ADCARE HEALTH SYSTEMS, INC
Form 10-K
April 17, 2017

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, 2016

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.)
454 Satellite Boulevard NW, Suite 100, Suwanee, GA	30024-7191
(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
10.875% Series A Cumulative Redeemable 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. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See definition of "large accelerated filer", "accelerated filer", "smaller reporting company" and "emerging growth 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	Emerging growth company o

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. Yes o No o

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 30, 2016, the last business day of AdCare Health Systems Inc's most recently completed second fiscal quarter, was $36,685,983. The number of shares of AdCare Health Systems, Inc., common stock, no par value, outstanding as of April 17, 2017, was 19,813,499.

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Special Note Regarding Forward Looking Statements

Certain statements in this Annual Report on Form 10-K (this "Annual Report") contain "forward-looking" information as that term is defined by the Private Securities Litigation Reform Act of 1995. Any statements that do not relate to historical or current facts or matters are forward-looking statements. Examples of forward-looking statements include all statements regarding our expected future financial position, results of operations, cash flows, liquidity, financing and refinancing plans, strategic and business plans, projected expenses and capital expenditures, competitive position, growth and acquisition opportunities, and compliance with, and changes in, governmental regulations. You can identify some of the forward-looking statements by the use of forward-looking words such as "anticipate," "believe," "plan," "estimate," "expect," "intend," "should," "may" and other similar expressions, although not all forward-looking statements contain these identifying words.

Our actual results may differ materially from those projected or contemplated by our forward-looking statements as a result of various factors, including, among others, the following:

- Our ability to achieve the benefits that we expected to achieve from our transition to a healthcare property holding and leasing company, including increased cash flow, reduced general and administrative expenses, and a lower cost of capital;
- The impact of liabilities associated with our legacy business of owning and operating healthcare properties, including pending and potential professional and general liability claims;
- Our dependence on the operating success of our tenants and their ability to meet their obligations to us;
- The effect of increasing healthcare regulation and enforcement on our tenants, and the dependence of our tenants on reimbursement from governmental and other third-party payors;
- The impact of litigation and rising insurance costs on the business of our tenants;
- The effect of our tenants declaring bankruptcy or becoming insolvent;
- The ability and willingness of our tenants to renew their leases with us upon expiration, and our ability to reposition our properties on the same or better terms in the event of nonrenewal or if we otherwise need to replace an existing tenant;
- The significant amount of our indebtedness, our ability to service our indebtedness, covenants in our debt agreements that may restrict our ability to pay dividends or incur additional indebtedness, and our ability to refinance our indebtedness on favorable terms;
- Our ability to raise capital through equity and debt financings, and the cost of such capital;
- The availability of, and our ability to identify, suitable acquisition opportunities, and our ability to complete such acquisitions and lease the respective properties on favorable terms; and
- Other risks inherent in the real estate business, including uninsured or underinsured losses affecting our properties, the possibility of environmental compliance costs and liabilities, and the illiquidity of real estate investments.

We urge you to carefully consider these risks and review the additional disclosures we make concerning risks and other factors that may materially affect the outcome of our forward-looking statements and our future business and operating results, including those made in Part I, Item IA, "Risk Factors" in this Annual Report, as such risk factors may

be amended, supplemented or superseded from time to time by other reports we file with the Securities and Exchange Commission ("SEC"), including subsequent Annual Reports on Form 10-K and Quarterly Reports on Form 10-Q. We caution you that any forward-looking statements made in this Annual Report are not guarantees of future performance, events or results, and you should not place undue reliance on these forward-looking statements, which speak only as of the date of this Annual Report. We do not intend, and we undertake no obligation, to update any forward-looking information to reflect events or circumstances after the date of this Annual Report or to reflect the occurrence of unanticipated events, unless required by law to do so.

PART I.

Item 1. Business

Overview

AdCare Health Systems, Inc. (“AdCare”), through its subsidiaries (together, the “Company” or “we”), is a self-managed real estate investment company that invests primarily in real estate purposed for long-term care and senior living. Our business primarily consists of leasing and subleasing such facilities to third-party tenants, which operate the facilities. As of December 31, 2016, the Company owned, leased, or managed for third parties 29 facilities primarily in the Southeast. The Company’s facilities provide a range of healthcare and related services to patients and residents, including skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term and short-stay patients and residents.

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. AdCare completed its initial public offering in November 2006. Initially based in Ohio, we expanded our portfolio through a series of strategic acquisitions to include properties in a number of other states, primarily in the Southeast. In 2012, we relocated our executive offices and accounting operations to Georgia, and AdCare changed its state of incorporation from Ohio to Georgia on December 12, 2013.

Historically, the Company’s business has focused primarily on owning and operating skilled nursing facilities and managing such facilities for unaffiliated owners with whom the Company has management contracts. In July 2014, AdCare's Board of Directors (the "Board" or "Board of Directors") approved and commenced a strategic plan to transition the Company from an operator of healthcare facilities to a healthcare property holding and leasing company (the "Transition"). To effect the Transition, the Company: (i) leased to third-party operators all of the healthcare properties which the Company owns and previously operated; (ii) subleased to third-party operators all of the healthcare properties which the Company leases (but does not own) and previously operated; and (iii) retained a management agreement to manage two skilled nursing facilities and one independent living facility for third parties. The Transition was completed in December 2015 and, as a result, the Company now has many of the characteristics of a REIT and is focused on the ownership, acquisition and leasing of healthcare properties.

On February 13, 2017, Regional Health Properties, Inc. (“RHE”), a wholly owned subsidiary of AdCare, filed a registration statement on Form S-4 with the SEC in connection with the proposed merger of AdCare with and into RHE. We are proposing to reorganize our corporate structure by merging with and into RHE in order to ensure the effective adoption of certain charter provisions restricting the ownership and transfer of the common stock, subject to approval by the holders of the common stock. The effective adoption of these ownership and transfer restrictions will serve two purposes. First, it will position AdCare to regain compliance with certain NYSE MKT continued listing standards regarding stockholders’ equity. Second, if the Board determines for any future taxable year, after further consideration and evaluation, that qualifying for and electing status as a real estate investment trust ("REIT") under the Internal Revenue Code of 1986, as amended (the “Code”), would be in the best interests of AdCare and its shareholders, then the ownership and transfer restrictions will better position the Company to comply with certain of the U.S. federal income tax rules applicable to REITs under the Code to the extent such rules relate to the common stock. The registration statement filed by RHE with the SEC also serves as a preliminary proxy statement for AdCare and provides information regarding the proposed merger and the shareholder meeting at which shareholders of the common stock of AdCare will be given an opportunity to vote on the merger.

Our principal executive offices are located at 454 Satellite Boulevard NW, Suite 100, Suwanee, GA 30024, and our telephone number is (678) 869-5116. We maintain a website at www.adcarehealth.com. The contents of our website are not incorporated by reference herein or in any of our filings with the SEC.

Portfolio of Healthcare Investments

As of December 31, 2016, our portfolio consisted of 27 skilled nursing facilities, one assisted living facility, and one independent living facility. Skilled nursing facilities provide daily nursing care, therapeutic rehabilitation, social services, housekeeping, nutrition and administrative services for individuals requiring certain assistance with activities in daily living. A typical skilled nursing facility includes mostly two bed units, each equipped with a private or shared

bathroom and community dining facilities. Assisted living facilities provide personal care services, support and housing for those who need help with activities of daily living, such as bathing, eating and dressing, yet require limited medical care. Assisted living facilities typically are comprised of one and two bedroom suites equipped with private bathrooms and efficiency kitchens. Independent living facilities are similar to assisted living facilities but typically provide fewer personal care services.

Our leases generally have initial terms of ten to fifteen years with one or more renewal options. The leases are "triple-net leases" under which the tenant is responsible for the payment of all taxes, utilities, insurance premium costs, repairs and other charges relating to the operation of the properties. The tenant is obligated at its expense to keep all improvements, fixtures and other components of the properties covered by "all risk" insurance and to maintain specified minimal personal injury and property damage insurance, protecting us as well as the tenant. All of our leases contain annual escalators in rent payments. Leases typically contain cross renewal and shared security deposit provisions with other leases of tenants affiliated with the same operator. Leases are also typically backed by other collateral such as security deposits, machinery, equipment, furnishings and other personal property.

The following table provides summary information regarding the number of facilities and related operational beds/units by state and property type as of December 31, 2016:

	Owned		Leased		Managed for Third-Parties		Total	
	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
State								
Alabama	2	304	—	—	—	—	2	304
Georgia	4	463	10	1,168	—	—	14	1,631
North Carolina	1	106	—	—	—	—	1	106
Ohio	4	279	1	94	3	332	8	705
Oklahoma	2	197	—	—	—	—	2	197
South Carolina	2	180	—	—	—	—	2	180
Total	15	1,529	11	1,262	3	332	29	3,123
Facility Type								
Skilled Nursing	14	1,449	11	1,262	2	249	27	2,960
Assisted Living	1	80	—	—	—	—	1	80
Independent Living	—	—	—	—	1	83	1	83
Total	15	1,529	11	1,262	3	332	29	3,123

The following table provides summary information regarding the number of facilities and related operational beds/units by operator affiliation as of December 31, 2016:

Operator Affiliation	Number of Facilities [1]	Beds / Units
Beacon Health Management	7	585
C.R. Management	7	830
Wellington Health Services	4	641
Peach Health Group	3	252
Symmetry Healthcare	3	286
Southwest LTC	2	197
Subtotal	26	2,791
AdCare Managed	3	332
Total	29	3,123

[1] Represents the number of facilities which are leased or subleased to separate tenants, which tenants are affiliates of the entity named in the table above.

Acquisitions, Dispositions, and Leasing Transactions

Acquisitions. The Company did not complete any acquisitions during the two years ended December 31, 2016.

Dispositions. On July 1, 2015, the Company sold its Bentonville Manor Nursing Home, an 83-bed skilled nursing facility located in Bentonville, Arkansas, for approximately $3.4 million. Net proceeds were used to repay certain mortgage indebtedness with respect to the facility.

On October 30, 2015, the Company sold its Companions Specialized Care Center, a 121-bed skilled nursing facility located in Tulsa, Oklahoma, for approximately $3.5 million. Net proceeds were used to repay certain mortgage indebtedness with respect to the facility.

