Contractors, Program Safeguard Contractors and Medicaid Integrity Contractors, in which third-party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper government payments. We make no assurances that our claims will not be selected for any such audits in the future and, if they are selected for any such audit, the extent to which these audits may have a material adverse effect on our business, financial condition, results of operations and prospects.

We are subject to claims under the self-referral and anti-kickback legislation.

In the United States, various state and federal laws regulate the relationships between providers of health care services, physicians and other clinicians. In particular, various laws, including federal and state anti-kickback and anti-fraud statutes, prohibit certain business practices and relationships that might affect the provision and cost of health care services reimbursable under Medicaid and Medicare programs, including the payment or receipt of compensation for the referral of patients whose care will be paid by federal governmental programs. Sanctions for violating the anti-kickback and anti-fraud statutes include criminal penalties and civil sanctions, including fines and possible exclusion from governmental programs such as Medicaid and Medicare.

These laws and regulations are complex, and limited judicial or regulatory interpretation exists. While we make every effort to ensure compliance, we make no assurances that governmental officials charged with responsibility for enforcing the provisions of these laws and regulations will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations. Violations of these laws may result in substantial civil or criminal penalties for individuals or entities, including large civil monetary penalties and exclusion from participation in the Medicare or Medicaid programs. Such exclusion or penalties, if applied to us, could have a material adverse effect on our business, financial condition, results of operations and prospects.

We are required to comply with laws governing the transmission and privacy of health information.

HIPAA requires us to comply with standards for the exchange of health information within our Company and with third parties, such as payors, business associates and patients. These include standards for common health care transactions, such as claims information, plan eligibility, payment information and the use of electronic signatures, unique identifiers for providers, employers, health plans and individuals, and security, privacy and enforcement. If we are found to be in violation of the privacy or security rules under HIPAA or other federal or state laws protecting the confidentiality of patient health information, we could be subject to criminal penalties and civil sanctions, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial condition, results of operations and prospects.

We rely on information technology in our operations, and any material failure, inadequacy, interruption or security failure of that technology could harm our business, financial condition, results of operations and prospects.

We rely on information technology networks and systems, including the Internet, to process, transmit and store electronic information, and manage or support a variety of business processes, including medical records, financial transactions and records, personal identifying information, payroll data and workforce scheduling information. We purchase some of our

information technology from vendors, on whom our systems depend. We rely on commercially available systems, software, tools and monitoring to provide security for processing, transmission and storage of confidential patient, resident and other customer information, such as individually identifiable information, including information relating to health protected by HIPAA. Although we have taken steps to protect the security of our information systems and the data maintained in those systems, it is possible that our safety and security measures will not prevent the systems' improper functioning or damage or the improper access or disclosure of personally identifiable information such as in the event of cyber-attacks. Security breaches, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches can create system disruptions or shutdowns or the unauthorized disclosure of confidential information. If personal or otherwise protected information of our patients is improperly accessed, tampered with or distributed, we may incur significant costs to remediate possible injury to the affected patients and we may be subject to sanctions and civil or criminal penalties if we are found to be in violation of the privacy or security rules under HIPAA or other similar federal or state laws protecting confidential patient health information. Any failure to maintain proper functionality and security of our information systems could interrupt our operations, damage our reputation, subject us to liability claims or regulatory penalties and could have a material adverse effect on our business, financial condition, results of operations and prospects.

We intend to continue to expand our business through acquisitions.

Our business model calls for seeking to acquire existing cash flowing operations and to expand our operations by pursuing an acquisition growth strategy to acquire and lease long-term care facilities, primarily skilled nursing facilities. Our success will largely depend on our ability to finance the new acquisitions and implement and integrate the new acquisitions into our management systems. As a result, we expect to experience all of the risks that generally occur with rapid expansion such as:

- adapting our management systems and personnel into the new acquisition;
- integrating the new acquisition and businesses into our structure;
- acquiring and operating new acquisitions and businesses in geographic regions in which we have not historically operated;
- obtaining adequate financing under reasonable and acceptable terms;
- retaining key personnel, customers and vendors of the acquired business and the hiring of new personnel;
- obtaining all necessary state and federal regulatory approvals to authorize acquisitions;
- impairments of goodwill and other intangible assets; and
- contingent and latent risks associated with the past operations of, and other unanticipated costs and problems arising in, an acquired business.

If we are unable to successfully integrate the operations of an acquired property or business into our operations, we could be required to undertake unanticipated changes. These changes could increase our operating costs and have a material adverse effect on our business, financial condition, results of operations and prospects.

We continue to seek acquisitions and other strategic opportunities that may require a significant amount of management resources and costs.

We continue to seek acquisitions and other strategic opportunities. Accordingly, we are often engaged in evaluating potential transactions and other strategic alternatives. In addition, from time to time, we engage in preliminary discussions that may result in one or more transactions. Although there is uncertainty that any of these discussions will result in definitive agreements or the completion of any transaction, we may devote a significant amount of our management resources to such transactions, which could negatively impact our existing and continuing operations. In addition, we may incur significant costs in connection with exploring and targeting acquisitions, regardless of whether these acquisitions are completed. In the event that we consummate an acquisition or strategic alternative in the future, there is no assurance that we would complete the acquisition or fully realize the potential benefit of such a transaction even if it is completed.

We will require additional financing in order to fund future acquisitions.

The pursuit of our growth strategy and the acquisition of new skilled nursing facilities may involve significant cash expenditures, debt incurrence, capital expenditures, additional operating losses, amortization of the intangible assets of acquired companies, dilutive issuances of equity securities and other expenses that could have a material adverse effect on our business, financial condition, results of operations and prospects.

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During 2014, we will need to obtain additional financing to implement our expansion strategy and fund our acquisitions. We are currently exploring several financing alternatives and may seek to raise additional capital through the sale of additional debt or equity securities. As of December 31, 2013, we had an accumulated deficit of $39.9 million and a working capital deficit of approximately $15.6 million. There is no assurance that we will succeed in obtaining financing or will be able to raise additional capital through the issuance of debt or equity securities on terms acceptable to us, or at all, or that any financing obtained will not contain restrictive covenants that limit our operating flexibility. If we are unable to secure such additional financing, then we may be required to delay or modify our expansion plans.

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

The profitability of our operations relies on acquiring existing cash flowing operations and expanding our operations by acquiring and leasing long-term care facilities, primarily skilled nursing facilities.

We face competition for the acquisition of these facilities and related businesses and expect this competition to increase. Based upon factors such as our ability to identify suitable acquisition candidates, the purchase price of the facilities, prevailing market conditions, the availability of leadership to manage new facilities and our 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 and financial condition.

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

In acquiring new facilities, we may be adversely impacted by unforeseen liabilities attributable to prior providers who operated those facilities, against whom we may have little or no recourse. For example, when we acquire a facility, we may 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 fines 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. These may include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status.

Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant facilities into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of expenditures or other resources or may otherwise not meet a risk profile that our investors find acceptable.

We may be unable to improve every facility that we acquire. Even if we improve operations and patient care at facilities that we have acquired, we still may face post-acquisition regulatory issues related to pre-acquisition events. 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 may not be able to successfully integrate acquired facilities and businesses into our operations, and we may not achieve the benefits we expect from any of our facility acquisitions.

We may not be able to efficiently or effectively integrate newly acquired facilities 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, financial or other resources, and the integration process may ultimately be unsuccessful. We recognize the importance of maintaining adequate staffing and supervision in our facilities at all times to ensure a high quality of care for our patients and residents. The financial benefits we expect to realize from many of our acquisitions rely largely upon our ability to improve performance, overcome regulatory deficiencies, increase and maintain

occupancy and control costs. If we are unable to accomplish any of these objectives at facilities we acquire, we may not realize the expected benefits, which may have a material adverse effect on our business, financial condition, results of operations and prospects.

State efforts to regulate the construction or expansion of health care providers could impair our ability to expand our operations or make acquisitions.

Some states require health care providers (including skilled nursing facilities, hospices and assisted living facilities) to obtain prior approval, in the form of a Certificate of Need ("CON"), for the purchase, construction or expansion of health care facilities, capital expenditures exceeding a prescribed amount or changes in services or bed capacity. To the extent that we are unable to obtain any required CON or other similar approvals, our expansion could be materially adversely affected. Additionally, failure to obtain the necessary state approvals can also result in sanctions or adverse action on the facility's license and adverse reimbursement action. No assurances are given that we will be able to obtain a CON or other similar approval for any future projects requiring this approval or that such approvals will be timely.

