ADCARE HEALTH SYSTEMS, INC
Form 10-K
March 31, 2015

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, 2014

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

For the transition period from to

Commission file number 001-33135

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The aggregate market value of AdCare Health Systems, Inc., common stock held by non-affiliates as of June 30, 2014, the last business day of the registrant's most recently completed second fiscal quarter, was $64,173,083. The number of shares of AdCare Health Systems, Inc., common stock, no par value, outstanding as of March 27, 2015 was 19,348,769.

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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 and the federal securities laws. 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, strategic and business plans, the expected amounts and timing of dividends, 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" a 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 lease our healthcare properties on favorable terms and to otherwise transition successfully from an owner/operator of healthcare properties to a healthcare property holding and leasing company;
- The significant amount of our indebtedness, our ability to service our indebtedness and our ability to refinance our indebtedness on favorable terms;
- Covenants in our debt agreements that may restrict our ability to pay dividends, make investments, incur additional indebtedness and refinance indebtedness on favorable terms;
- Our ability to raise capital through equity and debt financings;
- The availability and cost of capital;
- Increases in market interest rates;
- Our dependence on the operating success of our tenants;
- The effect of increasing healthcare regulation and enforcement on us and our tenants and the dependence by us and our tenants on reimbursement from governmental and other third-party payors;
- The impact of litigation and rising insurance costs on our business and that of our tenants;
- The effect of our tenants declaring bankruptcy or becoming insolvent;
- Our ability to find replacement tenants as needed;
- The impact of required regulatory approvals of transfers of healthcare properties;
- Our ability to successfully engage in strategic acquisitions;
- Competition in the acquisition and ownership of healthcare properties;
- The relatively illiquid nature of real estate investments;

- The loss of key management personnel or other employees; and

- Uninsured or underinsured losses affecting our properties and the possibility of environmental compliance costs and liabilities.

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

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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 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.

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PART I.

Item 1. Business

Overview

AdCare Health Systems, Inc. ("AdCare"), through its subsidiaries (together, the "Company" or "we"), own, operate, and manage for third-parties skilled nursing facilities and assisted living facilities in the states of Arkansas, Georgia, North Carolina, Ohio, Oklahoma, and South Carolina. As of December 31, 2014, the Company operates or manages 32 facilities comprised of 29 skilled nursing facilities, two assisted living facilities and one independent living/senior housing facility totaling approximately 3,600 beds. The Company's facilities provide a range of health care services to patients and residents, including, but not limited to, skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term residents and short-stay patients. As of December 31, 2014, of the 32 facilities, the Company owned and operated 22 facilities, leased and operated six facilities, and managed four facilities for third-parties.

As of December 31, 2014, we also have leased three owned and subleased five leased skilled nursing and rehabilitation facilities to local third-party operators in the states of Alabama and Georgia. The patient care revenue, related cost of services, and facility rental expense prior to the commencement of subleasing are classified as discontinued operations.

On July 23, 2014, we announced that the Board of Directors (the "Board") had approved a strategic plan to transition the Company to a healthcare property holding and leasing company. Through a series of leasing and subleasing transactions, the Company is in the process of transitioning to third-parties the operations of the Company’s currently owned and operated healthcare facilities, which are principally skilled nursing facilities. In furtherance of this strategic plan, the Company is now focused on the ownership, acquisition and leasing of healthcare related properties.

On October 29, 2014 , the Company entered into separate agreements with third-party operators to: (i) to lease one of our facilities; (ii) to sublease three of our facilities; and (iii) to sub-sublease one of our facilities. All of the facilities are located in Ohio and the leases and subleases will commence on the first day of the month after lessees' receipt of: (a) all licenses and other approvals from the State of Ohio to operate the facility, and (b) approval of the lease by the United States Department of Housing and Urban Development ("HUD").

The Company entered into additional leasing agreements subsequent to December 31, 2014. See Note 20 - Subsequent Events, in Part II, Item 8., "Financial Statements and Supplementary Data" for details of the agreements.

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

Company History

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

The Transition to a Facilities Holding Company and the Additional Leasing Transactions

The Transition

We intend to effect the Company’s transition from an owner and operator of healthcare properties to lessor and sublessor of healthcare properties through a series of leasing and subleasing transactions (the "Transition"). Specifically, in order to effect such transition, we seek to:

• lease to third-party operators the healthcare properties which we currently own and operate, consisting of 20 skilled nursing facilities with a total of 2,028 operational beds and two assisted living facilities with a total of 112 operational units;

• sublease to third-party operators the healthcare properties which we do not own but currently lease and operate, consisting of six skilled nursing facilities with a total of 872 operational beds;

• terminate one of the management agreements under which we manage for a third party, a skilled nursing facility with a total of 261 operational beds; (as of January 1, 2015, this management agreement has been terminated);

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• continue in effect the one remaining management agreement to manage two skilled nursing facilities with a total of 249 operational beds and one independent living facility with a total of 83 operational units.

Through the transition, the Company will take on the characteristics and general structure of a Real Estate Investment Trust ("REIT") while proceeding with the intent toward the eventual conversion to a REIT. The Company's net operating losses will be available to offset future tax liabilities after the transition.

In connection with the transition, we intend to reduce our financial leverage over time and adjust our capital structure by repaying certain of our corporate level indebtedness prior to maturity, renegotiating and restructuring certain of our other corporate level indebtedness to reduce the cost of capital, and refinancing our facility level mortgage indebtedness with lower-cost financing guaranteed by HUD.

Terms of Leases/Subleases

We seek to lease our currently-owned healthcare properties, and sublease our currently-leased healthcare properties, on a triple net basis, meaning that the lessee (i.e., the new third-party operator of the property) is obligated under the lease or sublease, as applicable, for all liabilities of the property in respect to insurance, taxes and facility maintenance, as well as the lease or sublease payments, as applicable. These leases are generally long-term in nature with renewal options and annual escalation clauses.

Acquisitions and Dispositions

The Company had one skilled nursing facility entity classified as held for sale and one variable interest entity classified as held for sale at December 31, 2014 as described further below.

Acquisitions

The Company had no acquisitions during the year ended December 31, 2014.

Dispositions

The Company entered into a sublease arrangement in the fourth quarter of 2012 to exit the operations of a skilled nursing facility in Jeffersonville, Georgia.

On February 28, 2013, the Company completed the sale of the facility known as Lincoln Lodge Retirement Residence and used the proceeds to pay the principal balance of the mortgage note with respect to the facility of $1.9 million. The Company recognized a gain on the sale of approximately $0.1 million and cash proceeds, net of costs and debt payoff, of $0.6 million.

On June 11, 2013, the Company completed the sale of its former Springfield, Ohio corporate office building which was sold for the approximate net book value. The Company used the proceeds to pay off the principal balance of the mortgage note with respect to the building of approximately $0.1 million.

On June 12, 2013, the Company entered into two sublease agreements to exit the operations of two skilled nursing facilities located in Tybee Island, Georgia effective June 30, 2013. On December 18, 2013, a sales listing agreement was executed for the 105-bed assisted living facility located in Hoover, Alabama, which is owned by a consolidated variable interest entity. The two skilled nursing facilities located in Tybee Island, Georgia and the assisted living facility located in Hoover, Alabama are reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

On March 31, 2014, the Company entered into a representation agreement to sell a 102-bed skilled nursing facility located in Tulsa, Oklahoma, to exit the operations.

On July 1, 2014, the Company entered into an agreement effective July 1, 2014 to sublease a 52-bed skilled nursing facility located in Thomasville, Georgia to a local nursing home operator.

On September 22, 2014, two wholly-owned subsidiaries of the Company entered into separate lease agreements to lease a 182-bed skilled nursing facility located in Attalla, Alabama and a 124-bed skilled nursing facility located in Glencoe, Alabama to a local nursing home operator that commenced on December 1, 2014.

On September 30, 2014, the lease agreement to operate a 90-bed skilled nursing facility located in Cassville, Missouri expired. The Company elected not to renew the lease agreement consistent with its strategic plan to transition to a healthcare property holding and leasing company.

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On October 22, 2014, two wholly-owned subsidiaries of the Company entered into separate sublease agreements that commenced on November 1, 2014 to sublease a 130-bed skilled nursing facility located in Dublin, Georgia and an 86-bed skilled nursing facility located in Lumber City, Georgia to a local nursing home operator.

On October 29, 2014, the Company entered into separate agreements with third-party operators to: (i) lease one of our facilities, (ii) sublease three of our facilities, and (iii) sub-sublease one of our facilities. All of the facilities are located in Ohio and the leases and subleases will commence on the first day of the month after lessees' receipt of all licenses and other approvals from the State of Ohio to operate the facility and approval of the lease by HUD.

The results of operations and cash flows for the Jeffersonville, Georgia skilled nursing facility, the two skilled nursing facilities in Tybee Island, Georgia, the assisted living facility in Hoover, Alabama, the skilled nursing facility in Tulsa, Oklahoma, the skilled nursing facility in Thomasville, Georgia, the two skilled nursing facilities in Attalla, Alabama and Glencoe, Alabama, the skilled nursing facility in Cassville, Missouri, and the two skilled nursing facilities in Dublin, Georgia and Lumber City, Georgia are reported as discontinued operations in 2014 and 2013. Current assets and liabilities of the disposal groups are classified as such in the Consolidated Balance Sheets at December 31, 2014 and 2013 included in Part II, Item 8, "Financial Statements and Supplementary Data."

Facility Summary

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

	December 31,	
	2014	2013
Cumulative number of facilities	32	39
Cumulative number of operational beds	3,605	3,908

		Number of Facilities			
State	Number of Operational Beds/Units	Owned	Leased	Managed for Third Parties	Total
Arkansas	1,041	10	—	—	10
Georgia	1,376	3	5	1	9
North Carolina	106	1	—	—	1
Ohio	705	4	1	3	8
Oklahoma	197	2	—	—	2
South Carolina	180	2	—	—	2
Total	3,605	22	6	4	32
Facility Type					
Skilled Nursing	3,410	20	6	3	29
Assisted Living	112	2	—	—	2
Independent Living	83	—	—	1	1
Total	3,605	22	6	4	32

Leased and Subleased Facilities to Third-Party Operators

As of December 31, 2014, we have leased three owned and subleased five leased skilled nursing and rehabilitation facilities to local third-party operators in the states of Alabama and Georgia with the operational capacity of approximately 820 operational beds.

The following table provides summary information regarding the number of operational beds at our leased and subleased facilities to third-parties as of December 31:

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	December 31,	
	2014	2013
Cumulative number of facilities leased and subleased to third-parties	8	3
Cumulative number of operational beds	820	252

		Number of Facilities Leased and Subleased to Third-Parties		
State	Number of Operational Beds/Units	Owned Facilities	Leased Facilities	Total Leased and Subleased Facilities
Alabama	304	2	—	2
Georgia	516	1	5	6
Total	820	3	5	8

Industry Trends

Consistent with our plan to transition the Company to a healthcare property holding and leasing company, the healthcare REIT industry has trended toward owning and triple net-leasing healthcare real estate assets. Specifically, the skilled nursing segment of this 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 due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.

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

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

Medicaid and Medicare Reimbursement

Rising healthcare costs due to a variety of factors, including an aging population and increasing life expectancies, has generated growing demand for post-acute healthcare services in recent years. In an effort to mitigate the cost of providing healthcare benefits, third-party payors, including Medicaid, Medicare, managed care providers, insurance companies and others, have increasingly encouraged the treatment of patients in lower-cost care settings. As a result, in recent years skilled nursing facilities, which typically have significantly lower cost structures than acute care hospitals and certain other post-acute care settings, have generally been serving larger populations of higher-acuity patients than in the past. However, Medicaid and Medicare reimbursement rates are subject to change from time to time and reduction in rates could materially and adversely impact our revenue.

Revenue derived directly or indirectly from Medicare reimbursement has historically comprised a substantial portion of our consolidated revenue. Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our skilled nursing facilities under a prospective payment system (“PPS”) for certain inpatient covered services. Under the PPS, facilities are paid a predetermined

amount per patient, per day, based on the anticipated costs of treating patients. The amount to be paid is determined by classifying each patient into a resource utilization group ("RUG") category that is based upon each patient's acuity level. In October 2010, the number of RUG categories was expanded from 53 to 66 as part of the implementation of the RUGs IV system and the introduction of a revised and substantially expanded patient assessment tool called the Minimum Data Set, Version 3.0. Should future changes in skilled nursing facility payments reduce rates or increase the standards for reaching certain reimbursement levels, our Medicare

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revenues could be reduced and/or our costs to provide those services could increase, with a corresponding adverse impact on our financial condition or results of operations.

On July 31, 2014, the Centers for Medicare & Medicaid Services ("CMS") issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA).

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimated that aggregate payments to skilled nursing facilities would increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase is attributable to a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% multi-factor productivity adjustment (MFP) as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. In its 2014 report to Congress, the Medicare Payment Advisory Commission recommended eliminating the market basket update and reducing payments through the SNF prospective payments system.

On July 27, 2012, CMS announced a final rule updating Medicare skilled nursing facility PPS payments in fiscal year 2013. The update, a 1.8% or $670 million increase, reflected a 2.5% market basket increase, reduced by a 0.7% MFP adjustment mandated by the PPACA. This increase was offset by the 2% sequestration reduction, which became effective April 1, 2013.

On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014, which averted a 24% cut in Medicare payments to physicians and other Part B providers until March 31, 2015. In addition, this law maintains the 0.5% update for such services through December 31, 2014 and provides a 0.0% update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015. Among other things, this law provides the framework for implementation of a value-based purchasing program for skilled nursing facilities. Under this legislation HHS is required to develop by October 1, 2016 measures and performance standards regarding preventable hospital readmission from skilled nursing facilities. Beginning October 1, 2018, HHS will withhold 2% of Medicare payments to all skilled nursing facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

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

On January 2, 2013, the President signed the American Taxpayer Relief Act of 2012 into law. This statute creates a Commission of Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of recommendations from this commission may have an impact on coverage and payment for our services.

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

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

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

Regulatory Matters. Laws and regulations governing Federal Medicare and state Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from certain governmental programs.

The regulatory environment within the skilled nursing industry continues to intensify in the amount and type of laws and regulations affecting it. In addition to this changing regulatory environment, federal, state and local officials are increasingly focusing their efforts on the enforcement of these laws. In order to operate our business, we must comply with federal, state and local laws relating to licensure, delivery and adequacy of medical care, equipment, personnel, operating policies, fire prevention, rate-setting, billing and reimbursement, building codes and environmental protection. Additionally, we must also adhere to the anti-kickback laws, physician referral laws, and safety and health standards set by the Occupational Safety and Health Administration (OSHA). Changes in the laws or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

Our operations are also subject to various regulations and licensing requirements promulgated by state and local health and social service agencies and other regulatory authorities. Requirements vary from state to state and these requirements can affect, among other things, personnel education and training, patient and personnel records, services, staffing levels, monitoring of patient wellness, patient furnishings, housekeeping services, dietary requirements, emergency plans and procedures, certification and licensing of staff prior to beginning employment, and patient rights.

On October 6, 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014. This legislation requires post-acute care providers, such as skilled nursing facilities, to report standardized patient assessment data, data on quality measures, and data on resource use and other measures, and directs HHS to provide feedback reports to providers and arrange for public reporting of provider performance on the reported data. Post-acute care providers that do not report such data will have their Medicare payments reduced.

CMS also recently announced a proposed post-acute care provider initiative. CMS proposes to expand and strengthen the Five Star Quality Rating System for nursing homes to improve consumer information about quality measures at individual nursing homes.

In December 2010, the Office of Inspector General released a report entitled “Questionable Billing by Skilled Nursing Facilities.” The report examined the billing practices of skilled nursing facilities based on Medicare Part A claims from 2006 to 2008 and found, among other things, that for-profit skilled nursing facilities were more likely to bill for higher paying therapy RUGs, particularly in the ultra-high therapy categories, than government and not-for-profit operators. It also found that for-profit skilled nursing facilities showed a higher incidence of patients using RUGs with higher activities of daily living (ADL) scores, and had a “long” average length of stay among Part A beneficiaries, compared to their government and not-for-profit counterparts. The OIG recommended that CMS vigilantly monitor overall payments to skilled nursing facilities, adjust RUG rates annually, change the method for determining how much therapy is needed to ensure appropriate payments and conduct additional reviews for skilled nursing operators that exceed certain thresholds for higher paying therapy RUGs. CMS concurred with and agreed to take action on three of the four recommendations, declining only to change the methodology for assessing a patient's therapy needs. The OIG issued a separate memorandum to CMS listing 384 specific facilities that the OIG had identified as being in the top one percent for use of ultra-high therapy, RUGs with high ADL scores, or “long” average lengths of stay, and CMS agreed to forward the list to the appropriate fiscal intermediaries or other contractors for follow up. Although we believe our billing practices are consistent with applicable law and CMS requirements, we cannot predict the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit

contractors and others, as well as other government agencies, unions, advocacy groups and others who seek to pursue their own mandates and agendas. In its fiscal year 2014 work plan, OIG specifically stated that it will continue to study and report on questionable Part A and Part B billing practices among skilled nursing facilities. Also, according to its 2015 work plan, OIG has identified reducing waste in Medicare Parts A and ensuring quality, including in nursing home care as top management challenges facing OIG. Efforts by officials and others to make or advocate for any increase in regulatory monitoring and oversight, adversely change RUG rates, revise methodologies for assessing and treating patients, or conduct more frequent or

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intense reviews of our treatment and billing practices, could reduce our reimbursement, increase our costs of doing business and otherwise adversely affect our business, financial condition and results of operations.

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

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

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

Revenue Sources

Total Revenue by Payor Sources. We derive revenue primarily from the Medicaid and Medicare programs, private pay patients and managed care payors. Medicaid typically covers patients that require standard custodial services and provides reimbursement rates that are generally lower than rates earned from other sources. We monitor our patient mix, which is the percentage of non-Medicaid revenue from each of our facilities, to measure the level received from each payor across each of our business units.

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

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

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

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

Billing and Reimbursement. Our revenues from government payors, including Medicare and state Medicaid agencies, is subject to retroactive adjustments in the form of claimed overpayments and underpayments based on rate adjustments and asserted billing and reimbursement errors. We believe billing and reimbursement errors, disagreements, overpayments and underpayments are common in our industry, and we are regularly engaged with

government payors and their fiscal intermediaries in reviews, audits and appeals of our claims for reimbursement due to the subjectivity inherent in the processes related to patient diagnosis and care, recordkeeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce.

Management fees. Management fee revenues are received under various contractual agreements with third-party companies.

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Rental Revenue. Rental revenue is received under contractual agreements for the leasing of our facilities. The Company, as lessor, makes a determination with respect to each of its leases whether they should be accounted for as operating leases. The Company recognizes rental revenues on a straight-line basis over the term of the lease when collectibility is reasonably assured. Differences between rental income earned and amounts due under the lease are charged or credited, as applicable, to straight-line rent receivable, net. Payments received under operating leases are accounted for in the statements of operations as rental revenue for actual rent collected plus or minus a straight-line adjustment for estimated minimum lease escalators.

We employ accounting, reimbursement and compliance specialists who assist our clerical, clinical and rehabilitation staffs in the preparation of claims and supporting documentation, regularly monitor billing and reimbursement practices within our facilities, and assist with the appeal of overpayment and recoupment claims by governmental, fiscal intermediary and other auditors and reviewers. The table below sets forth our annual revenue by payor source during the years ended December 31, 2014 and 2013.

	Year Ended December 31,	
Annual Revenue by Payor (000's)	2014	2013
Medicaid	$96,491	$95,583
Medicare	62,696	57,015
Other	30,802	30,179
Management fees	1,493	2,097
Rental revenue	$1,832	$876
Total	$193,314	$185,750

Competition

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

We are in a competitive, yet fragmented, industry. While there are several national and regional companies that provide skilled nursing services, our primary source of competition is the smaller regional and local operators and third party facility management companies. There is limited, if any, price competition with respect to Medicaid and Medicare patients, since revenues for services to such patients are strictly controlled and are based on fixed rates and cost reimbursement principles. Our competitors include assisted living communities and other retirement facilities and communities, home health care agencies, skilled nursing facilities and convalescent centers, some of which operate on a not-for-profit or charitable basis.