On November 20, 2015, Riverchase Village ADK, LLC (“Riverchase”) completed the sale of the Riverchase Village facility, a 125-unit assisted living facility located in Hoover, Alabama, for a purchase price of $6.9 million. Until the sale of the Riverchase Village facility, Riverchase was a consolidating variable interest entity of the Company. Riverchase financed its acquisition of the Riverchase Village facility using the proceeds of revenue bonds issued by the Medical Clinic Board of the City of Hoover (the “Riverchase Bonds”), as to which the Company was a guarantor. In connection with the sale of the Riverchase Village facility, the Riverchase Bonds were repaid in full, and AdCare was released from its guaranty.
On October 6, 2016, nine wholly-owned subsidiaries of the Company completed the sale of nine facilities located in Arkansas, together with substantially all of the fixtures, equipment, furniture and other assets relating to such facilities (the “Arkansas Facilities”), to an affiliate of Skyline Healthcare LLC (“Skyline”), pursuant to a Purchase and Sale Agreement, dated May 10, 2016, as subsequently amended. The aggregate purchase price for the Arkansas Facilities was $55 million, which consisted of cash consideration of $52.0 million and a promissory note maturing March 31, 2022 with a principal amount of $3 million. The Company realized net proceeds of approximately $20.0 million (excluding the promissory note in the amount of $3.0 million) after repayment of certain mortgage indebtedness with respect to the Arkansas Facilities.

The Arkansas Facilities consist of:

- River Valley Health and Rehabilitation Center, a 129-bed skilled nursing facility located in Fort Smith, Arkansas;
- Heritage Park Nursing Center, a 110-bed skilled nursing facility located in Rogers, Arkansas;
- Homestead Manor Nursing Home, a 104-bed skilled nursing facility located in Stamps, Arkansas;
- Stone County Nursing and Rehabilitation Center, a 97-bed skilled nursing facility located in Mountain View, Arkansas;
- Stone County Residential Care Center, a 32-bed assisted living facility located in Mountain View, Arkansas;
- Northridge Health Care, a 140-bed skilled nursing facility located in North Little Rock, Arkansas;
- Little Rock Health & Rehabilitation ("West Markham"), a 154-bed skilled nursing facility located in Little Rock, Arkansas;
- Woodland Hills Health & Rehabilitation, a 140-bed skilled nursing facility located in Little Rock, Arkansas; and
- Cumberland Health & Rehabilitation Center, a 120-bed skilled nursing facility located in Little Rock, Arkansas.

Bed numbers above refer to the number of licensed beds.

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Leasing Transactions. During the two years ended December 31, 2016, the Company leased or subleased, as applicable, to tenants:

Facility Name	State	Owned / Leased	Disposition Type	Operations Disposition Date
2015				
College Park	GA	Owned	Lease	4/1/2015
LaGrange	GA	Leased	Sublease	4/1/2015
Sumter Valley	SC	Owned	Lease	4/1/2015
Georgetown	SC	Owned	Lease	4/1/2015
Powder Springs	GA	Leased	Sublease	4/1/2015
Tara	GA	Leased	Sublease	4/1/2015
Heritage Park	AR	Owned	Lease	5/1/2015
Homestead Manor	AR	Owned	Lease	5/1/2015
Stone County SNF	AR	Owned	Lease	5/1/2015
Stone County ALF	AR	Owned	Lease	5/1/2015
Northridge	AR	Owned	Lease	5/1/2015
West Markham	AR	Owned	Lease	5/1/2015
Woodland Hills	AR	Owned	Lease	5/1/2015
Cumberland	AR	Owned	Lease	5/1/2015
Mountain Trace	NC	Owned	Lease	6/1/2015
Glenvue	GA	Owned	Lease	7/1/2015
Hearth & Care of Greenfield	OH	Owned	Lease	8/1/2015
The Pavilion Care Center	OH	Owned	Lease	8/1/2015
Eaglewood ALF	OH	Owned	Lease	8/1/2015
Eaglewood Care Center	OH	Owned	Lease	8/1/2015
Covington Care Center	OH	Leased	Sublease	8/1/2015
Bonterra	GA	Leased	Sublease	9/1/2015
Parkview	GA	Leased	Sublease	9/1/2015
Autumn Breeze	GA	Owned	Lease	9/30/2015
River Valley	AR	Owned	Lease	11/1/2015
Quail Creek	OK	Owned	Lease	12/31/2015
Northwest	OK	Owned	Lease	12/31/2015

On February 3, 2016, the Company terminated the separate sublease agreements for the Arkansas Facilities (the “Aria Subleases”) with affiliates of Aria Health Group, LLC (“Aria”) and entered into leases with affiliates of Skyline, pursuant to a Master Lease Agreement, dated February 5, 2016 (the “Skyline Lease”), which commenced on April 1, 2016. On October 6, 2016, the Company sold the Arkansas Facilities to Little Ark Realty Holdings, LLC, an affiliate of Skyline.

On June 18, 2016, a subsidiary of the Company, entered into a new master sublease agreement (the “Peach Health Sublease”) with affiliates (collectively, “Peach Health Sublessee”) of Peach Health Group, LLC (“Peach Health”), providing that Peach Health Sublessee would take possession of the facilities (the “Peach Facilities”) subleased to affiliates of New Beginnings Care, LLC (“New Beginnings”). The Peach Facilities are comprised of: (i) an 85-bed skilled nursing facility located in Tybee Island, Georgia (the “Oceanside Facility”); (ii) a 50-bed skilled nursing facility located in Tybee Island, Georgia (the “Savannah Beach Facility”); and (iii) a 131-bed skilled nursing facility located in Jeffersonville, Georgia (the “Jeffersonville Facility”). The Peach Health Sublease became effective for the Jeffersonville Facility, on June 18, 2016 and for the Savannah Beach and Oceanside Facilities on July, 13, 2016.

Industry Trends

The skilled nursing segment of the long-term care industry has evolved to meet the growing demand for post-acute and custodial healthcare services generated by an aging population, increasing life expectancies and the trend toward shifting of patient care to lower cost settings. The 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, highly fragmented, and characterized predominantly by numerous local and regional providers. 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. 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 care 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.
Competitive Strengths

We believe we possess the following competitive strengths:

Long-Term, Triple-Net Lease Structure. All of our real estate properties are leased under triple-net operating leases with initial terms generally ranging from ten to fifteen years pursuant to which the tenants are responsible for all facility maintenance, insurance and taxes, and utilities. As of December 31, 2016, the leases had an average remaining initial term of approximately 10 years. In addition, the average rent escalator is approximately 2.5%. We also typically receive additional security under these leases in the form of security deposits from the lessee and guarantees from the parent or other related entities of the lessee.

Operator/Tenant Diversification. Our 29 properties (including the three facilities that are managed by us) are operated by a total of 29 separate tenants, with each of our tenants being affiliated with one of six local or regionally-focused operators. We refer to our tenants who are affiliated with the same operator as a group of affiliated tenants. Each of our operators operate (through a group of affiliated tenants) between two and seven of our facilities, with our most significant operators, C.R Management and Beacon Health Management, each operating (through a group of affiliated tenants) seven facilities, or 24% of the total number of our facilities. We believe that our tenant diversification should limit the effect of any operator’s financial or operating performance decline on our overall performance.

Geographically Diverse Property Portfolio. Our portfolio of 29 properties, comprising 3,123 beds/units, is diversified across six states. Our properties in any one state did not account for more than 53% of our total beds/units as of December 31, 2016. Properties in our largest state, Georgia, are geographically dispersed throughout the state. We believe this geographic diversification will limit the effect of a decline in any one regional market on our overall performance.

Business Strategy

Our business strategy primarily is focused on investing capital in our current portfolio and growing our portfolio through the acquisition of skilled nursing and other healthcare facilities. More specifically, we seek to:

Focus on Senior Housing Segment. We intend to continue to focus our investment program on senior housing, primarily the skilled nursing facility segment of the long-term care continuum. We have historically been focused on senior housing, and senior management has operating and financial experience and a significant number of relationships in the long-term care industry. In addition, we believe investing in the sector best meets our investing criteria.

Invest Capital in Our Current Portfolio. We intend to continue to support our operators by providing capital to them for a variety of purposes, including facility modernization and potentially replacing or renovating facilities in our portfolio that may have become less competitive. We expect to structure these investments as either lease amendments that produce additional rent or as loans that are repaid by operators during the applicable lease term. We believe such projects will provide an attractive return on capital and improve the underlying performance of facility operations.

Provide Capital to Underserved Operators. We believe that there is a significant opportunity to be a capital source to long-term care operators through the acquisition and leasing of healthcare properties that are consistent with our investment and financing strategy, but that, due to size and other considerations, are not a focus for large healthcare REITs. We seek primarily small to mid-size acquisition transactions with a focus on individual facilities with existing operators, as well as small groups of facilities and larger portfolios. In addition to pursuing acquisitions using triple-net lease structures, we may pursue other forms of investment, including mortgage loans and joint ventures.

Identify Talented Operators. As a result of our management team's operating experience, network of relationships and industry insight, we have been able and expect to continue to be able to identify qualified tenants. We seek tenants who possess local market knowledge, demonstrate hands-on management, have proven track records and focus on patient care.

Monitor Investments. We monitor our real estate investments through, among other things: (i) reviewing and evaluating tenant financial statements to assess operational and financial trends and performance; (ii) reviewing the state surveys, occupancy rates and patient payor mix of our facilities; (iii) verifying the payments of property and other taxes and insurance with respect to our facilities; and (iv) conducting periodic physical inspections of our facilities. For tenants or facilities that do not meet performance expectations, we may seek to work with our tenants to ensure our mutual success or seek to re-lease facilities to stronger operators.

Resolve Legacy Professional and General Liability Claims. As a result of the Transition (which was completed in December 2015), the Company no longer operates skilled nursing facilities. The Company, however, continues to be subject to certain pending professional and general liability actions with respect to the time it operated skilled nursing facilities, including claims that the services the Company provided while an operator resulted in the injury or death of patients and claims related to professional and general negligence, employment, staffing requirements and commercial matters. Management is committed to resolving pending claims.

Competition

We generally compete for real property investments with publicly traded, private and non-listed healthcare REITs, real estate partnerships, healthcare providers, healthcare lenders and other investors, including developers, banks, insurance companies, pension funds, government-sponsored entities and private equity firms, some of whom may have greater financial resources and lower costs of capital than we do. Increased competition challenges our ability to identify and successfully capitalize on opportunities that meet our investment criteria, which is affected by, among other factors, the availability of suitable acquisition or investment targets, our ability to negotiate acceptable transaction terms and our access to and cost of capital.

Our ability to generate rental revenues from our properties also depends on the competition faced by our tenants. Our tenants compete on a local and regional basis with other healthcare operating companies that provide comparable services. Our tenants compete to attract and retain patients and residents based on scope and quality of care, reputation and financial condition, price, location and physical appearance of the properties, services offered, qualified personnel, physician referrals and family preferences. The ability of our tenants to compete successfully could be

affected by private, federal and state reimbursement programs and other laws and regulations.