Circumstances that adversely affect the ability of seniors, or their families, to pay for our services could have material adverse effects on our business, financial condition, results of operations and prospects.

Approximately 6% of our skilled nursing occupants and nearly all of the occupants of our assisted living facilities rely on their personal investments and wealth to pay for their stay in our facilities. We expect to continue to rely on the ability of our residents to pay for our services from their own financial resources. Inflation, continued high levels of unemployment, declines in market values of investments and home prices, or other circumstances that may adversely affect the ability of the elderly or their families to pay for our services could have a material adverse effect on our business, financial condition, results of operations and prospects.

We depend largely upon reimbursement from third-party payors, and our business, financial condition, results of operations and prospects could be adversely affected by any changes in the 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 our patient mix, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, may significantly affect our profitability because we generally receive higher reimbursement rates for certain patients, such as rehabilitation patients, and because the payors reimburse us at different rates. As a result, changes in the case mix of patients as well as the payor mix may significantly affect our profitability. Particularly, a significant increase in Medicaid patients will have a material adverse effect on our business, financial condition, results of operations and prospects, especially if states operating Medicaid programs continue to limit, or more aggressively seek limits on, reimbursement rates.

We operate in an industry that is highly competitive.

The long-term care industry is highly competitive and we believe that it will become even more competitive in the future. We face direct competition for patients, employees and the acquisition of facilities. Our skilled nursing and assisted living facilities face competition from skilled nursing, assisted living, independent living facilities, homecare services, community-based service programs, retirement communities and other operations that provide services comparable to those offered by us.

We compete with national companies with respect to both our skilled nursing and assisted living facilities. Additionally, we also compete with local and regional based entities. Many of these competing companies have greater financial and other resources than we have. Failure to effectively compete with these companies may have a material adverse effect on our business, financial condition, results of operations and prospects.

Our ability to compete is based on several factors, including, without limitation, building age, appearance, reputation, availability of patients, survey history and CMS rankings. We make no assurances that increases in competition in the future will not adversely affect our business, financial condition, results of operations and prospects.

The cost to replace or retain qualified personnel may affect our business, financial condition, results of operations and prospects, and we may not be able to comply with the staffing requirements of certain states.

We could experience significant increases in our costs due to shortages in qualified nurses, health care professionals and other key personnel. We compete with other providers of home health care, nursing home care, and assisted living with respect to attracting and retaining qualified personnel, and the market is competitive. Because of the small markets in which we operate, shortages of nurses and trained personnel may require us to enhance our wage and benefit package in order to compete and attract qualified employees from more metropolitan areas. Further,

acquisitions of new facilities may require us to pay increased compensation or offer other incentives to retain key personnel and other employees in any newly acquired facilities. Increased competition in the future with respect to attracting and maintaining key personnel could limit our ability to attract and retain residents or to expand our business.

Certain states in which we currently operate, or may operate in the future, may have adopted minimum staffing standards, and additional states may also establish similar requirements in the future. Our ability to satisfy these requirements will depend upon our ability to attract and retain qualified, nurses, certified nurses' assistants and other personnel. Failure to comply with these requirements may result in the imposition of fines or other sanctions. If states do not appropriate sufficient additional funding, through Medicaid appropriations or otherwise, to pay for any additional operating costs resulting from minimum staffing requirements, then our business, financial condition, results of operations and prospects may be adversely affected.

To date, we have been able to adequately staff all of our operations and future operations following an acquisition. However, we make no assurances that the ability to adequately staff all of our operations will continue in the future. Additionally, increasing employee health and workers' compensation insurance costs may materially and negatively affect our profitability. We provide no assurances that our labor costs will not increase or that any increase will be matched by corresponding increases in rates we charge to facility residents. Our ability to control labor costs will significantly effect on our business, financial condition and results of operation in the future.

Successful union organization of our employees may adversely affect our business, financial condition, results of operations and prospects.

Periodically, labor unions attempt to organize our employees. Although we currently have no collective bargaining agreements with unions with respect to our employees or our facilities, there is no assurance that this will continue to be the case in the future. If future federal legislation makes it easier for employee groups to unionize, then groups of our employees may seek union representation. If more of our employees unionize, we could experience business interruptions, work stoppages, declines in service levels due to union specific rules or increased operating expenses that may adversely affect our business, financial condition, results of operations and prospects.

A petition has been filed by the Retail Wholesale and Department Store Union for a union election in our Attalla, Alabama facility. An election date of April 11, 2014 has been set.

If we lose our key management personnel, we may not be able to successfully manage our business or achieve our objectives, which could have a material adverse effect on our business, financial condition, results of operations and prospects.

We are dependent on our management team, and our future success depends largely upon the management experience, skill, and contacts of our management, and the loss of any of our key management team could harm our business. If we lose the services of any or all of our management team, we may not be able to replace them with similarly qualified personnel, which could have a material adverse effect on our business, financial condition, results of operations and prospects.

Termination of assisted living resident agreements and resident attrition could adversely affect our revenues and earnings.

State regulations governing assisted living facilities typically require a written resident agreement with each resident. Most of these regulations also require that each resident have the right to terminate our assisted living resident agreement for any reason on reasonable notice. Consistent with these regulations, most resident agreements allow residents to terminate their agreements on 30 days' notice. Unlike typical leasing relationships which require a commitment of one year or more, we cannot contract with our residents for longer periods of time.

Environmental compliance costs and liabilities associated with our facilities may have a material adverse effect on our business, financial condition, results of operations and prospects.

We are subject to various federal, state and local environmental and health and safety laws and regulations with respect to our facilities. These laws and regulations address various matters, including asbestos, fuel oil management, wastewater discharges, air emissions, medical wastes and hazardous wastes. The costs of complying with these laws and regulations and the penalties for non-compliance can be substantial. For example, with respect to our owned and leased property, we may be held liable for costs relating to the investigation and cleanup of any of our owned or leased properties from which there has been a release or threatened release of a regulated material as well as other properties affected by the release. In addition to these costs, which are typically not limited by law or regulation and could exceed the property's value, we could be liable for certain other costs, including, without limitation, governmental fines and injuries to persons, property or natural resources. Further, some environmental laws create a lien on the contaminated site in favor of the government for damages and the costs it incurs in connection with the

contamination. While we are not aware of any potential environmental problems, no assurances are made that such problems and the costs associated with them will not arise in the future. If any of our properties were found to violate environmental laws, we may be required to expend significant amounts of time and money to rehabilitate the property, and we may be subject to significant liability. Any environmental compliance costs and liabilities incurred may have a material adverse effect on our business, financial condition, results of operations and prospects.

Disasters and other adverse events may seriously harm our business.

Our facilities and residents may suffer harm as a result of natural or man-made disasters such as storms, earthquakes, hurricanes, tornadoes, floods, fires, terrorist attacks and other conditions. Such events may disrupt our operations, harm our patients and employees, severely damage or destroy one more of our facilities, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that cannot currently be predicted.

The nature of business exposes us to certain litigation risks.

The provision of health care services entails an inherent risk of liability. In recent years, participants in the long-term care industry have become subject to an increasing number of lawsuits alleging malpractice, negligence or other related legal theories. In several well publicized instances, private litigation by residents of senior living facilities for alleged abuses has resulted in large damage awards against other operating companies. Certain lawyers and firms specialize in bringing litigation against companies such as ours. As a result of this litigation, our cost of liability insurance has increased during the past few years.

We currently maintain liability insurance. This insurance is intended to cover malpractice and other lawsuits. Although we believe that it is in keeping with industry standards, no assurances are made that claims in excess of our limits will not arise. Any such successful claims could have a material adverse effect upon our business, financial condition, results of operations and prospects. Claims against us, regardless of their merit or eventual outcome, may also have a material adverse effect upon our ability to attract and retain patients and key personnel. In addition, our insurance policies must be renewed annually, and no assurances are made that we will be able to retain coverage in the future or, if coverage is available, that it will be available on acceptable terms.