We seek to compete effectively in each market by establishing a reputation within the local community for quality of care, attractive and comfortable facilities, and providing specialized healthcare with an ability to care for high-acuity patients. We believe that the average cost to a third-party payor for the treatment of our typical high-acuity patient is lower if that patient is treated in one of our skilled nursing facilities than if that same patient were to be treated in an inpatient rehabilitation facility or long-term acutecare hospital. The skilled nursing facilities operated by us compete with other facilities in their respective markets, including rehabilitation hospitals and other "skilled" and personal care residential facilities. In addition, our facilities also face competition for employees.

As announced in July 2014, our Board approved a strategic plan to transition the Company to a healthcare property holding and leasing company. Through a series of leasing and sublease transactions, the Company will transition to third-parties the operations of the Company’s currently owned and operated healthcare facilities, which are principally skilled nursing facilities.The Company is focused on the ownership, acquisition and leasing of healthcare related properties. This strategy in essence minimizes certain competitive forces and provides a more consistent and predictable stream of income to the Company.

Increased competition could limit our ability to attract and retain patients, maintain or increase rates or to expand our business. Many of our competitors have greater financial and other resources than we have, may have greater brand recognition and may be more established in their respective communities than we are. Competing companies may also offer newer facilities or different programs or services than we do and may as a result be more attractive to our current

patients, to potential patients and to referral sources. Some of our competitors may accept lower profit margins than we do, which could present significant price competition, particularly for managed care and private pay patients.

Government Regulation

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

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

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

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

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

- Enhanced CMPs and Escrow Provisions. PPACA includes expanded civil monetary penalty ("CMP") and related provisions applicable to all Medicaid and Medicare providers. CMS rules adopted to implement applicable provisions of PPACA also provide that assessed CMPs may be collected and placed in whole or in part into an escrow account pending final disposition of the applicable administrative and judicial appeals process. To the extent our businesses are assessed large CMPs that are collected and placed into an escrow account pending lengthy appeals, such actions could adversely affect our business, financial condition and results of operations.
- Nursing Home Transparency Requirements. In addition to expanded CMP provisions, PPACA imposes new transparency requirements for Medicare-participating nursing facilities. In addition to previously required disclosures regarding a facility's owners, management, and secured creditors, PPACA expanded the required disclosures to include information regarding the facility's organizational structure, additional information on officers, directors, trustees, and "managing employees" of the facility (including their names, titles, and start dates of services), and information regarding certain parties affiliated with the facility. The transparency provisions could result in the

potential for greater government scrutiny and oversight of the ownership and investment structure for skilled nursing facilities, as well as more extensive disclosure of entities and individuals that comprise part of skilled nursing facilities' ownership and management structure.

- Suspension of Payments During Pending Fraud Investigations. PPACA provides the federal government with expanded authority to suspend Medicaid and Medicare payments if a provider is investigated for allegations or issues of fraud. This suspension authority creates a new mechanism for the federal government to suspend both Medicaid and Medicare payments for allegations of fraud, independent of whether a state exercises its authority to suspend Medicaid payments pending a fraud

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investigation. To the extent the suspension of payment provision is applied to one of our businesses for allegations of fraud, such a suspension could adversely affect our business, financial condition and results of operations.

- Overpayment Reporting and Repayment; Expanded False Claims Act Liability. PPACA enacted several important changes that expand potential liability under the federal False Claims Act. Overpayments related to services provided to both Medicaid and Medicare beneficiaries must be reported and returned to the applicable payor within specified deadlines, or else they are considered obligations of the provider for purposes of the federal False Claims Act. This new provision substantially tightens the repayment and reporting requirements generally associated with the operations of health care providers to avoid False Claims Act exposure.
- Home and Community Based Services. PPACA provides that states can provide home and community-based attendant services and support through the Community First Choice State plan option. States choosing to provide home and community-based services under this option must make them available to assist with activities of daily living, instrumental activities of daily living and health-related tasks under a plan of care agreed upon by the individual and his/her representative. For states that elect to make coverage of home and community-based services available through the community First Choice State plan option, the percentage of the state's Medicaid expenses paid by the federal government will increase by six percentage points. PPACA also includes additional measures related to the expansion of community and home-based services and authorizes states to expand coverage of community and home-based services to individuals who would not otherwise be eligible for them. The expansion of home and community-based services could reduce the demand for the facility-based services that we provide.
- Health Care-Acquired Conditions. PPACA provides that the Secretary of Department of Health and Human Services ("DHHS") must prohibit payments to states for any amounts expended for providing medical assistance for certain medical conditions acquired during the patient's receipt of health care services. CMS adopted a final rule to implement this provision of PPACA in the third quarter of 2011. The rule prohibits states from making payments to providers under the Medicaid program for conditions that are deemed to be reasonably preventable. It uses Medicare's list of preventable conditions in inpatient hospital settings as the base (adjusted for the differences in the Medicaid and Medicare populations) and provides states the flexibility to identify additional preventable conditions and settings for which Medicaid payments will be denied.
- Value-Based Purchasing. PPACA requires the DHHS to develop a plan to implement a value-based purchasing ("VBP") program for payments under the Medicare program for skilled nursing facilities and to submit a report containing the plan to Congress. The intent of the provision is to potentially reconfigure how Medicare pays for health care services, moving the program towards rewarding better value, outcomes, and innovations, instead of volume. According to the plan submitted to Congress in June 2012, the funding for the VBP program could come out of payment withholds from poor-performing skilled nursing facilities or by holding back a portion of the base payment rate or the annual update for all skilled nursing facilities. If a VBP program is ultimately implemented, it is uncertain what effect it would have upon skilled nursing facilities, but its funding or other provisions could negatively affect them.
- Voluntary Pilot Program - Bundled Payments. To support the policies of making all providers responsible during an episode of care and rewarding value over volume, HHS will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 to 90 days following discharge. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. Payment arrangements among providers participating in the bundled payment must navigate regulatory compliance under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law and the related waivers. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.
- Anti-Kickback Statute Amendments. PPACA amended the Anti-Kickback Statute so that: (i) a claim that includes items or services violating the Anti-Kickback Statute also would constitute a false or fraudulent claim under the

federal False Claims Act; and (ii) the intent required to violate the Anti-Kickback Statute is lowered such that a person need not have actual knowledge or specific intent to violate the Anti-Kickback Statute in order for a violation to be deemed to have occurred. These modifications of the Anti-Kickback Statute could expose us to greater risk of inadvertent violations of the statute and to related liability under the federal False Claims Act.

- Accountable Care Organizations. PPACA authorized CMS to enter into contracts with Accountable Care Organizations (ACOs), which are entities of providers and suppliers organized to deliver services to Medicare beneficiaries and eligible to

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receive a share of any cost savings the entity can achieve by delivering services to those beneficiaries at a cost below a set baseline and with sufficient quality of care. CMS recently finalized regulations to implement the ACO initiative. The widespread adoption of ACO payment methodologies in the Medicare program, and in other programs and payors, could impact our operations and reimbursement for our services. On January 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018.

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

In addition, we incur considerable administrative costs in monitoring the changes made within the various reimbursement programs in which we participate, determining the appropriate actions to be taken in response to those changes, and implementing the required actions to meet the new requirements and minimize the repercussions of the changes to our organization, reimbursement rates and costs.

Medicare and Medicaid. Medicare is a federally-funded and administered health insurance program for the aged and for certain chronically disabled individuals. Part A of the Medicare program covers inpatient hospital services and certain services furnished by other institutional providers such as skilled nursing facilities. Part B of the Medicare program covers the services of doctors, suppliers of medical items, various types of outpatient services and certain ancillary services of the type provided by long-term and acute care facilities. Medicare payments under Part A and Part B are subject to certain caps and limitations, as provided in Medicare regulations. Medicare benefits are not available for intermediate and custodial levels of nursing center care or for assisted living center arrangements.

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

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

Health Insurance Portability and Accountability Act of 1996 Compliance. There are numerous legislative and regulatory requirements at the federal and state levels addressing patient privacy and security of health information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") contains provisions that require us to adopt and maintain business procedures designed to protect the privacy, security and integrity of patients' individual health information. States also have laws that apply to the privacy of healthcare information. We must comply with these state privacy laws to the extent that they are more protective of healthcare information or provide additional

protections not afforded by HIPAA. HIPAA's security standards were designed to protect electronic information against reasonably anticipated threats or hazards to the security or integrity of the information and to protect the information against unauthorized use or disclosure. These standards have had and are expected to continue to have a significant impact on the health care industry because they impose extensive requirements and restrictions on the use and disclosure of identifiable patient information. In addition, HIPAA established uniform standards governing the conduct of certain electronic healthcare transactions and protecting the privacy and security of individually identifiable health information. The Health Information Technology for Clinical Health Act of 2009 expanded the requirements

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and noncompliance penalties under HIPAA and requires correspondingly intensive compliance efforts by companies such as ours, including self-disclosures of breaches of unsecured health information to affected patients, federal officials, and, in some cases, the media.

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

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

Antitrust Laws. We are also subject to federal and state antitrust laws. Enforcement of the antitrust laws against healthcare providers is common, and antitrust liability may arise in a wide variety of circumstances, including third party contracting, physician relations, joint venture, merger, affiliation and acquisition activities. In some respects, the application of federal and state antitrust laws to healthcare is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, healthcare providers and insurance and managed care organizations may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

Transition. As our Company transitions to a concentrated healthcare property holding and leasing company, the impact of certain government regulations to us may change. Specifically, the third-party operators of the Company's currently owned and operated healthcare facilities will take on the responsibility for such government regulation compliance as it relates to the specific operations.

Employees

As of December 31, 2014, excluding discontinued operations, we had approximately 3,414 total employees of which 2,494 were full-time employees.

Item 1A. Risk Factors

The following are certain risk factors that could affect our business, operations and financial condition. These risk factors should be considered in connection with evaluating the forward-looking statements contained in this Annual Report because these factors could cause the actual results and conditions to differ materially from those projected in forward-looking statements. This section does not describe all risks applicable to our business, and we intend it only as a summary of certain material factors. If any of the following risks actually occur, our business, financial condition or results of operations could be negatively affected. In that case, the trading price of our common stock and our Series A Preferred Stock could decline.

Risks Related to Us and Our Operations as an Operator of Healthcare Facilities

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

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

Company.

In March 2010, the PPACA and the Health Care and Education Reconciliation Act of 2010 were signed into law. Together, these two measures make the most sweeping changes to the U.S. health care system since the creation of Medicaid and Medicare. These new laws include a large number of health care related provisions scheduled to take effect over the next four years, including expanding Medicaid eligibility, requiring most individuals to have health insurance, establishing new

regulations on health plans, establishing health insurance exchanges and modifying certain payment systems to encourage more cost-effective care and a reduction of inefficiencies and waste, including new tools to address fraud and abuse. As the implementation of, and rulemaking with respect to, these measures is ongoing, we are unable to accurately predict the effect these laws or any future legislation or regulation will have on us or our operations, including future reimbursement rates and occupancy in our inpatient facilities.

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

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

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting, among other things, base rates or basis of payment, retroactive rate adjustments, annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to Medicare beneficiaries, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates and frequency at which these programs reimburse us for our services.

On August 2, 2011, the President signed into law the Budget Control Act of 2011 (the "Budget Control Act"), which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act created a Congressional Joint Select Committee on Deficit Reduction (the "Committee") that was tasked with proposing additional deficit reduction of at least $1.5 trillion over ten years. As the Committee was unable to achieve its targeted savings, this regulation triggered automatic reductions in discretionary and mandatory spending, or budget sequestration, starting in 2013, including reductions of not more than 2% to payments to Medicare providers. We are unable to accurately predict the impact these automatic and potential reductions will have on our business, and those reductions could materially adversely affect our business, financial condition, results of operations and prospects.

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

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

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

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

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

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

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

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

We are unable to accurately predict the future course of federal, state and local regulation or legislation, including Medicaid and Medicare statutes and regulations, or the intensity of federal and state enforcement actions. An adverse review, inquiry, investigation or audit could result in:

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

An expanded federal program is underway to recover Medicare overpayments.

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

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

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

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

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

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

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

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

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

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

business, financial condition, results of operations and prospects.

We depend largely upon reimbursement from third-party payors, and our business, financial condition, results of operations and prospects could be adversely affected by any changes in the mix of patients in our facilities as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of our patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in our patient mix, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, may significantly affect our profitability because we generally receive higher reimbursement rates for certain patients, such as rehabilitation patients, and because the payors reimburse us at different rates. As a result, changes in the case mix of patients as well as the payor mix may significantly affect our profitability. Particularly, a significant increase in Medicaid patients will have a material adverse effect on our business, financial condition, results of operations and prospects, especially if states operating Medicaid programs continue to limit, or more aggressively seek limits on, reimbursement rates.

We operate in an industry that is highly competitive.

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

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

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

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

We could experience significant increases in our costs due to shortages in qualified nurses, health care professionals and other key personnel. We compete with other providers of home health care, nursing home care, and assisted living with respect to attracting and retaining qualified personnel, and the market is competitive. Because of the small markets in which we operate, shortages of nurses and trained personnel may require us to enhance our wage and benefit package in order to compete and attract qualified employees from more metropolitan areas. Further, acquisitions of new facilities may require us to pay increased compensation or offer other incentives to retain key personnel and other employees in any newly acquired facilities. Increased competition in the future with respect to attracting and maintaining key personnel could limit our ability to attract and retain residents or to expand our business.

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

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

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

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

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

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

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

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

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

We are subject to various federal, state and local environmental and health and safety laws and regulations with respect to our facilities. These laws and regulations address various matters, including asbestos, fuel oil management, wastewater discharges, air emissions, medical wastes and hazardous wastes. The costs of complying with these laws and regulations and the penalties for non-compliance can be substantial. For example, with respect to our owned and leased property, we may be held liable for costs relating to the investigation and cleanup of any of our owned or leased properties from which there has been a release or threatened release of a regulated material as well as other properties affected by the release. In addition to these costs, which are typically not limited by law or regulation and could exceed the property's value, we could be liable for certain other costs, including, without limitation, governmental fines and injuries to persons, property or natural resources. Further, some environmental laws create a lien on the contaminated site in favor of the government for damages and the costs it incurs in connection with the contamination. While we are not aware of any potential environmental problems, no assurances are made that such problems and the costs associated with them will not arise in the future. If any of our properties were found to violate environmental laws, we may be required to expend significant amounts of time and money to rehabilitate the property, and we may be subject to significant liability. Any environmental compliance costs and liabilities incurred may have a material adverse effect on our business, financial condition, results of operations and prospects.

Disasters and other adverse events may seriously harm our business.

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

The nature of business exposes us to certain litigation risks.

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

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

future or, if coverage is available, that it will be available on acceptable terms.

Risks Related to Us as a Facilities Holding Company

We may be unable to achieve any of the benefits that we expect to achieve from the Transition.

We may not derive any of the strategic or financial benefits that we expect from the Transition or such benefits may be delayed, if they materialize at all. The anticipated benefits of the Transition are based on a number of assumptions, which may prove incorrect. For example, we believe that the Transition will allow us to increase our cash flow, pay consistent cash quarterly dividends, maximize the value of our properties, expand into new geographic areas, reduce our financing costs and make opportunistic acquisitions. If the Transition does not have these and other expected benefits for any reason, then the Transition could have a negative effect on our financial condition.

We may be unable to obtain the consents, approvals and authorizations of third parties necessary to successfully implement the Transition.

In connection with the Transition, we will need the consent, approval or authorization of certain of our lenders, the lessors of our currently-leased healthcare properties and appropriate governmental entities, as well as other third parties, as applicable. We make no assurances that these consents, approvals or authorizations will be obtained, or obtained on a timely basis. Failure to obtain these consents, approvals or authorizations, or failure to obtain them on a timely basis, will hinder our ability to effect the Transition and could have a negative effect on our financial condition.

Economic conditions and turbulence in the credit markets may create challenges in securing third-party borrowings or refinancing our existing indebtedness, which may prevent us from successfully implementing the Transition.

Depressed economic conditions, the availability and cost of credit, turmoil in the mortgage market and depressed real estate markets have in the past contributed, and will in the future contribute, to increased volatility and diminished expectations for real estate markets and the economy as a whole. Significant market disruption and volatility could impact our ability to secure third-party borrowings or refinance our existing indebtedness, which may prevent us from successfully implementing the Transition.

We rely on external sources of capital to fund future capital needs, and if we encounter difficulty in obtaining such capital, we may not be able to make future investments necessary to grow our business or meet maturing commitments.

We rely on external sources of capital, including debt and equity financing. If we are unable to obtain needed capital at all or only on unfavorable terms from these sources, we might not be able to make the investments needed to grow our business or to meet our obligations and commitments as they mature. Our access to capital depends upon a number of factors over which we have little or no control, including the performance of the national and global economies generally; competition in the healthcare industry; issues facing the healthcare industry, including regulations and government reimbursement policies; our operators' operating costs; the market's perception of our growth potential; the market value of our properties; our current and potential future earnings and cash dividends; and the market price of the shares of our capital stock. While we currently have sufficient cash flow from operations to fund our obligations and commitments, we may not be in a position to take advantage of future investment opportunities if we are unable to access capital markets on a timely basis or are only able to obtain financing on unfavorable terms.

Our ability to raise capital through equity sales is dependent, in part, on the market price of the common stock, and our failure to meet market expectations with respect to our business could negatively impact the market price of the common stock and availability of equity capital.

As with other publicly-traded companies, the availability of equity capital will depend, in part, on the market price of the common stock, which, in turn, will depend upon various market conditions and other factors that may change from time to time, including:

- the extent of investor interest;
- our financial performance and that of our operators;
- general stock and bond market conditions; and
- other factors such as governmental regulatory action.

We are subject to risks associated with debt financing, which would negatively impact our business and limit our ability to pay dividends to our shareholders and to repay maturing indebtedness.

The financing required to make future investments and satisfy maturing commitments may be provided by borrowings under our credit facilities, private or public offerings of debt or equity, the assumption of secured indebtedness, or mortgage financing on a portion of our owned portfolio. To the extent we must obtain debt financing from external sources to fund our capital requirements, no assurance is given that such financing will be available on favorable terms, if at all. In addition, if we are unable to refinance or extend principal payments due at maturity or pay them with proceeds from other capital transactions, our cash flow may not be sufficient to pay dividends to our shareholders and repay our maturing indebtedness. Furthermore, if we have to pay higher interest rates in connection with a refinancing, the interest expense relating to that refinanced indebtedness would increase, which could reduce our profitability . Moreover, additional debt financing increases the amount of our leverage. The degree of leverage could have important consequences to our shareholders, including affecting our ability to obtain additional financing in the future, and making us more vulnerable to a downturn in our results of operations or the economy generally.

Unforeseen costs associated with the acquisition of new healthcare properties could reduce our profitability.

Our business strategy contemplates future acquisitions that may not prove to be successful. For example, we might encounter unanticipated difficulties and expenditures relating to our acquired healthcare properties, including contingent liabilities, or our newly acquired healthcare properties might require significant management attention that would otherwise be devoted to our ongoing business. Such costs may negatively affect our results of operations.

We may not be able to adapt our management and operational systems to integrate and manage our growth without additional expense.

No assurance is given that we will be able to adapt our management, administrative, accounting and other systems to integrate the long-term care facilities that we may acquire. Our failure to timely integrate and manage future acquisitions or other developments could have a material adverse effect on our results of operations and financial condition.

We may be subject to additional risks in connection with the long-term care facilities that we own or may acquire.

We may be subject to additional risks in connection with long-term care facilities that we own or may acquire, including the following:

- our lack of, or our limited, prior business experience with certain of the operators of the facilities we own or may acquire in the future;
- the facilities may underperform due to various factors, including unfavorable terms and conditions of the lease agreements, disruptions caused by the management of the operators of the facilities or changes in economic conditions impacting the facilities or the operators;
- diversion of our management’s attention away from other business concerns;
- exposure to any undisclosed or unknown potential liabilities relating to the facilities; and
- potential underinsured losses on the facilities.

Our assets may be subject to impairment charges.

We periodically, but not less than annually, evaluate our real estate investments and other assets for impairment indicators. The judgment regarding the existence of impairment indicators is based on factors such as market conditions, operator performance and legal structure. If we determine that a significant impairment has occurred, then we are required to make an adjustment to the net carrying value of the asset, which could have a material adverse effect on our results of operations and funds from operations in the period in which the write-off occurs.