Revenue Sources and Recognition

Triple-Net Leased Properties. Our triple-net leases provide for periodic and determinable increases in rent. We recognize rental revenues under these leases on a straight-line basis over the applicable lease term when collectibility is reasonably assured. Recognizing rental income on a straight-line basis generally results in recognized revenues during the first half of a lease term exceeding the cash amounts contractually due from our tenants, creating a straight-line rent receivable that is included in other assets on our consolidated balance sheets.

Other. We recognize management fee revenues received currently under one contractual agreement with a third party. Further, we recognize interest income from lease inducements receivables and capital loans as made to tenants.

Allowances. We assess the collectibility of our rent receivables, including straight-line rent receivables. We base our assessment of the collectibility of rent receivables (other than straight-line rent receivables) on several factors, including payment history, the financial strength of the tenant, the value of the underlying collateral, and current economic conditions. If our evaluation of these factors indicates it is probable that we will be unable to recover the full value of the receivable, then we provide a reserve against the portion of the receivable that we estimate may not be recovered. If our evaluation of these factors indicates it is probable that we will be unable to receive the rent payments, then we provide a reserve against the recognized straight-line rent receivable asset for the portion that we estimate may not be recovered. If we change our assumptions or estimates regarding the collectibility of future rent payments required by a lease, then we may adjust our reserve to increase or reduce the rental revenue recognized in the period we make such change in our assumptions or estimates.

Accounts receivable, net totaled $2.4 million at December 31, 2016 compared to $8.8 million at December 31, 2015, of which $0.9 million and $8.0 million, respectively, related to patient care receivables from our legacy operations. At December 31, 2016, we allowed for approximately $7.5 million on approximately $8.4 million of gross patient care related receivables. Allowance for patient care receivables are estimated based on an aged bucket method as well as additional analyses of remaining balances incorporating different payor types. Any changes in patient care receivable allowances are recognized as a component of discontinued operations.

Government Regulation

Healthcare Regulation. Our tenants are typically subject to extensive and complex federal, state and local laws and regulations relating to quality of care, licensure and certain certificate of need requirements ("CON"), government reimbursement, fraud and abuse practices, qualifications of personnel, adequacy of plant and equipment, data privacy and security, and other laws and regulations governing the operation of healthcare facilities. We expect that the healthcare industry will, in general, continue to face increased regulation and pressure in these areas. The applicable rules are wide-ranging and can subject our tenants to civil, criminal, and administrative sanctions, including: the possible loss of accreditation or license; denial of reimbursement; imposition of fines; suspension, decertification, or exclusion from federal and state healthcare programs; or facility closure. Changes in laws or regulations, reimbursement policies, enforcement activity and regulatory non-compliance by tenants, operators and managers can all have a significant effect on their operations and financial condition, which in turn may adversely impact us, as detailed below and set forth under “Risk Factors” in this document.

Although the properties within our portfolio may be subject to varying levels of governmental scrutiny, we expect that the healthcare industry, in general, will continue to face increased regulation and pressure in the areas of fraud, waste and abuse, including, but not limited to, the Federal Anti-Kickback Statute, the Federal Stark Law, the Federal False Claims Act, and comparable state counterparts, as well as cost control, healthcare management and provision of services, among others. We also expect that efforts by third-party payors, such as the federal Medicare program, state Medicaid programs and private insurance carriers (including health maintenance organizations and other health plans), to impose greater discounts and more stringent cost controls upon tenants (through changes in reimbursement rates and methodologies, discounted fee structures, the assumption by healthcare providers of all or a portion of the financial risk or otherwise) will intensify and continue. A significant expansion of applicable federal, state or local laws and regulations, existing or future healthcare reform measures, new interpretations of existing laws and regulations, changes in enforcement priorities, or significant limits on the scope of services reimbursed or reductions

in reimbursement rates could have a material adverse effect on certain of our tenants' liquidity, financial condition and results of operations and, in turn, their ability to satisfy their contractual obligations, including making rental payments under and otherwise complying with the terms of our leases.

Licensure, Certification and CONs. In general, the operators of our skilled nursing facilities must be licensed and periodically certified through various regulatory agencies that determine compliance with federal, state and local laws to participate in the Medicare and Medicaid programs. Legal requirements pertaining to such licensure and certification relate to the quality of medical care provided by the operator, qualifications of the tenant's administrative personnel and clinical staff, adequacy of the physical plant and equipment and continuing compliance with applicable laws and regulations. A loss of licensure or certification could adversely affect a skilled nursing facility's ability to receive payments from the Medicare and Medicaid programs, which, in turn, could adversely affect its ability to satisfy its obligations to us.

In addition, many of our skilled nursing facilities are subject to state CON laws that require governmental approval prior to the development or expansion of healthcare facilities and services. The approval process in these states generally requires a facility to demonstrate the need for additional or expanded healthcare facilities or services. CONs, where applicable, are also sometimes necessary for changes in ownership or control of licensed facilities, addition of beds, investment in major capital equipment, introduction of new services or termination of services previously approved through the CON process. CON laws and regulations may restrict a tenant's ability to expand our properties and grow its business in certain circumstances, which could have an adverse effect on the tenant's revenues and, in turn, its ability to make rental payments under and otherwise comply with the terms of our leases. In addition, CON laws may constrain the ability of an operator to transfer responsibility for operating a particular facility to a new operator. If we have to replace a property operator who is excluded from participating in a federal or state healthcare program (as discussed below), our ability to replace the operator may be affected by a particular state's CON laws, regulations, and applicable guidance governing changes in provider control.

Compared to skilled nursing facilities, seniors housing communities (other than those that receive Medicaid payments) do not receive significant funding from governmental healthcare programs and are subject to relatively few, if any, federal regulations. Instead, to the extent they are regulated, such regulation consists primarily of state and local laws governing licensure, provision of services, staffing requirements and other operational matters, which vary greatly from one jurisdiction to another. Although recent growth in the U.S. seniors housing industry has attracted the attention of various federal agencies that believe more federal regulation of these properties is necessary, Congress thus far has deferred to state regulation of seniors housing communities. However, as a result of this growth and increased federal scrutiny, some states have revised and strengthened their regulation of seniors housing communities, and more states are expected to do the same in the future.

Fraud and Abuse Enforcement, Other Related Laws, Initiatives, and Considerations. Long-term/post-acute care facilities (and seniors housing facilities that receive Medicaid payments) are subject to federal, state, and local laws, regulations, and applicable guidance that govern the operations and financial and other arrangements that may be entered into by healthcare providers. Certain of these laws prohibit direct or indirect payments of any kind for the purpose of inducing or encouraging the referral of patients for medical products or services reimbursable by government healthcare programs. Other laws require providers to furnish only medically necessary services and submit to the government valid and accurate statements for each service. Still other laws require providers to comply with a variety of safety, health and other requirements relating to the condition of the licensed property and the quality of care provided. Sanctions for violations of these laws, regulations, and other applicable guidance may include, but are not limited to, criminal and/or civil penalties and fines, loss of licensure, immediate termination of government payments, and exclusion from any government healthcare program. In certain circumstances, violation of these rules (such as those prohibiting abusive and fraudulent behavior) with respect to one property may subject other facilities under common control or ownership to sanctions, including exclusion from participation in the Medicare and Medicaid programs, as well as other government healthcare programs. In the ordinary course of its business, a property operator is regularly subjected to inquiries, investigations, and audits by the federal and state agencies that oversee these laws and regulations.

Long-term/post-acute care facilities (and seniors housing facilities that receive Medicaid payments) are also subject to the Federal Anti-Kickback Statute, which generally prohibits persons from offering, providing, soliciting, or receiving remuneration to induce either the referral of an individual or the furnishing of a good or service for which payment may be made under a federal healthcare program, such as Medicare or Medicaid. Long-term/post-acute care facilities are also subject to the Federal Ethics in Patient Referral Act of 1989, commonly referred to as the Stark Law. The

Stark Law generally prohibits the submission of claims to Medicare for payment if the claim results from a physician referral for certain designated services and the physician has a financial relationship with the health service provider that does not qualify under one of the exceptions for a financial relationship under the Stark Law. Similar prohibitions on physician self-referrals and submission of claims apply to state Medicaid programs. Further, long-term/post-acute care facilities (and seniors housing facilities that receive Medicaid payments) are subject to substantial financial penalties under the Civil Monetary Penalties Act and the Federal False Claims Act and, in particular, actions under the Federal False Claims Act's "whistleblower" provisions. Private enforcement of healthcare fraud has increased due in large part to amendments to the Federal False Claims Act that encourage private individuals to sue on behalf of the government. These whistleblower suits brought by private individuals, known as qui tam actions, may be filed by almost anyone, including present and former patients, nurses and other employees, and competitors. Significantly, if a claim is successfully adjudicated, the Federal False Claims Act provides for treble damages and a civil penalty of up to $11,000 per claim.

Prosecutions, investigations, or whistleblower actions could have a material adverse effect on a property operator's liquidity, financial condition, and operations, which could adversely affect the ability of the operator to meet its financial obligations to us. Finally, various state false claim act and anti-kickback laws may also apply to each property operator. Violation of any of the foregoing statutes can result in criminal and/or civil penalties that could have a material adverse effect on the ability of an operator to meet its financial obligations to us.

Other legislative developments, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), have greatly expanded the definition of healthcare fraud and related offenses and broadened its scope to include private healthcare plans in addition to government payors. Congress also has greatly increased funding for the Department of Justice, Federal Bureau of Investigation and The Office of the Inspector General ("OIG") to audit, investigate and prosecute suspected healthcare fraud. Moreover, a significant portion of the billions in healthcare fraud recoveries over the past several years has also been returned to government agencies to further fund their fraud investigation and prosecution efforts.