We are subject to possible conflicts of interest; we have engaged in, and expect to continue to engage in, transactions with parties that may be considered related parties.

From time to time, we have engaged in various transactions with Christopher Brogdon, Vice Chairman of the Board of Directors, owner of greater than 5% of our outstanding common stock and former Chief Acquisition Officer of the Company. These transactions, along with other related party transactions, are described in Note 19 to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data," and Part III., Item 13., “Certain Relationships and Related Transactions, and Director Independence.”

We believe that our affiliations with Mr. Brogdon, and other related parties have been, and will be, beneficial to us. Although we do not believe the potential conflicts have adversely affected, or will adversely affect, our business, others may disagree with this position and litigation could ensue in the future. Our relationships with Mr. Brogdon and other related parties may give rise to litigation, nominations or proposals which could result in substantial costs to us and a diversion of our resources and our management's attention, whether or not any allegations made are substantiated.

The costs of being publicly owned may strain our resources and impact our business, financial condition, results of operations and prospects.

As a public company, we are subject to the reporting requirements of the Exchange Act and the Sarbanes-Oxley Act of 2002 ("Sarbanes-Oxley Act"). The Exchange Act requires that we file annual, quarterly and current reports with respect to our business and financial condition. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal controls for financial reporting. We are required to document and test our internal control procedures in order to satisfy the requirements of Section 404 of the Sarbanes-Oxley Act, which requires annual management assessments of the effectiveness of our internal controls over financial reporting.

These requirements may place a strain on our systems and resources and have required us, and may in the future require us, to hire additional accounting and financial resources with appropriate public company experience and technical accounting knowledge. In addition, failure to maintain such internal controls could result in us being unable to provide timely and reliable financial information which could potentially subject us to sanctions or investigations by the SEC or other regulatory authorities or cause us to be late in the filing of required reports or financial results. Any of the foregoing events could have an adverse effect on our business, financial condition, results of operations and prospects.

We have a history of operating losses and may incur losses in the future.

For the year ended December 31, 2013, for amounts attributable to the Company, we had a net loss of $13.4 million compared to a net loss of $6.9 million for the year ended December 31, 2012. We make no assurances that we will be

able to operate profitably. As of December 31, 2013, we have a working capital deficit of approximately $15.6 million.

We intend to seek to improve our liquidity and profitability in future years by:

- refinancing debt where possible to obtain more favorable terms;
- increasing facility occupancy and the proportion of sub-acute patients within our skilled nursing facilities;
- continuing our cost optimization and efficiency strategies;
- acquiring additional long-term care facilities with existing cash flowing operations to expand our operations.

We believe the foregoing actions, if taken, will provide the opportunity for the Company to improve liquidity and achieve profitability. No assurances are made that such improvements or achievements will occur.

Our business requires us to make capital expenditures to maintain and improve our facilities.

Our facilities sometimes require capital expenditures to address ongoing required maintenance and to make them attractive to residents. Physical characteristics of senior living facilities and rehabilitation centers are mandated by various governmental authorities; and changes in these regulations may require us to make significant expenditures. In addition, we often are required to make significant capital expenditures when we acquire new facilities in pursuit of our growth strategy. Our available financial resources may be insufficient to fund these expenditures.

Our substantial debt could adversely affect our cash flow and impair our ability to raise additional capital.

As of December 31, 2013, we had approximately $160.3 million in indebtedness, including current maturities and discontinued operations. We may also obtain additional short-term and long-term debt to meet future capital needs, including to fund acquisitions, subject to certain restrictions under our existing indebtedness, which would increase our total debt. Our substantial amount of debt could have negative consequences to our business. For example, it could:

- increase our vulnerability to general adverse economic and industry conditions;
- require us to dedicate a substantial portion of cash flows from operations to interest and principal payments on outstanding debt, thereby limiting the availability of cash flow to fund acquisitions, capital expenditures, working capital and other general corporate requirements;
- limit our flexibility in planning for, or reacting to, changes in our business and industry;
- place us at a competitive disadvantage compared with our competitors that have less debt; and
- limit our ability to borrow additional funds, even when necessary to maintain adequate liquidity.

In addition, our ability to borrow funds in the future will depend in part on the satisfaction of the covenants in our credit facilities and other debt agreements. If we are unable to satisfy the financial covenants contained in those agreements, or are unable to generate cash sufficient to make required debt payments, the lenders and other parties to those arrangements could accelerate the maturity of some or all of our outstanding indebtedness.

We may not have sufficient liquidity to meet our capital needs.

For the year ended and as of December 31, 2013, we had a net loss of $13.4 million and negative working capital of $15.6 million. At December 31, 2013, we had $19.4 million in cash and cash equivalents and $160.3 million in indebtedness, including current maturities and discontinued operations, of which $32.2 million is current debt (including the Company's outstanding convertible promissory notes with a principal amount in the aggregate of $4.5 million and $6.9 million which mature March 31, 2014 and August 29, 2014, respectively, and approximately $6.0 million of mortgage notes included in liabilities of variable interest entity held for sale).

Based on existing cash balances, anticipated cash flows for the year ending December 31, 2014, and new sources of capital, we believe there will be sufficient funds for our operations, scheduled debt service, and capital expenditures through the next 12 months. On a longer term basis, at December 31, 2013 we have approximately $73.9 million of debt payments and maturities due between 2015 and 2017, excluding convertible promissory notes which are convertible into shares of common stock. We believe our long-term liquidity needs will be satisfied by these same sources, as well as borrowings as required to refinance indebtedness.

In order to satisfy these capital needs, we intend to: (i) improve our operating results by increasing facility occupancy, optimizing our payor mix by increasing the proportion of sub-acute patients within our skilled nursing facilities, continuing our cost optimization and efficiency strategies and acquiring additional long-term care facilities with existing operating cash flow; (ii) expand our borrowing arrangements with certain existing lenders; (iii) refinance current debt where possible to obtain more

favorable terms; and (iv) raise capital through the issuance of debt or equity securities. We anticipate that these actions, if successful, will provide the opportunity for us to maintain liquidity on a short and long term basis, thereby permitting us to meet our operating and financing obligations for the next 12 months and provide for the continuance of our acquisition strategy. However, there is no guarantee that such actions will be successful or that anticipated operating results will be achieved. We currently have limited borrowing availability under our existing revolving credit facilities. If the Company is unable to improve operating results, expand existing borrowing agreements, refinance current debt (including the $6.4 million of bullet maturities due July 2014), the convertible promissory notes due August 29, 2014 are not converted into common stock and are required to be repaid by us in cash, or raise capital through the issuance of securities, then the Company may be required to restructure its outstanding indebtedness, implement further cost reduction initiatives, sell assets, or delay, modify, or abandon its expansion plans.

An increase in market interest rates could increase our interest costs on existing and future debt.

We have incurred and expect in the future to incur floating rate indebtedness in connection with our acquisition of new facilities, as well as for other purposes. Accordingly, increases in interest rates would increase the Company's interest costs. These increased costs could make the financing of any acquisition more costly and could limit our ability to refinance existing debt when it matures.

We do not currently pay cash dividends on our common stock and do not anticipate doing so in the future.

We have never declared or paid any cash dividends on our common stock. We intend to retain any future earnings after payment of dividends on our Series A Preferred Stock to fund our operations and, therefore, we currently do not anticipate paying any cash dividends on our common stock in the foreseeable future. In addition, no cash dividends may be declared or paid on our common stock unless full cumulative dividends on our Series A Preferred Stock have been, or contemporaneously are, declared and paid, or declared and a sum sufficient for the payment thereof is set apart for payment, for all past dividend periods.

We could be prevented from paying dividends on our Series A Preferred Stock and our common stock.

We are a holding company, and we have no significant operations. We rely primarily on dividends and other distributions from our subsidiaries to us so we may, among other things, pay dividends on our stock, if and to the extent declared by the Board of Directors. The ability of our subsidiaries to pay dividends and other distributions to us depends on their earnings and is restricted by the terms of certain agreements governing their indebtedness. If our subsidiaries are in default under such agreements, then they may not pay dividends or other distributions to us.