We may not be able to sell certain long-term care facilities for their book value.

From time to time, we may close facilities and actively market such facilities for sale. To the extent we are unable to sell these properties for our book value, we may be required to take a non-cash impairment charge or loss on the sale, either of which would reduce our net income.

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

Our facilities sometimes require capital expenditures to address ongoing required maintenance and to make them attractive to residents. Physical characteristics of senior living facilities and rehabilitation centers are mandated by various governmental authorities; and changes in these regulations may require us to make significant expenditures. Our available financial resources may be insufficient to fund these expenditures.

Our indebtedness could adversely affect our financial condition.

We have a material amount of indebtedness, and we may increase our indebtedness in the future. Debt financing could have important consequences to our shareholders. For example, it could:

- increase our vulnerability to adverse changes in general economic, industry and competitive conditions;
- limit our ability to borrow additional funds for working capital, capital expenditures, acquisitions, debt service requirements, execution of our business plan or other general corporate purposes on satisfactory terms or at all;
- require us to dedicate a substantial portion of our cash flow from operations to make payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;
- limit our ability to make acquisitions or take advantage of business opportunities that may arise;
- expose us to fluctuations in interest rates to the extent our borrowings bear variable rates of interest;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate; and
- place us at a competitive disadvantage compared to our competitors that have less debt.

Covenants in the agreements evidencing our indebtedness limit our operational flexibility, and a covenant breach could materially adversely affect our operations.

The terms of our credit agreements and other agreements evidencing our indebtedness require us to comply with a number of customary financial and other covenants which may limit our management’s discretion by restricting our ability to, among other things, incur additional debt, redeem our capital stock, enter into certain transactions with affiliates, pay dividends and make other distributions, make investments and other restricted payments, and create liens. Any additional financing we may obtain could contain similar or more restrictive covenants. Our continued ability to incur indebtedness and conduct our operations is subject to compliance with these financial and other covenants. Breaches of these covenants could result in defaults under the instruments governing the applicable indebtedness in addition to any other indebtedness cross-defaulted against such instruments. Any such breach could materially adversely affect our business, results of operations and financial condition.

We are subject to particular risks associated with real estate ownership, which could result in unanticipated losses or expenses.

Our business is subject to many risks that are associated with the ownership of real estate. For example, if our operators do not renew their leases, then we may be unable to re-lease the long-term care facilities at favorable rental rates, if at all. Other risks that are associated with real estate acquisition and ownership include the following:

- general liability, property and casualty losses, some of which may be uninsured;
- the inability to purchase or sell our assets rapidly to respond to changing economic conditions, due to the illiquid nature of real estate and the real estate market;
- leases that are not renewed or are renewed at lower rental amounts at expiration;
- costs relating to maintenance and repair of our facilities and the need to make expenditures due to changes in governmental regulations, including the Americans with Disabilities Act;
- environmental hazards created by prior owners or occupants, existing tenants, mortgagors or other persons for which we may be liable;

- acts of God affecting our healthcare properties; and
- acts of terrorism affecting our healthcare properties.

Our real estate investments are relatively illiquid.

Real estate investments are relatively illiquid and generally cannot be sold quickly. In addition, all of our healthcare properties serve as collateral for our secured debt obligations and cannot be readily sold. Additional factors that are specific to our industry also tend to limit our ability to vary our portfolio promptly in response to changes in economic or other conditions. For example, all of our healthcare properties are “special purpose” properties that cannot be readily converted into general residential, retail or office use. In addition, transfers of operations of skilled nursing facilities, assisted living facilities and other healthcare facilities are subject to regulatory approvals not required for transfers of other types of commercial operations and other types of real estate. Thus, if the operation of any of our healthcare properties becomes unprofitable due to competition, age of improvements or other factors such that an operator becomes unable to meet its obligations to us, then the liquidation value of the property may be substantially less, particularly relative to the amount owing on any related mortgage loan, than would be the case if the property were readily adaptable to other uses. Furthermore, the receipt of liquidation proceeds or the replacement of an operator that has defaulted on its lease could be delayed by the approval process of any federal, state or local agency necessary for the transfer of the property or the replacement of the operator with a new operator licensed to manage the facility. In addition, certain significant expenditures associated with real estate investment, such as real estate taxes and maintenance costs, are generally not reduced when circumstances cause a reduction in income from the investment. Should such events occur, our income and cash flows from operations would be adversely affected.

As an owner with respect to real property, we may be exposed to possible environmental liabilities.

Under various federal, state and local environmental laws, ordinances and regulations, a current or previous owner of real property, such as us, may be liable in certain circumstances for the costs of investigation, removal or remediation of, or related releases of, certain hazardous or toxic substances at, under or disposed of in connection with such property, as well as certain other potential costs relating to hazardous or toxic substances, including government fines and damages for injuries to persons and adjacent property. Such laws often impose liability based on the owner’s knowledge of, or responsibility for, the presence or disposal of such substances. As a result, liability may be imposed on the owner in connection with the activities of an operator of the property. The cost of any required investigation, remediation, removal, fines or personal or property damages and the owner’s liability therefor could exceed the value of the property and the assets of the owner. In addition, the presence of such substances, or the failure to properly dispose of or remediate such substances, may adversely affect an operator’s ability to attract additional residents and our ability to sell or rent such property or to borrow using such property as collateral which, in turn, could negatively impact our revenues.

The industry in which we operate is highly competitive. Increasing investor interest in our sector and consolidation at the operator level could increase competition and reduce our profitability.

Our business is highly competitive, and we expect that it may become more competitive in the future. We compete for healthcare facility investments with other healthcare investors, many of which have greater resources and lower costs of capital than we do. Increased competition makes it more challenging for us to identify and successfully capitalize on opportunities that meet our business goals. If we cannot identify and purchase a sufficient number of healthcare facilities at favorable prices, or if we are unable to finance such acquisitions on commercially favorable terms, our business, results of operations and financial condition may be materially adversely affected. In addition, if our cost of capital should increase relative to the cost of capital of our competitors, the spread that we realize on our investments may decline if competitive pressures limit or prevent us from charging higher lease rates.

We may change our investment strategies and policies and capital structure.

The Board, without the approval of our shareholders, may alter our investment strategies and policies if it determines that a change is in our shareholders’ best interests. The methods of implementing our investment strategies and policies may vary as new investments and financing techniques are developed.

Our success depends, in part, on our ability to retain key personnel and our ability to attract or retain other qualified personnel.

Our future performance depends to a significant degree upon the continued contributions of our executive management team and other key employees. The loss of the services of our current executive management team could

have an adverse impact on our operations. In addition, our future success depends, in part, on our ability to attract, hire, train and retain other qualified

personnel. Competition for qualified employees is intense, and we compete for qualified employees with companies with greater financial resources. Our failure to successfully attract, hire, retain and train the people we need would significantly impede our ability to implement our business strategy.

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

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

In order to satisfy these capital needs, we intend to: (i) improve our operating results through a series of leasing and subleasing transactions with favorable terms and consistent and predictable cash flow; (ii) expand our borrowing arrangements with certain existing lenders; (iii) refinance current debt where possible to obtain more favorable terms; and (iv) raise capital through the issuance of debt or equity securities. We anticipate that these actions, if successful, will provide the opportunity for us to maintain liquidity on a short and long term basis, thereby permitting us to meet our operating and financing obligations for the next 12 months and provide for the continuance of our business strategy. However, there is no guarantee that such actions will be successful or that anticipated operating results will be achieved. We currently have limited borrowing availability under our existing revolving credit facilities. If the Company is unable to improve operating results, expand existing borrowing agreements, refinance current debt, the convertible promissory notes due are not converted into common stock and are required to be repaid by us in cash, or raise capital through the issuance of securities, then the Company may be required to restructure its outstanding indebtedness, implement further cost reduction initiatives, sell assets, or delay, modify, or abandon its transition plans.

There are no assurances with respect to our ability to pay dividends in the future.

We are a holding company, and we have no significant operations. We rely primarily on dividends and other distributions from our subsidiaries to us so we may, among other things, pay dividends on our capital stock, if and to the extent declared by the Board. The ability of our subsidiaries to pay dividends and make other distributions to us depends on their earnings and is restricted by the terms of certain agreements governing their indebtedness. If our subsidiaries are in default under such agreements, then they may not pay dividends or make other distributions to us. In addition, we may only pay dividends on our capital stock if we have funds legally available to pay dividends and such payment is not restricted or prohibited by law, the terms of any shares with higher priority with respect to dividends or any documents governing our indebtedness. We are restricted by Georgia law from paying dividends on our capital stock if we are not able to pay our debts as they become due in the normal course of business or if our total assets would be less than the sum of our total liabilities plus the amount that would be needed to satisfy the preferential rights upon dissolution of the shareholders whose preferential rights are superior. In addition, no cash dividends may be declared or paid on the common stock unless full cumulative dividends on our Series A Preferred Stock have been, or contemporaneously are, declared and paid, or declared and a sum sufficient for the payment thereof is set apart for payments, for all past dividend periods. In addition, future debt, contractual covenants or arrangements we or our subsidiaries enter into may restrict or prevent future dividend payments.

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

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

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

Relationships and Related Transactions, and Director Independence."

We believe that our affiliations with Mr. Brogdon, and other related parties have been, and will be, beneficial to us. Although we do not believe the potential conflicts have adversely affected, or will adversely affect, our business, others may

disagree with this position and litigation could ensue in the future. Our relationships with Mr. Brogdon and other related parties may give rise to litigation, nominations or proposals which could result in substantial costs to us, and a diversion of our resources and management's attention, whether or not any allegations made are substantiated.

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

As a public company, we are subject to the reporting requirements of the Securities Exchange Act of 1934 (the "Exchange Act") and the Sarbanes-Oxley Act of 2002 ("Sarbanes-Oxley Act"). The Exchange Act requires that we file annual, quarterly and current reports with respect to our business and financial condition. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal controls for financial reporting. We are required to document and test our internal control procedures in order to satisfy the requirements of Section 404 of the Sarbanes-Oxley Act, which requires annual management assessments of the effectiveness of our internal controls over financial reporting.

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

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

For the year ended December 31, 2014, for amounts attributable to the Company, we had a net loss of $13.6 million compared to a net loss of $12.6 million for the year ended December 31, 2013. We make no assurances that we will be able to operate profitably. As of December 31, 2014, we have a working capital deficit of approximately $12.9 million.

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

- leasing our currently-owned healthcare properties, and subleasing our currently-leased healthcare properties, on a triple net basis;
- reducing our financial leverage;
- renegotiating and restructuring certain of our other corporate level indebtedness to reduce the cost of capital;
- refinancing our facility level mortgage indebtedness with lower-cost financing guaranteed by HUD.

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

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

As of December 31, 2014, we had approximately $151.4 million in indebtedness, including current maturities and discontinued operations. We may also obtain additional short-term and long-term debt to meet future capital needs, subject to certain restrictions under our existing indebtedness, which would increase our total debt. Our substantial amount of debt could have negative consequences to our business. For example, it could:

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

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

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

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

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

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

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

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

- variations in our operating results;
- changes in our financial condition, performance and prospects;
- changes in general economic and market conditions;
- the departure of any of our key executive officers and directors;
- announcements by us or our competitors of significant acquisitions, strategic partnerships, or transactions;
- press releases or negative publicity relating to us or our competitors or relating to trends in health care;
- government action or regulation, including changes in federal, state, and local health-care regulations to which we are subject;
- the level and quality of securities analysts' coverage for our stock;
- changes in financial estimates or recommendations by securities analysts with respect to us or our competitors; and
- with respect to our common stock, future sales of our common stock.

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

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

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

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

Our directors and officers substantially control all major decisions.

Our directors and officers beneficially own approximately 19.2% of our outstanding common stock. Therefore, our directors and officers will be able to influence major corporate actions required to be voted on by shareholders, such as the election of directors, the amendment of our charter documents and the approval of significant corporate transactions such as mergers, reorganizations, sales of substantially all of our assets and liquidation. Furthermore, our directors will be able to make decisions affecting our capital structure, including decisions to issue additional capital stock, implement stock repurchase programs and incur indebtedness. This control may have the effect of deterring hostile takeovers, delaying or preventing changes in control or changes in management, or limiting the ability of our other shareholders to approve transactions that they may deem to be in their best interest.

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

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

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

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

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

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

Risks Related to the Operators of Our Facilities

Our financial position could be weakened and our ability to pay dividends to our shareholders and fulfill our obligations with respect to our indebtedness could be limited if any of the major operators of our long-term care facilities becomes unable to meet its obligations to us or fails to renew or extend its relationship with us as its lease terms expires, or if we become unable to lease or re-lease our facilities on economically favorable terms. We have no operational control over our operators. Adverse developments concerning our operators could arise due to a number of factors, including those listed below.

The bankruptcy, insolvency or financial deterioration of our operators 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 operator 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. 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, assisted living facilities and other healthcare 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.

Although each of our lease agreements typically provides us with or will provide us with, the right to terminate, evict an operator, foreclose on our collateral, demand immediate payment and exercise other remedies upon the bankruptcy or insolvency of an operator, the U.S. federal Bankruptcy 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 operator. A bankruptcy filing by one of our lessee operators would typically prevent us from collecting unpaid pre-bankruptcy rents or evicting the operator absent approval of the bankruptcy court. The Bankruptcy Code provides a lessee 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 lessee operator 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 lessee operator 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 operator'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 operator.

Several other factors could impact our rights under leases with bankrupt operators. First, the operator 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 an operator 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.

Failure by our operators 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 operators' costs of doing business and on the amount of reimbursement by both government and other third-party payors. The failure of any of our operators to comply with these laws, requirements and regulations could adversely affect its ability to meet its obligations to us.

- Healthcare Reform. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Healthcare Reform Law"), which were signed into law in March 2010, represent the most comprehensive change to healthcare benefits since the inception of the Medicare program in 1965

and affect 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 operators 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. The Center for Medicare and Medicaid Services ("CMS") has implemented a number of initiatives focused on the quality of care provided by nursing homes that could affect our operators. Any unsatisfactory rating of our operators under any rating system promulgated by the CMS could result in the loss of 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. Governmental agencies administering these laws and regulations regularly inspect facilities and investigate complaints. Failure to obtain any required licensure or certification, the loss or suspension of any required licensure or certification, 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 or certifications 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. Many of these complex laws raise issues that have not been clearly interpreted by the relevant governmental authorities and courts. 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 operators 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 an operator'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 an operator's ability to meet its obligations to us.
- Other Laws. Other federal, state and local laws and regulations affect how operators conduct their business. We cannot accurately predict the effect that the costs of complying with these laws may have on the revenues of our operators 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 operators or our business.

The impact of healthcare reform legislation on us and our operators cannot be accurately predicted.

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 operators or our business, the Healthcare Reform Law could result in decreases in payments to our operators, increase our operators' costs or otherwise adversely affect the financial condition of our operators, 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 operators 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.

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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, the President 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 operators 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 operators could result in a substantial reduction in the revenues and operating margins of our operators. 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 operators, 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 operators.

Government budget deficits could lead to a reduction in Medicare and Medicaid reimbursement.

Many states are focusing on the reduction of expenditures under their Medicaid programs, which may result in a reduction in reimbursement rates for our operators. These potential reductions could be compounded by the potential for federal cost-cutting efforts that could lead to reductions in reimbursement to our operators under both the Medicare and Medicaid programs. Reductions in Medicare and Medicaid reimbursement to our operators could reduce the cash flow of our operators and their ability to make rent payments to us. The need to control Medicaid expenditures may be exacerbated by the potential for increased enrollment in Medicaid due to unemployment and declines in family incomes. Because the Healthcare Reform Law allows states to increase the number of people who are eligible for Medicaid and simplifies enrollment in this program, Medicaid enrollment may significantly increase in the future. Since our operators' profit margins with respect to Medicaid patients are generally relatively low, more than modest reductions in Medicaid reimbursement and an increase in the number of Medicaid patients could place some operators in financial distress, which, in turn, could adversely affect us. If funding for Medicare or Medicaid is reduced, then it could have a material adverse effect on our operators' results of operations and financial condition, which could adversely affect their ability to meet their obligations to us.

We may be unable to find a replacement operator for one or more of our leased properties.

From time to time, we may need to find a replacement operator for one or more of our leased properties for a variety of reasons, including upon the expiration of the lease term or the occurrence of an operator default. During any period in which we are attempting to locate one or more replacement operators, there could be a decrease or cessation of rental payments on the applicable property or properties. No assurance is given that any of our current or future operators will elect to renew its leases with us upon expiration of the terms thereof. Similarly, no assurance is given that we will be able to locate a suitable replacement operator or, if we are successful in locating a replacement operator, that the rental payments from the new operator would not be significantly less than the existing rental payments. Our ability to locate a suitable replacement operator may be significantly delayed or limited by various state licensing, receivership, certificate of need or other laws, as well as by Medicare and Medicaid

change-of-ownership rules. We also may incur substantial additional expenses in connection with any such licensing, receivership or change-of-ownership proceedings. Any such delays, limitations and expenses could materially delay or impact our ability to collect rent, obtain possession of leased properties or otherwise exercise remedies for default.

A prolonged economic slowdown could adversely impact our operating income and earnings, as well as the results of operations of our operators, 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 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 operators to maintain occupancy rates, which could harm their financial condition. Any sustained period of increased payment delinquencies, foreclosures or losses by our operators under our leases could adversely affect our income from investments in our portfolio.

Certain third parties may not be able to satisfy their obligations to us or our operators due to uncertainty in the capital markets.

Interest rate fluctuations, financial market volatility or credit market disruptions could limit the ability of our operators to obtain credit to finance their businesses on acceptable terms, which could adversely affect their ability to satisfy their obligations to us. Similarly, if any of our other counterparties, such as banking institutions, title companies and escrow agents, experiences difficulty in accessing capital or other sources of funds or fails to remain viable, it could have an adverse effect on our business.

Our operators 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 healthcare industry, our operators 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 operators 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 operators 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. Insurance is not available to our operators 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 an operator's financial condition. If an operator is unable to obtain or maintain insurance coverage, if judgments are obtained in excess of the insurance coverage, if an operator is required to pay uninsured punitive damages, or if an operator is subject to an uninsurable government enforcement action, then such operator could be exposed to substantial additional liabilities. Such liabilities could adversely affect an operator'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 operators. Although we generally have no involvement in the services provided by our operators, and our standard lease agreements generally require (or will require) our operators 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 operators' insurance coverage, which would require us to make payments to cover any such judgment.

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

The long-term healthcare industry is highly competitive, and we expect that it will become more competitive in the future. Our operators 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 operators 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 operators 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 operators may encounter increased competition in the future that could limit their ability to attract 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 operators 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 operators 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.

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

Our properties are located in different states, with concentrations in Arkansas, Georgia, and Ohio. As a result of this concentration, the conditions of local economies and real estate markets, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our tenants' revenue, costs and results of operations, which may affect their ability to meet their obligations to us.

Item 1B. Unresolved Staff Comments

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

Item 2. Properties

Operating Facilities

As of December 31, 2014, we operated 32 facilities in six states with the operational capacity to serve approximately 3,605 residents. Of the facilities, we owned and operated 22 facilities, leased and operated six facilities, and managed four facilities.

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

	December 31,	
	2014	2013
Cumulative number of facilities	32	39
Cumulative number of operational beds	3,605	3,908

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State	Number of Operational Beds/Units	Number of Facilities Owned	Leased	Managed for Third Parties	Total
Arkansas	1,041	10	—	—	10
Georgia	1,376	3	5	1	9
North Carolina	106	1	—	—	1
Ohio	705	4	1	3	8
Oklahoma	197	2	—	—	2
South Carolina	180	2	—	—	2
Total	3,605	22	6	4	32
Facility Type					
Skilled Nursing	3,410	20	6	3	29
Assisted Living	112	2	—	—	2
Independent Living	83	—	—	1	1
Total	3,605	22	6	4	32

Leased and Subleased Facilities to Third-Party Operators

As of December 31, 2014, we have leased three owned and subleased five leased skilled nursing and rehabilitation facilities to local third-party operators in the states of Alabama and Georgia with the operational capacity of approximately 820 operational beds. These properties are leased and subleased on a triple net basis, meaning that the lessee (i.e., the new third-party operator of the property) is obligated under the lease or sublease, as applicable, for all liabilities of the property in respect to insurance, taxes and facility maintenance, as well as the lease or sublease payments, as applicable.