Additionally, other HIPAA provisions and regulations provide for communication of health information through standard electronic transaction formats and for the privacy and security of health information. In order to comply with the regulations, healthcare providers often must undertake significant operational and technical implementation efforts. Operators also may face significant financial exposure if they fail to maintain the privacy and security of medical records and other personal health information about individuals. The Health Information Technology for Economic and Clinical Health ("HITECH") Act, passed in February 2009, strengthened the Department of Health and Human Services ("HHS") Secretary's authority to impose civil money penalties for HIPAA violations occurring after February 18, 2009. HITECH directs the HHS Secretary to provide for periodic audits to ensure covered entities and their business associates (as that term is defined under HIPAA) comply with the applicable HITECH requirements, increasing the likelihood that a HIPAA violation will result in an enforcement action. The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS") issued an interim Final Rule which conformed HIPAA enforcement regulations to HITECH, increasing the maximum penalty for multiple violations of a single requirement or prohibition to $1.5 million. Higher penalties may accrue for violations of multiple requirements or prohibitions. Additionally, on January 17, 2013, CMS released an omnibus final rule, which expands the applicability of HIPAA and HITECH and strengthens the government's ability to enforce these laws. The final rule broadens the definition of "business associate" and provides for civil money penalty liability against covered entities and business associates for the acts of their agents regardless of whether a business associate agreement is in place. This rule also modified the standard for when a breach of unsecured personally identifiable health information must be reported. Some covered entities have entered into settlement agreements with HHS for allegedly failing to adopt policies and procedures sufficient to implement the breach notification provisions in the HITECH Act. Additionally, the final rule adopts certain changes to the HIPAA enforcement regulations to incorporate the increased and tiered civil monetary penalty structure provided by HITECH, and makes business associates of covered entities directly liable under HIPAA for compliance with certain of the HIPAA privacy standards and HIPAA security standards. HIPAA violations are also potentially subject to criminal penalties.

There has been increased federal and state HIPAA privacy and security enforcement efforts and we expect this trend to continue. Under HITECH, state attorneys general have the right to prosecute HIPAA violations committed against residents of their states. Several such actions have already been brought against both covered entities and a business associate, and continued enforcement actions are likely to occur in the future. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities and business associates. It also tasks HHS with establishing a methodology whereby individuals who are harmed by HIPAA violations may receive a percentage of the civil monetary penalty fine or monetary settlement paid by the violator.

In addition to HIPAA, numerous other state and federal laws govern the collection, dissemination, use, access to and confidentiality of individually identifiable health information. In addition, some states are considering new laws and regulations that further protect the confidentiality, privacy or security of medical records or other types of medical or personal information. These laws may be similar to or even more stringent than the federal provisions and are not preempted by HIPAA. Not only may some of these state laws impose fines and penalties upon violators, but some afford private rights of action to individuals who believe their personal information has been misused.

Also with respect to HIPAA, in September, 2015, OIG issued two reports calling for better privacy oversight of covered entities by the CMS Office for Civil Rights ("OCR"). The first report, titled "OCR Should Strengthen its Oversight of Covered Entities' Compliance with the HIPAA Privacy Standards," found that OCR's oversight is primarily reactive, as OCR has not fully implemented the required audit program to proactively assess possible noncompliance from covered entities. OIG recommended, among other things, that OCR fully implement a permanent audit program and develop a policy requiring OCR staff to check whether covered entities had previously been investigated for noncompliance. The second report, titled "OCR Should Strengthen its Follow-up of Breaches of Patient Information Reported by Covered Entities," found that (1) OCR did not record corrective action information for 23% of closed "large-breach" cases in which it made determinations of noncompliance, and (2) OCR did

not record “small-breach” information in its case-tracking system, which limits its ability to track and identify covered entities with multiple small breaches. OIG recommended, among other things, that OCR enter small-breach information into its case-tracking system and maintain complete documentation of corrective actions taken. OCR agreed with OIG’s recommendations in both reports. If followed, these reports and recommendations may impact our tenants.

More recently with respect to HIPAA, OCR announced on March 21, 2016, that it has begun a new phase of audits of covered entities and their business associates. OCR stated that it will review policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules.

Congress has significantly increased funding to the governmental agencies charged with enforcing the healthcare fraud and abuse laws to facilitate increased audits, investigations and prosecutions of providers suspected of healthcare fraud. As a result, government investigations and enforcement actions brought against healthcare providers have increased significantly in recent years and are expected to continue. A violation of federal or state anti-fraud and abuse laws or regulations, or other related laws or regulations discussed above, by a tenant of our properties could have a material adverse effect on the tenant’s liquidity, financial condition or results of operations, which could adversely affect its ability to satisfy its contractual obligations, including making rental payments under and otherwise complying with the terms of our leases.

Government Reimbursement

The majority of skilled nursing facilities’ reimbursement is through Medicare and Medicaid. These programs are often their largest source of funding. Senior housing communities generally do not receive funding from Medicare or Medicaid, but their ability to retain their residents is impacted by policy decisions and initiatives established by the administrators of Medicare and Medicaid. In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “Healthcare Reform Law”). The passage of the Healthcare Reform Law allowed formerly uninsured Americans to acquire coverage and utilize additional healthcare services. In addition, the Healthcare Reform Law gave the CMS new authorities to implement Medicaid waiver and pilot programs that impact healthcare and long term custodial care reimbursement by Medicare and Medicaid. These activities promote “aging in place”, allowing senior citizens to stay longer in seniors housing communities, and diverting or delaying their admission into skilled nursing facilities. The potential risks that accompany these regulatory and market changes are discussed below.

- Enabled by the Medicare Modernization Act (2003) and subsequent laws, Medicare and Medicaid have implemented pilot programs (officially termed demonstrations or models) to “divert” elderly from skilled nursing facilitates and promote “aging in place” in “the least restrictive environment.” Several states have implemented Home and Community-based Medicaid waiver programs that increase the support services available to senior citizens in senior housing, lengthening the time that many seniors can live outside of a skilled nursing facility. These Medicaid waiver programs are subject to re-approval and pilots are time-limited. Roll-back or expiration of these programs could have an adverse effect on the senior housing market.
- Changes in certification and participation requirements of the Medicare and Medicaid programs have restricted, and are likely to continue to restrict further, eligibility for reimbursement under those programs. On July 16, 2015, CMS issued a proposed rule that, for the first time in nearly 25 years, would comprehensively update the skilled nursing facility (“SNF”) requirements for participation under Medicare and Medicaid. Among other things, the proposed rule addresses requirements relating to quality of care and quality of life, facility responsibilities and staffing considerations, resident assessments, and compliance and ethics programs. We cannot accurately predict the effect the final rule will have on our tenants’ business once it is promulgated. Failure to obtain and maintain Medicare and Medicaid certification by our tenants would result in denial of Medicare and Medicaid payments which would likely result in a significant loss of revenue. In addition, private payors, including managed care payors, increasingly are demanding that providers accept discounted payments resulting in lost revenue for specific patients. Efforts to impose reduced payments, greater discounts and more stringent cost controls by government and other payors are expected to continue. Any reforms that significantly limit rates of reimbursement under the Medicare and Medicaid programs could have a material adverse effect on our tenants’ profitability and cash flows which, in turn, could adversely affect

their ability to satisfy their obligations to us. We are unable to predict what reform proposals or reimbursement limitations will be adopted in the future or the effect such changes will have on our tenants' operations. No assurance can be given that such reforms will not have a material adverse effect on our tenants or on their ability to fulfill their obligations to us.

- As a result of the Healthcare Reform Law, and specifically Medicaid expansion and establishment of Health Insurance Exchanges providing subsidized health insurance, more Americans have health insurance. These newly-insured Americans utilize services delivered by providers at medical buildings and other healthcare facilities. The Healthcare Reform Law remains controversial and continued attempts to repeal or reverse aspects of the law (see discussion in the section entitled

"Risk Factors" concerning a possible repeal of Healthcare Reform Law following the 2016 presidential election) could result in insured individuals losing coverage, and consequently foregoing services offered by provider tenants in medical buildings and other healthcare facilities. On June 28, 2012, the United States Supreme Court upheld the individual mandate of the Healthcare Reform Law but partially invalidated the expansion of Medicaid. The ruling on Medicaid expansion will allow states not to participate in the expansion - and to forego funding for the Medicaid expansion - without losing their existing Medicaid funding. Given that the federal government substantially funds the Medicaid expansion, it is unclear how many states will ultimately pursue this option. The participation by states in the Medicaid expansion could have the dual effect of increasing our tenants' revenues, through new patients, but could also further strain state budgets. While the federal government will pay for approximately 100% of those additional costs from 2014 to 2016, states will be expected to pay for part of those additional costs beginning in 2017. We cannot predict whether other current or future efforts to repeal or amend the Healthcare Reform Law will be successful, nor can we predict the impact that such a repeal or amendment would have on our operators or tenants and their ability to meet their obligations to us. We cannot predict whether the existing Healthcare Reform Law, or future healthcare reform legislation or regulatory changes, will have a material impact on our operators' or tenants' property or business. If the operations, cash flows or financial condition of our operators and tenants are materially adversely impacted by the Healthcare Reform Law or future legislation, our revenue and operations may be adversely affected as well.

- The CMS is currently in the midst of transitioning Medicare from a traditional fee for service reimbursement model to capitated, value-based, and bundled payment approaches in which the government pays a set amount for each beneficiary for a defined period of time, based on that person's underlying medical needs, rather than the actual services provided. The result is increasing use of management tools to oversee individual providers and coordinate their services. This puts downward pressure on the number and expense of services provided. Roughly eight million Medicare beneficiaries now receive care via Accountable Care Organizations, and Medicare Advantage health plans now provide care for roughly seventeen million Medicare beneficiaries. The continued trend toward capitated, value-based, and bundled payment approaches has the potential to diminish the market for certain healthcare providers. In addition, on April 1, 2014, the Protecting Access to Medicare Act of 2014 was enacted, which implements value-based purchasing for SNFs. Beginning in fiscal year 2019, 2% of SNF payments will be withheld and approximately 50% to 70% of the amount withheld will be paid to SNFs through value-based payments. SNFs began reporting the claims-based 30-Day All-Cause Readmission Measure on October 1, 2015 and will begin reporting a resource use measure by October 1, 2016. Both measures will be publicly available by October 1, 2017. In October 2015, the U.S. Government Accountability Office ("GAO") released a report recommending that CMS continue to improve data and oversight of nursing home quality measures. The GAO found that although CMS collects several types of data that give some insight into the quality of nursing homes, the data could provide a clearer picture of nursing home quality if some underlying problems with the data (i.e., the use of self-reported data and non-standardized survey methodologies) are corrected. The GAO recommends, among other things, that CMS implement a clear plan for ongoing auditing of self-reported data and establish a process for monitoring oversight modifications to better assess their effects. According to the GAO, timely completion of these actions is particularly important because Medicare payments to nursing homes will be dependent on quality data, through the implementation of the value based purchasing program, starting in fiscal year 2019. HHS agreed with the GAO's recommendations, and to the extent such recommendations are implemented, they could impact our operators and tenants.
- The majority of Medicare payments continue to be made through traditional Medicare Part A and Part B fee-for-service schedules. The Medicare and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 ("MACRA") addresses the risk of a Sustainable Growth Rate cut in Medicare payments for physician services. However, other annual Medicare payment regulations, particularly with respect to certain hospitals, skilled nursing care, and home health services have resulted in lower net pay increases than providers of those services have often expected. In addition, MACRA establishes a multi-year transition into pay-for-quality approaches for Medicare physicians and other providers. This will include payment reductions for providers who do not meet government quality standards. The implementation of pay-for-quality models is expected to produce funding disparities that could adversely impact some provider tenants in medical buildings and other healthcare properties.
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Medicare reimburses nursing centers under a fixed payment methodology named the Skilled Nursing Facility Prospective Payment System ("SNF PPS"). SNF PPS is an acuity based classification system that uses nursing and therapy indexes adjusted by geographical wage indexes to calculate per diem rates for each Medicare patient. Payment rates are updated annually and are generally increased or decreased each October when the federal fiscal year begins. On July 30, 2015, CMS released its final rule outlining the fiscal year 2016 Medicare payments for skilled nursing facilities, which began October 1, 2015. The 2016 final rule provided for an approximate 1.2% rate update. This estimated increase consisted of a 2.3% market basket increase, reduced by a 0.6% forecast error adjustment and further reduced 0.5% for a multifactor productivity adjustment required by the Healthcare Reform Law. CMS estimated the update would increase overall payments to skilled nursing facilities in fiscal year 2016 by $430 million compared to fiscal year 2015 levels.