In addition, we may only pay dividends on our stock if we have funds legally available for the payment of dividends and such payment is not restricted or prohibited by law, the terms of any shares with higher priority with respect to dividends or any documents governing our indebtedness. Furthermore: (i) one of our mortgage loans prohibits the payment of dividends on our stock if we fail to comply with certain financial covenants or if a default or event of default under the loan agreement has occurred; and (ii) another one of our mortgage loans requires the consent of the lender and the guarantor prior to payment of dividends on our stock. As such, we could become unable, on a temporary or permanent basis, to pay dividends on our stock, including our Series A Preferred Stock. In addition, future debt, contractual covenants or arrangements we or our subsidiaries enter into may restrict or prevent future dividend payments.

The payment of any future dividends on our stock will be at the discretion of the Board of Directors and will depend, among other things, the earnings and results of operations of our subsidiaries, their ability to pay dividends and other distributions to AdCare under agreements governing their indebtedness, our financial condition and capital requirements, any debt service requirements and any other factors the Board of Directors deems relevant.

The price of our stock, in particular our common stock, has fluctuated, and a number of factors may cause the price of our stock to decline.

The market price of our stock has fluctuated and could fluctuate significantly in the future as a result of various factors and events, many of which are beyond our control. These factors may include:

- variations in our operating results;
- changes in our financial condition, performance and prospects;
- changes in general economic and market conditions;
- the departure of any of our key executive officers and directors;
- announcements by us or our competitors of significant acquisitions, strategic partnerships, or transactions;

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- press releases or negative publicity relating to us or our competitors or relating to trends in health care;
- government action or regulation, including changes in federal, state, and local health-care regulations to which we are subject;
- the level and quality of securities analysts' coverage for our stock;
- changes in financial estimates or recommendations by securities analysts with respect to us or our competitors; and
- with respect to our common stock, future sales of our common stock.

In addition, the market price of our Series A Preferred Stock will also depend upon:

- prevailing interest rates, increases in which may have an adverse effect on the market price of our Series A Preferred Stock;
- trading prices of preferred equity securities issued by other companies in the industry;
- the annual yield from distributions on our Series A Preferred Stock as compared to yields on other financial instruments; and
- our issuance of additional preferred equity or debt securities.

Furthermore, the stock market in recent years has experienced sweeping price and volume fluctuations that often have been unrelated to the operating performance of affected companies. These market fluctuations may also cause the price of our stock to decline.

In the event of fluctuations in the price of our stock, shareholders may be unable to resell shares of our stock at or above the price at which they purchased such shares. Additionally, due to fluctuations in the price of our stock, comparing our operating results on a period-to-period basis may not be meaningful, and you should not rely on past results as an indication of future performance.

Our directors and officers substantially control all major decisions.

Our directors and officers beneficially own approximately 21.8% of our outstanding common stock. Therefore, our directors and officers will be able to influence major corporate actions required to be voted on by shareholders, such as the election of directors, the amendment of our charter documents and the approval of significant corporate transactions such as mergers, reorganizations, sales of substantially all of our assets and liquidation. Furthermore, our directors will be able to make decisions affecting our capital structure, including decisions to issue additional capital stock, implement stock repurchase programs and incur indebtedness. This control may have the effect of deterring hostile takeovers, delaying or preventing changes in control or changes in management, or limiting the ability of our other shareholders to approve transactions that they may deem to be in their best interest.

Takeover defense provisions in Georgia law and our charter documents may delay or prevent takeover attempts thereby preventing our shareholders from realizing a premium on their common stock.

Various provisions of Georgia corporation law and of our charter documents may inhibit changes in control not approved by our Board of Directors and may have the effect of depriving our investors of an opportunity to receive a premium over the prevailing market price of our common stock in the event of an attempted hostile takeover. In addition, the existence of these provisions may adversely affect the market price of our common stock. These provisions include:

- a requirement that special meetings of shareholders be called by our Board of Directors, the Chairman, the President, or the holders of shares with voting power of at least 25%;
- staggered terms among our directors with three classes of directors and only one class to be elected each year;
- advance notice requirements for shareholder proposals and nominations; and
- availability of "blank check" preferred stock.

Our Board of Directors can use these and other provisions to prevent, delay or discourage a change in control of the Company or a change in our management. Any such delay or prevention of a change in control or management could deter potential acquirers or prevent the completion of a takeover transaction pursuant to which our shareholders could receive a substantial premium over the current market price of our common stock, which in turn may limit the price investors might be willing to pay for our common stock.

Provisions in our charter documents provide for indemnification of officers and directors, which could require us to direct funds away from our business and future operations.

Our charter documents provide for the indemnification of our officers and directors. We may be required to advance costs incurred by an officer or director and to pay judgments, fines and expenses incurred by an officer or director, including reasonable attorneys' fees, as a result of actions or proceedings in which our officers and directors are involved by reason of being or having been an officer or director of our Company. Funds paid in satisfaction of judgments, fines and expenses may be funds we need for the operation and growth of our business.

Item 1B. Unresolved Staff Comments

Disclosure pursuant to Item 1B of Form 10-K is not required to be provided by smaller reporting companies.

Item 2. Properties

Facilities

As of December 31, 2013, we operated 46 facilities in eight states with the operational capacity to serve approximately 4,677 residents. Of the facilities, we owned and operated 26 facilities, leased and operated nine facilities, and managed 11 facilities.

The following table provides summary information regarding the number of operational beds at our facilities as of December 31 (excluding discontinued operations):

	December 31,	
	2013	2012
Cumulative number of facilities	46	46
Cumulative number of operational beds	4,677	4,677

		Number of Facilities			
State	Number of Operational Beds/Units	Owned	Leased	Managed for Third Parties	Total
Alabama	304	2	—	—	2
Arkansas	1,041	10	—	—	10
Georgia	1,379	4	7	—	11
Missouri	80	—	1	—	1
North Carolina	106	1	—	—	1
Ohio	705	4	1	3	8
Oklahoma	882	3	—	8	11
South Carolina	180	2	—	—	2
Total	4,677	26	9	11	46
Facility Type					
Skilled Nursing	4,482	24	9	10	43
Assisted Living	112	2	—	—	2
Independent Living	83	—	—	1	1
Total	4,677	26	9	11	46

Corporate Office

Our corporate office is located in Roswell, Georgia. We own two office buildings in Roswell, which contain approximately 13,700 square feet of office space. In addition, we have a lease and a sublease totaling approximately 5,300 square feet of office space in the Atlanta, Georgia area.

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Item 3. Legal Proceedings

We are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that our services have resulted in injury or death to the residents of our facilities and claims related to employment, staffing requirements and commercial matters. Although we intend to vigorously defend ourselves in these matters, there is no assurance that the outcomes of these matters will not have a material adverse effect on our business, results of operations and financial condition.

We operate in an industry that is extremely regulated. As such, in the ordinary course of business, we are continuously subject to state and federal regulatory scrutiny, supervision and control. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine. In addition, we believe that there has been, and will continue to be, an increase in governmental investigations of long-term care providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse determinations in legal proceedings or governmental investigations against or involving us, whether currently asserted or arising in the future, could have a material adverse effect on our business, results of operations and financial condition.

On June 24, 2013, South Star Services, Inc. (“SSSI”), Troy Clanton and Rose Rabon (collectively, the “Plaintiffs”) filed a complaint in the District Court of Oklahoma County, State of Oklahoma against: (i) AdCare, certain of its wholly owned subsidiaries and AdCare’s Chief Executive Officer (collectively, the “AdCare Defendants”); (ii) Christopher Brogdon(Vice Chairman of the Board of Directors, owner of greater than 5% of the outstanding common stock and former Chief Acquisition Officer of the Company,) and his wife; and (iii) five entities controlled by Mr. and Mrs. Brogdon, which entities own five skilled-nursing facilities located in Oklahoma (the “Oklahoma Facilities”) that are managed by an AdCare subsidiary. The complaint alleges, with respect to the AdCare Defendants, that: (i) the AdCare Defendants tortuously interfered with contractual relations between the Plaintiffs and Mr. Brogdon, and with Plaintiffs’ prospective economic advantage, relating to SSSI’s right to manage the Oklahoma Facilities and seven other skilled-nursing facilities located in Oklahoma (collectively, the “Facilities”), respectively; (ii) the AdCare Defendants fraudulently induced the Plaintiffs to perform work and incur expenses with respect to the Facilities; and (iii) one of the AdCare subsidiaries which is an AdCare Defendant provided false and defamatory information to an Oklahoma regulatory authority regarding SSSI’s management of one of the Oklahoma Facilities. The complaint seeks damages against the AdCare Defendants, including punitive damages, in an unspecified amount, as well as costs and expenses, including reasonable attorney fees. On March 7, 2014, the Plaintiffs filed an amended complaint in which they alleged additional facts regarding the alleged fraudulent inducement caused by Mr. and Mrs. Brogdon and the AdCare Defendants. The Company intends to file a response to the amended complaint in a timely manner, and the trial is scheduled to begin in January 2015. The Company believes that the complaint is without merit and intends to vigorously defend itself against the claims set forth therein.