The following table provides summary information regarding the number of operational beds at our facilities leased and subleased to third-parties as of December 31:

	December 31, 2014	2013
Cumulative number of facilities leased and subleased to third-parties	8	3
Cumulative number of operational beds	820	252

State	Number of Operational Beds/Units	Number of Facilities Leased and Subleased to Third-Parties Owned	Leased	Total
Alabama	304	2	—	2
Georgia	516	1	5	6
Total	820	3	5	8

Corporate Office

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

Item 3. Legal Proceedings

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

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

On June 24, 2013, South Star Services, Inc. (“SSSI”), Troy Clanton and Rose Rabon (collectively, the “Plaintiffs”) filed a complaint in the District Court of Oklahoma County, State of Oklahoma against: (i) AdCare, certain of its wholly owned subsidiaries and Boyd P. Gentry, AdCare’s former Chief Executive Officer (collectively, the “AdCare Defendants”); (ii) Christopher Brogdon (a director of the Company, owner of greater than 5% of the outstanding commons stock and a former Chief Acquisition Officer of the Company) and his wife; and (iii) five entities controlled by Mr. and Mrs. Brogdon, which entities own five skilled-nursing facilities located in Oklahoma (the “Oklahoma Facilities”) that are managed by an AdCare subsidiary. The complaint alleges, with respect to the AdCare Defendants, that: (i) the AdCare Defendants tortuously interfered with contractual relations between the Plaintiffs and Mr. Brogdon, and with Plaintiffs’ prospective economic advantage, relating to SSSI’s right to manage the Oklahoma Facilities and seven other skilled-nursing facilities located in Oklahoma (collectively, the “Facilities”), respectively; (ii) the AdCare Defendants fraudulently induced the Plaintiffs to perform work and incur expenses with respect to the Facilities; and (iii) one of the AdCare subsidiaries which is an AdCare Defendant provided false and defamatory information to an Oklahoma regulatory authority regarding SSSI’s management of one of the Oklahoma Facilities. The complaint sought damages against the AdCare Defendants, including punitive damages, in an unspecified amount, as well as costs and expenses, including reasonable attorney fees. On March 7, 2014, the Plaintiffs filed an amended complaint in which they alleged additional facts regarding the alleged fraudulent inducement caused by Mr. and Mrs. Brogdon and the AdCare Defendants. On February 10, 2015, Plaintiffs and the defendants participated in a voluntary mediation in an attempt to resolve the case. Although the case did not settle at the mediation, Plaintiffs and defendants continued to negotiate over the following weeks and executed a settlement agreement on March 30, 2015 (the " Clanton Settlement Agreement") to settle all claims for a lump sum payment of $2,000,000. Under the Clanton Settlement Agreement, the Company is to pay $600,000 to the Plaintiffs with the balance thereof to be paid by two of the Company's insurance carriers. The Company and the other defendants in the matter deny all of the Plaintiff's claims and any wrongdoing but agreed to settle the matter to avoid the continued expense and unpredictability of litigation.

On October 2, 2013, the Company responded to certain letters received from Georgia Department of Community Health ("GDCH") in September 2013 requesting payment of past due provider fees totaling $1.2 million for certain nursing facilities for periods prior to the Company's operation of the facilities. The Company received a final determination from GDCH in April 2014 confirming the Company was responsible for the payment of approximately $0.1 million relating to these past due provider fees. The Company paid these past due provider fees in the second quarter of 2014.

On March 7, 2014 the Company responded to a letter received from the Ohio Attorney General ("OAG") dated February 25, 2014 demanding repayment of approximately $1.0 million as settlement for alleged improper Medicaid payments related to seven Ohio facilities affiliated with the Company. The OAG alleged that the Company had submitted improper Medicaid claims for independent laboratory services for glucose blood tests and capillary blood draws. The Company intends to defend itself against the claims. The Company has not recorded a liability for this matter because the liability, if any, and outcome cannot be determined at this time.

On October 30, 2014, the Company and the prior owner of a certain 118-bed skilled nursing facility located in Oklahoma City, Oklahoma entered into a confidential settlement agreement that resolved pending claims between the parties, including breach of contract and tort claims that had been asserted by the Company and\or its affiliates. As a result of the settlement, the Company has not recorded a reserve against any receivable that it contended might be owed.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

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

Market for Registrant's Common Equity

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

"ADK"		High	Low
2014	First Quarter	$4.67	$4.00
	Second Quarter	$4.70	$3.65
	Third Quarter	$5.05	$4.22
	Fourth Quarter	$4.77	$3.58
2013	First Quarter	$5.12	$3.66
	Second Quarter	$6.26	$3.85
	Third Quarter	$4.98	$3.82
	Fourth Quarter	$4.50	$3.62

Based on information supplied from our transfer agent, there were approximately 2,053 shareholders of record of our common stock as of March 27, 2015.

We have never paid any cash dividends with respect to our common stock. Our ability to pay dividends will depend upon our future earnings and net worth. We are restricted by Georgia law from paying dividends on the common stock if we are not able to pay our debts as they become due in the normal course of business or if our total assets would be less than the sum of our total liabilities plus the amount that would be needed to satisfy the preferential rights upon dissolution of the shareholders whose preferential rights are superior. In addition, no cash dividends may be declared or paid on our common stock unless full cumulative dividends on our Series A Preferred Stock have been, or contemporaneously are, declared and paid, or declared and a sum sufficient for the payment thereof is set apart for payments, for all past dividend periods.

Equity Compensation Plan Information

The following table sets forth additional information as of December 31, 2014, concerning shares of our common stock that may be issued upon the exercise of options and other rights under our existing equity compensation plans and arrangements, divided between plans approved by our shareholders and plans or arrangements not submitted to the shareholders for approval. The information includes the number of shares covered by and the weighted average exercise price of, outstanding options and other rights and the number of shares remaining available for future grants excluding the shares to be issued upon exercise of outstanding options, warrants, and other rights.

Plan Category	(a) Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights	(b) Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	(c) Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a))
Equity compensation plans approved by security holders[1]	934,594	$4.91	471,526
Equity compensation plans not approved by security holders[2]	2,716,332	$3.45	—

Total	3,650,926	$3.82	471,526

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

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

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- On November 16, 2007, we issued to our Board of Directors, as partial consideration for serving on our Board, ten-year warrants to purchase 649,000 shares of our common stock at exercise prices ranging from $1.21 to $4.00. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. During 2014, 4,630 warrants were exercised. As a result, the warrants now represent the right to purchase 746,670 shares at exercise prices ranging from $1.04 to $3.43 per share.
- On November 16, 2007, we issued to members of our management team, as incentive compensation, ten year warrants to purchase 83,275 shares of our common stock at exercise prices ranging from $1.21 to $4.00. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrants now represent the right to purchase 96,401 shares at exercise prices ranging from $1.04 to $3.43 per share.
- On September 24, 2009, we issued to Christopher Brogdon, as inducement to become our Chief Acquisition Officer, an eight-year warrant to purchase 300,000 shares of our common stock at exercise prices ranging from $3.00 to $5.00. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2010, October 2011, and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 347,288 shares at exercise prices ranging from $2.59 to $4.32 per share.
- On May 2, 2011, we issued to Noble Financial, as partial consideration for providing certain financing to the Company, a five-year warrant to purchase 50,000 shares of our common stock at an exercise price of $4.50. This warrant was subject to certain anti-dilution adjustments, and, therefore, was adjusted in October 2011 and October 2012 for a 5% stock dividend in each year. As a result, the warrant now represents the right to purchase 55,125 shares at an exercise price of $4.08 per share.
- On December 19, 2011, we issued to David Rubenstein, as inducement to become our Chief Operating Officer, a ten-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.13, and a ten-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.97. These warrants were subject to certain anti-dilution adjustments, and, therefore, were adjusted in October 2012 for a 5% stock dividend. In accordance with Mr. Rubenstein's Separation Agreement, the unvested portion of his warrants was forfeited as of December 31, 2014 (see Part III, Item 11. "Executive Compensation - Employment Agreements - "David Rubenstein"). As a result, the warrants now represent the right to purchase 105,000 shares at an exercise price of $3.93 per share and 69,993 shares at an exercise price of $4.58 per share.
- On March 30, 2012, we issued to Cantone Asset Management LLC, as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 300,000 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti dilution adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 315,000 shares at an exercise price of $3.81 per share. This warrant was exercised in March 2015.
- On April 1, 2012, we issued to Strome Alpha Offshore Ltd., as partial consideration for providing certain financing to the Company, a three-year warrant to purchase 312,500 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti-dilution, adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. On September 3, 2014, 200,000 of these shares were exercised. As a result, the warrant now represents the right to purchase 128,125 shares at an exercise price of $3.81 per share. This warrant was exercised in March 2015.
- On July 2, 2012, we issued to Cantone Research, Inc., as partial consideration for serving as placement agent for the sale of certain promissory notes of the Company, a three-year warrant to purchase 100,000 shares of our common stock at an exercise price of $4.00. This warrant is subject to certain anti-dilution adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 105,000 shares at an exercise price of $3.81 per share.
- On August 31, 2012, we issued to an investor relations firm, as partial consideration for providing certain investor relations services to the Company, a three-year warrant to purchase 15,000 shares of our common stock at an exercise price of $4.59. This warrant is subject to certain anti-dilution adjustments, and, therefore, was adjusted on October 22, 2012 for a 5% stock dividend. As a result, the warrant now represents the right to purchase 15,750 shares at an

exercise price of $4.37 per share.

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- On December 28, 2012, we issued to Strome Alpha Offshore, Ltd., as partial consideration for providing certain financing to the Company, a ten-year warrant to purchase 50,000 shares of our common stock at an exercise price of $3.80. This warrant is subject to certain anti-dilution adjustments.
- On May 15, 2013, we issued to Ronald W. Fleming, as an inducement to become our Chief Financial Officer, a ten-year warrant to purchase 70,000 shares of our common stock at an exercise price of $5.90, which vests as to one-third of the underlying shares on each of the successive three anniversaries of the issue date. On October 8, 2014, Mr. Fleming left the Company and forfeited the unvested portion of his warrant. As a result, the warrant now represents the right to purchase 23,333 shares at an exercise price of $5.90 per share.
- On October 26, 2013 we issued to Cantone Research, Inc., as partial consideration for providing certain financing to the Company, a two-year warrant to purchase 75,000 shares of our common stock at an exercise price of $3.96 per share.
- On November 26, 2013, we issued to an investor relations firm, as partial consideration for providing certain investor relations services to the Company, a ten-year warrant to purchase 10,000 shares of our common stock at an exercise price of $3.96.
- On March 28, 2014, we issued to the placement agents in the Company’s offering of the 2014 Notes, as partial compensation for serving as placement agents in such offering, five-year warrants to purchase an aggregate of 48,889 shares of common stock at an exercise price of $4.50 per share.
- On July 1, 2014, David Tenwick, Director, sold an aggregate total of 218,946 fully vested and unexercised warrants for a total sale price of $328,419 to Park City Capital Offshore Master, Ltd., an affiliate of Director Michael J. Fox.
- On October 10, 2014, we issued to William McBride III, as an inducement to become our Chief Executive Officer, a ten-year warrant to purchase 300,000 shares of our common stock at an exercise price of $4.49, which vests as to one-third of the underlying shares on each of the successive three anniversaries of the issue date.
- On December 23, 2014, we issued to Knaup Business Advisors, LLC, as partial consideration for providing certain professional services to the Company, a five-year warrant to purchase 224,758 shares of our common stock at an exercise price of $4.04.

Issuance of Unregistered Securities

See Part II, Item 9B. Other Information - "Issuance of Other Unregistered Securities” of this Annual Report for a description of unregistered securities issuances.

Item 6. Selected Financial Data

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

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

Overview

We own, operate and manage for third-parties skilled nursing facilities and assisted living facilities in the states of Arkansas, Georgia, North Carolina, Ohio, Oklahoma, and South Carolina. As of December 31, 2014, we operate or manage 32 facilities, consisting of 29 skilled nursing facilities, two assisted living facilities and one independent living/senior housing facility totaling approximately 3,600 beds. Our facilities provide a range of health care services to their patients and residents including, but not limited to, skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term residents and short-stay patients. As of December 31, 2014, of the total 32 facilities operated, we owned and operated 22 facilities, leased and operated six facilities, and managed four facilities for third-parties.

As of December 31, 2014, the Company also has leased three owned and subleased five leased skilled nursing and rehabilitation facilities to local third-party operators in the states of Alabama and Georgia. The patient care revenue, related cost of services, and facility rental expense prior to the commencement of subleasing are classified as discontinued operations.

On February 28, 2013, the Company completed the sale of the facility known as Lincoln Lodge Retirement Residence and used the proceeds to pay the principal balance of the mortgage note with respect to the facility of $1.9 million. The Company recognized a gain on the sale of approximately $0.1 million and cash proceeds, net of costs and debt payoff, of $0.6 million.

On June 11, 2013, the Company completed the sale of its former Springfield, Ohio corporate office building which was sold for the approximate net book value. The Company used the proceeds to pay off the principal balance of the mortgage note with respect to the building of approximately $0.1 million.

On June 12, 2013, the Company entered into two sublease agreements to exit the operations of two skilled nursing facilities located in Tybee Island, Georgia effective June 30, 2013. On December 18, 2013, a sales listing agreement was executed for the 105-bed assisted living facility located in Hoover, Alabama, which is owned by a consolidated variable interest entity. The two skilled nursing facilities located in Tybee Island, Georgia and the assisted living facility located in Hoover, Alabama are reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

On March 31, 2014, the Company entered into a representation agreement to sell a 102-bed skilled nursing facility located in Tulsa, Oklahoma, to exit the operations. On July 1, 2014, the Company entered into an agreement effective July 1, 2014 to sublease a 52-bed skilled nursing facility located in Thomasville, Georgia to a local nursing home operator. These two facilities are reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

On July 23, 2014, we announced that the Board had approved a strategic plan to transition the Company to a healthcare property holding and leasing company. Through a series of leasing and subleasing transactions, the Company is in the process of transitioning to third-parties the operations of the Company’s currently owned and operated and leased and operated healthcare facilities, which are principally skilled nursing facilities. In furtherance of this strategic plan, the Company is now focused on the ownership, acquisition and leasing of healthcare related properties.

On September 22, 2014, as part of its ongoing strategic plan, the Company entered into two separate lease agreements to lease two of its skilled nursing and rehabilitation facilities in Alabama to a local nursing home operator that commenced on December 1, 2014. These two facilities are reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

On September 30, 2014, the lease agreement to operate a 90-bed skilled nursing facility located in Cassville, Missouri expired. The Company elected not to renew the lease agreement consistent with its strategic plan to transition to a healthcare property holding and leasing company. This facility is reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

On October 22, 2014, the Company entered into separate sublease agreements that commenced on November 1, 2014 to sublease a 130-bed skilled nursing facility located in Dublin, Georgia and an 86-bed skilled nursing facility located in Lumber City, Georgia to a local nursing home operator. These two facilities are reported as discontinued operations (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

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On October 29, 2014 , the Company entered into separate agreements with third-party operators to: (i) lease one of our facilities; (ii) sublease three of our facilities; and (iii) sub-sublease one of our facilities. All of the facilities are located in Ohio and the leases and subleases will commence on the first day of the month after lessees' receipt of: (a) all licenses and other approvals from the State of Ohio to operate the facility; and (b) approval of the lease by HUD. The Company entered into additional leasing agreements subsequent to December 31, 2014. See Note 20 - Subsequent Events to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data" for details of the agreements.

Liquidity

We have access to various cash resources to offset our significant cash needs.

Sources of Liquidity

At December 31, 2014, we had $10.7 million in cash and cash equivalents as well as restricted cash and investments of $8.8 million. During 2015, we anticipate both access to and receipt of several sources of liquidity. At December 31, 2014, we have one facility and one office building held for sale, and one variable interest entity held for sale that we anticipate selling during 2015. We expect that the cash proceeds and the release of restricted cash will approximate the related obligations.

In January 2015, we entered into exclusive listing agreements on the two office buildings located in Roswell, Georgia that we also anticipate selling during 2015. We expect that the cash proceeds will exceed obligations by approximately $0.6 million.

We routinely have ongoing discussions with existing and potential new lenders to refinance current debt on a longer term basis and, in recent periods, have refinanced shorter term acquisition debt, including seller notes, with traditional longer term mortgage notes, some of which have been executed under government guaranteed lending programs. During 2015, we anticipate net proceeds for working capital of approximately $3.0 million on refinancing of existing debt, primarily in the second and third quarters of 2015.

In July 2014, we announced that the Board of Directors had approved a strategic plan to transition the Company to a healthcare property holding and leasing company. Through a series of leasing and subleasing transactions, the Company will transition to third-parties the operations of the Company’s currently owned and operated healthcare facilities, which are principally skilled nursing facilities. The Company is focused on the ownership, acquisition and leasing of healthcare related properties. We estimate cash flow from operations and other working capital changes of approximately $7.8 million for the year ending December 31, 2015.

We maintain certain revolving lines of credit for which we have limited remaining capacity and all of which are due in 2015. Given our transition out of healthcare operations, we do not anticipate any additional draws on these facilities.

Other liquidity sources include but to a lesser extent, the proceeds from the exercise of options and warrants.

Cash Requirements

At December 31, 2014, we had $151.4 million in indebtedness of which the current portion is $33.3 million. This current portion is comprised of the following components: i) convertible debt of approximately $14.0 million, ii) debt of held for sale entities of approximately $11.2 million, primarily senior debt - bond and mortgage indebtedness, and iii) remaining debt of approximately $8.1 million which includes revolver debt, senior debt - bonds, and senior debt - mortgage indebtedness. For a complete debt listing and facility detail, see Note 9, Notes Payable and Other Debt, to the Company’s consolidated financial statements in Part II, Item 8 of this Annual Report.

The convertible debt includes two subordinated convertible debt issuances. One was issued in 2012 (the “2012 Notes”) and has an outstanding principal amount of $7.5 million at December 31, 2014 with maturity on July 31, 2015. At any time on or after the six-month anniversary of the date of issuance of the 2012 Notes, the notes are convertible at the option of the holder into shares of the Company's common stock at a conversion price equal to $3.97 per share (adjusted for a 5% stock dividend paid on October 22, 2012, and subject to adjustment for stock dividends, stock splits, combination of shares, recapitalization and other similar events). The other was issued in 2014 (the “2014 Notes”) and has an outstanding principal amount of $6.5 million at December 31, 2014 with maturity on April 30, 2015. At any time on or after the date of issuance of the 2014 Notes, the notes are convertible at the option of the holder into shares of the common stock at an initial conversion price equal to $4.50 per share, subject to adjustment for stock dividends, stock splits, combination of shares, recapitalization and other similar

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events. While management cannot predict with certainty, we anticipate that some holders of the subordinated convertible notes may elect to convert their subordinated convertible notes into shares of common stock provided the common stock continues to trade above the applicable conversion price for such notes.

On March 31, 2015, the Company entered into subscription agreements with certain accredited investors pursuant to which the Company accepted subscriptions for an aggregate of $8.5 million in principal amount of the Company's 10% Convertible Subordinated Notes Due April 30, 2017 ("2015 Notes"). In connection therewith, the Company issued approximately $1.7 million in principal amount of 2015 Notes on March 31, 2015, and will issue 2015 Notes for the remaining principal amount of the accepted subscriptions on or before April 30, 2015, upon receipt of payment thereof.

The current debt maturing in 2015 for all other debt approximates $8.1 million . As indicated previously, we routinely have ongoing discussions with existing and potential new lenders to refinance current debt on a longer term basis and, in recent periods, have refinanced shorter term acquisition debt, including seller notes, with traditional longer term mortgage notes, some of which have been executed under government guaranteed lending programs. We anticipate net principal disbursements of approximately $5.1 million which reflect the offset of anticipated proceeds on refinancing of approximately $3.0 million.

We anticipate our operating cash requirements as being substantially less than in 2014 due to the transition to a healthcare property holding and leasing company. Based on the described sources of liquidity and related cash requirements, we expect sufficient funds for our operations, scheduled debt service, and capital expenditures at least through the next 12 months. On a longer term basis, at December 31, 2014 we have approximately $74.4 million of debt maturities due between 2015 and 2017, excluding convertible promissory notes which are convertible into shares of the Company's common stock. We have been successful in recent years in raising new equity capital and believe, based on recent discussions that these markets will continue to be available to us for raising capital in 2015 and beyond. We believe our long-term liquidity needs will be satisfied by these same sources, as well as borrowings as required to refinance indebtedness.