In January 2016, the Medicare Payment Advisory Commission finalized its recommendations, among other things advising Congress to eliminate market basket updates for SNFs for fiscal years 2017 and 2018 and directing the Secretary of HHS to revise the SNF prospective payment system. The OIG has increased focus in recent years on billing practices by SNFs. In September 2015, OIG issued a report calling for reevaluation of the Medicare payment system for skilled nursing facilities. In particular, OIG found that Medicare payments for therapy greatly exceeded SNFs' costs for therapy, and that, under the current payment system, SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. OIG determined that its findings demonstrated the need for CMS to reevaluate the Medicare SNF payment system, concluding that payment reform could save Medicare billions of dollars and encourage SNFs to provide services that are better aligned with beneficiaries' care needs. OIG issued (1) its findings regarding the fiscal year 2015 Top Management and Performance Challenges Facing HHS and (2) the FY 2016 OIG Work Plan. Both cited SNF billing as an area that creates incentives for providers to bill more expensive care instead of the appropriate levels of care, requiring ongoing government monitoring and auditing for compliance. The OIG formulates a formal work plan each year for nursing centers. The OIG's most recent work plan indicates that among other things, the OIG's investigative and review focus in 2017 for nursing facilities will include complaint investigations by state agencies, unreported incidents of potential abuse and neglect, reimbursement, background checks, compliance with prospective payment requirements, and potentially avoidable hospitalizations. If followed, these reports and recommendations may impact our tenants. We cannot predict the likelihood, scope or outcome of any such investigations on our tenants.at these recommendations are implemented, they could impact our tenants.

- On April 27, 2016, CMS added six new quality measures to its consumer-based Nursing Home Compare website. These quality measures include the rate of rehospitalization, emergency room use, community discharge, improvements in function, independently worsened and antianxiety or hypnotic medication among nursing home residents. Beginning in July 2016, CMS incorporates all of these measures, except for the antianxiety/hypnotic medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings.
- On July 29, 2016, CMS released its final rule outlining fiscal year 2017 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the final rule continue to shift Medicare payments from volume to value. CMS projects that aggregate payments to skilled nursing facilities will increase by a net 2.4% for fiscal year 2017. This estimated increase reflected a 2.7% market basket increase, reduced by a 0.3% multi-factor productivity adjustment required under Healthcare Reform Law. This final rule also further defines the skilled nursing facilities' Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports. CMS projects that the update will increase overall payments to skilled nursing facilities in fiscal year 2017 by $920 million compared to fiscal year 2016 levels. The effect of the 2017 PPS rate update on our tenants' revenues will be dependent upon their census and the mix of patients at the various PPS pay rates. In addition, we cannot predict how future changes may impact reimbursement rates under the SNF PPS system.
- On July 29, 2016, CMS issued its final rule laying out the performance standards relating to preventable hospital readmissions from skilled nursing facilities. The final rule includes the skilled nursing facility (SNF) 30-day All Cause Readmission Measure, which assesses the risk-standardized rates of all-cause, all conditions, unplanned inpatient readmissions for Medicare fee-for-service patients of skilled nursing facilities within 30 days of discharge from admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital. The final rule includes the SNF 30-Day Potentially Preventable Readmission Measure as the SNF all condition risk adjusted potentially preventable hospital readmission measure. This measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital. Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable.
- On September 16, 2016, CMS issued its final rule concerning emergency preparedness requirements for Medicare and Medicaid participating providers, including long-term care facilities and intermediate care facilities for individuals with intellectual disabilities. The rule is designed to ensure providers and suppliers have comprehensive and integrated emergency policies and procedures in place, in particular during natural and man-made disasters. Under the

rule, facilities are required to (i) document risk assessment and emergency planning, (ii) develop and implement policies and procedures based on that risk assessment, (iii) develop and maintain an emergency preparedness communication plan in compliance with both federal and state law, and (iv) develop and maintain an emergency-preparedness training and testing program. The regulations outlined in the final rule must be implemented by November 15, 2017. We cannot predict the impact of these regulations on our tenants.

We are neither an ongoing participant in, nor a direct recipient of, any reimbursement under these programs with respect to our facilities. However, a significant portion of the revenue of the healthcare operators to which we lease and sublease properties is

derived from governmentally-funded reimbursement programs, and any adverse change in such programs could negatively impact an operator’s ability to meet its obligations to us.

Environmental Regulation

As an owner of real property, we are subject to various federal, state and local laws and regulations regarding environmental, health and safety matters.

These laws and regulations address, among other things, asbestos, polychlorinated biphenyls, fuel oil management, wastewater discharges, air emissions, radioactive materials, medical wastes, and hazardous wastes, and, in certain cases, the costs of complying with these laws and regulations and the penalties for non-compliance can be substantial. Although we do not currently operate or manage our properties, we may be held primarily or jointly and severally liable for costs relating to the investigation and clean-up of our current and former properties from which there is or has been an actual or threatened release of a regulated material and any other affected properties, regardless of whether we knew of or caused the release. Such costs typically are not limited by law or regulation and could exceed the property’s value. In addition, we may be liable for certain other costs, such as governmental fines and injuries to persons, property or natural resources, as a result of any such actual or threatened release.

Under the terms of our leases, we generally have a right to indemnification by the tenants of our properties for any contamination caused by them. However, we cannot be assured that our tenants will have the financial capability or willingness to satisfy their respective indemnification obligations to us, and any failure, inability or unwillingness to do so may require us to satisfy the underlying environmental claims. In general, we have also agreed to indemnify our tenants against any environmental claims (including penalties and clean-up costs) resulting from any condition arising in, on or under, or relating to, our properties at any time before the applicable lease commencement date.

We did not make any material capital expenditures in connection with environmental, health, and safety laws, ordinances and regulations in 2015 and 2016.

Employees

As of December 31, 2016, we had 19 employees of which 16 were full-time employees (excluding facility-level employees related to the Company's management services agreement for three facilities in Ohio).

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 10.875% Series A Cumulative Redeemable Preferred Stock (the "Series A Preferred Stock") could decline.

Risks Related to the Delisting of Our Securities

If we fail to meet all applicable continued listing requirements of the NYSE MKT and the NYSE MKT determines to delist the common stock and Series A Preferred Stock, the delisting could adversely affect the market liquidity of such securities, impair the value of your investment, adversely affect our ability to raise needed funds and subject us to additional trading restrictions and regulations.

On April 18, 2016, the Company received notice from NYSE Regulation, Inc. ("NYSE Regulation") that it is not in compliance with certain NYSE MKT continued listing standards relating to stockholders' equity. Specifically, the Company is not in compliance with Section 1003(a)(i) (requiring stockholders' equity of $2.0 million or more if an issuer has reported losses from continuing operations and/or net losses in two of its three most recent fiscal years), Section 1003(a)(ii) (requiring stockholders' equity of $4.0 million or more if an issuer has reported losses from continuing operations and/or net losses in three of its four most recent fiscal years) and Section 1003(a)(iii) (requiring stockholders' equity of $6.0 million or more if an issuer has reported losses from continuing operations and/or net losses in its five most recent fiscal years) of the NYSE MKT Company Guide (Collectively, the "Stockholders' Equity Continued Listing Standards") because the Company reported a stockholders' deficit of $23.8 million as of December 31, 2015 and net losses for the last five fiscal years.

As a result, the Company became subject to the procedures and requirements of Section 1009 of the NYSE MKT Company Guide and was required to submit a plan (a "Compliance Plan") by May 18, 2016 describing the actions the Company has taken or will take to regain compliance with the Stockholders' Equity Continued Listing Standards during the period ending October 18, 2017 (the "Plan Period").The Company submitted a Compliance Plan by the May 18, 2016 deadline and was notified on June 2, 2016 that the NYSE Regulation had accepted the Compliance Plan. During the Plan Period, the Company is subject to periodic review by NYSE MKT, and the common stock and Series A Preferred Stock will continue to be listed on the NYSE MKT pursuant to an extension granted by NYSE Regulation. If the Company is not in compliance with Stockholders' Equity Continued Listing Standards by October 18, 2017, or if the Company does not make progress consistent with its Compliance Plan during the Plan Period, then NYSE Regulation will initiate delisting proceedings.

If the common stock and Series A Preferred Stock are delisted from the NYSE MKT, such securities may trade in the over-the-counter market. If our securities were to trade on the over-the-counter market, selling the common stock and Series A Preferred Stock could be more difficult because smaller quantities of shares would likely be bought and sold, transactions could be delayed, and any security analysts' coverage of us may be reduced. In addition, in the event the common stock and Series A Preferred Stock are delisted, broker-dealers have certain regulatory burdens imposed upon them, which may discourage broker-dealers from effecting transactions in such securities, further limiting the liquidity of the common stock and Series A Preferred Stock. These factors could result in lower prices and larger spreads in the bid and ask prices for our securities. Such delisting from the NYSE MKT and continued or further declines in our share price could also greatly impair our ability to raise additional necessary capital through equity or debt financing and could significantly increase the ownership dilution to shareholders caused by our issuing equity in financing or other transactions. Any such limitations on our ability to raise debt and equity capital could prevent us from making future investments and satisfying maturing debt commitments.

In addition, if the Company fails for 180 or more consecutive days to maintain a listing of the Series A Preferred Stock on a national exchange, then: (i) the annual dividend rate on the Series A Preferred Stock will be increased from 10.875% per annum to 12.875% per annum on the 181st day; and (ii) the holders of the Series A Preferred Stock will

be entitled to vote for the election of two additional directors to serve on the Board. Such increased dividend rate and voting rights will continue for so long as the Series A Preferred Stock is not listed on a national exchange.