On March 7, 2014 the Company responded to a letter received from the Ohio Attorney General ("OAG") dated February 25, 2014 demanding repayment of approximately $1.0 million as settlement for alleged improper Medicaid payments related to seven Ohio facilities affiliated with the Company. The OAG alleged that the Company had submitted improper Medicaid claims for independent laboratory services for glucose blood tests and capillary blood draws. The Company intends to defend itself against the claims.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market for Registrant's Common Equity

Our common stock is listed for trading on the NYSE MKT under the symbol "ADK." The high and low sales prices of our common stock during the quarters listed below were as follows:

"ADK"		High	Low
2013	First Quarter	$5.12	$3.66
	Second Quarter	$6.26	$3.85
	Third Quarter	$4.98	$3.82
	Fourth Quarter	$4.50	$3.62
2012	First Quarter	$4.96	$3.60
	Second Quarter	$4.63	$3.15
	Third Quarter	$5.19	$3.39
	Fourth Quarter	$5.50	$3.66

Based on information supplied from our transfer agent, there were approximately 500 shareholders of record of our common stock as of March 26, 2014.

We have never declared or paid any cash dividends with respect to our common stock. Our ability to pay dividends will depend upon our future earnings and net worth. We are restricted by Georgia law from paying dividends on the common stock if we are not able to pay our debts as they become due in the normal course of business or if our total assets would be less than the sum of our total liabilities plus the amount that would be needed to satisfy the preferential rights upon dissolution of the shareholders whose preferential rights are superior. In addition, no cash dividends may be declared or paid on our common stock unless full cumulative dividends on our Series A Preferred Stock have been, or contemporaneously are, declared and paid, or declared and a sum sufficient for the payment thereof is set apart for payments, for all past dividend periods. Furthermore: (i) one of our mortgage loans prohibits the payment of dividends on our stock if we fail to comply with certain financial covenants or if a default or event of default under the loan agreement has occurred; and (ii) another one of our mortgage loans requires the consent of the lender and the guarantor prior to payment of dividends on our stock.

Except for payment of dividends on our Series A Preferred Stock, we currently intend to retain any future earnings to fund the operation and growth of our business. We do not anticipate paying cash dividends on our common stock in the foreseeable future.

Equity Compensation Plan Information

The following table sets forth additional information as of December 31, 2013, concerning shares of our common stock that may be issued upon the exercise of options and other rights under our existing equity compensation plans and arrangements, divided between plans approved by our shareholders and plans or arrangements not submitted to the shareholders for approval. The information includes the number of shares covered by and the weighted average exercise price of, outstanding options and other rights and the number of shares remaining available for future grants excluding the shares to be issued upon exercise of outstanding options, warrants, and other rights.

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Plan Category	(a) Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights	(b) Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	(c) Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a))
Equity compensation plans approved by security holders[1]	1,804,310	$4.54	1,727,739
Equity compensation plans not approved by security holders[2]	3,864,715	$3.48	—
Total	5,669,025	$3.81	1,727,739

(1) Represents options issued pursuant to the: (i) AdCare Health Systems, Inc. 2011 Stock Incentive Plan and (ii) 2005 Stock Option Plan of AdCare Health Systems, Inc. which were all approved by our shareholders.

(2) Represents warrants issued outside of our shareholder approved plans as described below:

- On March 5, 2007, we issued to a consultant, as partial consideration for providing consulting services to the Company, a seven-year warrant to purchase 80,000 shares of our common stock at an exercise price of $2.68. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result of dividends and partial exercises, as of December 31, 2013, the warrant represented the right to purchase 28,941 shares at an exercise price of $2.27 per share. This warrant expired on March 5, 2014.
- On November 16, 2007, we issued to our Board of Directors, as partial consideration for serving on our Board, ten-year warrants to purchase 649,000 shares of our common stock at exercise prices ranging from $1.21 to $4.00. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrants now represent the right to purchase 751,300 shares at exercise prices ranging from $1.04 to $3.43 per share.
- On November 16, 2007, we issued to members of our management team, as incentive compensation, ten year warrants to purchase 83,275 shares of our common stock at exercise prices ranging from $1.21 to $4.00. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrants now represent the right to purchase 96,401 shares at exercise prices ranging from $1.04 to $3.43 per share.
- On September 24, 2009, we issued to Christopher Brogdon, as inducement to become our Chief Acquisition Officer, an eight-year warrant to purchase 300,000 shares of our common stock at exercise prices ranging from $3.00 to $5.00. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 347,288 shares at exercise prices ranging from $2.59 to $4.32 per share.
- On September 15, 2009, we issued to members of our management team, as incentive compensation, five-year warrants to purchase 108,334 shares of our common stock at an exercise price of $3.00. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrants now represent the right to purchase 125,410 shares at an exercise price of $2.59 per share.
- On December 15, 2009, we issued to certain placement agents, as partial consideration for serving as placement agents for the sale of Company stock under a private placement, five-year warrants to purchase 13,811 shares of our common stock at an exercise price of $2.00. These warrants were subject to certain anti-dilution adjustments, and,

therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrants now represent the right to purchase 15,989 shares at an exercise price of $1.73 per share.

- On September 30, 2010, we issued to various investors, as partial consideration for providing certain financing to the Company, three-year warrants to purchase 350,000 shares of our common stock at an exercise price of $4.13. These warrants were subject to certain anti-dilution adjustments, and, therefore, were

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adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, as of December 31, 2013, the warrants represented the right to purchase 405,166 shares at an exercise price of $3.57 per share. During February and March 2014, 385,486 of these warrants were exercised and 19,680 were forfeited.

- On September 30, 2010, we issued to placement agents, as partial consideration for serving as placement agents for the sale of certain promissory notes of the Company, three-year warrants to purchase 116,900 shares of our common stock at an exercise price of $4.13. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, as of December 31, 2013, the warrants represented the right to purchase 135,326 shares at an exercise price of $3.57 per share. During February and March 2014, 134,631 of these warrants were exercised and 695 were forfeited.
- On September 30, 2010, we issued to Cantone Research, Inc., as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 150,000 shares of our common stock at an exercise price of $4.13. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, as of December 31, 2013, the warrant represented the right to purchase 173,644 shares at an exercise price of $3.57 per share. This warrant was exercised in March 2014.
- On January 10, 2011, we issued to Boyd Gentry, as inducement to become our Chief Executive Officer, a ten year warrant to purchase 250,000 shares of our common stock at an exercise price of $4.13. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2011 and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 275,625 shares at an exercise price of $3.75 per share.
- On March 31, 2011, we issued to Cantone Research, Inc., as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 250,000 shares of our common stock at an exercise price of $5.30. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2011 and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 275,625 shares at an exercise price of $4.81 per share.
- On May 2, 2011, we issued to Noble Financial, as partial consideration for providing certain financing to the Company, a five-year warrant to purchase 50,000 shares of our common stock at an exercise price of $4.50. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2011 and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 55,125 shares at an exercise price of $4.08 per share.
- On December 19, 2011, we issued to David Rubenstein, as inducement to become our Chief Operating Officer, a ten-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.13, and a ten-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.97. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2012 for a 5% stock dividend. As a result, the warrants now represent the right to purchase 105,000 shares at an exercise price of $3.93 per share and 105,000 shares at an exercise price of $4.58 per share.
- On March 30, 2012, we issued to Cantone Asset Management LLC, as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 300,000 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti dilution adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 315,000 shares at an exercise price of $3.81 per share.
- On April 1, 2012, we issued to Strome Alpha Offshore Ltd., as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 312,500 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti-dilution, adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 328,125 shares at an exercise price of $3.81 per share.
- On July 2, 2012, we issued to Cantone Research, Inc., as partial consideration for serving as placement agent for the sale of certain promissory notes of the Company, a three-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti-dilution adjustments, and, therefore, was

adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 105,000 shares at an exercise price of $3.81 per share.