In order to satisfy our capital needs, we seek to: (i) improve our operating results through a series of leasing and subleasing transactions with favorable terms and consistent and predictable cash flow; (ii) expand our borrowing arrangements with certain existing lenders; (iii) refinance current debt where possible to obtain more favorable terms; and (iv) raise capital through the issuance of debt or equity securities. We anticipate that these actions, if successful, will provide the opportunity for us to maintain liquidity on a short and long term basis, thereby permitting us to meet our operating and financing obligations for the next 12 months. However, there is no guarantee that such actions will be successful or that anticipated operating results will be achieved. We currently have limited borrowing availability under our existing revolving credit facilities. If the Company is unable to improve operating results, expand existing borrowing agreements, refinance current debt, the convertible promissory notes due July 31, 2015 are not converted into shares of the Company's common stock and are required to be repaid by us in cash, or raise capital through the issuance of securities, then the Company may be required to restructure its outstanding indebtedness, implement further cost reduction initiatives or sell assets.

Acquisitions

The Company had no acquisitions during the years ended December 31, 2014 or 2013.

Divestitures

On December 1, 2012, the Company entered into a sublease arrangement to exit the operations of a skilled nursing facility located in Jeffersonville, Georgia.

On June 12, 2013, the Company entered into two sublease agreements to exit the operations of two skilled nursing facilities located in Tybee Island, Georgia effective June 30, 2013.

On December 18, 2013, our consolidated variable interest entity entered into a sales listing agreement to sell a 105-bed assisted living facility owned by it located in Hoover, Alabama.

On March 31, 2014, the Company entered into a representation agreement to sell a 102-bed skilled nursing facility located in Tulsa, Oklahoma, to exit the operations.

On July 1, 2014, the Company entered into an agreement, effective July 1, 2014, to sublease a 52-bed skilled nursing facility located in Thomasville, Georgia to a local nursing home operator.

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On September 22, 2014, two wholly-owned subsidiaries of the Company entered into separate lease agreements to lease a 182-bed skilled nursing facility located in Attalla, Alabama and a 124-bed skilled nursing facility located in Glencoe, Alabama to a local nursing home operator. These leases commenced on December 1, 2014.

On September 30, 2014, the lease agreement to operate a 90-bed skilled nursing facility located in Cassville, Missouri expired. The Company elected not to renew the lease agreement consistent with its strategic plan to transition to a healthcare property holding and leasing company.

On October 22, 2014, two wholly-owned subsidiaries of the Company entered into separate sublease agreements that commenced on November 1, 2014, to sublease a 130-bed skilled nursing facility located in Dublin, Georgia and an 86-bed skilled nursing facility located in Lumber City, Georgia to a local nursing home operator.

The results of operations and cash flows for the Jeffersonville, Georgia skilled nursing facility, the two skilled nursing facilities in Tybee Island, Georgia, the assisted living facility in Hoover, Alabama, the skilled nursing facility in Tulsa, Oklahoma, the skilled nursing facility in Thomasville, Georgia, the two skilled nursing facilities in Attalla, Alabama and Glencoe, Alabama, the skilled nursing facility in Cassville, Missouri, and the two skilled nursing facilities in Dublin, Georgia and Lumber City, Georgia are reported as discontinued operations in the years ended December 31, 2014 and 2013.

The following table summarizes the activity of discontinued operations for the years ended December 31, 2014 and 2013:

(Amounts in 000’s)	December 31, 2014	December 31, 2013
Total revenues from discontinued operations	$32,282	$43,532
Net loss from discontinued operations	$(1,510)	$(1,255)
Interest expense, net from discontinued operations	$(1,049)	$(1,128)
Income tax benefit (expense) from discontinued operations	$253	$(33)
Loss on impairment from discontinued operations	$(1,782)	$(1,972)
Loss on disposal of assets from discontinued operations	$—	$(467)

Segments

Beginning in the fourth quarter of 2012, we only evaluate operating performance for our 29 skilled nursing facilities, our remaining two assisted living facilities and one independent living facility on a combined basis. Accordingly, management discussion and analysis on a segment basis is not included herein.

Primary Performance Indicators

We focus on two primary indicators in evaluating our financial performance. Those indicators are facility average occupancy and patient mix. Facility average occupancy is important as higher occupancy generally leads to higher revenues. In addition, concentrating on increasing the number of Medicare covered admissions ("the patient mix") helps in increasing revenues. We include commercial insurance covered admissions that are reimbursed at the same level as those covered by Medicare in our Medicare utilization percentages and analysis.

The tables below reflect our patient care revenue key performance indicators for our skilled nursing facilities ("SNF"), excluding discontinued operations, for the years ended December 31, 2014 and 2013 . Excluding discontinued operations, our assisted living facilities represent approximately 1.5% of our total consolidated revenues for the years ended December 31, 2014 and 2013.

SNF Average Occupancy

	Year Ended December 31,	
	2014	2013
SNF Average Occupancy	79.9 %	78.2 %

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SNF Patient Mix

	All Facilities			
	2014		2013	
Medicare	16.1	%	15.3	%
Medicaid	70.0	%	71.0	%
Other	13.9	%	13.7	%
Total	100.0	%	100.0	%

Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our SNFs under a prospective payment system ("PPS") for certain inpatient covered services. Under the PPS, facilities are paid a predetermined amount per patient, per day, based on the anticipated costs of treating patients. The amount to be paid is determined by classifying each patient into a resource utilization group ("RUG") category that is based upon each patient's acuity level. In October 2010, the number of RUG categories was expanded from 53 to 66 as part of the implementation of the RUGs IV system and the introduction of a revised and substantially expanded patient assessment tool called the Minimum Data Set, version 3.0. Should future changes in skilled nursing facility payments reduce rates or increase the standards for reaching certain reimbursement levels, our Medicare revenues could be reduced and/or our costs to provide those services could increase, with a corresponding adverse impact on our financial condition or results of operations.

On July 31, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA).

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimated that aggregate payments to skilled nursing facilities would increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase is attributable to a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% multi-factor productivity adjustment (MFP) as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. In its 2014 report to Congress, the Medicare Payment Advisory Commission recommended eliminating the market basket update and reducing payments through the SNF prospective payments system.

On July 27, 2012, CMS announced a final rule updating Medicare skilled nursing facility PPS payments in fiscal year 2013. The update, a 1.8% or $670 million increase, reflected a 2.5% market basket increase, reduced by a 0.7% MFP adjustment mandated by the PPACA. This increase was offset by the 2% sequestration reduction, which became effective April 1, 2013.

On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014, which averted a 24% cut in Medicare payments to physicians and other Part B providers until March 31, 2015. In addition, this law maintains the 0.5% update for such services through December 31, 2014 and provides a 0.0% update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015. Among other things, this law provides the framework for implementation of a value-based purchasing program for skilled nursing facilities. Under this legislation HHS is required to develop by October 1, 2016 measures and performance standards regarding preventable hospital readmission from skilled nursing facilities. Beginning October 1, 2018, HHS will withhold 2% of Medicare payments to all skilled nursing facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

The Middle Class Tax Relief and Job Creation Act of 2012 was signed into law on February 22, 2012, extending the Medicare Part B outpatient therapy cap exceptions process through December 31, 2012. The statutory Medicare Part B outpatient therapy cap for occupational therapy ("OT") was $1,880 for 2012, and the combined cap for physical therapy ("PT") and speech-language pathology services ("SLP") was also $1,880 for 2012. This is the annual per beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. All therapy

services rendered above the $3,700 amount are subject to manual medical review and may be denied unless pre-approved by the provider's Medicare Administrative Contractor. The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning October 1, 2012, some therapy providers may submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the $3,700 threshold) to avoid denial of claims for services above the threshold amount. The $3,700 figure is the defined threshold that triggers the provision for an exception request. Prior to October 1, 2012, there was no provision for an exception request when the threshold was exceeded.

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On January 2, 2013, the President signed the American Taxpayer Relief Act of 2012 into law. This statute creates a Commission of Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of recommendations from this commission may have an impact on coverage and payment for our services.

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

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

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

Average occupancy and reimbursement rates at the Company’s skilled nursing facilities for the years ended December 31, 2014 and 2013 were as follows:

SNF Analysis by State For the Year Ended December 31, 2014:

State	Operational Beds at Period End[1]	Period's Average Operational Beds	Occupancy (Operational Beds)	Medicare Utilization (Skilled %ADC)[2]	2014 Total Revenues	Medicare (Skilled) $PPD	Medicaid $PPD[3]
Arkansas	1,009	1,009	67.9 %	18.2 %	$57,246	$477.42	$164.35
Georgia	1,115	1,115	90.7 %	14.8 %	$79,586	$456.85	$161.38
North Carolina	106	106	68.3 %	18.4 %	$6,218	$453.29	$162.46
Ohio	293	293	84.3 %	14.5 %	$20,617	$440.52	$164.57
Oklahoma	197	197	73.5 %	18.8 %	$11,252	$457.56	$144.68
South Carolina	180	180	87.9 %	13.7 %	$12,139	$437.17	$164.06
Total	2,900	2,900	79.9 %	16.1 %	$187,058	$460.93	$161.88

[1] Excludes managed beds which are not consolidated

[2] ADC is the Average Daily Census

[3] PPD is the Per Patient Day equivalent

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

State	Operational Beds at Period End[1]	Period's Average Operational Beds	Occupancy (Operational Beds)	Medicare Utilization (Skilled %ADC)[2]	2013 Total Revenues	Medicare (Skilled) $PPD	Medicaid $PPD[3]
Arkansas	1,009	1,009	62.3 %	16.6 %	$51,447	$446.41	$168.33
Georgia	1,115	1,115	92.4 %	15.1 %	$80,818	$461.45	$158.77
North Carolina	106	106	72.5 %	16.0 %	$6,368	$455.11	$163.83
Ohio	293	293	83.1 %	14.3 %	$20,219	$430.79	$167.24
Oklahoma	197	197	72.0 %	14.1 %	$10,084	$433.98	$142.60
South Carolina	180	180	82.4 %	14.4 %	$11,010	$410.31	$158.85
Total	2,900	2,900	78.2 %	15.3 %	$179,946	$448.93	$161.45

[1] Excludes managed beds which are not consolidated
[2] ADC is the Average Daily Census
[3] PPD is the Per Patient Day equivalent

Critical Accounting Policies

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

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

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

We have evaluated and concluded that as of December 31, 2014, we have one relationship with a variable interest entity in which we have determined that we are the primary beneficiary required to consolidate the entity (see Note 15 - Variable Interest Entity to our consolidated financial statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

Revenue Recognition

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

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Revenue from the Medicaid and Medicare programs accounted for 84% of our revenue for each of the years ended December 31, 2014 and 2013. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. We recorded retroactive adjustments to revenue which were not material to our consolidated revenue for the years ended December 31, 2014 and 2013.

The Company, as lessor, makes a determination with respect to each of its leases whether they should be accounted for as operating leases. The Company recognizes rental revenues on a straight-line basis over the term of the lease when collectibility is reasonably assured. Differences between rental income earned and amounts due under the lease are charged or credited, as applicable, to straight-line rent receivable, net. Payments received under operating leases are accounted for in the statements of operations as rental revenue for actual rent collected plus or minus a straight-line adjustment for estimated minimum lease escalators.

Accounts Receivable and Allowance for Doubtful Accounts

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

Accounts receivable are reported net of allowances for doubtful accounts. The administrators and managers of our facilities evaluate the collectibility of accounts; Corporate management reviews the adequacy of the allowance for doubtful accounts on a monthly basis, and adjustments are made if necessary.

Asset Impairment

The Company reviews the carrying value of long-lived assets that are held and used in our operations for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operations to which the assets relate, utilizing management’s best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. We estimate the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has identified asset impairment during the years ended December 31, 2014 and 2013.

The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a facility below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. For the year ended December 31, 2013, the Company recognized a goodwill impairment charge of approximately $0.8 million on a facility located in Tulsa, Oklahoma acquired in 2012 which is reflected in loss from discontinued operations. The impairment charge was a result of the required goodwill impairment test that requires the goodwill to be written down to the estimate of the implied fair value (see Note 6 - Intangible Assets and Goodwill to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data.").

The Company's asset impairment analysis is consistent with the fair value measurements described in ASC Topic 820, Fair Value Measurements and Disclosures. For the year ended December 31, 2013, the Company recognized a $0.5 million impairment charge to write down the carrying value of certain lease rights, equipment, and leasehold improvement values of a facility located in Thomasville, Georgia and an impairment charge of $0.7 million to write down the carrying value of certain lease rights, equipment, and leasehold improvement values related to two facilities located in Tybee Island, Georgia. During the year ended December 31, 2014, the Company recorded an impairment of

$1.8 million related to an adjustment to the fair value less the cost to sell the 102-bed nursing facility located in Tulsa, Oklahoma (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data"). The impairment charge represents a change in fair value from the carrying value.

Self-Insurance Accruals

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Effective October 1, 2012, the Company is self-insured for employee medical claims (in all states except for Oklahoma, where the Company participates in the Oklahoma state subsidy program) and has a large deductible workers' compensation plan (in all states except for Ohio, where workers' compensation is covered under a premium-only policy provided by the Ohio Bureau of Worker's Compensation, a state funded program required by Ohio's monopolistic workers' compensation system). Determining reserves for healthcare losses and costs that we have incurred as of the end of a reporting period involves significant judgments based upon our experience and our expectations of future events, including projected settlements for pending claims, known incidents which we expect may result in claims, estimates of incurred but not yet reported claims, expected changes in premiums for insurance provided by insurers whose policies provide for retroactive adjustments, estimated litigation costs and other factors. Since these reserves are based on estimates, the actual expenses we incur may differ from the amount reserved. We regularly adjust these estimates to reflect changes in the foregoing factors, our actual claims experience, recommendations from our professional consultants, changes in market conditions and other factors; it is possible that such adjustments may be material.

Business Combinations

The Company follows FASB Accounting Standards Codification (“ASC”) Topic 805, Business Combinations ("ASC 805"), which establishes principles and requirements for how an acquirer recognizes and measures in its financial statements the identifiable assets acquired, the liabilities assumed, any non-controlling interest in the acquiree as well as the goodwill acquired or gain recognized in a bargain purchase. The guidance also establishes disclosure requirements to enable the evaluation of the nature and financial effects of the business combination. The Company incurred acquisition costs of approximately $0.6 million during the year ended December 31, 2013 and no acquisition costs during the year ended December 31, 2014 as discussed in Note 10 - Acquisitions of the Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data." ASC 805 requires that we make certain valuations to determine the fair value of assets acquired and the liabilities assumed. Such valuations require us to make significant estimates, judgments and assumptions, including projections of future events and operating performance.

Stock-Based Compensation

The Company follows the provisions of ASC Topic 718, “Compensation - Stock Compensation” ("ASC 718"), previously referred to as Statement of Financial Accounting Standards No. 123R - Share-based Payments which requires the measurement and recognition of compensation expense for all share-based payment awards either modified or granted to employees and directors based upon estimated fair values. The Black-Scholes-Merton option-pricing model, consistent with the provisions of ASC 718, was used to determine the fair value of each option granted. Option valuation models require the input of highly subjective assumptions, including the expected stock price volatility. The Company uses projected volatility rates, which are based upon historical volatility rates, trended into future years. Because the Company's stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in management’s opinion, the existing models do not necessarily provide a reliable single measure of the fair value of our options.

Income Taxes

As required by ASC Topic 740, Income Taxes ("ASC 740"), the Company establishes deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. We generally expect to fully utilize our deferred tax assets; however, when necessary, we record a valuation allowance to reduce our net deferred tax assets to the amount that is more likely than not to be realized. At December 31, 2014, the Company has a valuation allowance of approximately $16.7 million. In future periods, we will continue to assess the need for and adequacy of the remaining valuation allowance. We follow the relevant ASC 740 guidance when accounting for uncertainty in income taxes. The guidance provides information and procedures for financial statement recognition and measurement of tax positions taken, or expected to be taken, in tax returns.

In determining the need for a valuation allowance, the annual income tax rate, or the need for and magnitude of liabilities for uncertain tax positions, we make certain estimates and assumptions. These estimates and assumptions

are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with our estimates and assumptions, actual results could differ.

In early 2014, the Internal Revenue Service ("IRS") initiated an examination of the Company's income tax return for the 2011 income tax year. On May 7, 2014, the IRS completed and closed the examination and no changes were required to the Company's 2011 income tax return.

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In October 2014, the Georgia Department of Revenue ("GDOR") initiated an examination of the Company's Georgia income tax returns and net worth returns for the 2010, 2011, 2012, and 2013 tax years. To date, the GDOR has not proposed any adjustments.

The Company is not currently under examination by any other major income tax jurisdiction.

Recently Issued Accounting Pronouncements

The information required by this Item is provided in Note 1 - Summary of Significant Accounting Policies to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data."

Results of Operations

Year Ended December 31, 2014 and 2013

Continuing Operations:

The following table sets forth, for the periods indicated, statement of operations items and the amount and percentage of change of these items. The results of operations for any particular period are not necessarily indicative of results for any future period. The following data should be read in conjunction with our consolidated financial statements and the notes thereto, which are included herein.

	Year Ended December 31,		Increase (Decrease)	
(Amounts in 000's)	2014	2013	Amount	Percent
Revenues:				
Patient care revenues	$189,989	$182,777	$7,212	4 %
Management revenues	1,493	2,097	(604)	(29)%
Rental revenues	1,832	876	956	109 %
Total revenues	193,314	185,750	7,564	4 %
Expenses:				
Cost of services (exclusive of facility rent, depreciation and amortization)	159.434	152.577	6.857	4 %
General and administrative expenses	15,541	19,032	(3,491)	(18)%
Audit committee investigation expense	—	2,386	(2,386)	(100)%
Facility rent expense	7,080	6,314	766	12 %
Depreciation and amortization	7,300	6,918	382	6 %
Salary retirement and continuation costs	2,636	154	2,482	1,612 %
Total expenses	191,991	187,381	4,610	2 %
Income (loss) from Operations	1,323	(1,631)	2,954	181 %
Other Income (Expense):				
Interest expense, net	(10,780)	(12,351)	(1,571)	(13)%
Acquisition costs, net of gains	(8)	(565)	(557)	(99)%
Derivative gain	—	3,006	(3,006)	(100)%
Loss on extinguishment of debt	(1,803)	(109)	1,694	1,554 %
Loss on legal settlement	(600)	—	600	— %
Loss on disposal of assets	(7)	(10)	(3)	(30)%
Other expense	(888)	(306)	582	190 %
Total other expense, net	(14,086)	(10,335)	3,751	36 %
Loss from Continuing Operations Before Income Taxes:	(12,763)	(11,966)	797	7 %
Income Tax Expense:	(132)	(142)	10	7 %
Loss from Continuing Operations:	$(12,895)	$(12,108)	$787	6 %

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Year Ended December 31, 2014 Compared to Year Ended December 31, 2013:

Dollars in (000's), except for rate per patient day	2014	2013	Change	% Change
Total Facility Results:				
Patient care revenues	$189,989	$182,777	$7,212	3.9 %
Cost of services	$159,434	$152,577	$6,857	4.5 %
Number of facilities at period end [1]	28	35	(7)	(20.0)%
Actual patient days	883,932	863,562	20,370	2.4 %
Occupancy percentage — Operational beds	80.4 %	78.5 %	1.9 %	2.4 %
Skilled patient mix	16.1 %	15.3 %	0.8 %	5.2 %
Average Medicare reimbursement rate per patient day	$460.93	$448.93	$12.00	2.7 %
Medicaid patient mix	70.0 %	71.0 %	(1.0)%	(1.4)%
Average Medicaid reimbursement rate per patient day	$161.88	$161.45	$0.43	0.3 %

[1] Includes assisted living and skilled nursing facilities; excludes managed facilities.