Risks Related to Our Business

If we are unable to resolve our professional and general liability actions on terms acceptable to us, then it could have a material adverse effect on our business, financial condition and results of operation.

The Company is a defendant in various legal actions and administrative proceedings arising in the ordinary course of business, including claims that the services the Company provided during the time it operated skilled nursing facilities resulted in injury or death to former patients. Although the Company settles cases from time to time if settlement can be achieved on a reasonable basis, the Company vigorously defends any matter in which it believes the claims lack merit and the Company has a reasonable chance to prevail at trial or in arbitration. Litigation is inherently unpredictable and there is risk in the Company's strategy of aggressively defending these cases. There is no assurance that the outcomes of these matters will not have a material adverse effect on the Company's financial condition.

The Company is a defendant in 44 professional and general liability actions commenced on behalf of former patients, of which 28 cases were filed in the State of Arkansas by the same plaintiff attorney who represented the plaintiffs in a purported class action lawsuit against the Company previously disclosed as the Amy Cleveland Class Action which settled in December 2015. These actions generally seek unspecified compensatory and punitive damages for former patients of the Company who were allegedly injured or died while patients of facilities operated by the Company due to professional negligence or understaffing. Three of the pending actions are covered by insurance, except that any award of punitive damages would be excluded from such coverage.

The Company has self-insured against professional and general liability claims since it discontinued its healthcare operations in connection with its Transition. The Company has established a self-insurance reserve for estimated costs associated with its professional liability claims, included within "Accrued expenses and other" in the Company's audited consolidated balance sheets, of $0.2 million and $6.9 million at December 31, 2015, and December 31, 2016, respectively. See Note 15 - Commitments and Contingencies to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data." Also see "Critical Accounting Policies - Self Insurance Reserve" and " Liquidity and Capital Resources - Cash Requirements" in Part II, Item 7., "Management's Discussion and Analysis of Financial Condition and Results of Operations."

The Company currently believes that most of these actions, and particularly many of the most recently filed actions, are defensible and intends to defend them through final judgment. Accordingly, the self-insurance reserve primarily reflects the Company's estimated legal costs of litigating the pending actions accordingly.

The amount of the self-insurance reserve may not be sufficient to cover the legal costs actually incurred in litigating the pending actions, and the amount of the self-insurance reserve may increase, perhaps by a material amount, in any given period, particularly if the Company determines that it has probable exposure in one or more actions. If we are unable to resolve the pending actions on terms acceptable to us, then it could have a material adverse effect on our business, financial condition and results of operations.

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

For the year ended December 31, 2016, the Company had a net loss of $7.5 million compared to a net loss of $23.5 million for the year ended December 31, 2015. We make no assurances that we will be able to operate profitably. As of December 31, 2016, we have a working capital deficit of approximately $4.8 million.

Our leases with tenants comprise our rental revenue and any failure, inability or unwillingness by these tenants to satisfy their obligations under our agreements could have a material adverse effect on us.

Our business depends upon our tenants meeting their obligations to us, including their obligations to pay rent, maintain certain insurance coverage, pay real estate and other taxes and maintain and repair the leased properties. We cannot assure you that these tenants will have sufficient assets, income and access to financing to enable them to satisfy their respective obligations to us, and any failure, inability or unwillingness by these tenants to do so could have a material adverse effect on us. In addition, any failure by these tenants to effectively conduct their operations or to maintain and improve our properties could adversely affect their business reputation and their ability to attract and retain patients and residents in our properties, which could have a material adverse effect on us. Our tenants have agreed to indemnify, defend and hold us harmless from and against various claims, litigation and liabilities arising in connection with their respective businesses, and we cannot assure you that our tenants will have sufficient assets, income, access to financing and insurance coverage to enable them to satisfy their respective indemnification

obligations.

We depend on affiliates of C.R Management and Beacon Health Management for a significant portion of our revenues and any inability or unwillingness by such entities to satisfy their obligations to us could have a material adverse effect on us.

Our 29 properties (including the three facilities that are managed by us) are operated by a total of 29 separate tenants, with each of our tenants being affiliated with one of six local or regionally-focused operators. Each of our operators operate (through a group of affiliated tenants) between two and seven of our facilities, with our most significant operators C.R Management and Beacon Health Management, each operating (through a group of affiliated tenants) seven facilities, or 24% of the total number of our facilities. We accordingly depend on our tenants who are affiliated C.R Management and Beacon Health Management for a significant portion of our revenues. Because our leases and subleases with our tenants who are affiliated with C.R Management and Beacon Health Management are on a triple-net basis, we also depend on such tenants to pay all insurance, taxes, utilities and maintenance and repair expenses in connection with the leased and subleased properties. We cannot assure you that the tenants affiliated with C.R Management and Beacon Health Management will have sufficient assets, income and access to financing to enable them to make rental payments to us or to otherwise satisfy their obligations under the applicable leases and subleases, and any inability or unwillingness by such tenants to do so could have a material adverse effect on us.

A prolonged economic slowdown could adversely impact the results of operations of our tenants, which could impair their ability to meet their obligations to us.

We believe the risks associated with our investments will be more acute during periods of economic slowdown or recession (such as the most recent recession) due to the adverse impact caused by various factors, including inflation, deflation, increased unemployment, volatile energy costs, geopolitical issues, the availability and cost of credit, the U.S. mortgage market, a distressed real estate market, market volatility and weakened business and consumer confidence. This difficult operating environment caused by an economic slowdown or recession could have an adverse impact on the ability of our tenants to maintain occupancy rates, which could harm their financial condition. Any sustained period of increased payment delinquencies, foreclosures or losses by our tenants could adversely affect our income from investments in our portfolio.

Increased competition, as well as increased operating costs, could result in lower revenues for some of our tenants and may affect their ability to meet their obligations to us.

The long-term care industry is highly competitive, and we expect that it will become more competitive in the future. Our tenants are competing with numerous other companies providing similar healthcare services or alternatives such as home health agencies, life care at home, community-based service programs, retirement communities and convalescent centers. Our tenants compete on a number of different levels, including the quality of care provided, reputation, the physical appearance of a facility, price, the range of services offered, family preference, alternatives for healthcare delivery, the supply of competing properties, physicians, staff, referral sources, location and the size and demographics of the population in the surrounding areas. We cannot be certain that the tenants of all of our facilities will be able to achieve occupancy and rate levels that will enable them to meet all of their obligations to us. Our tenants may encounter increased competition in the future that could limit their ability to attract patients or residents or expand their businesses and, therefore, affect their ability to make their lease payments.

In addition, the market for qualified nurses, healthcare professionals and other key personnel is highly competitive, and our tenants may experience difficulties in attracting and retaining qualified personnel. Increases in labor costs due to higher wages and greater benefits required to attract and retain qualified healthcare personnel incurred by our tenants could affect their ability to meet their obligations to us. This situation could be particularly acute in certain states that have enacted legislation establishing minimum staffing requirements.

Disasters and other adverse events may seriously harm our business.

Our facilities and our business 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. The impact, or impending threat, of such events may require that our tenants evacuate one or more facilities, which could be costly and would involve risks, including potentially fatal risks, for their patients. The impact of disasters and similar events is inherently uncertain. Such events could harm our tenants' patients and employees, severely damage or destroy one or more of our facilities, harm our tenants' business, reputation and financial performance, or otherwise cause our tenants' businesses to suffer in ways that we currently cannot predict.

A severe cold and flu season, epidemics, or any other widespread illnesses could adversely affect the occupancy of our tenants' facilities.

Our and our tenants' revenues are dependent upon occupancy. It is impossible to predict the severity of the cold and flu season or the occurrence of epidemics or any other widespread illnesses. The occupancy of our skilled nursing and assisted living facilities

could significantly decrease in the event of a severe cold and flu season, an epidemic, or any other widespread illness. Such a decrease could affect the operating income of our tenants and the ability of our tenants to make payments to us. The bankruptcy, insolvency or financial deterioration of our tenants could limit or delay our ability to collect unpaid rents or require us to find new tenants.

We are exposed to the risk that a distressed tenant may not be able to meet its obligations to us or other third parties. This risk is heightened during a period of economic or political instability. We are also exposed to increased risk in situations where we lease multiple properties to a single tenant (or affiliated tenants) under a master lease, as a tenant failure or default could reduce or eliminate rental revenue from multiple properties. If tenants are unable to comply with the terms of their leases, then we may be forced to modify the leases in ways that are unfavorable to us. Alternatively, the failure of a tenant to perform under a lease could require us to declare a default, repossess the property, find a suitable replacement tenant, hire third-party managers to operate the property or sell the property. There is no assurance that we would be able to lease a property on substantially equivalent or better terms than the prior lease, or at all, find another qualified tenant, successfully reposition the property for other uses or sell the property on terms that are favorable to us. It may be more difficult to find a replacement tenant for a healthcare property than it would be to find a replacement tenant for a general commercial property due to the specialized nature of the business. Even if we are able to find a suitable replacement tenant for a property, transfers of operations of skilled nursing facilities and assisted living facilities are subject to regulatory approvals not required for transfers of other types of commercial operations, which may affect our ability to successfully transition a property.

If any lease expires or is terminated, then we could be responsible for all of the operating expenses for that property until it is leased again or sold. If a significant number of our properties are unleased, then our operating expenses could increase significantly. Any significant increase in our operating costs may have a material adverse effect on our business, financial condition and results of operations, and our ability to pay dividends to our shareholders. Furthermore, to the extent we operate such property for an indeterminate amount of time, we would be subject to the various risks our tenants assume as operators and potentially fail to qualify as a REIT in any given year.

Although each of our lease agreements typically provides us with, or will provide us with, the right to terminate, evict a tenant, foreclose on our collateral, demand immediate payment and exercise other remedies upon the bankruptcy or insolvency of a tenant, the law relating to bankruptcy as codified and enacted as Title 11 of the United States Code (the "Bankruptcy Code") would limit or, at a minimum, delay our ability to collect unpaid pre-bankruptcy rents and to pursue other remedies against a bankrupt tenant. A bankruptcy filing by one of our tenants would typically prevent us from collecting unpaid pre-bankruptcy rents or evicting the tenant absent approval of the bankruptcy court. The Bankruptcy Code provides a tenant with the option to assume or reject an unexpired lease within certain specified periods of time. Generally, a lessee is required to pay all rent that becomes payable between the date of its bankruptcy filing and the date of the assumption or rejection of the lease (although such payments will likely be delayed as a result of the bankruptcy filing). Any tenant that chooses to assume its lease with us must cure all monetary defaults existing under the lease (including payment of unpaid pre-bankruptcy rents) and provide adequate assurance of its ability to perform its future obligations under the lease. Any tenant that opts to reject its lease with us would face a claim by us for unpaid and future rents payable under the lease, but such claim would be subject to a statutory “cap” and would generally result in a recovery substantially less than the face value of such claim. Although the tenant’s rejection of the lease would permit us to recover possession of the leased facility, we would likely face losses, costs and delays associated with re-leasing the facility to a new tenant.