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- On August 31, 2012, we issued to an investor relations firm, as partial consideration for providing certain investor relations services to the Company, a three-year warrant to purchase 15,000 shares of our common stock at an exercise price of $4.59. This warrant is subject to certain anti-dilution adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 15,750 shares at an exercise price of $4.37 per share.
- On December 28, 2012, we issued to Strome Alpha Offshore, Ltd., as partial consideration for providing certain financing to the Company, a ten-year warrant to purchase 50,000 shares of our common stock at an exercise price of $3.80. This warrant is subject to certain anti-dilution adjustments.
- On May 15, 2013, we issued to Ronald W. Fleming, as an inducement to become our Chief Financial Officer, a ten-year warrant to purchase 70,000 shares of our common stock at an exercise price of $5.90, which vests as to one-third of the underlying shares on each of the successive three anniversaries of the issue date.
- On October 26, 2013 we issued to Cantone Research, Inc., as partial consideration for providing certain financing to the Company, a two-year warrant to purchase 75,000 shares of our common stock at an exercise price of $3.96 per share.
- On November 26, 2013, we issued to an investor relations firm, as partial consideration for providing certain investor relations services to the Company, a ten-year warrant to purchase 10,000 shares of our common stock at an exercise price of $3.96.

Issuance of Unregulated Securities

See “Exercise of Warrants” in Part II., Item 9B. “Other Information” of this Annual Report for a description of unregistered securities issued during the quarter ended December 31, 2013.

Item 6. Selected Financial Data

Disclosure pursuant to Item 6 of Form 10-K is not required to be provided by smaller reporting companies.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

We own and operate skilled nursing and assisted living facilities in the states of Alabama, Arkansas, Georgia, Missouri, North Carolina, Ohio, Oklahoma, and South Carolina. As of December 31, 2013, through our wholly owned separate operating subsidiaries, we operate 46 facilities consisting of 43 skilled nursing facilities, two assisted living facilities and one independent living/senior housing facility totaling approximately 4,700 beds. Our facilities provide a range of health care services to their patients and residents including, but not limited to, skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term residents and short-stay patients. As of December 31, 2013, of the total 46 facilities, we owned and operated 26 facilities, leased and operated nine facilities, and managed 11 facilities. As part of our strategy to focus on the growth of skilled nursing facilities, we decided in the fourth quarter of 2011 to exit the home health business; and accordingly, this business is reported as discontinued operations. We sold the assets of the home health business in 2012. Additionally, in the fourth quarter of 2012 we entered into an agreement to sell six assisted living facilities located in Ohio and executed a sublease arrangement to exit the skilled nursing business in Jeffersonville, Georgia. The six Ohio assisted living facilities and the Jeffersonville, Georgia skilled nursing facility have an aggregate of 313 units in service. These seven facilities are also reported as discontinued operations. We sold the assets of four of the six Ohio assisted living facilities in December 2012, one in February 2013, and the other in May 2013. During the second quarter of 2013, the Company executed two sublease arrangements to exit the skilled nursing business in Tybee Island, Georgia. The two skilled nursing facilities had an aggregate of 135 units in service. A sales listing agreement was executed for the 105-unit assisted living facility located in Hoover, Alabama, which is a consolidated variable interest entity, during the fourth quarter of 2013. The two skilled nursing facilities located in Tybee Island, Georgia and the assisted living facility located in Hoover, Alabama are reported as discontinued operations (see Note 10 - Discontinued Operations).

As further discussed in the footnotes to the Consolidated Financial Statements included in this Annual Report (see Note 14 and Note 19 to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data."), effective August 1, 2011 entities (the "Oklahoma Owners") controlled by Christopher Brogdon (Vice Chairman of the Board of Directors, owner of greater than 5% of the outstanding common stock and former Chief Acquisition Officer of the Company) and his spouse, Connie Brogdon (related parties to the Company), acquired five skilled nursing facilities located in Oklahoma (the "Oklahoma Facilities"). The Company entered into a Management Agreement with the Oklahoma Owners pursuant to which a wholly-owned subsidiary of the Company supervises the management of the Oklahoma Facilities for a monthly fee equal to 5% of the monthly gross revenues of the Oklahoma Facilities. Upon acquisition, the Company concluded it was the primary beneficiary of the Oklahoma Owners and pursuant to Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") Topic 810-10, Consolidation—Overall, consolidated the Oklahoma Owners in its 2011 consolidated financial statements.

During the process of finalizing the 2012 financial statements, the Company reassessed its prior conclusion that it should consolidate the Oklahoma Owners. In the reassessment process, the Company concluded that it should not have consolidated the Oklahoma Owners. The Company has deconsolidated the Oklahoma Owners effective January 1, 2012 and the balance sheet, operations and cash flows of the Oklahoma Owners are not included in the Company's consolidated financial statements subsequent to that date. The Company further concluded that including the Oklahoma Owners in its 2011 financial statements was not material to such consolidated financial statements and therefore no adjustments have been made to the previously issued 2011 financial statements. Note 14, Variable Interest Entities, in the Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data," includes summarized financial statements of the Oklahoma Owners for 2011 that are included in the Company's 2011 consolidated financial statements.

Liquidity

For the year ended and as of December 31, 2013, we had a net loss of $13.4 million and negative working capital of $15.6 million. At December 31, 2013, we had $19.4 million in cash and cash equivalents and $160.3 million in indebtedness, including current maturities and discontinued operations, of which $32.2 million is current debt

(including the Company's outstanding convertible promissory notes with a principal amount in the aggregate of $4.5 million and $6.9 million, which mature March 31, 2014 and August 29, 2014, respectively, and approximately $6.0 million of mortgage notes included in liabilities of variable interest entity held for sale). Our ability to achieve profitable operations is dependent on continued growth in revenue and controlling costs.

We anticipate that scheduled debt service (excluding approximately $6.4 million of bullet maturities due July 2014 that the Company believes will be refinanced on a longer term basis and $6.9 million in outstanding convertible promissory notes that mature August 29, 2014 but including principal and interest), will total approximately $21.4 million and cash outlays for

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capital expenditures, dividends on our Series A Preferred Stock and income taxes will total approximately $6.5 million for the year ending December 31, 2014. We routinely have ongoing discussions with existing and potential new lenders to refinance current debt on a longer term basis and, in recent periods, have refinanced shorter term acquisition debt, including seller notes, with traditional longer term mortgage notes, some of which have been executed under government guaranteed lending programs. We anticipate the conversion to common stock of $4.0 million of the Company's outstanding convertible promissory notes that mature August 29, 2014, which excludes subordinated convertible promissory notes with a principal amount in the aggregate of $2.9 million that were converted into shares of common stock of the Company in January 2014 (see Note 20 - Subsequent Events, of the Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data). These promissory notes are convertible into shares of common stock of the Company at $3.73 per share. The closing price of the common stock exceeded $4.00 per share from January 1, 2014 through March 21, 2014. As discussed further below, if we were unable to refinance the $6.4 million of bullet maturities due July 2014 or were required to pay the $4.0 million of outstanding convertible promissory notes in cash, then the Company may be required to restructure its outstanding indebtedness, implement further cost reduction initiatives, sell assets, or delay, modify, or abandon its expansion plans due to our limited liquidity in such an event.

We estimate that cash flow from operations and other working capital changes will be approximately $15.4 million for the year ending December 31, 2014. During February and March 2014, the Company issued 693,761 shares of its common stock to holders of the Company's warrants dated September 30, 2010 upon conversion at an exercise price of $3.57 per share. The Company received proceeds of approximately $2.3 million, net of broker commissions of approximately $0.1 million (see Note 20 - Subsequent Events, of the Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data).