Patient Care Revenues—Total patient care revenues increased by $7.2 million, or 4%, to $190.0 million for the year ended December 31, 2014, compared with $182.8 million for the year ended December 31, 2013. The $7.2 million increase is primarily due to an increase in skilled patient mix percentage from 15.3% to 16.1%, increases in average Medicare reimbursement rate per patient day from $448.93 to $460.93, or 2.7%, an increase in facility occupancy rate from 78.5% to 80.4%, and increases in average Medicaid reimbursement rates per patient day from $161.45 to $161.88, or 0.3%, compared to 2013.

Rental Revenues—Total rental revenue increased by $1.0 million , or 109% , to $1.8 million for the year ended December 31, 2014, compared with $0.9 million for the year ended December 31, 2013. The $1.0 million increase is primarily due to leasing three owned skilled nursing facilities and subleasing five leased skilled nursing facilities during 2014 compared with only subleased three skilled nursing facilities during 2013.

Management Revenues—Management revenues (net of eliminations) decreased by $0.6 million, or 29%. The decrease is primarily due to the discontinuance of a management agreement effective as of March 1, 2014 (see Note 19 - Related Party Transactions to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately)—Cost of services increased by $0.0 million, or 4%, in 2014 as compared with 2013. The increase in cost of services is primarily due to: (i) an increase of approximately $2.0 million in pharmacy and therapy expenses and an increase of approximately $0.7 million in nursing expenses due to increased occupancy and skilled patient mix; (ii) an increase of approximately $1.3 million in dietary, housekeeping and plant operations expenses; (iii) an increase of approximately $1.3 million in employee benefits; (iv) an increase of approximately $1.1 million in property, general liability and other insurance expenses; and (v) an increase of approximately $0.5 million in regulatory and other expenses. Cost of services as a percentage of patient care revenue were 0.1% at both December 31, 2014 and December 31, 2013.

General and Administrative—General and administrative costs decreased by $3.5 million to $15.5 million in 2014 from $19.0 million in 2013. The decrease is primarily due to the following: (i) a decrease in salaries, wages and employee benefits expenses of approximately $1.8 million due to the Company’s transition from an operator of skilled nursing and assisted living facilities to a healthcare property holding and leasing company; (ii) a decrease of approximately $0.6 million in accounting and auditing expenses; (iii) a decrease of approximately $0.4 million in board of director fees; (iv) a decrease of approximately $0.3 million in travel expenses; (v) a decrease of approximately $0.3 million in recruiting costs; and (vi) a decrease of approximately $0.1 million in contract services expense. As a percentage of total revenue, general and administrative costs declined to 8.0% in 2014 compared with 10.2% in 2013, reflecting continued strategies to reduce general and administrative costs and the Transition to a healthcare property holding and leasing company.

Audit Committee Investigation Expense—As previously disclosed, the Audit Committee of the Board of Directors (the "Audit Committee"), in consultation with management, concluded in March 2013 that: (i) the Company's previously issued financial statements for the quarters ended March 31, 2012, June 30, 2012 and September 30, 2012 (the "Relevant Financial Statements") should no longer be relied upon due to errors in the Relevant Financial Statements identified in connection with

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the audit of the Company's financial statements for the year ended December 31, 2012; and (ii) the Company would restate the Relevant Financial Statements. The Audit Committee initiated a further review of, and inquiry with respect to, the accounting and financial issues related to these and other potential errors and engaged counsel to assist the Audit Committee with such matters. The Audit Committee completed its inquiry in April 2013 and, in connection therewith, assisted in the correction of certain errors relating to accounting and financial matters and identified certain material weaknesses in the Company's internal control over financial reporting, including weakness in the Company's ability to appropriately account for complex or non-routine transactions and in the quality and sufficiency of the Company's finance and accounting resources. On July 8, 2013, the Company restated the Relevant Financial Statements by filing with the SEC amendments to its Quarterly Reports on Form 10-Q/A for the quarters ended March 31, 2012, June 30, 2012 and September 30, 2012.

In connection with the restatement process and the Audit Committee's review and inquiry during 2013, the Company incurred significant professional services costs and other expenses which have been recognized as a special charge totaling approximately $2.4 million for the year ending December 31, 2013. The Company did not incur any additional expenses during 2014 relating to the audit committee investigation.

Facility Rent Expense—Facility rent expense was approximately $7.1 million for 2014 compared with $6.3 million in 2013. The increase is due to the Company's transition from an operator of skilled nursing and assisted living facilities to a healthcare property holding and leasing company. The Company had three subleased facilities during 2013 that were included in discontinued operations.

Depreciation and Amortization—Depreciation and amortization increased by $0.4 million in 2014 compared with 2013. The increase is primarily due to the finalization of planned renovations at several skilled nursing facilities and the addition of fixed assets during 2014.

Salary Retirement and Continuation Costs—Salary Retirement and Continuation Costs increased by $2.5 million to $2.6 million for the year ended December 31, 2014, compared with $0.1 million for the same period in 2013. The Company incurred certain retirement and salary continuation costs related to the Transition of approximately $0.9 million, certain retirement and salary continuation costs related to a separation agreement with a former officer of the Company of approximately $0.9 million, salary continuation costs related to a separation agreement with an officer of the Company of approximately $0.4 million, and approximately $0.4 million related to the amendment to the consulting agreement with the Company's prior Vice Chairman during 2014.

Interest Expense, net—Interest expense, net decreased $1.6 million, or 13% , to $10.8 million for the year ended 2014 compared with $12.4 million for the same period in 2013. The decrease is primarily due to the following: (i) a decrease of approximately $0.9 million relating to the holders of the Company's subordinated convertible promissory notes due August 2014 converting approximately $4.8 million of principal and accrued and unpaid interest outstanding under such notes into shares of common stock; (ii) a decrease of approximately $0.4 million due to the Company's payment of the remaining outstanding principal amount of $4.0 million under the Company's subordinated convertible promissory notes due March 2014; (iii) a decrease of approximately $0.2 million relating to the repayment of the outstanding bonds on March 3, 2014 at par plus accrued interest in the amount of $3.1 million from funds that were previously deposited into a restricted defeased bonds escrow account; and (iv) a decrease of approximately $0.1 million relating to interest savings from the 2014 refinancings of certain senior debt guaranteed by HUD.

Acquisition Costs, Net of Gains—The Company incurred minimal expense for acquisition costs during 2014 compared with $0.6 million for 2013. The decrease is a result of limited acquisition activity and the Company's transition to a healthcare property holding and leasing company.

Derivative Gain—There was no derivative gain during 2014 compared to the gain of $3.0 million in 2013. The derivative is a product of a convertible debt instrument entered into during the third quarter of 2010. The expense associated with the derivative is subject to volatility based on a number of factors, including increases or decreases in our stock price. Increases in our stock price generally result in increases in expense. Conversely, a decrease in our stock price generally results in the recognition of a gain in our statements of operations. The expense or gain recognized in a period is based on the fair value of the derivative instrument at the end of the year in comparison to the beginning of the year. The Company amended the debt instruments in October 2013 to eliminate the derivative feature, among other items. Consequently, the fair value of the derivative instrument was eliminated as of October

2013.

Loss on Debt Extinguishment—Loss on extinguishment of debt increased by $1.7 million to $1.8 million for the year ended December 31, 2014, compared with the loss of $0.1 million for the same period in 2013. The $1.8 million loss is due to the difference between the conversion price and the market price on the date the subordinated convertible promissory notes were converted into shares of common stock during 2014.

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Loss on Legal Settlement—For the year ended December 31, 2014, loss on legal settlement was $0.6 million compared with no expense for the same period in 2013. This $0.6 million loss is due to the settlement of the claims filed in the District Court of Oklahoma County, State of Oklahoma on June 24, 2013. On March 30, 2015, a settlement agreement was executed to settle all claims for a lump sum payment of $2.0 million. Under the settlement agreement, the Company is to pay $0.6 million to the Plaintiffs with the balance thereof to be paid by two of the Company's insurance carriers. The Company and the other defendants in the matter deny all of the Plaintiff's claims and any wrongdoing but agreed to settle the matter to avoid the continued expense and unpredictability of litigation (for further information, see Part I, Item 3., "Legal Proceedings").

Other Expense—For the year ended December 31, 2014, other expense was $0.9 million compared with $0.3 million for the same period in 2013. In 2014, the Company incurred approximately $0.3 million of costs associated with the transition to a healthcare property and holding company and approximately $0.3 million of legal fees associated with on-going litigation matters.

Income Tax Expense—The Company recognized an income tax expense of approximately $0.1 million for both years ended December 31, 2014 and December 31, 2013.

Liquidity and Capital Resources

We have access to various cash resources to offset our significant cash needs.

Sources of Liquidity

At December 31, 2014, we had $10.7 million in cash and cash equivalents as well as restricted cash and investments of $8.8 million. During 2015, we anticipate both access to and receipt of several sources of liquidity. At December 31, 2014, we have one facility and one office building held for sale, and one variable interest entity held for sale that we anticipate selling during 2015. We expect that the cash proceeds and the release of restricted cash will approximate the related obligations.

In January 2015, we entered into exclusive listing agreements on the two office buildings located in Roswell, Georgia that we also anticipate selling during 2015. We expect that the cash proceeds will exceed obligations by approximately $0.6 million.

We routinely have ongoing discussions with existing and potential new lenders to refinance current debt on a longer term basis and, in recent periods, have refinanced shorter term acquisition debt, including seller notes, with traditional longer term mortgage notes, some of which have been executed under government guaranteed lending programs. During 2015, we anticipate net proceeds for working capital of approximately $3.0 million on refinancing of existing debt, primarily in the second and third quarters of 2015.

In July 2014, we announced that the Board of Directors had approved a strategic plan to transition the Company to a healthcare property holding and leasing company. Through a series of leasing and subleasing transactions, the Company will transition to third-parties the operations of the Company’s currently owned and operated healthcare facilities, which are principally skilled nursing facilities. The Company is focused on the ownership, acquisition and leasing of healthcare related properties. We estimate cash flow from operations and other working capital changes of approximately $7.8 million for the year ending December 31, 2015.

We maintain certain revolving lines of credit for which we have limited remaining capacity and all of which are due in 2015. Given our transition out of healthcare operations, we do not anticipate any additional draws on these facilities.

Other liquidity sources include but to a lesser extent, the proceeds from the exercise of options and warrants.

Cash Requirements

At December 31, 2014, we had $151.4 million in indebtedness of which the current portion is $33.3 million. This current portion is comprised of the following components: i) convertible debt of approximately $14.0 million, ii) debt of held for sale entities of approximately $11.2 million, primarily senior debt - bond and mortgage indebtedness, and iii) remaining debt of approximately $8.1 million which includes revolver debt, senior debt - bonds, and senior debt - mortgage indebtedness. For a complete debt listing and facility detail, see Note 9, Notes Payable and Other Debt, to the Company’s consolidated financial statements in Part II, Item 8 of this Annual Report.

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The convertible debt includes two subordinated convertible debt issuances. One was issued in 2012 (the “2012 Notes”) and has an outstanding principal amount of $7.5 million at December 31, 2014 with maturity on July 31, 2015. At any time on or after the six-month anniversary of the date of issuance of the 2012 Notes, the notes are convertible at the option of the holder into shares of the Company's common stock at a conversion price equal to $3.97 per share (adjusted for a 5% stock dividend paid on October 22, 2012, and subject to adjustment for stock dividends, stock splits, combination of shares, recapitalization and other similar events). The other was issued in 2014 (the “2014 Notes”) and has an outstanding principal amount of $6.5 million at December 31, 2014 with maturity on April 30, 2015. At any time on or after the date of issuance of the 2014 Notes, the notes are convertible at the option of the holder into shares of the common stock at an initial conversion price equal to $4.50 per share, subject to adjustment for stock dividends, stock splits, combination of shares, recapitalization and other similar events. While management cannot predict with certainty, we anticipate that some holders of the subordinated convertible notes may elect to convert their subordinated convertible notes into shares of common stock provided the common stock continues to trade above the applicable conversion price for such notes.

On March 31, 2015, the Company entered into subscription agreements with certain accredited investors pursuant to which the Company accepted subscriptions for an aggregate of $8.5 million in principal amount of the Company’s 10% Convertible Subordinated Notes Due April 30, 2017 ("2015 Notes"). In connection therewith, the Company issued approximately $1.7 million in principal amount of 2015 Notes on March 31, 2015, and will issue 2015 Notes for the remaining principal amount of the accepted subscriptions on or before April 30, 2015, upon receipt of payment thereof.

The current debt maturing in 2015 for all other debt approximates $8.1 million. As indicated previously, we routinely have ongoing discussions with existing and potential new lenders to refinance current debt on a longer term basis and, in recent periods, have refinanced shorter term acquisition debt, including seller notes, with traditional longer term mortgage notes, some of which have been executed under government guaranteed lending programs. We anticipate net principal disbursements of approximately $5.1 million which reflect the offset of anticipated proceeds on refinancing of approximately $3.0 million.

We anticipate our operating cash requirements as being substantially less than in 2014 due to the transition to a healthcare property holding and leasing company. Based on the described sources of liquidity and related cash requirements, we expect sufficient funds for our operations, scheduled debt service, and capital expenditures at least through the next 12 months. On a longer term basis, at December 31, 2014 we have approximately $74.4 million of debt maturities due between 2015 and 2017, excluding convertible promissory notes which are convertible into shares of the Company's common stock. We have been successful in recent years in raising new equity capital and believe, based on recent discussions that these markets will continue to be available to us for raising capital in 2015 and beyond. We believe our long-term liquidity needs will be satisfied by these same sources, as well as borrowings as required to refinance indebtedness.

In order to satisfy our capital needs, we seek to: (i) improve our operating results through a series of leasing and subleasing transactions with favorable terms and consistent and predictable cash flow; (ii) expand our borrowing arrangements with certain existing lenders; (iii) refinance current debt where possible to obtain more favorable terms; and (iv) raise capital through the issuance of debt or equity securities. We anticipate that these actions, if successful, will provide the opportunity for us to maintain liquidity on a short and long term basis, thereby permitting us to meet our operating and financing obligations for the next 12 months. However, there is no guarantee that such actions will be successful or that anticipated operating results will be achieved. We currently have limited borrowing availability under our existing revolving credit facilities. If the Company is unable to improve operating results, expand existing borrowing agreements, refinance current debt, the convertible promissory notes due July 31, 2015 are not converted into shares of the Company's common stock and are required to be repaid by us in cash, or raise capital through the issuance of securities, then the Company may be required to restructure its outstanding indebtedness, implement

further cost reduction initiatives or sell assets.

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

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	Year Ended December 31,	
Amounts in (000's)	2014	2013
Net cash (used in) provided by operating activities—continuing operations	$(6,383)	$825
Net cash provided by operating activities—discontinued operations	1,091	4,238
Net cash provided by (used in) investing activities—continuing operations	2,246	(7,391)
Net cash (used in) provided by investing activities—discontinued operations	(3,001)	4,268
Net cash (used in) provided by financing activities—continuing operations	(2,551)	7,181
Net cash used in financing activities—discontinued operations	(41)	(5,684)
Net Change in Cash	(8,639)	3,437
Cash, Beginning	19,374	15,937
Cash, Ending	$10,735	$19,374

Year Ended December 31, 2014

Net cash used in operating activities—continuing operations for the year ended December 31, 2014, was approximately $6.4 million consisting primarily of our income from operations less changes in working capital, and noncash charges (primarily depreciation and amortization, the derivative gain, share-based compensation, difference between straight-line rent and rent paid, and amortization of debt discounts and related deferred financing costs) all primarily the result of routine operating activity. Net cash provided by operating activities—discontinued operations was approximately $1.1 million.

Net cash provided by investing activities—continuing operations for the year ended December 31, 2014, was approximately $2.2 million. This is primarily the result of a decrease in restricted cash deposits while offset by capital expenditures throughout the facilities. Net cash used in investing activities—discontinued operations was approximately $3.0 million related to restricted cash changes and capital expenditures.

Net cash used in financing activities—continuing operations was approximately $2.6 million for the year ended December 31, 2014. This is primarily the result of cash proceeds received from additional debt borrowings, partially offset by repayments of existing debt obligations and payments of preferred stock dividends. Net cash used in financing activities—discontinued operations was approximately $0.04 million consisting of repayments of existing debt obligations.

Year Ended December 31, 2013

Net cash provided by operating activities—continuing operations for the year ended December 31, 2013, was $0.8 million consisting primarily of our loss from continuing operations less changes in working capital, and noncash charges (primarily depreciation and amortization, the derivative loss, share-based compensation, difference between straight-line rent and rent paid, and amortization of debt discounts and related deferred financing costs) all primarily the result of routine operating activity. Net cash provided by operating activities—discontinued operations was approximately $4.2 million consisting primarily of our loss from discontinued operations less changes in working capital, and noncash charges (primarily depreciation and amortization, loss on goodwill impairment, loss on disposal of assets, and bad debt expense) all primarily the result of routine operating activity.

Net cash used in investing activities—continuing operations for the year ended December 31, 2013, was approximately $7.4 million. This is primarily the result of additional restricted cash deposits and capital expenditures throughout the facilities offset by proceeds received from notes receivable. Net cash provided by investing activities—discontinued operations was approximately $4.3 million for the year ended December 31, 2013 related to proceeds from the sale of four of the six Ohio assisted living facilities.

Net cash provided by financing activities—continuing operations was approximately $7.2 million for the year ended December 31, 2013. This is primarily the result of cash proceeds received from preferred stock issuances, proceeds received from additional debt borrowings, partially offset by repayments of existing debt obligations and payments of preferred stock dividends. Net cash used in financing activities—discontinued operations was approximately $5.7 million consisting of repayments of existing debt obligations.

Notes Payable and Other Debt

Notes payable and other debt consists of the following:

	December 31,

Amounts in (000's)	2014	2013
Revolving credit facilities and lines of credit [a]	$6,832	$8,503
Senior debt—guaranteed by HUD	26,022	4,063
Senior debt—guaranteed by USDA	27,128	27,763
Senior debt—guaranteed by SBA	3,703	5,954
Senior debt - bonds, net of discount [b]	12,967	16,102
Senior debt - other mortgage indebtedness [c]	60,277	78,408
Other debt	430	625
Convertible debt issued in 2010, net of discount	—	6,930
Convertible debt issued in 2011	—	4,459
Convertible debt issued in 2012	7,500	7,500
Convertible debt issued in 2014	6,500	—
Total	151,359	160,307
Less current portion	22,113	26,154
Less: portion included in liabilities of disposal group held for sale [a],[c]	5,197	—
Less: portion included in liabilities of variable interest entity held for sale [b]	5,956	6,034
Notes payable and other debt, net of current portion	$118,093	$128,119

[a] The revolving credit facilities and lines of credit includes $0.2 million related to the outstanding loan entered into in conjunction with the acquisition of the Companions skilled nursing facility in August 2012.

[b] The senior debt - bonds, net of discount includes $6.0 million related to the Company's consolidated variable interest entity, Riverchase Village ADK, LLC, revenue bonds, in two series, issued by the Medical Clinical Board of the City of Hoover in the state of Alabama which AdCare has guaranteed the obligation under the bonds.

[c] The senior debt - other mortgage indebtedness includes $5.0 million related to the outstanding loan entered into in conjunction with the acquisition of Companions in August 2012.

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Scheduled Maturities

The schedule below summarizes the scheduled maturities as of December 31, 2014 for each of the next five years and thereafter. The 2015 maturities include $0.2 million and $5.0 million, respectively, related to the Companions Specialized Care Center ("Companions") outstanding loans classified as liabilities of disposal group held for sale and $6.0 million related to the Riverchase bonds classified as liabilities of a variable interest entity held for sale at December 31, 2014 (see Note 19 - Related Party Transactions to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

	Amounts in (000's)
2015	$33,440
2016	49,970
2017	4,966
2018	1,869
2019	1,966
Thereafter	59,541
Subtotal	151,752
Less: unamortized discounts ($174 classified as current)	(393)
Total notes and other debt	$151,359

Debt Covenant Compliance

As of December 31, 2014, the Company (including its consolidated variable interest entity) has approximately forty credit related instruments (credit facilities, mortgage notes, bonds and other credit obligations) outstanding that include various financial and administrative covenant requirements. Covenant requirements include, but are not limited to, fixed charge coverage ratios, debt service coverage ratios, minimum EBITDA or EBITDAR, current ratios and tangible net worth requirements. Certain financial covenant requirements are based on consolidated financial measurements whereas others are based on subsidiary level (i.e. facility, multiple facilities or a combination of subsidiaries comprising less than the Company's consolidated financial measurements). Some covenants are based on annual financial metric measurements whereas others are based on quarterly financial metric measurements. The Company routinely tracks and monitors its compliance with its covenant requirements. In recent periods, including as of December 31, 2014, the Company has not been in compliance with certain financial and administrative covenants. For each instance of such non-compliance, the Company has obtained waivers or amendments to such requirements including as necessary modifications to future covenant requirements or the elimination of certain requirements in future periods.

The table below indicates which of the Company's credit-related instruments are out of compliance as of December 31, 2014:

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Credit Facility	Balance at December 31, 2014 (000's)	Consolidated or Subsidiary Level Covenant Requirement	Financial Covenant	Measurement Period	Min/Max Financial Covenant Required	Financial Covenant Metric Achieved		Future Financial Covenant Metric Required	
Gemino Lines of Credit	$ 2,575	Consolidated	Fixed Charge Coverage Ratio (FCCR)	Quarterly	1.10	0.82	*	1.10	
PrivateBank - Line of Credit	$ 3,002	Subsidiary	Coverage of Rent and Debt Service	Quarterly	1.25	0.98	*	1.25	
		Consolidated	Maximum Leverage to EBITDA	Annual	11.00	11.03	*	11.00	
PrivateBank - Line of Credit - HUD	$ 1,059	Consolidated	Maximum Leverage to EBITDA	Annual	11.00	11.03	*	11.00	
Contemporary Healthcare Capital - Term Note and Line of Credit - CSCC Nursing, LLC	$ 197	Subsidiary	Minimum Implied Current Ratio	Quarterly	1.00	0.94	*	1.00	
		Subsidiary	DSCR	Quarterly	1.15	0.04	*	1.15	
	$ 5,000	Subsidiary	Minimum Occupancy	Quarterly	70 %	67 %	*	70 %	
PrivateBank - Mortgage Note - Valley River Nursing, LLC; Park Heritage Nursing, LLC; Benton Nursing, LLC	$ 11,007	Subsidiary	Minimum EBITDAR	Quarterly	$450	$136	*	$450	
		Subsidiary	Fixed Charge Coverage Ratio (FCCR)	Quarterly	1.05	0.84	*	1.05	
	$ 11,627	Subsidiary	Minimum EBITDAR	Quarterly	$358	$348	*	$358	
PrivateBank - Mortgage Note - Little Rock HC&R Nursing, LLC		Subsidiary	Borrowers Coverage of Debt Service	Annual	1.10	1.09	*	1.10	
		Consolidated	Maximum Leverage to EBITDA	Annual	11.00	11.03	*	11.00	
	$ 6,130	Subsidiary	Borrowers Coverage of Debt Service	Annual	1.20	(0.50)	*	1.20	
Medical Clinic Board of the City of Hoover - Bonds - Riverchase Village ADK, LLC		Subsidiary	Days Cash on Hand	Annual	15	0	*	15	
		Subsidiary	Maximum Days Outstanding on Trade Payables	Annual	10 %	69 %	*	10 %	
City of Springfield - Bonds - Eaglewood Village, LLC	$ 7,230	Subsidiary	Borrowers Coverage of Debt Service	Annual	1.10	0.74	*	1.10	

* Waiver or amendment for violation of covenant obtained.

Revolving Credit Facilities and Lines of Credit

Gemino Northwest Credit Facility

On May 30, 2013, NW 61st Nursing, LLC (“Northwest”), a wholly-owned subsidiary of the Company, entered into a Credit Agreement (the “Northwest Credit Facility”) with Gemino Healthcare Finance, LLC ("Gemino"). The Northwest Credit Facility provided for a $1.0 million principal amount senior-secured revolving credit facility.

The Northwest Credit Facility matures on January 31, 2015 and interest accrues on the principal balance thereof at an annual rate of 4.75% plus the current LIBOR rate. Northwest also pays to Gemino: (i) a collateral monitoring fee equal to 1.0% per annum of the daily outstanding balance of the Northwest Credit Facility; and (ii) a fee equal to 0.5% per annum of the unused portion of the Northwest Credit Facility. In the event the Northwest Credit Facility is terminated prior to January 31, 2015, Northwest shall also be required to pay a fee to Gemino in an amount equal to 1.0% of the Northwest Credit Facility. The Northwest Credit Facility is secured by a security interest in the accounts receivable and the collections and proceeds thereof relating to the Company’s skilled nursing facility located in Oklahoma City, Oklahoma known as the Northwest Nursing Center. AdCare has unconditionally guaranteed all amounts owing under the Northwest Credit Facility.

The Northwest Credit Facility contains customary events of default, including material breach of representations and warranties, failure to make required payments, failure to comply with certain agreements or covenants and certain events of bankruptcy and insolvency. Upon the occurrence of an event of default, Gemino may terminate the Northwest Credit Facility.

In connection with entering into the Northwest Credit Facility, certain affiliates of the Company and Northwest, as applicable, also entered into an intercreditor and subordination agreement, governmental depository agreement and subordination of

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management fee agreement, each containing customary terms and conditions.

On June 25, 2013, Northwest entered into a First Amendment to the Credit Agreement which amended the Northwest Credit Facility. The amendment, among other things: (i) amends certain financial covenants regarding fixed charge coverage ratio and minimum EBITDA; and (ii) amends the credit facility to include the Bonterra Credit Facility (discussed below) as an affiliated credit agreement in determining whether certain financial covenants are being met.

On June 28, 2013, two wholly-owned subsidiaries of the Company, entered into a Joinder Agreement, Second Amendment and Supplement to Credit Agreement with Northwest and Gemino pursuant to which such subsidiaries became additional borrowers under the Northwest Credit Facility. Pursuant to the joinder, the borrowers granted a continuing security interest in, among other things, their accounts receivables, payment intangibles, chattel paper, general intangibles, collateral relating to any accounts or payment intangibles, commercial lockboxes and cash, as additional collateral under the Northwest Credit Facility. In connection with the execution of the joinder, the borrowers issued an amended and restated revolving promissory note in favor of Gemino in the amount of $1.5 million.

On February 10, 2014, Northwest entered into a Waiver and Amendment with Gemino which modified the: (i) Northwest Credit Facility; and (ii) Gemino-Bonterra Credit Facility (described below). The Waiver and Amendment, among other things, adjusted the required: (a) minimum fixed charge coverage ratio; (b) maximum loan turn days; (c) minimum earnings before interest, taxes, depreciation and amortization; and (d) waived certain specified defaults in existence as of the date of the Waiver and Amendment.

As of December 31, 2014, $1.3 million was outstanding under the Northwest Credit Facility. At December 31, 2014, the Company was not in compliance with covenants contained in the Northwest Credit Facility and has obtained a waiver from Gemino (see table above).

On January 30, 2015, a certain wholly-owned subsidiary of the Company, entered into a Fourth Amendment to the Credit Agreement with Gemino which amended the Northwest Credit Facility. The amendment extends the term of the Northwest Credit Facility from January 31, 2015 to March 31, 2015.

Gemino-Bonterra Credit Facility

On September 20, 2012, ADK Bonterra/Parkview, LLC, a wholly owned subsidiary of the Company ("Bonterra") entered into a Second Amendment to the Credit Agreement with Gemino ("Gemino-Bonterra Credit Facility"), which amended the original Credit Agreement dated April 27, 2011 between Bonterra and Gemino. The Gemino-Bonterra Credit Facility is a secured credit facility for borrowings up to $2.0 million. The amendment extended the term of the Gemino-Bonterra Credit Facility from October 29, 2013 to January 31, 2014 and amended certain financial covenants regarding Bonterra's fixed charge coverage ratio, maximum loan turn days and applicable margin. Interest accrues on the principal balance outstanding at an annual rate equal to the LIBOR rate plus the applicable margin of 4.75% to 5.00%, which fluctuates depending upon the principal amount outstanding.

On December 20, 2012, Bonterra entered into a Third Amendment to the Gemino-Bonterra Credit Facility, which altered the financial covenant in the original credit agreement to exclude the Oklahoma Owners under another credit agreement with Gemino from the covenant calculation of maximum loan turn days and acknowledged that Bonterra shall not be obligated, directly or indirectly, for any indebtedness or obligations of the Oklahoma Owners to Gemino.

On May 30, 2013, Bonterra, entered into a Fourth Amendment to Credit Agreement with Gemino, which among other things: (i) extends the term of the Gemino-Bonterra Credit Facility from January 31, 2014 to January 31, 2015; (ii) amended certain financial covenants regarding Bonterra’s fixed charge coverage ratio and maximum loan turn days; and (iii) amended the Gemino-Bonterra Credit Facility to include the Northwest Credit Facility as an affiliated credit agreement in determining whether certain financial covenants are being met.

On February 10, 2014, Bonterra entered into a Waiver and Amendment with Gemino which modified the: (i) Northwest Credit Facility; and (ii) Gemino-Bonterra Credit Facility. The Waiver and Amendment, among other things, adjusted the required: (a) minimum fixed charge coverage ratio; (b) maximum loan turn days; (c) minimum earnings before interest, taxes, depreciation and amortization; and (d) waived certain specified defaults in existence as

of the date of the Waiver and Amendment.

As of December 31, 2014, $1.3 million was outstanding under the Gemino-Bonterra Credit Facility. At December 31, 2014, the Company was not in compliance with covenants contained in the Gemino-Bonterra Credit Facility and has obtained a waiver from Gemino (see table above).

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On January 30, 2015, a certain wholly owned subsidiary of the Company, entered into a Seventh Amendment to the Credit Agreement with Gemino which amended the Gemino-Bonterra Credit Facility. The amendment extends the term of the Bonterra Credit Facility from January 31, 2015 to March 31, 2015.

PrivateBank Credit Facility

On September 20, 2012, the Company entered into a Loan and Security Agreement with PrivateBank ("PrivateBank Credit Facility"). Under the terms of the PrivateBank Credit Facility, PrivateBank provided a $10.6 million senior secured revolving credit facility for a three-year period with the borrowings thereunder being subject to a borrowing base and are offset by a $0.7 million standby letter of credit at December 31, 2012, increasing to $2.5 million at July 31, 2013.

The PrivateBank Credit Facility matures on September 20, 2015. Interest is accrued on the principal balance at an annual rate of the greater of (i) 1% plus the prime interest rate per annum, or (ii) 5% per annum. Payments for the interest are due monthly and commenced on October 1, 2012. In addition, there is a non-utilization fee of 0.5% on the unused portion of the available credit. The PrivateBank Credit Facility may be prepaid at any time without premium or penalty, provided that such prepayment is accompanied by a simultaneous payment of all accrued and unpaid interest, through the date of prepayment. The PrivateBank Credit Facility is secured by a first priority security interest in the real property and improvements constituting skilled nursing facilities owned and operated by the Company. AdCare has unconditionally guaranteed all amounts owed to PrivateBank under the PrivateBank Credit Facility. Proceeds from the PrivateBank Credit Facility were used to pay off all amounts outstanding under a separate 2.0 million credit facility with PrivateBank under which certain subsidiaries of AdCare were borrowers.

On October 26, 2012, the Company and certain of its wholly owned subsidiaries, on the one hand, and PrivateBank entered into a Modification Agreement which amends the PrivateBank Credit Facility. The Modification Agreement amended the loan agreement to: (i) allow PrivateBank to issue additional letters of credit for the account of the borrowers under the loan agreement; and (ii) change the total amount that may be issued under any letters of credit to $2.5 million. The modification agreement did not change the maximum amount that may be borrowed under the loan agreement by the borrowers which remained at $10.6 million.

On January 25, 2013, the Company entered into a Memorandum of Agreement with PrivateBank pursuant to which three of the Company’s subsidiaries and their assets that collateralized the loan, which consist of the three skilled nursing facilities located in Arkansas known as the Aviv facilities, were released from liability under the PrivateBank Credit Facility. In exchange for the release from liability under the loan agreement, the Company made a payment in the amount of $0.7 million on December 28, 2012. The Memorandum of Agreement did not change the maximum amount that may be borrowed under the PrivateBank Credit Facility, which remained $10.6 million.

On September 30, 2013, certain wholly-owned subsidiaries of the Company entered into a Third Modification Agreement with PrivateBank pursuant to which: (i) a wholly-owned subsidiary of the Company was added as a borrower to the PrivateBank Credit Facility; and (ii) three of the subsidiaries and their assets that collateralized the loan were released from their obligations under the PrivateBank Credit Facility because such entities no longer operate skilled nursing facilities.

On November 26, 2013, certain wholly-owned subsidiaries of the Company entered into a Fourth Modification Agreement with PrivateBank which modified the PrivateBank Credit Facility. The modification, among other things: (i) increased the letter of credit amount available under the PrivateBank Credit Facility from $2.5 million to $3.5 million.

On July 24, 2014, certain wholly-owned subsidiaries of the Company entered into a Fifth Modification Agreement with PrivateBank, effective July 22, 2014, which modified the PrivateBank Credit Facility. The modification, among other things: (i) increased the letter of credit amount available under the PrivateBank Credit Facility from $3.5 million to $3.8 million; and (ii) amended certain financial terms under the PrivateBank Credit Facility regarding debt service and interest charges.

On September 24, 2014, certain wholly-owned subsidiaries of the Company entered into a Sixth Modification Agreement with PrivateBank, which modified the PrivateBank Credit Facility. Pursuant to the Modification: (i) the outstanding amount owing under the PrivateBank Credit Facility was reduced from $10.6 million to $9.1 million; (ii) three of the Company's subsidiaries and their collateral were released from their obligations under the PrivateBank

Credit Facility because one of the entities no longer operates a skilled nursing facility and each of the two remaining released entities have entered into new financing arrangements with HUD, as discussed below; and (iii) certain financial terms under the PrivateBank Credit Facility regarding minimum fixed charge coverage ratio were amended.

On December 17, 2014, certain wholly-owned subsidiaries of the Company entered into a Seventh Modification Agreement with PrivateBank, which modified the PrivateBank Credit Facility. Pursuant to the Modification: (i) the outstanding amount owing under the PrivateBank Credit Facility was reduced from $9.1 million to $8.8 million and a Letter of Credit in the

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amount of $3.8 million was provided; and (iii) one of the PrivateBank Borrowers and their collateral were released from their obligations under the PrivateBank Credit Facility because the entity entered into new financing arrangements with HUD, as discussed below.

Certain subsidiaries of the Company are also borrowers under: (i) a credit facility with PrivateBank used to fund the purchase price of the acquisition of three skilled nursing facilities and an office facility located in Arkansas; and (ii) a credit facility with PrivateBank used to fund the purchase price of the West Markham Sub Acute and Rehabilitation Center located in Arkansas.

As of December 31, 2014, $3.0 million was outstanding of the maximum borrowing amount of $8.8 million under the PrivateBank Credit Facility, subject to borrowing base limitations. As of December 31, 2014, the Company has $3.8 million of outstanding letters of credit relating to this credit facility. At December 31, 2014, the Company was not in compliance with covenants contained in the PrivateBank Credit Facility and has obtained a waiver from PrivateBank (see table above).

PrivateBank-Woodland Nursing and Glenvue Nursing Credit Facility

On September 24, 2014, certain wholly-owned subsidiaries of the Company entered into a Loan and Security Agreement (the “Woodland Nursing and Glenvue Nursing Credit Facility”) with PrivateBank. The Woodland Nursing and Glenvue Nursing Credit Facility provides for a $1.5 million principal amount senior secured revolving credit facility.

The Woodland Nursing and Glenvue Nursing Credit Facility matures on September 24, 2017. Interest on the Woodland Nursing and Glenvue Nursing Credit Facility accrues on the principal balance thereof at a rate of interest equal to the greater of: (i) a floating per annum rate of interest equal to the prime rate plus 1.0%; or (ii) 5.0% per annum. These certain wholly-owned subsidiaries of the Company shall also pay to PrivateBank: (i) a one time non-refundable loan fee in the amount of $11,250 and (ii) a fee equal to 0.5% per annum of the unused portion of the Woodland Nursing and Glenvue Nursing Credit Facility. The Woodland Nursing and Glenvue Nursing Credit Facility is secured by a security interest in, without limitation, the accounts receivable and the collections and proceeds thereof relating to the Company’s two skilled nursing facilities located in Springfield, Ohio known as the Eaglewood Care Center and located in Glennville, Georgia known as the Glenview Health and Rehabilitation Center. AdCare has unconditionally guaranteed all amounts owing under the Woodland Nursing and Glenvue Nursing Credit Facility.

The Woodland Nursing and Glenvue Nursing Credit Facility contains customary events of default, including material breach of representations and warranties, failure to make required payments, failure to comply with certain agreements or covenants and certain events of bankruptcy and insolvency. Upon the occurrence of an event of default, PrivateBank may terminate the Woodland Nursing and Glenvue Nursing Credit Facility.

As of December 31, 2014, $1.1 million was outstanding of the maximum borrowing amount of $1.5 million under the Woodland Nursing and Glenvue Nursing Credit Facility, subject to borrowing base limitations. At December 31, 2014, the Company was in compliance with covenants contained in the Woodland Nursing and Glenvue Nursing Credit Facility.

Georgetown and Sumter Credit Facility

On January 30, 2015, two wholly-owned subsidiaries of the Company, entered into a Loan Agreement (the "Georgetown and Sumter Credit Facility"), between Georgetown, Sumter and PrivateBank. The Georgetown and Sumter Credit Facility provides for a $9.3 million principal amount secured credit facility.

The Georgetown and Sumter Credit Facility matures on September 1, 2016. Interest on the Georgetown and Sumter Credit Facility accrues on the principal balance thereof at the LIBOR rate plus 4.25%. Interest payments on the loan shall be due and payable monthly, beginning on March 1, 2015. The Georgetown and Sumter Credit Facility is

secured by, among other things, an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Georgetown and Sumter Credit Facility.

The Georgetown and Sumter Credit Facility contains customary events of default, including fraud or material misrepresentation or material omission, failure to make required payments, and failure to perform or comply with certain agreements. Upon the occurrence of certain events of default, PrivateBank may terminate the Georgetown and Sumter Credit Facility and all amounts under the Georgetown and Sumter Credit Facility will become due and payable.

AdCare has unconditionally guaranteed all amounts owing under the Georgetown and Sumter Credit Facility. On January 30, 2015, proceeds from the Georgetown and Sumter Credit Facility were used to pay off all amounts outstanding under a separate $9.0 million credit facility with Metro City Bank under which certain subsidiaries of the Company were borrowers.

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Northridge, Woodland Hills and Abington Credit Facility

On February 25, 2015, three wholly-owned subsidiaries of the Company entered into a Loan Agreement (the "Northridge, Woodland Hills and Abington Credit Facility") with PrivateBank. The PrivateBank Credit Facility provides for a $12.0 million principal amount secured credit facility.

The Northridge, Woodland Hills and Abington Credit Facility matures on September 1, 2016. Interest accrues on the principal balance thereof at the LIBOR rate plus 4.25%. Principal and interest payments on the note shall be due and payable monthly, beginning on March 1, 2015. The facility is secured by, among other things, an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Northridge, Woodland Hills and Abington Credit Facility.

AdCare has unconditionally guaranteed all amounts owing under the Northridge, Woodland Hills and Abington Credit Facility. On January 30, 2015, proceeds from the Northridge, Woodland Hills and Abington Credit Facility were used to pay off all amounts outstanding under a separate $12.0 million credit facility with KeyBank National Association ("KeyBank") under which certain subsidiaries of the Company were borrowers.

Contemporary Healthcare Senior

On August 17, 2012, in conjunction with the acquisition of Companions, a wholly owned subsidiary of the Company entered into a Loan Agreement with Contemporary Healthcare Capital LLC ("Contemporary") and issued a promissory note in favor of Contemporary with a principal amount of $0.6 million ("Contemporary $0.6 million Loan"). The Contemporary $0.6 million Loan matures on August 20, 2015 and interest accrues on the principal balance at an annual rate of 9.0%. Payments for the interest and a portion of the principal in excess of the borrowing base are payable monthly, commencing on September 20, 2012.

As of December 31, 2014, $0.2 million was outstanding under the Contemporary $0.6 million Loan. At December 31, 2014, the Company was not in compliance with covenants contained in the Contemporary $0.6 million Loan and has obtained a waiver from Contemporary (see table above).