Several other factors could impact our rights under leases with bankrupt tenants. First, the tenant could seek to assign its lease with us to a third party. The Bankruptcy Code generally disregards anti-assignment provisions in leases to permit the assignment of unexpired leases to third parties (provided all monetary defaults under the lease are cured and the third party can demonstrate its ability to perform its obligations under the lease). Second, in instances in which we have entered into a master lease agreement with a tenant that operates more than one facility, the bankruptcy court could determine that the master lease was comprised of separate, divisible leases (each of which could be separately assumed or rejected), rather than a single, integrated lease (which would have to be assumed or rejected in its entirety). Finally, the bankruptcy court could recharacterize our lease agreement as a disguised financing arrangement, which could require us to receive bankruptcy court approval to foreclose or pursue other remedies with respect to the facility.

In 2016, New Beginnings and its affiliates (including a former tenant of the Company), who operated the Oceanside Facility, the Savannah Beach Facility and the Jeffersonville Facility, filed petitions to reorganize their finances under the Bankruptcy Code. We give no assurance that our current tenants will not undergo bankruptcy, insolvency or financial deterioration that could have a material adverse effect our business, financial condition and results of operations.

If we must replace any of our tenants, we might be unable to rent the properties on as favorable terms, or at all, and we could be subject to delays, limitations and expenses, which could have a material adverse effect on us.

We cannot predict whether our tenants will renew existing leases beyond their current term. If any of our triple-net leases are not renewed, we would attempt to rent those properties to another tenant. In addition, following expiration of a lease term or if we exercise our right to replace a tenant in default, rental payments on the related properties could decline or cease altogether while we reposition the properties with a suitable replacement tenant. We also might not be successful in identifying suitable replacements or entering into leases or other arrangements with new tenants on a timely basis or on terms as favorable to us as our current leases, if at all, and we may be required to fund certain expenses and obligations (e.g., real estate and bed taxes, and maintenance expenses) to preserve the value of, and avoid the imposition of liens on, our properties while they are being repositioned. In addition, we may incur certain obligations and liabilities, including obligations to indemnify the replacement tenant, which could have a material adverse effect on us.

In the event of non-renewal or a tenant default, our ability to reposition our properties with a suitable replacement tenant could be significantly delayed or limited by state licensing, receivership, CON or other laws, as well as by the Medicare and Medicaid change-of-ownership rules, and we could incur substantial additional expenses in connection with any licensing, receivership or change-of-ownership proceedings. Our ability to locate and attract suitable replacement tenants also could be impaired by the specialized healthcare uses or contractual restrictions on use of the properties, and we may be forced to spend substantial amounts to adapt the properties to other uses. Any such delays, limitations and expenses could adversely impact our ability to collect rent, obtain possession of leased properties or otherwise exercise remedies for tenant default and could have a material adverse effect on us.

Moreover, in connection with certain of our properties, we have entered into intercreditor agreements with the tenants' lenders or tri-party agreements with our lenders. Our ability to exercise remedies under the applicable leases or to reposition the applicable properties may be significantly delayed or limited by the terms of the intercreditor agreement or tri-party agreement. Any such delay or limit on our rights and remedies could adversely affect our ability to mitigate our losses and could have a material adverse effect on us.

Our tenants may be subject to significant legal actions that could result in their increased operating costs and substantial uninsured liabilities, which may affect their ability to meet their obligations to us.

As is typical in the long term care industry, our tenants may be subject to claims for damages relating to the services that they provide. We give no assurance that the insurance coverage maintained by our tenants will cover all claims made against them or continue to be available at a reasonable cost, if at all. In some states, insurance coverage for the risk of punitive damages may not, in certain cases, be available to operators due to state law prohibitions or limitations of availability. As a result, our tenants doing business in these states may be liable for punitive damage awards that are either not covered by their insurance or are in excess of their insurance policy limits.

We also 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. The OIG, the enforcement arm of the Medicare and Medicaid programs, formulates a formal work plan each year for nursing centers. The OIG's most recent work plan indicates that, among other things, the OIG's investigative and review focus in 2017 for nursing facilities will include complaint investigations by state agencies, unreported incidents of potential abuse and neglect, reimbursement, background checks, compliance with prospective payment requirements, and potentially avoidable hospitalizations. We cannot predict the likelihood, scope or outcome of any such investigations and reviews with respect to our facilities or our tenants. Insurance is not available to our tenants to cover such losses. Any adverse determination in a legal proceeding or governmental investigation, whether currently asserted or arising in the future, could have a material adverse effect on a tenant's financial condition. If a tenant is unable to obtain or maintain insurance coverage, if judgments are obtained in excess of the insurance coverage, if a tenant is required to pay uninsured punitive damages, or if a tenant is subject to an uninsurable government enforcement action, then such tenant could be exposed to substantial additional liabilities. Such liabilities could adversely affect a tenant's ability to meet its obligations to us.

In addition, we may, in some circumstances, be named as a defendant in litigation involving the services provided by our tenants. Although we generally have no involvement in the services provided by our tenants, and our standard lease agreements generally require (or will require) our tenants to indemnify us and carry insurance to cover us in

certain cases, a significant judgment against us in such litigation could exceed our and our tenants' insurance coverage, which would require us to make payments to cover any such judgment.

Our tenants may be sued under a federal whistleblower statute.

Our tenants who engage in business with the federal government may be sued under a federal whistleblower statute designed to combat fraud and abuse in the healthcare industry. See "Governmental Regulation-Healthcare Regulation" included in Item 1 of this Annual Report. These lawsuits can involve significant monetary damages and award bounties to private plaintiffs who successfully bring these suits. If any of these lawsuits were brought against our tenants, such suits combined with increased operating costs and substantial uninsured liabilities could have a material adverse effect on our tenants' liquidity, financial condition and results of operations and on their ability to satisfy their obligations under our leases, which, in turn, could have a material adverse effect on us.

The amount and scope of insurance coverage provided by policies maintained by our tenants may not adequately insure against losses.

We maintain or require in our leases that our tenants maintain all applicable lines of insurance on our properties and their operations. Although we regularly review the amount and scope of insurance maintained by our tenants and believe the coverage provided to be customary for similarly situated companies in our industry, we cannot assure you that our tenants will continue to be able to maintain adequate levels of insurance. We also cannot assure you that our tenants will maintain the required coverages, that we will continue to require the same levels of insurance under our leases, that such insurance will be available at a reasonable cost in the future or that the policies maintained will fully cover all losses on our properties upon the occurrence of a catastrophic event, nor can we make any guaranty as to the future financial viability of the insurers that underwrite the policies maintained by our tenants.

For various reasons, including to reduce and manage costs, many healthcare companies utilize different organizational and corporate structures coupled with captive programs that may provide less insurance coverage than a traditional insurance policy. Companies that insure any part of their general and professional liability risks through their own captive limited purpose entities generally estimate the future cost of general and professional liability through actuarial studies that rely primarily on historical data. However, due to the rise in the number and severity of professional claims against healthcare providers, these actuarial studies may underestimate the future cost of claims, and reserves for future claims may not be adequate to cover the actual cost of those claims. As a result, the tenants of our properties who self-insure could incur large funded and unfunded general and professional liability expenses, which could materially adversely affect their liquidity, financial condition and results of operations and, in turn, their ability to satisfy their obligations to us. If tenants of our properties decide to implement a captive or self-insurance program, any large funded and unfunded general and professional liability expenses incurred could have a material adverse effect on us.

Should an uninsured loss or a loss in excess of insured limits occur, we could incur substantial liability or lose all or a portion of the capital we have invested in a property, as well as the anticipated future revenues from the property. Following the occurrence of such an event, we might nevertheless remain obligated for any mortgage debt or other financial obligations related to the property. We cannot assure you that material uninsured losses, or losses in excess of insurance proceeds, will not occur in the future.

Failure by our tenants to comply with various local, state and federal government regulations may adversely impact their ability to make lease payments to us.

Healthcare operators are subject to numerous federal, state and local laws and regulations, including those described below, that are subject to frequent and substantial changes (sometimes applied retroactively) resulting from new legislation, adoption of rules and regulations, and administrative and judicial interpretations of existing law. Although we cannot accurately predict the ultimate timing or effect of these changes, such changes could have a material effect on our tenants' costs of doing business and on the amount of reimbursement by both government and other third-party payors. The failure of any of our tenants to comply with these laws, requirements and regulations could adversely affect its ability to meet its obligations to us.

- Healthcare Reform. The Healthcare Reform Law, which was signed into law in March 2010, represents the most comprehensive change to healthcare benefits since the inception of the Medicare program in 1965 and affects reimbursement for governmental programs, private insurance and employee welfare benefit plans in various ways. Among other things, the Healthcare Reform Law expands Medicaid eligibility, requires most individuals to have health insurance, establishes new regulations for health plans, creates health insurance exchanges, and modifies certain payment systems to encourage more cost-effective care and a reduction of inefficiencies and waste, including

through new tools to address fraud and abuse. We cannot accurately predict the impact of the Healthcare Reform Law on our tenants or their ability to meet their obligations to us.

- Reimbursement; Medicare and Medicaid. A significant portion of the revenue of the healthcare operators to which we lease, or will lease, properties is, or will be, derived from governmentally-funded reimbursement programs, primarily Medicare and Medicaid. Failure to maintain certification in these programs would result in a loss of funding from such programs and could negatively impact an operator's ability to meet its obligations to us.
- Quality of Care Initiatives. CMS has implemented a number of initiatives focused on the quality of care provided by nursing homes that could affect our tenants. Any unsatisfactory rating of our tenants under any rating system promulgated by the CMS could result in the loss of patients or residents or lower reimbursement rates, which could adversely impact their revenues and our business.
- Licensing and Certification. Healthcare operators are subject to various federal, state and local licensing and certification laws and regulations, including laws and regulations under Medicare and Medicaid requiring operators to comply with extensive standards governing operations. Many of our properties may require a license, registration, and/or CON to operate. State and local laws also may regulate the expansion, including the addition of new beds or services or acquisition of medical equipment, and the construction or renovation of health care facilities, by requiring a CON or other similar approval from a state agency. Governmental agencies administering these laws and regulations regularly inspect facilities and investigate complaints. Failure to obtain any required licensure, certification, or CON, the loss or suspension of any required licensure, certification, or CON, or any violations or deficiencies with respect to relevant operating standards may require a facility to cease operations or result in ineligibility for reimbursement until the necessary licenses, certifications, or CON are obtained or reinstated or until any such violations or deficiencies are cured. In such event, our revenues from these facilities could be reduced or eliminated for an extended period of time or permanently.
- Fraud and Abuse Laws and Regulations. There are various federal and state civil and criminal laws and regulations governing a wide array of healthcare provider referrals, relationships and arrangements, including laws and regulations prohibiting fraud by healthcare providers. In addition, the Stark Law broadly defines the scope of prohibited physician referrals under federal health care programs to providers with which they have ownership or other financial arrangements. Many states have adopted, or are considering, legislative proposals similar to these laws, some of which extend beyond federal health care programs, to prohibit the payment or receipt of remuneration for the referral of patients and physician referrals regardless of the source of the payment for the care. Many of these complex laws raise issues that have not been clearly interpreted by the relevant governmental authorities and courts. We cannot assure you 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. In addition, federal and state governments are devoting increasing attention and resources to anti-fraud initiatives against healthcare providers. The violation of any of these laws or regulations by any of our tenants may result in the imposition of fines or other penalties, including exclusion from Medicare, Medicaid and all other federal and state healthcare programs. Such fines or penalties could jeopardize a tenant's ability to make lease payments to us or to continue operating its facility.
- Privacy Laws. Healthcare operators are subject to federal, state and local laws and regulations designed to protect the privacy and security of patient health information. These laws and regulations require operators to expend the requisite resources to protect and secure patient health information, including the funding of costs associated with technology upgrades. Operators found in violation of these laws may face large penalties. In addition, compliance with an operator's notification requirements in the event of a breach of unsecured protected health information could cause reputational harm to an operator's business. Such penalties and damaged reputation could adversely affect a tenant's ability to meet its obligations to us.
- Other Laws. Other federal, state and local laws and regulations affect how our tenants conduct their business. We cannot accurately predict the effect that the costs of complying with these laws may have on the revenues of our tenants and, thus, their ability to meet their obligations to us.
- Legislative and Regulatory Developments. Each year, legislative and regulatory proposals are introduced at the federal, state and local levels that, if adopted, would result in major changes to the healthcare system in addition to those described herein. We cannot accurately predict whether any proposals will be adopted and, if adopted, what effect (if any) these proposals would have on our tenants or our business.

Our tenants may be adversely affected by healthcare regulation and enforcement.

Regulation of the long-term healthcare industry generally has intensified over time both in the number and type of regulations and in the efforts to enforce those regulations. This is particularly true for large for-profit, multi-facility providers. Federal, state and local laws and regulations affecting the healthcare industry include those relating to, among other things, licensure, conduct of operations, ownership of facilities, addition of facilities and equipment, allowable costs, services, prices for services, qualified beneficiaries, quality of care, patient rights, fraudulent or abusive behavior, data privacy and security, and financial and other arrangements that may be entered into by healthcare providers. In addition, changes in enforcement policies by federal and state governments have resulted in an increase in the number of inspections, citations of regulatory deficiencies and other regulatory

sanctions, including terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions, civil monetary penalties and even criminal penalties. We are unable to predict the scope of future federal, state and local regulations and legislation, including the Medicare and Medicaid statutes and regulations, or the intensity of enforcement efforts with respect to such regulations and legislation, and any changes in the regulatory framework could have a material adverse effect on our tenants, operators and managers, which, in turn, could have a material adverse effect on us.

If our tenants fail to comply with the extensive laws, regulations and other requirements applicable to their businesses and the operation of our properties, they could become ineligible to receive reimbursement from governmental and private third-party payor programs, face bans on admissions of new patients or residents, suffer civil or criminal penalties or be required to make significant changes to their operations. Our tenants also could face increased costs related to healthcare regulation, such as the Healthcare Reform Law, or be forced to expend considerable resources in responding to an investigation or other enforcement action under applicable laws or regulations. In such event, the results of operations and financial condition of our tenants and the results of operations of our properties operated or managed by those entities could be adversely affected, which, in turn, could have a material adverse effect on us.

The impact of healthcare reform legislation on our tenants cannot be accurately predicted.

The health care industry in the United States is subject to fundamental changes due to ongoing health care reform efforts and related political, economic and regulatory influences. Notably, the Healthcare Reform Law resulted in expanded health care coverage to millions of previously uninsured people beginning in 2014 and has resulted in significant changes to the U.S. health care system. To help fund this expansion, the Healthcare Reform Law outlines certain reductions in Medicare reimbursements for various health care providers, including skilled nursing facilities, as well as certain other changes to Medicare payment methodologies.

Several provisions of the Healthcare Reform Law affect Medicare payments to skilled nursing facilities, including provisions changing Medicare payment methodology and implementing value-based purchasing and payment bundling. Although we cannot accurately predict how all of these provisions may be implemented, or the effect any such implementation would have on our tenants or our business, the Healthcare Reform Law could result in decreases in payments to our tenants, increase our tenants' costs or otherwise adversely affect the financial condition of our tenants, thereby negatively impacting their ability to meet their obligations to us.

The Healthcare Reform Law also requires skilled nursing facilities to have a compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations and in promoting quality of care. If our tenants fall short in their compliance and ethics programs and quality assurance and performance improvement programs, then their reputations and ability to attract residents could be adversely affected.

This comprehensive health care legislation has resulted and will continue to result in extensive rulemaking by regulatory authorities, and also may be altered or amended. It is difficult to predict the full impact of the Healthcare Reform Law due to the complexity of the law and implementing regulations, as well our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. We also cannot accurately predict whether any new or pending legislative proposals will be adopted or, if adopted, what effect, if any, these proposals would have on our tenants' business. Similarly, while we can anticipate that some of the rulemaking that will be promulgated by regulatory authorities will affect our tenants and the manner in which they are reimbursed by the federal health care programs, we cannot accurately predict today the impact of those regulations on their business and therefore on our business. The provisions of the legislation and other regulations implementing the provisions of the Healthcare Reform Law may increase our tenants' costs or otherwise adversely affect the financial condition of our tenants, thereby negatively impacting their ability to meet their obligations to us.

Other legislative changes have been proposed and adopted since the Healthcare Reform Law was enacted that also may impact our business. For instance, on April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014, which, among other things, requires CMS to measure, track, and publish readmission rates of skilled nursing facilities by 2017 and implement a value-based purchasing program for skilled nursing facilities (the "SNF VBP Program") by October 1, 2018. The SNF VBP Program will increase Medicare reimbursement rates for skilled nursing facilities that achieve certain levels of quality performance measures to be developed by CMS, relative to other facilities. The value-based payments authorized by the SNF VBP Program will be funded by reducing Medicare payment for all skilled nursing facilities by 2% and redistributing up to 70% of those funds to high-performing skilled

nursing facilities. If Medicare reimbursement provided to our tenants is reduced under the SNF VBP Program, that reduction may have an adverse impact on the ability of our tenants to meet their obligations to us.

Our tenants depend on reimbursement from governmental and other third-party payors, and reimbursement rates from such payors may be reduced.

Changes in the reimbursement rate or methods of payment from third-party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursements for services provided by our tenants could result in a substantial reduction in the revenues and operating margins of our tenants. Significant limits on the scopes of services reimbursed and on reimbursement rates could have a material adverse effect on the results of operations and financial condition of our tenants, which could cause their revenues to decline and could negatively impact their ability to meet their obligations to us.

Additionally, net revenue realizable under third-party payor agreements can change after examination and retroactive adjustment by payors during the claims settlement processes or as a result of post-payment audits. Payors may disallow requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable, additional documentation is necessary or certain services were not covered or were not medically necessary. New legislative and regulatory proposals could impose further limitations on government and private payments to healthcare providers. In some cases, states have enacted or are considering enacting measures designed to reduce Medicaid expenditures and to make changes to private healthcare insurance. No assurance is given that adequate third-party payor reimbursement levels will continue to be available for the services provided by our tenants.

The Healthcare Reform Law provides those states that expand their Medicaid coverage to otherwise eligible state residents with incomes at or below 138% of the federal poverty level with an increased federal medical assistance percentage, effective January 1, 2014, when certain conditions are met. On June 28, 2012, the United States Supreme Court upheld the individual mandate of the Healthcare Reform Laws but partially invalidated the expansion of Medicaid. The ruling on Medicaid expansion allows states to elect not to participate in the expansion-and to forego funding for the Medicaid expansion-without losing their existing Medicaid funding. Given that the federal government substantially funds the Medicaid expansion, it is unclear how many states will ultimately pursue this option, although, as of early February 2016, roughly half of the states have expanded Medicaid coverage. The participation by states in the Medicaid expansion could have the dual effect of increasing our tenants' revenues, through new patients, but further straining state budgets and their ability to pay our tenants. While the federal government will pay for approximately 100% of those additional costs from 2014 through 2016, states will be expected to pay for part of those additional costs beginning in 2017. In light of this, at least one state that has passed legislation to allow the state to expand its Medicaid coverage has included sunset provisions in the legislation that require that the expanded benefits be reduced or eliminated if the federal government's funding for the program is decreased or eliminated, permitting the state to re-visit the issue once it begins to share financial responsibility for the expansion. With increasingly strained budgets, it is unclear how states that do not include such sunset provisions will pay their share of these additional Medicaid costs and what other health care expenditures could be reduced as a result. A significant reduction in other health care related spending by states to pay for increased Medicaid costs could affect our tenants' revenue streams.

Furthermore, the Supreme Court's decision upholding the constitutionality of the individual healthcare mandate while striking down the provisions linking federal funding of state Medicaid programs with a federally mandated expansion of those programs has contributed to the uncertainty regarding the impact that the law will have on healthcare delivery systems over the next decade. We can expect that federal authorities will continue to implement the law, but because of the Supreme Court's mixed ruling, the implementation will take longer than originally expected, with a commensurate increase in the period of uncertainty regarding the long-term financial impact on the delivery of and payment for healthcare.

A repeal of the Healthcare Reform Law, in whole or in part, may have unforeseen consequences.

It is possible that following the inauguration of President Trump, which occurred on January 20, 2017, legislation will be introduced and passed by the Republican-controlled Congress repealing the Healthcare Reform Law in whole or in part and signed into law by President Trump, consistent with statements made by him during his presidential campaign indicating his intention to do so within a short time following his inauguration. It is also possible that this may be accomplished in part through the issuance of presidential executive orders. Because of the continued uncertainty about the implementation of the