Based on existing cash balances, anticipated cash flows for the year ending December 31, 2014, the anticipated refinancing of $6.4 million of bullet maturities due July 2014, the expected conversion of $4.0 million of convertible promissory notes due August 29, 2014 into shares of the Company's common stock, the net proceeds of approximately $6.3 million from the issuance and sale of the Company's 10% subordinated convertible notes due April 30, 2015 that were received on March 28, 2014 (see Note 20 - Subsequent Events), and anticipated new sources of capital, we believe there will be sufficient funds for our operations, scheduled debt service, and capital expenditures at least through the next 12 months. On a longer term basis, at December 31, 2013 we have approximately $73.9 million of debt payments and maturities due between 2015 and 2017, excluding convertible promissory notes which are convertible into shares of the Company's common stock. We have been successful in recent years in raising new equity capital and believe, based on recent discussions, that these markets will continue to be available to us for raising capital in 2014. We believe our long-term liquidity needs will be satisfied by these same sources, as well as borrowings as required to refinance indebtedness.

In order to satisfy our capital needs, we seek to: (i) improve our operating results by increasing facility occupancy, optimizing our payor mix by increasing the proportion of sub-acute patients within our skilled nursing facilities, continuing our cost optimization and efficiency strategies and acquiring additional long-term care facilities with existing operating cash flow; (ii) expand our borrowing arrangements with certain existing lenders; (iii) refinance current debt where possible to obtain more favorable terms; and (iv) raise capital through the issuance of debt or equity securities. We anticipate that these actions, if successful, will provide the opportunity for us to maintain liquidity on a short and long term basis, thereby permitting us to meet our operating and financing obligations for the next 12 months and provide for the continuance of our acquisition strategy. However, there is no guarantee that such actions will be successful or that anticipated operating results will be achieved. We currently have limited borrowing availability under our existing revolving credit facilities. If the Company is unable to improve operating results, expand existing borrowing agreements, refinance current debt (including the $6.4 million of bullet maturities due July 2014), the convertible promissory notes due August 29, 2014 are not converted into shares of the Company's common stock and are required to be repaid by us in cash, or raise capital through the issuance of securities, then the Company may be required to restructure its outstanding indebtedness, implement further cost reduction initiatives, sell assets, or delay, modify, or abandon its expansion plans.

Acquisitions

We have embarked on a strategy to grow our business through acquisitions and leases of senior care facilities and businesses providing services to those facilities. During the year ended December 31, 2013, the Company incurred acquisition costs totaling approximately $0.6 million. Acquisition costs are recorded in “Other Income (Expense)” section of the Consolidated Statements of Operations included in Part II, Item 8., "Financial Statements and Supplementary Data."

As noted above in Part I, Item 1 "Business," on February 15, 2013, the Company entered into a Purchase and Sale Agreement with Avalon to acquire certain land, buildings, improvements, furniture, vehicles, contracts, fixtures and equipment consisting of: (i) a 180-bed skilled nursing facility known as Bethany Health and Rehab; and (ii) a 240-bed skilled nursing facility known as Trevecca Health and Rehab, both located in Nashville, Tennessee. The Company deposited $0.4 million of

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earnest money escrow deposits in February 2013. On June 1, 2013, the Purchase and Sale Agreement was terminated due to the failure of the transaction to close by May 31, 2013. On August 1, 2013, the Company entered into a settlement agreement regarding the return of the $0.4 million previously deposited earnest money escrow deposits. Pursuant to the agreement, the previously deposited earnest money escrow deposits were released and distributed, $0.3 million to the Company and $0.1 million to Avalon.

Divestitures

As part of the Company's strategy to focus on the growth of its skilled nursing segment, the Company decided in the fourth quarter of 2011 to exit the home health segment of the business and sold the assets of the home health business in 2012. In the fourth quarter of 2012, the Company continued this strategy and entered into an agreement to sell six assisted living facilities located in Ohio. The Company also entered into a sublease arrangement in the fourth quarter of 2012 to exit the operations of a skilled nursing facility in Jeffersonville, Georgia. On June 12, 2013, the Company executed two sublease agreements to exit the skilled nursing business in Tybee Island, Georgia effective June 30, 2013 relating to two facilities. A sales listing agreement was executed for the 105-unit assisted living facility located in Hoover, Alabama, which is a consolidated variable interest entity, during the fourth quarter of 2013.

The results of operations and cash flows for the home health business, the six Ohio assisted living facilities, the Jeffersonville, Georgia skilled nursing facility, the two facilities in Tybee Island, Georgia, and the assisted living facility located in Hoover, Alabama are reported as discontinued operations in 2013 and 2012.

The following table summarizes the activity of discontinued operations for the years ended December 31, 2013 and 2012:

(Amounts in 000's)	December 31, 2013	December 31, 2012
Total revenues from discontinued operations	$5,559	$21,768
Net (loss) income from discontinued operations	$(2,248)	$5,846
Interest expense, net from discontinued operations	$591	$1,183
Income tax (expense) benefit from discontinued operations	$(33)	$20
(Loss) gain on disposal of assets from discontinued operations	$(467)	$6,729

Segments

Consistent with our strategy to focus on the growth of our skilled nursing facilities and in light of our sale of the majority of our assisted living facilities (the completed sale of four of our assisted living facilities located in Ohio in fourth quarter of 2012), beginning in the fourth quarter of 2012, we only evaluate operating performance for our 43 skilled nursing facilities, our remaining two assisted living facilities and one independent living facility on a combined basis. Through the third quarter of 2012, we previously evaluated our operations under three segments: skilled nursing facilities ("SNF"), assisted living facilities ("ALF"), and Corporate & Other. Accordingly, management discussion and analysis on a segment basis is not included herein.

Primary Performance Indicators

We focus on two primary indicators in evaluating our financial performance. Those indicators are facility average occupancy and patient mix. Facility average occupancy is important as higher occupancy generally leads to higher revenues. In addition, concentrating on increasing the number of Medicare covered admissions ("the patient mix") helps in increasing revenues. We include commercial insurance covered admissions that are reimbursed at the same level as those covered by Medicare in our Medicare utilization percentages and analysis. We also evaluate "Same Facilities" and "Recently Acquired Facilities" results. Same Facilities represent those owned and leased facilities we began to operate prior to January 1, 2012. Recently Acquired Facilities results represents those owned and leased facilities we began to operate subsequent to January 1, 2012.

The tables below reflect our 2013 and 2012 patient care revenue key performance indicators for our skilled nursing facilities excluding discontinued operations. Excluding discontinued operations, our assisted living facilities represent approximately 1% of our total consolidated revenues in both 2013 and 2012. We continue our work towards maximizing the number of patients covered by Medicare where our operating margins are higher.

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SNF Average Occupancy

	Year Ended December 31,			
	2013		2012	
Same Facilities	80.6	%	82.9	%
Recently Acquired Facilities	67.7	%	61.3	%
Total	76.6	%	79.1	%

SNF Patient Mix

	Same Facilities				Recently Acquired Facilities				All Facilities			
	2013		2012		2013		2012		2013		2012	
Medicare	14.4	%	15.0	%	16.1	%	13.3	%	14.9	%	14.7	%
Medicaid	71.3	%	72.0	%	71.0	%	72.4	%	71.2	%	72.1	%
Other	14.3	%	13.0	%	12.9	%	14.3	%	13.9	%	13.2	%
Total	100.0	%	100.0	%	100.0	%	100.0	%	100.0	%	100.0	%

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. In October 2010, the number of RUG categories was expanded from 53 to 66 as part of the implementation of the RUGs IV system and the introduction of a revised and substantially expanded patient assessment tool called the Minimum Data Set, version 3.0.

On July 29, 2011, the Centers for Medicare & Medicaid Services (“CMS”) issued a final rule providing for, among other things, a net 11.1% reduction in PPS payments to skilled nursing facilities for CMS’s fiscal year 2012 (which began October 1, 2011) as compared to PPS payments in CMS’s fiscal year 2011 (which ended September 30, 2011). The 11.1% reduction is on a net basis, after the application of a 2.7% market basket increase, and reduced by a 1.0% multi-factor productivity ("MFP") adjustment required by the Patient Protection and Affordable Care Act of 2010 (“PPACA”). The final CMS rule also adjusted the method by which group therapy is counted for reimbursement purposes, and changed the timing in which patients who are receiving therapy must be reassessed for purposes of determining their RUG category.