Senior Debt—Guaranteed by HUD

Hearth and Home of Vandalia

In connection with the Company's January 2012 refinancing of the assisted living facility known as Hearth and Home of Vandalia, owned by a wholly owned subsidiary of AdCare, the Company obtained a term loan, insured by HUD, with a financial institution for a total amount of $3.7 million that matures in 2041. The term loan requires monthly principal and interest payments with a fixed interest rate of 3.74%. Deferred financing costs incurred on the term loan amounted to $0.2 million and are being amortized to interest expense over the life of the loan. The term loan has a prepayment penalty of 8% starting in 2014, which declines by 1% each year through 2022. This term loan was assumed by the buyer in the closing of the sale of this facility that occurred in May 2013 pursuant to the terms of the sale agreement related to the sale of six of the Company's assisted living facilities located in Ohio (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

The Pavilion Care Center

The Company has a term loan insured by HUD that totaled approximately $1.7 million at December 31, 2013. The HUD term loan requires monthly principal and interest payments of approximately $15,000 with a fixed interest rate of 5.95%. The term loan matures in 2027. Deferred financing costs incurred on this loan amounted to approximately $0.2 million and are being amortized to interest expense over the life of the loan. The loan has a prepayment penalty of 5% through 2013 declining by 1% each year through 2017. The loan has certain restrictive covenants and HUD regulatory compliance requirements including maintenance of certain restricted escrow deposits and reserves for replacement. The Company had $0.2 million of restricted assets related to this loan at December 31, 2013.

On October 1, 2014, a certain wholly-owned subsidiary of the Company entered into a Modification Agreement with Red Mortgage Capital, LLC ("Red Capital") and HUD which modified the Pavilion Care Center Loan Agreement, dated November 27, 2007, that matures in 2027. The modification, among other things: (i) reduced the rate of interest therein provided from 5.95% per annum to 4.16% per annum, effective as of November 1, 2014; (ii) revised the amount of monthly installments of interest and principal payable on and after December 1, 2014, so as to re-amortize

in full the loan over the remaining term thereof; and (iii) modified the prepayment provision of the loan.

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As of December 31, 2014, the outstanding balance on the loan was $1.6 million. Additionally, the Company has $0.3 million in restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants contained in the Pavilion Care Center Loan Agreement.

Hearth and Care of Greenfield

The Company has a term loan insured by HUD that totaled approximately $2.4 million at December 31, 2013. The HUD term loan requires monthly principal and interest payments of approximately $16,000 with a fixed interest rate of 6.5%. The term loan matures in 2038. Deferred financing costs incurred on this loan amounted to approximately $0.1 million and are being amortized to interest expense over the life of the loan. The loan has a prepayment penalty of 5% through 2013 declining by 1% each year through 2018. The loan has certain restrictive covenants and HUD regulatory compliance requirements including maintenance of certain restricted escrow deposits and reserves for replacement. The Company had $0.2 million of restricted assets related to this loan at December 31, 2013.

On October 1, 2014, a certain wholly-owned subsidiary of the Company entered into a Modification Agreement with Red Capital and HUD which modified the Hearth and Care of Greenfield Loan Agreement, dated July 29, 2008, that matures in 2038. The modification, among other things: (i) reduced the rate of interest therein provided from 6.50% per annum to 4.20% per annum, effective as of November 1, 2014; (ii) revised the amount of monthly installments of interest and principal payable on and after December 1, 2014, so as to re-amortize in full the loan over the remaining term thereof; and (iii) modified the prepayment provision of the loan.

As of December 31, 2014, the outstanding balance on the loan was $2.3 million. Additionally, the Company has $0.3 million in restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants contained in the Hearth and Care of Greenfield Loan Agreement.

Woodland Manor

On September 24, 2014, a wholly owned subsidiary of the Company, entered into a Mortgage and Deed of Trust Agreement (the “Woodland Credit Facility”), with Housing & Healthcare Finance, LLC (“H&H”) in connection with the refinancing of the skilled nursing facility known as Eaglewood Care Center ("Eaglewood") located in Springfield, Ohio. The Woodland Credit Facility provides for a $5.7 million principal amount secured credit facility.

On September 24, 2014, the proceeds from the Woodland Credit Facility were used to pay off an existing credit facility with PrivateBank with respect to Eaglewood in the amount of 4.5 million and the Company received net proceeds of $0.6 million for working capital purposes.

The Woodland Credit Facility matures on October 1, 2044. Interest on the Woodland Credit Facility accrues on the principal balance thereof at an annual rate of 3.75%. The Woodland Credit Facility is secured by, among other things, an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Woodland Credit Facility. HUD has insured all amounts owing under the Woodland Credit Facility. The Woodland Credit Facility contains customary events of default, including fraud or material misrepresentations or material omission, the commencement of a forfeiture action or proceeding, failure to make required payments, failure to perform or comply with certain agreements and certain events of bankruptcy and insolvency. Upon the occurrence of certain events of default, H&H may, after receiving the prior written approval of HUD, terminate the Woodland Credit Facility and all amounts under the Woodland Credit Facility will become immediately due and payable.

In connection with entering into the Woodland Credit Facility, Woodland entered into a healthcare regulatory agreement and a promissory note, each containing customary terms and conditions. As of December 31, 2014, $5.7 million was outstanding under the Woodland Credit Facility. The Company has $0.3 million of restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants contained in the Woodland Credit Facility.

Glenvue

On September 24, 2014, a wholly owned subsidiary of the Company entered into a Mortgage and Deed of Trust Agreement (the “Glenvue Credit Facility”), with H&H in connection with the refinancing of the skilled nursing facility

known as Glenvue Health and Rehabilitation ("Glenvue"). The Glenvue Credit Facility provides for an $8.8 million principal amount secured credit facility.

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The proceeds from the Glenvue Credit Facility were used to pay off an existing credit facility with PrivateBank with respect to the Glenvue facility in the amount of 6.3 million and the Company received net proceeds of $1.8 million for working capital purposes.

The Glenvue Credit Facility matures on October 1, 2044. Interest on the Glenvue Credit Facility accrues on the principal balance thereof at an annual rate of 3.75%. The Glenvue Credit Facility is secured by, among other things, an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Glenvue Credit Facility. HUD has insured all amounts owing under the Glenvue Credit Facility.

The Glenvue Credit Facility contains customary events of default, including fraud or material misrepresentations or material omission, the commencement of a forfeiture action or proceeding, failure to make required payments, failure to perform or comply with certain agreements and certain events of bankruptcy and insolvency. Upon the occurrence of certain events of default, H&H may, after receiving the prior written approval of HUD, terminate the Glenvue Credit Facility and all amounts under the Glenvue Credit Facility will become immediately due and payable.

In connection with entering into the Glenvue Credit Facility, Glenvue entered into a healthcare regulatory agreement and a promissory note, each containing customary terms and conditions. As of December 31, 2014, $8.8 million was outstanding under the Glenvue Credit Facility. The Company has $0.4 million of restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants contained in the Glenvue Credit Facility.

Autumn Breeze

On December 17, 2014, Mt. Kenn Property Holdings, LLC (“Mt. Kenn”), a wholly owned subsidiary of the Company, entered into a Mortgage and Deed of Trust Agreement (the “Mt. Kenn Credit Facility”), with KeyBank. The Mt. Kenn Credit Facility provides for a $7.6 million principal amount secured credit facility.

On December 17, 2014, the proceeds from the Mt Kenn Credit Facility were used to pay off two existing credit facilities with respect to the skilled nursing facility known as Autumn Breeze located in Marietta, Georgia, in the amount of 4.9 million and the Company received net proceeds of $0.9 million for working capital purposes.

The Mt. Kenn Credit Facility matures on January 1, 2045. Interest on the Mt. Kenn Credit Facility accrues on the principal balance thereof at an annual rate of 3.65%. The Mt. Kenn Credit Facility is secured by, among other things, an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Mt. Kenn Credit Facility. HUD has insured all amounts owing under the Mt. Kenn Credit Facility.

The Mt. Kenn Credit Facility contains customary events of default, including fraud or material misrepresentations or material omission, the commencement of a forfeiture action or proceeding, failure to make required payments, and failure to perform or comply with certain agreements. Upon the occurrence of certain events of default, KeyBank may, after receiving the prior written approval of HUD, terminate the Mt. Kenn Credit Facility and all amounts under the Mt. Kenn Credit Facility will become immediately due and payable.

In connection with entering into the Mt. Kenn Credit Facility, Mt. Kenn entered into a healthcare regulatory agreement and a promissory note, each containing customary terms and conditions. The term loan 75% insured by the Small Business Administration ("SBA"), an agency of the United States of America, was repaid in conjunction with this financing.

As of December 31, 2014, $7.6 million was outstanding under the Mt. Kenn Credit Facility. The Company has $0.8 million of restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants contained in the Mt. Kenn Credit Facility.

Sale of Ohio ALFs

On December 28, 2012, the Company sold four of its assisted living facilities located in Ohio and used a portion of the proceeds to pay off the principal balance of their HUD loans in the amount of $6.4 million. On February 28, 2013, AdCare completed the sale of one additional assisted living facility and used the proceeds to repay the principal balance of the HUD loan with respect to the facility in the amount of $1.9 million (see Note 11 - Discontinued Operations to our Consolidated Financial Statements included in Part II, Item 8., "Financial Statements and Supplementary Data").

Senior Debt—Guaranteed by USDA

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For five skilled nursing facilities, the Company has term loans insured 70% to 80% by the United States Department of Agriculture ("USDA") with financial institutions that totaled approximately $27.1 million at December 31, 2014. The Company has $1.8 million of restricted assets related to these loans. The combined USDA loans require monthly principal and interest payments of approximately $0.2 million adjusted quarterly with a variable interest rate of prime plus 1% to 1.75%, with floors of 5.50% to 6.00%. The loans mature at various dates starting in 2035 through 2036. Deferred financing costs incurred on these loans amounted to approximately $0.8 million and are being amortized to interest expense over the life of the loans. In addition, the loans have an annual renewal fee for the USDA guarantee of 0.25% of the guaranteed portion. The loans have prepayment penalties of 6% to 8% through 2014, which decline 1% each year capped at 1% for the remainder of the term.

At December 31, 2014, the Company was not in compliance with covenants contained in two of the five USDA loans and has obtained waivers with the USDA (see table above).

Senior Debt—Guaranteed by SBA

Stone County

In June 2012, Mt. V Property Holdings, LLC ("Stone County"), a wholly owned subsidiary of AdCare, entered into a loan agreement with the Economic Development Corporation of Fulton County (the "CDC"), an economic development corporation working with the SBA, in the amount of $1.3 million. The funding from the CDC loan of $1.3 million was used to satisfy a $1.3 million loan from Metro City Bank that was used to acquire the assets of a skilled nursing facility located in Arkansas known as the Stone County Nursing and Rehabilitation facility.

The CDC loan matures in July 2032 and accrues interest at a rate of 2.42% per annum. The CDC loan is payable in equal monthly installments of principal and interest based on a twenty (20) year amortization schedule. The CDC loan may be prepaid, subject to prepayment premiums, during the first ten years. There are also annual fees associated with the CDC loan, including an SBA guarantee fee. The CDC loan is secured by a second in priority security deed on the Stone County Nursing and Rehabilitation facility and guarantees from AdCare, the SBA and a wholly owned subsidiary of AdCare.

As of December 31, 2014, $1.2 million was outstanding under the CDC loan. At December 31, 2014, the Company was in compliance with covenants contained in the Stone County loan agreement.

Other Senior Debt—Guaranteed by SBA

For two facilities, the Company has term loans insured 75% by the SBA with a financial institution that totaled approximately $2.5 million at December 31, 2014. The combined SBA mortgage notes require monthly principal and interest payments of approximately $16,000 with an interest rate of 2.81% to 5.5%. The notes mature at various dates starting in 2031 through 2036. Deferred financing costs incurred on these loans amounted to approximately $0.2 million and are being amortized to interest expense over the life of the note. One of the loans has a prepayment penalty of 2.2% declining each year until year ten.

For one facility, a term loan in an amount of $2.0 million insured 75% by the SBA with a financial institution was paid off in 2014 in connection with a refinancing by HUD.

At December 31, 2014, the Company was in compliance with covenants contained in the SBA term loans.

Senior Debt—Bonds, net of Discount

Eaglewood Village Bonds

In April 2012, a wholly-owned subsidiary of the Company entered into a loan agreement with the City of Springfield in the State of Ohio pursuant to which City of Springfield lent to such subsidiary the proceeds from the sale of City of Springfield's Series 2012 Bonds. The Series 2012 Bonds consist of $6.6 million in Series 2012A First Mortgage Revenue Bonds and $0.6 million in Taxable Series 2012B First Mortgage Revenue Bonds. The Series 2012 Bonds were issued pursuant to an April 2012 Indenture of Trust between the City of Springfield and the Bank of Oklahoma. The Series 2012A Bonds mature in May 2042 and accrue interest at a fixed rate of 7.65% per annum. The Series 2012B Bonds mature in May 2021 and accrue interest at a fixed rate of 8.5% per annum. Deferred financing costs incurred on the loan amounted to $0.6 million and are being amortized to interest expense over the life of the loan. The bonds are secured by the Company's assisted living facility located in Springfield, Ohio known as Eaglewood Village and guaranteed by AdCare. There is an original issue discount of $0.3 million and restricted assets of $0.3 million related to this loan.

As of December 31, 2014, $6.6 million was outstanding under the Series 2012A First Mortgage Revenue Bonds and $0.6 million was outstanding under the Taxable Series 2012B First Mortgage Revenue Bonds. The unamortized discount on the

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bonds was $0.2 million at December 31, 2014. At December 31, 2014, the Company was not in compliance with covenants contained in the Series 2012 Bonds and has obtained a waiver from the City of Springfield (see table above).

Quail Creek

In July 2012, a wholly owned subsidiary of the Company financed the purchase of a skilled nursing facility located in Oklahoma City, Oklahoma known as Quail Creek Nursing & Rehabilitation Center ("Quail Creek") by the assumption of existing indebtedness under that certain Loan Agreement and Indenture of First Mortgage with The Bank of New York Mellon Global Corporate Trust, as assignee of The Liberty National Bank and Trust of that certain Bond Indenture, dated September 1, 1986, as amended as of September 1, 2001. The indebtedness under the Loan Agreement and Indenture consisted of a principal amount of $2.8 million. In July of 2012, the purchase price allocation of fair value totaling $3.2 million was assigned to this indebtedness resulting in a $0.4 million premium that was being amortized to maturity. The loan was originally scheduled to mature in August 2016 and accrued interest at a fixed rate of 10.25% per annum. The loan was secured by the Quail Creek facility.

On September 27, 2013, the outstanding principal and accrued interest to the prepayment date in the amount of $3.1 million was deposited into a restricted defeased bonds escrow account. Pursuant to the Loan Agreement and Indenture, the outstanding loan was prepaid on March 3, 2014, at par plus accrued interest in the amount of $3.1 million from the funds that were previously deposited into a restricted defeased bonds escrow account.

Riverchase

The Company's consolidated variable interest entity, Riverchase Village ADK, LLC ("Riverchase"), is obligated to repay revenue bonds, in two series, issued by the Medical Clinical Board of the City of Hoover in the state of Alabama, which AdCare has guaranteed the obligation under the bonds.

The Series 2010A portion of $5.8 million matures on June 1, 2039. The Series 2010B portion of $0.5 million matures serially beginning on June 1, 2012 through June 1, 2017, with annual redemption amounts ranging from $75,000 to $100,000. The Series 2010A and 2010B bonds may be redeemed early beginning on June 1, 2012 through May 31, 2015 at a redemption price ranging from 101% to 103% of the principal amount plus accrued interest. Any early redemption after May 31, 2015 is at a redemption price of 100% of the principal amount plus accrued interest. The bonds require monthly payments of fixed interest of $41,000 at a weighted average effective interest rate of 7.9%.

As of December 31, 2013, the liabilities of Riverchase were classified as Liabilities of Variable Interest Entity Held for Sale.

As of December 31, 2014, $5.8 million was outstanding under the Series 2010A portion and $0.3 million was outstanding under the Series 2010 B portion of the bonds. The bonds contain an original issue discount that is being amortized over the term of the notes. The unamortized discount on the bonds was $0.2 million at December 31, 2014. At December 31, 2014, the Company was not in compliance with covenants contained in the Series 2010A and 2010B bonds and has obtained a waiver from the Medical Clinical Board of the City of Hoover (see table above).

Senior Debt—Other Mortgage Indebtedness

Quail Creek Credit Facility

In September 2013, QC Property Holdings, LLC ("QC"), a wholly owned subsidiary of the Company, entered into a loan agreement with Housing & Healthcare Funding, LLC in the amount of $5.0 million. The proceeds of this agreement were used to repay certain outstanding bonds that were assumed by QC upon its acquisition of the skilled nursing facility located in Oklahoma. Pursuant to the loan agreement, the bonds' outstanding principal and accrued interest to the prepayment date in the amount of $3.1 million was deposited into a restricted defeased bonds escrow account (see Senior Debt—Bonds, net of Discount, Quail Creek). The bonds were paid in full in March 2014.

The loan agreement matures on September 27, 2016 and accrues interest at the one-month LIBOR rate plus 4.75%. The loan is secured by: (i) a first mortgage on the real property and improvements constituting the Quail Creek facility; (ii) a first priority interest on all furnishing, fixtures and equipment associated with the Quail Creek facility; and (iii) an assignment of all rents paid under any existing or future leases and rental agreements with respect to the Quail Creek facility. AdCare has unconditionally guaranteed all amounts owning under the loan.

As of December 31, 2014, $5.0 million was outstanding under the loan agreement. The Company has $0.1 million of restricted assets related to this loan. At December 31, 2014, the Company was in compliance with covenants

contained in the Quail Creek Credit Facility.

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Woodland Manor

In connection with the Company's January 2012 acquisition of the skilled nursing facility known as Woodland Manor, the Company entered into a loan agreement for $4.8 million (the "Woodland Credit Facility") with PrivateBank. The loan matured in December 2016 with a required final payment of $4.3 million and accrued interest at the LIBOR rate plus 4% with a minimum rate of 6% per annum. The loan required monthly payments of principal and interest. Deferred financing costs incurred on the loan amounted to $0.1 million and were being amortized to interest expense over the life of the loan. The loan had a prepayment penalty of 5% through 2012, which declined by 1% each year through 2015. The loan was secured by Woodland Manor and guaranteed by AdCare.

On September 24, 2014, that certain Loan Agreement, dated December 30, 2011, with PrivateBank in the outstanding principal amount of $4.5 million was repaid by the proceeds from the Woodland Credit Facility, noted above, and the Company received net proceeds of $0.5 million for working capital purposes.

Little Rock, Northridge and Woodland Hills

On March 30, 2012, Little Rock HC&R Property Holdings, LLC ("Little Rock"), Northridge HC&R Property Holdings, LLC ("Northridge") and Woodland Hills HC Property Holdings, LLC ("Woodland Hills"), in connection with the Company's April 2012 acquisition of three skilled nursing facilities located in Arkansas known as Little Rock, Northridge and Woodland Hills, entered into a loan agreement for $21.8 million with PrivateBank. The loan originally matured in March 2017 with a required final payment of $19.7 million and has since been amended. The loan accrues interest at the LIBOR rate plus 4% with a minimum rate of 6% per annum and requires monthly principal payments plus interest for total current monthly payments of $0.2 million. Deferred financing costs incurred on the loan amounted to $0.4 million and are being amortized to interest expense over the life of the loan. The loan has a prepayment penalty of 5% through 2012, declining by 1% each year through 2015. The loan is secured by the three facilities and guaranteed by Little Rock HC&R Nursing, LLC and AdCare.

On June 15, 2012, the Company entered into a modification agreement with PrivateBank to modify the terms of the loan agreement. The loan modification agreement, among other things, amended the loan agreement to reflect a maturity date of March 30, 2013.

A portion of the loan with respect to the Northridge facility and Woodland Hills facility was paid off and refinanced with a portion of the proceeds from a new credit facility with KeyBank on December 28, 2012, as discussed below.

On December 28, 2012, certain subsidiaries of the Company entered into a Second Modification Agreement with PrivateBank which modified the loan agreement. The modification, among other things, extended the term of the PrivateBank loan from March 30, 2013 to December 31, 2016, released certain subsidiaries of the Company related to the Northridge faci