The Middle Class Tax Relief and Job Creation Act of 2012 was signed into law on February 22, 2012, extending the Medicare Part B outpatient therapy cap exceptions process through December 31, 2012. The statutory Medicare Part B outpatient therapy cap for occupational therapy (“OT”) was $1,880 for 2012, and the combined cap for physical therapy (“PT”) and speech-language pathology services (“SLP”) was also $1,880 for 2012. This is the annual per beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. All therapy services rendered above the $3,700 amount are subject to manual medical review and may be denied unless pre-approved by the provider’s Medicare Administrative Contractor. The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning October 1, 2012, some therapy providers may submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the $3,700 threshold) to avoid denial of claims for services above the threshold amount. The $3,700 figure is the defined threshold that triggers the provision for an exception request. Prior to October 1, 2012, there was no provision for an exception request when the threshold was exceeded.

On July 27, 2012, CMS issued a final rule providing for, among other things, a net 1.8% increase in PPS payments to skilled nursing facilities for CMS's fiscal year 2013 (which began on October 1, 2012) as compared to PPS payments to skilled nursing facilities in CMS's fiscal year 2012 (which ended September 30, 2012). The 1.8% increase was on a net basis, reflecting the application of a 2.5% market basket increase, less a 0.7% MFP adjustment mandated by PPACA. This increase is offset by the 2% sequestration reduction, discussed below, which became effective April 1, 2013.

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On January 1, 2013 the American Taxpayer Relief Act of 2012 (the "ATRA") extended the therapy cap exception process for one year. The ATRA also made additional changes to the Multiple Procedure Payment Reduction previously implemented in 2010. The existing discount to multiple therapy procedures performed in an outpatient environment during a single day was 25%. Effective April 1, 2013, ATRA increased the discount rate by an additional 25% to 50%. The ATRA additionally delayed the sequestration reductions of 2% to all Medicare payments until April 1, 2013.

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase is attributable to a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% MFP adjustment as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. For fiscal year 2012 (most recent available fiscal year), the projected market basket percentage change exceeds the actual market basket percentage change by 0.51%. The 2014 Medicare payment rates for skilled nursing facilities were effective on October 1, 2013.

Should future changes in PPS include further reduced rates or increased standards for reaching certain reimbursement levels (including as a result of automatic cuts tied to federal deficit cut efforts or otherwise), our Medicare revenues derived from our skilled nursing facilities) could be reduced, with a corresponding adverse impact on our financial condition or results of operation.

We also derive a substantial portion of our consolidated revenue from Medicaid reimbursement, primarily through our skilled nursing business. Medicaid programs are administered by the applicable states and financed by both state and federal funds. Medicaid spending nationally has increased significantly in recent years, becoming an increasingly significant component of state budgets. This, combined with slower state revenue growth and other state budget demands, has led both the federal government to institute measures aimed at controlling the growth of Medicaid spending and, in some instances, reducing it.

Historically, adjustments to reimbursement under Medicare and Medicaid have had a significant effect on our revenue and results of operations. Recently enacted, pending and proposed legislation and administrative rulemaking at the federal and state levels could have similar effects on our business. Efforts to impose reduced reimbursement rates, greater discounts and more stringent cost controls by government and other payors are expected to continue for the foreseeable future and could adversely affect our business, financial condition and results of operations. Additionally, any delay or default by the federal or state governments in making Medicare and/or Medicaid reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

Average occupancy and reimbursement rates at the Company's skilled nursing facilities for the years ended December 31, 2013 and 2012 were as follows:

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SNF Analysis by State For the Year Ended December 31, 2013:

State	Operational Beds at Period End(1)	Period's Average Operational Beds	Occupancy (Operational Beds)	Medicare Utilization (Skilled %ADC)(2)	2013 Total Revenues	Medicare (Skilled) $PPD	Medicaid $PPD(3)
Alabama	304	304	71.3 %	10.8 %	$15,323	$395.98	$166.23
Arkansas	1,009	1,009	62.3 %	16.6 %	$51,447	$446.41	$168.33
Georgia	1,379	1,379	88.7 %	15.3 %	$94,898	$452.45	$156.90
Missouri	80	80	74.3 %	14.3 %	$4,033	$425.90	$134.58
North Carolina	106	106	72.5 %	16.0 %	$6,368	$455.11	$163.83
Ohio	293	293	83.1 %	14.3 %	$20,219	$430.79	$167.24
Oklahoma	318	318	67.0 %	12.1 %	$14,621	$440.62	$141.68
South Carolina	180	180	82.4 %	14.4 %	$11,010	$410.31	$158.85
Total	3,669	3,669	76.6 %	14.9 %	$217,919	$442.62	$159.71

SNF Analysis by State For the Year Ended December 31, 2012:

State	Operational Beds at Period End(1)	Period's Average Operational Beds	Occupancy (Operational Beds)	Medicare Utilization (Skilled %ADC)(2)	2012 Total Revenues	Medicare (Skilled) $PPD	Medicaid $PPD(3)
Alabama	304	304	79.4 %	11.4 %	$18,341	$384.68	$178.26
Arkansas	1,009	869	63.3 %	13.2 %	$41,929	$389.72	$172.79
Georgia	1,379	1,312	89.4 %	15.6 %	$92,010	$456.99	$157.16
Missouri	80	80	65.4 %	17.0 %	$3,560	$407.05	$133.34
North Carolina	106	106	83.7 %	18.6 %	$7,353	$456.49	$160.74
Ohio	293	293	83.7 %	15.8 %	$20,989	$461.20	$162.91
Oklahoma	230	100	72.6 %	13.9 %	$5,052	$432.60	$134.85
South Carolina	—	—	— %	— %	$—	$—	$—
Total	3,401	3,064	79.1 %	14.7 %	$189,234	$436.22	$162.52

Critical Accounting Policies

We prepare our financial statements in accordance with accounting principles generally accepted in the United States ("GAAP"). The preparation of these financial statements requires us to make estimates and judgments that affect the reported amount of assets, liabilities, revenues and expenses. On an ongoing basis we review our judgments and estimates, including, but not limited to, those related to doubtful accounts, income taxes, stock compensation, intangible assets and loss contingencies. We base our estimates on historical experience, business knowledge and on various other assumptions that we believe to be reasonable under the circumstances at the time. Actual results may vary from our estimates. These estimates are evaluated by management and revised as circumstances change. We believe that the following represents our critical accounting policies:

Consolidation with Entities in Which We Have Determined to Have a Controlling Financial Interest

Arrangements with other business enterprises are evaluated, and those in which AdCare is determined to have controlling financial interest are consolidated. Guidance is provided by FASB ASC Topic 810-10, Consolidation—Overall, which addresses the consolidation of business enterprises to which the usual condition of consolidation (ownership of a majority voting interest) does not apply. This interpretation focuses on controlling financial interests that may be achieved through arrangements that do not involve voting interests. It concludes that, in absences of clear control through voting interests, a company's exposure (variable interest) to the economic risks and potential rewards from the variable interest entity's assets and activities are the best evidence of control. If an enterprise holds a majority of the variable interests of an entity, it would be considered the primary beneficiary. The primary beneficiary is required to consolidate the assets, liabilities and results of operations of the variable interest

entity in its financial statements.

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We have evaluated and concluded that as of December 31, 2013, we have one relationship with a variable interest entity in which we have determined that we are the primary beneficiary required to consolidate the entity. See Note 14 to our consolidated financial statements included in Part II, Item 8., "Financial Statements and Supplementary Data." As further discussed in Note 14 and Note 19 to the Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data," during the process of finalizing the 2012 financial statements, the Company re-assessed its prior conclusion that it should consolidate the Oklahoma Owners. In the reassessment process, the Company concluded that it should not have consolidated the Oklahoma Owners. The Company has deconsolidated the Oklahoma Owners effective January 1, 2012 and the balance sheet, operations and cash flows of the Oklahoma Owners are not included in the Company's consolidated financial statements. The Company further concluded that including the Oklahoma Owners in its 2011 financial statements was not material to such consolidated financial statements and therefore no adjustments have been made to the previously issued 2011 financial statements subsequent to that date.

Revenue Recognition

The Company recognizes revenue when the following four conditions have been met: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii)