FIVE STAR QUALITY CARE INC
Form 10-K
February 19, 2010

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

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

For the fiscal year ended December 31, 2009

or

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

Commission File Number 001-16817

FIVE STAR QUALITY CARE, INC.

(Exact Name of Registrant as Specified in Its Charter)

Maryland	**04-3516029**
(State of Incorporation)	(IRS Employer Identification No.)

400 Centre Street, Newton, Massachusetts 02458
(Address of Principal Executive Offices) (Zip Code)

(Registrant's Telephone Number, Including Area Code): **617-796-8387**

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

Title Of Each Class	**Name Of Each Exchange On Which Registered**
Common Stock	NYSE Amex

Securities registered pursuant to Section 12(g) of the 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 Section 15(d) of the 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 o

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 during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No o

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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 ý	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company o

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

The aggregate market value of the voting shares of the registrant held by non-affiliates was $60.0 million based on the $1.91 closing price per common share on the NYSE Amex on June 30, 2009. For purposes of this calculation, an aggregate of 846,227.7 shares of common stock, including 35,000 shares of common stock held by Senior Housing Properties Trust, are held by the directors and officers of the registrant and Senior Housing Properties Trust and have been included in the number of shares of common stock held by affiliates. Subsequent to June 30, 2009, Senior Housing Properties Trust acquired 3.2 million shares of common stock.

Number of the registrant's shares of common stock outstanding as of February 19, 2010: 35,668,814.

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In this Annual Report on Form 10-K, the terms the "Company," "Five Star", "FVE", "we", "us" or "our", include Five Star Quality Care, Inc., and its consolidated subsidiaries, unless the context indicates otherwise.

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K is incorporated by reference to our to be filed definitive Proxy Statement for the Annual Meeting of Shareholders scheduled to be held on May 10, 2010, or our definitive Proxy Statement.

WARNING CONCERNING FORWARD LOOKING STATEMENTS

THIS ANNUAL REPORT ON FORM 10-K CONTAINS STATEMENTS AND IMPLICATIONS WHICH CONSTITUTE FORWARD LOOKING STATEMENTS WITHIN THE MEANING OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995 AND OTHER FEDERAL SECURITIES LAWS. ALSO, WHENEVER WE USE WORDS SUCH AS "BELIEVE", "EXPECT", "ANTICIPATE", "INTEND", "PLAN", "ESTIMATE" OR SIMILAR EXPRESSIONS, WE ARE MAKING FORWARD LOOKING STATEMENTS. THESE FORWARD LOOKING STATEMENTS ARE BASED UPON OUR PRESENT INTENT, BELIEFS OR EXPECTATIONS, BUT FORWARD LOOKING STATEMENTS ARE NOT GUARANTEED TO OCCUR AND MAY NOT OCCUR. FORWARD LOOKING STATEMENTS IN THIS REPORT RELATE TO VARIOUS ASPECTS OF OUR BUSINESS, INCLUDING:

OUR ABILITY TO OPERATE OUR SENIOR LIVING COMMUNITIES AND REHABILITATION HOSPITALS PROFITABLY,

OUR ABILITY TO INTEGRATE NEW ACQUISITIONS AND LEASE OR PURCHASE ADDITIONAL SENIOR LIVING COMMUNITIES AND REHABILITATION HOSPITALS,

OUR ABILITY TO MEET OUR DEBT OBLIGATIONS,

OUR ABILITY TO COMPLY AND TO REMAIN IN COMPLIANCE WITH APPLICABLE MEDICARE, MEDICAID AND OTHER RATE SETTING AND REGULATORY REQUIREMENTS,

THE FINANCIAL CAPACITY OF UBS AG, OR UBS, TO MEET ITS OBLIGATIONS TO US AND TO PURCHASE OUR AUCTION RATE SECURITIES, OR ARS,

OUR ABILITY TO RAISE DEBT OR EQUITY CAPITAL,

THE FUTURE AVAILABILITY OF BORROWINGS UNDER OUR REVOLVING CREDIT FACILITY,

OUR EXPECTATION THAT WE WILL BENEFIT FINANCIALLY BY PARTICIPATING IN THE INSURANCE COMPANY WITH REIT MANAGEMENT & RESEARCH LLC, OR RMR, AND COMPANIES TO WHICH RMR PROVIDES MANAGEMENT SERVICES, AND

OTHER MATTERS.

OUR ACTUAL RESULTS MAY DIFFER MATERIALLY FROM THOSE CONTAINED IN OR IMPLIED BY OUR FORWARD LOOKING STATEMENTS AS A RESULT OF VARIOUS FACTORS. FACTORS THAT COULD HAVE A MATERIAL ADVERSE

EFFECT ON OUR FORWARD LOOKING STATEMENTS AND UPON OUR BUSINESS, RESULTS OF OPERATIONS, FINANCIAL CONDITION, CASH FLOWS, LIQUIDITY AND PROSPECTS INCLUDE, BUT ARE NOT LIMITED TO:

- THE IMPACT OF CHANGES IN THE ECONOMY AND THE CAPITAL MARKETS ON US AND OUR RESIDENTS AND OTHER CUSTOMERS,

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COMPETITION WITHIN THE SENIOR LIVING INDUSTRY AND OUR OTHER BUSINESSES,

INCREASES IN INSURANCE AND TORT LIABILITY COSTS,

CHANGES IN MEDICARE AND MEDICAID PAYMENTS WHICH COULD RESULT IN A REDUCTION OF RATES OR A FAILURE OF THESE RATES TO MATCH OUR COST INCREASES,

ACTUAL AND POTENTIAL CONFLICTS OF INTEREST WITH OUR MANAGING DIRECTORS, SENIOR HOUSING PROPERTIES TRUST, OR SNH, AND RMR AND ITS RELATED ENTITIES, AND

CHANGES IN PERSONNEL OR THE LACK OF AVAILABILITY OF QUALIFIED PERSONNEL,

COMPLIANCE WITH, AND CHANGES TO, FEDERAL, STATE AND LOCAL LAWS AND REGULATIONS WHICH COULD AFFECT OUR SERVICES.

FOR EXAMPLE:

THIS ANNUAL REPORT ON FORM 10-K STATES THAT THE TERMS OF OUR LEASE REALIGNMENT AGREEMENT WERE NEGOTIATED AND APPROVED BY SPECIAL COMMITTEES OF OUR AND SNH'S BOARDS COMPOSED ONLY OF OUR DIRECTORS AND SNH TRUSTEES WHO ARE NOT ALSO DIRECTORS OR TRUSTEES OF THE OTHER COMPANY. THE IMPLICATION OF THIS STATEMENT MAY BE THAT THIS AGREEMENT WAS NEGOTIATED ON AN ARMS LENGTH BASIS AND MAY NOT BE LEGALLY CHALLENGED BECAUSE THIS AGREEMENT PROVIDES A FAIR EXCHANGE OF CONSIDERATION BETWEEN US AND SNH. IN FACT, (I) WE WERE FORMERLY A 100% OWNED SUBSIDIARY OF SNH AND WE BECAME A SEPARATELY OWNED PUBLIC COMPANY AS A RESULT OF A SPIN OFF TO SNH SHAREHOLDERS IN 2001; (II) RMR PROVIDES MANAGEMENT SERVICES TO BOTH US AND SNH; (III) BOTH SNH AND CERTAIN OF OUR OFFICERS ARE ALSO OFFICERS OF RMR; (IV) RMR AND ITS OFFICERS PROVIDED INFORMATION AND ASSISTANCE TO BOTH OUR AND SNH'S SPECIAL COMMITTEES; (V) THE MEMBERS OF BOTH OUR AND SNH'S SPECIAL COMMITTEES ALSO SERVE AS DIRECTORS OR TRUSTEES OF OTHER COMPANIES MANAGED BY RMR; AND (VI) WE AND SNH HAVE EXTENSIVE AND CONTINUING BUSINESS WITH EACH OTHER. ALTHOUGH WE BELIEVE THAT THE LEASE REALIGNMENT AGREEMENT IS FAIR TO US, IN THE CIRCUMSTANCES OF THE MULTIPLE RELATIONSHIPS BETWEEN US AND SNH, IT IS POSSIBLE THAT LITIGATION MAY BE BROUGHT ALLEGING THAT THIS AGREEMENT IS UNFAIR TO US OR SNH. LITIGATION MAY BE EXPENSIVE AND DISTRACTING TO MANAGEMENT. WE CAN PROVIDE NO ASSURANCE THAT OUR ENTRY INTO THE LEASE REALIGNMENT AGREEMENT WILL NOT CAUSE US TO BECOME INVOLVED IN LITIGATION THAT CHALLENGES THE FAIRNESS OF THIS LEASE REALIGNMENT AGREEMENT. SUCH ALLEGATIONS OR LITIGATION COULD CAUSE OUR SHARE TRADING PRICE TO DECLINE AND THE OUTCOME OF SUCH LITIGATION IS IMPOSSIBLE TO PREDICT,

IF THE AVAILABILITY OF DEBT CAPITAL BECOMES MORE RESTRICTED, WE MAY BE UNABLE TO REPAY OUR FINANCIAL OBLIGATIONS WHEN THEY BECOME DUE OR TO REFINANCE OR OBTAIN ADDITIONAL FINANCING ON TERMS WHICH ARE AS FAVORABLE AS WE NOW HAVE,

UBS MAY BE UNABLE TO PURCHASE OUR ARS AS A RESULT OF ITS FINANCIAL CAPACITY AND OTHER CIRCUMSTANCES BEYOND OUR CONTROL,

PARTICIPATION IN AFFILIATES INSURANCE COMPANY, OR AIC, INVOLVES POTENTIAL FINANCIAL RISKS AND REWARDS TYPICAL OF ANY START UP

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BUSINESS VENTURE AS WELL AS OTHER FINANCIAL RISKS AND REWARDS SPECIFIC TO INSURANCE COMPANIES. AMONG THE RISKS THAT ARE SPECIFIC TO INSURANCE COMPANIES IS THE RISK THAT AIC MAY NOT BE ABLE TO ADEQUATELY PAY CLAIMS. TO THE EXTENT WE PURCHASE INSURANCE FROM AIC IN THE FUTURE AND AIC IS UNABLE TO FUND CLAIMS, WE COULD BE UNDERINSURED AND FACE INCREASED COSTS FOR CLAIMS THAT MIGHT OTHERWISE HAVE BEEN FUNDED IF INSURANCE WAS PURCHASED FROM MORE FINANCIALLY SECURE INSURERS. ACCORDINGLY, OUR EXPECTED FINANCIAL BENEFITS FROM OUR INITIAL OR FUTURE INVESTMENTS IN AIC MAY BE DELAYED OR MAY NOT OCCUR AND AIC MAY REQUIRE A LARGER INVESTMENT THAN WE EXPECT,

WE EXPECT TO OPERATE OUR REHABILITATION HOSPITALS AND PHARMACIES PROFITABLY. HOWEVER, WE HAVE HISTORICALLY EXPERIENCED LOSSES FROM THESE OPERATIONS AND WE MAY BE UNABLE TO OPERATE THESE BUSINESSES PROFITABLY,

OUR RESIDENTS MAY BE UNABLE TO AFFORD OUR SERVICES WHICH COULD RESULT IN DECREASED OCCUPANCY AND REVENUES AT OUR SENIOR LIVING COMMUNITIES AND REHABILITATION HOSPITALS, AND

OTHER RISKS MAY ADVERSELY IMPACT US, AS DESCRIBED MORE FULLY IN THIS REPORT UNDER "ITEM IA. RISK FACTORS".

THESE RESULTS COULD OCCUR DUE TO MANY DIFFERENT CIRCUMSTANCES, SOME OF WHICH ARE BEYOND OUR CONTROL, SUCH AS NATURAL DISASTERS OR CHANGES IN OUR RESIDENTS' ABILITY TO AFFORD OUR SERVICES, CHANGES IN LAWS OR REGULATIONS APPLICABLE TO OUR OPERATIONS, OR CHANGES IN CAPITAL MARKETS OR THE ECONOMY GENERALLY.

THE INFORMATION CONTAINED ELSEWHERE IN THIS ANNUAL REPORT ON FORM 10-K OR INCORPORATED HEREIN IDENTIFIES OTHER IMPORTANT FACTORS THAT COULD CAUSE DIFFERENCES FROM OUR FORWARD LOOKING STATEMENTS.

YOU SHOULD NOT PLACE UNDUE RELIANCE UPON FORWARD LOOKING STATEMENTS.

EXCEPT AS REQUIRED BY LAW, WE DO NOT INTEND TO UPDATE OR CHANGE ANY FORWARD LOOKING STATEMENTS AS A RESULT OF NEW INFORMATION, FUTURE EVENTS OR OTHERWISE.

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FIVE STAR QUALITY CARE, INC.

2009 ANNUAL REPORT ON FORM 10-K

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* Incorporated by reference to our definitive Proxy Statement.

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PART I

Item 1. Business

GENERAL

We operate senior living communities, including independent living or congregate care communities, assisted living communities and skilled nursing facilities, or SNFs. As of December 31, 2009, we leased or owned and operated 217 senior living communities containing 22,905 living units, including 170 primarily independent and assisted living communities with 18,627 living units and 47 SNFs with 4,278 living units.

Of our 170 primarily independent and assisted living communities, we:

- leased 143 communities containing 16,451 living units from SNH, our former parent;
- leased four communities with 200 living units from Health Care Property Investors, or HCPI; and
- owned 23 communities with 1,976 living units.

Of our 47 SNFs, we:

- leased 45 facilities from SNH with 4,007 living units; and
- owned two facilities with 271 living units.

In aggregate, our 217 senior living communities included 6,315 independent living apartments, 10,352 assisted living suites and 6,238 skilled nursing units. Excluded from the preceding data are two assisted living communities containing 173 living units, leased from SNH, that have been classified as discontinued operations.

We also own and operate five institutional pharmacies and we operate two rehabilitation hospitals with 321 beds that we lease from SNH. Our two rehabilitation hospitals provide inpatient services at the two hospitals and three satellite locations. In addition, we operate 13 outpatient clinics affiliated with these rehabilitation hospitals.

We were created by SNH in April 2000 to operate 54 SNFs and two assisted living communities repossessed from former SNH tenants. We were incorporated in Delaware in April 2000 and reincorporated in Maryland on September 17, 2001. On December 31, 2001, SNH distributed substantially all of our then outstanding shares to its shareholders and we became a separate, publicly owned company listed on the American Stock Exchange (now the NYSE Amex).

Our principal executive offices are located at 400 Centre Street, Newton, Massachusetts 02458, and our telephone number is (617) 796-8387.

TYPES OF PROPERTIES

Our present business plan contemplates the ownership, leasing and management of independent living apartments or congregate care communities, assisted living communities, SNFs and rehabilitation hospitals. Some of our properties combine more than one type of service in a single building or campus.

Independent Living Apartments or Congregate Care Communities. Independent living apartments or congregate care communities provide high levels of privacy to residents and require residents to be capable of relatively high degrees of independence. An independent living apartment usually bundles several services as part of a regular monthly charge. For example, the base charge may include one or two meals per day in a central dining room, weekly maid service or services of a social director. Additional services are generally available from staff

employees on a fee for service basis. In some

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independent living communities, separate parts of the community are dedicated to assisted living or nursing services. As of December 31, 2009, our business included 6,315 independent living apartments in 53 communities.

Assisted Living Communities. Assisted living communities are typically comprised of one bedroom units which include private bathrooms and efficiency kitchens. Services bundled within one charge usually include three meals per day in a central dining room, daily housekeeping, laundry, medical reminders and 24 hour availability of assistance with the activities of daily living such as dressing and bathing. Professional nursing and healthcare services are usually available at the community as requested or at regularly scheduled times. As of December 31, 2009, our business included 10,352 assisted living suites in 154 communities.

Skilled Nursing Facilities. SNFs generally provide extensive nursing and healthcare services similar to those available in hospitals, without the high costs associated with operating theaters, emergency rooms or intensive care units. A typical purpose built SNF generally includes one or two beds per room with a separate bathroom in each room and shared dining facilities. SNFs are staffed by licensed nursing professionals 24 hours per day. As of December 31, 2009, our business included 6,238 skilled nursing beds in 78 communities.

Rehabilitation Hospitals. Rehabilitation hospitals, also known as inpatient rehabilitation facilities, or IRFs, provide intensive physical therapy, occupational therapy and speech language pathology services beyond the capabilities customarily available in SNFs. Patients in IRFs generally receive a minimum of three hours of rehabilitation services daily. IRFs also provide onsite pharmacy, radiology, laboratory, telemetry, hemodialysis and orthotics/prosthetics services. Outpatient satellite clinics are often included as part of the services offered by IRFs. As of December 31, 2009, our two rehabilitation hospitals had 321 beds available for inpatient services and provided services at three satellite locations. In addition, these two hospitals operate 13 affiliated outpatient clinics where patients discharged from hospitals can continue their therapy programs and receive amputee, brain injury, neurorehabilitation, cardio-pulmonary, orthopedic, spinal cord injury and stroke rehabilitation services.

Institutional Pharmacies. Institutional pharmacies provide large quantities of drugs at locations where patients with recurring pharmacy requirements are concentrated. Our institutional pharmacies included in continuing operations are located in six leased commercial spaces and one owned commercial space containing a total of approximately 71,659 square feet plus parking areas for our employees and delivery vehicles.

OUR HISTORY

Senior living acquisitions and initiation of long term leases

We have grown our business through acquisitions and through initiation of long term leases of independent and assisted living communities where residents' private resources account for a large majority of revenues.

In 2009, we commenced operations at 11 senior living communities with a total of 952 living units that we leased from SNH. Ten of these communities are assisted living communities and one community is a continuing care retirement community which offers independent living, assisted living and skilled nursing services.

Institutional Pharmacies

In December 2007, we decided to sell one institutional pharmacy located in California and our mail order pharmacy located in Nebraska. We sold the institutional pharmacy located in California in two separate transactions in 2009, which resulted in a gain on sale of $1.2 million. We were unable to

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sell the mail order pharmacy on acceptable terms and we ceased its operations on March 31, 2009. Accordingly, the operating results of these two businesses are now included in discontinued operations.

Rehabilitation Hospitals

In October 2006, we began to operate two rehabilitation hospitals located in Braintree and Woburn, Massachusetts that provide extensive inpatient and outpatient health rehabilitation services. These hospitals are leased from SNH through June 30, 2026.

Discontinued Operations

During 2007, we agreed with SNH that it should sell two assisted living communities located in Pennsylvania, which we lease from SNH. We and SNH are in the process of selling these assisted living communities and, upon their sale, our annual rent payable to SNH will decrease by approximately 9.0% of the net proceeds of the sale.

As discussed above, during 2009, we sold one institutional pharmacy located in California and closed our mail order pharmacy located in Nebraska.

During 2009, with our approval, SNH sold two SNFs, which we leased from SNH. On October 1, 2009, SNH sold a SNF located in Iowa to an unaffiliated party for approximately $473,000 and our rent payable to SNH decreased by approximately $47,300. On November 1, 2009, SNH sold a SNF located in Missouri to an unaffiliated party for net proceeds of approximately $1.2 million and our rent payable to SNH decreased by approximately $124,700.

Equity and Debt Financings

In 2006, we issued $126.5 million principal amount of Convertible Senior Notes due 2026, or the Notes. The Notes bear interest at 3.75% per annum, payable semi-annually, and will mature on October 15, 2026. We may prepay the Notes at anytime after October 20, 2011 and the Note holders may require that we purchase all or a portion of these Notes on each of October 15, 2013, 2016 and 2021. During 2009, we purchased and retired $76.8 million par value of our Notes for $39.9 million plus accrued interest. As a result of these purchases we recorded a $34.6 million gain, net of related unamortized costs, on early extinguishment of debt, and $49.7 million in principal amount of the Notes remain outstanding.

OUR GROWTH STRATEGY

We believe that the aging of the United States population will increase demand for independent living properties, assisted living communities, SNFs, institutional pharmacies and rehabilitation services. Our principal growth strategy is to profit from this increasing demand by operating properties that provide high quality services to seniors.

We seek to improve the profitability of our existing operations by increasing revenues and improving margins. We attempt to increase revenues by increasing rates and utilization of our facilities and services. We attempt to improve margins by limiting increases in expenses and improving operating efficiencies.

In addition to managing our existing operations, we intend to continue to grow our business through acquisitions, primarily through initiation of long term leases, of independent and assisted living communities where residents' private resources account for a large majority of revenues.

Since we became a public company in late 2001, we have acquired or leased, and continue to own or lease and operate, 169 primarily independent and assisted living communities that as of December 31, 2009 generated approximately 85.8% of their revenue from residents' private resources,

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rather than from Medicare or Medicaid. We prefer to acquire communities which have achieved or are close to achieving stabilized operations, although we occasionally purchase turn-around facilities where we believe we can make significant improvements in operations. We also seek to make acquisitions where we can realize cost efficiencies by adding communities to existing regional operations.

Although expansion of our free-standing SNF business is not our primary growth strategy, we consider the inclusion of skilled nursing operations in continuing care retirement communities to be a worthwhile growth opportunity.

OPERATING STRUCTURE

We have three divisional offices. Each divisional office is responsible for multiple regions and is headed by a divisional vice president with extensive experience in the senior living industry. We have several regional offices within each division. Each regional office is responsible for multiple communities and is headed by a regional director of operations with extensive experience in the senior living industry. Each regional office is typically supported by a clinical or wellness director, a rehabilitation services director, a regional accounts manager, a human resources specialist and a sales and marketing specialist. Regional staffs are responsible for all our senior living community operations within the region, including:

- resident services;
- Medicare and Medicaid billing;
- marketing and sales;
- hiring of community personnel;
- compliance with applicable legal and regulatory requirements; and
- supporting our development and acquisition plans within their region.

In addition, a fourth divisional vice president with extensive experience in the institutional pharmacy and rehabilitation industries oversees our institutional pharmacies and IRF businesses from our corporate office.

Our corporate office staff, located in Massachusetts, provides the following services:

- the establishment of company wide policies and procedures relating to resident care;
- human resources policies and procedures;
- information technology;
- private pay billing for our independent living apartments and assisted living communities;
- maintenance of licensing and certification;

legal services;

central purchasing;

budgeting and supervision of maintenance and capital expenditures;

implementation of our growth strategy; and

accounting and finance functions, including operations, budgeting, certain accounts receivable and collections functions, accounts payable, payroll and financial reporting.

As described in this Annual Report on Form 10-K, we have a business management and shared services agreement, or the business management agreement, with RMR pursuant to which RMR

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provides to us certain management, administrative and information system services including internal audit, investor relations and tax services.

STAFFING

Independent and Assisted Living Community Staffing. Each of the independent and assisted living communities we operate has an executive director responsible for the day to day operations of the community, including quality of care, resident services, sales and marketing, financial performance and staff supervision. The executive director is supported by department heads, who oversee the care and service of the residents, a wellness director, who is responsible for coordinating the services necessary to meet the health care needs of our residents and a marketing director, who is responsible for selling our services. Other important staff includes the dining services coordinator, the activities coordinator and the property maintenance coordinator.

Skilled Nursing Facility Staffing. Each of our SNFs is managed by a state licensed administrator who is supported by other professional personnel, including a director of nursing, an activities director, a marketing director, a social services director, a business office manager, and physical, occupational and speech therapists. Our directors of nursing are state licensed nurses who supervise our registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each SNF and on the type of care provided by the SNF. Our SNFs also contract with physicians who provide certain medical services.

Rehabilitation Hospital Staffing. Each of our IRFs is operated under the leadership of a hospital based chief executive officer with the support of senior staff, including a medical director, chief financial officer, director of patient care services, director of rehabilitation and director of case management. The hospitals are also staffed with board certified physicians who primarily specialize in internal medicine, neurology or physiatry, as well as other licensed professionals, including rehabilitation nurses, physical therapists, occupational therapists, speech and language pathologists, nutrition counselors, neuropsycologists and pharmacists. Each outpatient clinic associated with our IRFs is managed by an outpatient director who is a registered occupational or physical therapist.

Institutional Pharmacy Staffing. Our institutional pharmacies provide prescriptions, medical supplies, equipment and services only to operators and residents of senior living communities. Each of our institutional pharmacies is managed by an executive director, who is responsible for the day to day operations of each institutional pharmacy, including billings, sales and marketing, financial performance, compliance with regulatory codes regarding the dispensing of controlled substances and staff supervision. Other institutional pharmacy personnel include licensed dispensing pharmacists, a director of pharmacy consultation, a medical records director, a nurse consultant, pharmacy technicians and billing personnel.

EMPLOYEES

As of February 19, 2010, we had approximately 22,000 employees, including 14,212 full time equivalents. Approximately 85 employees, including approximately 68 full time equivalents, are represented under one collective bargaining agreement, which has a remaining term of approximately three years. We have no employment agreements with our employees except for one contract entered into with a former owner operator of an institutional pharmacy which we acquired. We believe our relations with our union and non-union employees are good.

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GOVERNMENT REGULATION AND REIMBURSEMENT

Our operations must comply with numerous federal, state and local statutes and regulations. Also, the healthcare industry depends significantly upon federal and state programs for revenues and, as a result, is vulnerable to the budgetary policies of both the federal and state governments.

Independent Living Communities. Government benefits generally are not available for services at independent living communities and the resident charges in these communities are paid from private resources. However, a number of Federal Supplemental Security Income program benefits pay housing costs for elderly or disabled residents to live in these types of residential communities. The Social Security Act requires states to certify that they will establish and enforce standards for any category of group living arrangement in which a significant number of Supplemental Security Income residents reside or are likely to reside. Categories of living arrangements which may be subject to these state standards include independent living communities and assisted living communities. Because independent living communities usually offer common dining facilities, in many locations they are required to obtain licenses applicable to food service establishments in addition to complying with land use and life safety requirements. In many states, independent living communities are licensed by state or county health departments, social service agencies or offices on aging with jurisdiction over group residential communities for seniors. To the extent that independent living communities include units in which assisted living or nursing services are provided, these units are subject to applicable state licensing regulations, and if the communities receive Medicaid or Medicare funds, to certification standards. In some states, insurance or consumer protection agencies regulate independent living communities in which residents pay entrance fees or prepay for services.

Assisted Living Communities. According to the National Center for Assisted Living, a majority of states provide or are approved to provide Medicaid payments for personal care and medical services to some residents in licensed assisted living communities under waivers granted by the Federal Centers for Medicare and Medicaid Services, or CMS, or under Medicaid state plans. Most other states are planning some Medicaid funding by preparing state plan amendments or requesting waivers. State Medicaid programs control costs for assisted living and other home and community-based services by various means such as restrictive financial and functional eligibility standards, enrollment limits and waiting lists. Because rates paid to assisted living community operators are generally lower than rates paid to nursing home operators, some states use Medicaid funding of assisted living as a means of lowering the cost of services for residents who may not need the higher intensity of health related services provided in SNFs. States that administer Medicaid programs for services in assisted living communities are responsible for monitoring the services at, and physical conditions of, the participating communities. Different states apply different standards in these matters, but generally we believe these monitoring processes are similar to the concerned states' inspection processes for SNFs.

As a result of the large number of states using Medicaid to purchase services at assisted living communities and the growth of assisted living in recent years, a majority of states have adopted licensing standards applicable to assisted living communities. A majority of states have licensing statutes or standards specifically using the term "assisted living" and have requirements for communities servicing people with Alzheimer's disease or dementia. The majority of states have revised their licensing regulations recently or are reviewing their policies or revising their regulations. State regulatory models vary; there is no national consensus on a definition of assisted living, and no uniform approach by the states to regulating assisted living communities. Most state licensing standards apply to assisted living communities whether or not they accept Medicaid funding. Also, a few states require certificates of need from state health planning authorities before new assisted living communities may be developed. Based on our analysis of current economic and regulatory trends, we believe that assisted living communities that become dependent upon Medicaid or other public payments for a majority of their revenues may decline in value because Medicaid and other public rates may fail to keep up with increasing costs. We also believe that assisted living communities located in states that adopt certificate

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of need requirements or otherwise restrict the development of new assisted living communities may increase in value because these limitations upon development may help ensure higher occupancy and higher non-governmental rates.

The United States Department of Health and Human Services, the Government Accountability Office, or GAO, and the Senate Special Committee on Aging have studied and reported on the development of assisted living and its role in the continuum of long term care and as an alternative to SNFs. In 2003, the GAO recommended that CMS strengthen its oversight of state quality assurance in Medicaid home and community-based services waiver programs. Since then, CMS has commenced a series of actions to increase its oversight of state quality assurance programs for assisted living facilities and has provided guidance and technical assistance to the states to improve their ability to monitor and improve the quality of services paid for through Medicaid waiver programs. Based upon our analysis of current economic and regulatory trends, we do not believe that the federal government is likely to have a material impact upon the current regulatory environment in which the assisted living industry operates unless it also undertakes expanded funding obligations. Although CMS is encouraging state Medicaid programs to expand their use of home and community based services as alternatives to institutional services, pursuant to provisions of the Deficit Reduction Act of 2005, or DRA, and other authorities, we do not believe a materially increased financial commitment from the federal government to fund assisted living is presently likely. However, we do anticipate that assisted living communities will increasingly be licensed and regulated by the various states, and that, in the absence of federal standards, the states' policies will continue to vary widely.

Skilled Nursing Facilities Reimbursement. About 62% of all SNF revenues in the United States in 2008 (the most recent date for which information is publicly available) came from publicly funded programs, including about 41% from Medicaid programs, 19% from the Medicare program and 2% from other public programs. SNFs are among the most highly regulated businesses in the country. The federal and state governments regularly monitor the quality of care provided at SNFs. State health departments conduct surveys of resident care and inspect the physical condition of nursing home properties. These periodic inspections and occasional changes in life safety and physical plant requirements sometimes require nursing home operators to make significant capital improvements. These mandated capital improvements have in the past usually resulted in Medicare and Medicaid rate adjustments, albeit on the basis of amortization of expenditures over expected useful lives of the improvements. Under the Medicare prospective payment system, or the PPS, capital costs are part of the prospective rate and are not community specific. The PPS and other recent legislative and regulatory actions with respect to state Medicaid rates are limiting the reimbursement levels for some nursing home services. At the same time, federal and state enforcement and oversight of SNFs have been increasing, making licensing and certification of these communities more rigorous.

The PPS was intended to reduce the rate of growth in Medicare payments for SNFs. Under the current Medicare payment system, SNFs receive a fixed payment for each day of care provided to residents who are Medicare beneficiaries. Each resident is assigned to a care group depending on that resident's medical characteristics and service needs. These care groups are known as Resource Utilization Groups, or RUGs. Per diem payment rates are established for each of these care groups. Medicare payments cover substantially all services provided to Medicare residents in SNFs, including ancillary services such as rehabilitation therapies. The PPS is intended to provide incentives to providers to furnish only necessary services and to deliver those services efficiently.

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From November 1999 to January 2006, Congress and CMS provided some periodic relief from the financial effect of the PPS, through temporary increases in SNF payment rates and temporary moratoria on some therapy limitations for skilled nursing residents covered under Medicare Part B. Effective January 1, 2006, CMS implemented changes to the payment categories it uses to set daily payment rates for Medicare beneficiaries in SNFs. CMS introduced nine new payment categories for medically complex patients, increasing the number of categories from 44 to 53, and made revisions to its payment rates for current RUGs. These RUG changes caused the elimination of certain temporary additional payments for certain skilled nursing care and rehabilitation groups. The financial impact of these changes to the Medicare rates on our operations was to effectively eliminate an October 2005 Medicare 3% rate increase; but then in each of the next three years, the Medicare rates were increased by approximately 3%, under a rule adding an annual update to account for inflation in the costs of goods and services included in a SNF stay. Effective as of October 1, 2009, CMS has adopted rules recalibrating the Medicare prospective payment categories for SNFs for federal fiscal year 2010. CMS estimates that the recalibration will result in a decrease of approximately 3.3% in projected SNF payments, offset by an increase of approximately 2.2% to account for inflation, and that as a result, aggregate Medicare payments to SNFs will be reduced by approximately 1.1% in federal fiscal year 2010.

Under the DRA, the federal government is slowing the growth of Medicare and Medicaid payments for nursing home services by several methods. Medicare bad debt reimbursement has been reduced from 100% to 70% for uncollected cost sharing payments from Medicare beneficiaries who are not eligible for Medicaid. Limits on Medicare payments were also implemented for outpatient therapies in 2006, with an exception process under which beneficiaries could request an exception from the cap and be granted the amount of services deemed medically necessary by Medicare. The Medicare outpatient therapy exception process has been extended under subsequent laws through December 31, 2009. This expiration of the Medicare outpatient therapy cap exception process may result in a reduction in our outpatient therapy revenues in 2010. Proposals to reinstate and extend the exception process have been introduced in Congress, but we cannot predict whether the exception process will be extended after December 31, 2009.

In addition, the DRA increased the "look-back" period for prohibited asset transfers that disqualify individuals from Medicaid nursing home benefits from three to five years. The period of Medicaid ineligibility begins on the date of the prohibited transfer or the date an individual has entered the nursing home and would otherwise be eligible for Medicaid coverage, whichever occurs later, rather than on the date of the prohibited transfer, effectively extending the Medicaid penalty period and placing added burdens on SNFs to collect charges directly from residents and their transferees. The DRA includes a five year demonstration project that in 2007 awarded competitive grants to 30 states to provide home and community based long term care services to qualified individuals relocated from SNFs, providing an increased federal medical assistance percentage for 12 months for each qualifying beneficiary, during a grant period of at least two years. The DRA also includes a post acute payment reform demonstration program that will compare and assess costs and outcomes of services at different long term care sites over three years. Since January 1, 2007, states may include home and community based services as optional services under their Medicaid state plans, rather than only pursuant to waivers or demonstration projects, and such states may cap enrollment, maintain waiting lists and offer the services in only some regions of a state, as they may with waivers.

Skilled Nursing Facilities Survey and Enforcement. More than twenty years ago, Congress enacted major reforms to federal and state regulatory systems for SNFs that participate in the Medicare and Medicaid programs, under the Omnibus Reconciliation Act of 1987. Since then, the GAO reports that, while much progress has been made, substantial problems remain in the effectiveness of federal and state regulatory activities. Since 1999, the U.S. Department of Health and Human Services, Office of Inspector General has issued several reports concerning quality of care in SNFs and the GAO has

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issued several reports, most recently in 2009, recommending that CMS and the states strengthen their compliance and enforcement practices, including federal oversight of state actions, to better ensure that SNFs provide adequate care and states act more consistently. The Senate Special Committee on Aging and other congressional committees have also held hearings on these issues. As a result, CMS has undertaken an initiative to increase the effectiveness of Medicare and Medicaid nursing home survey and enforcement activities. CMS is taking steps to focus more survey and enforcement efforts on SNFs with findings of substandard care or repeat violations of Medicare and Medicaid standards and to identify chain operated communities with patterns of noncompliance. CMS is increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey communities more consistently. In addition, CMS adopted regulations expanding federal and state authority to impose civil monetary penalties in instances of noncompliance. A small number of SNFs with a history of serious quality problems, designated by CMS as "special focus facilities," or SFFs, are inspected more frequently and subject to more stringent enforcement actions. Homes in the SFF initiative for six months or longer are now listed on the Medicare website at *www.medicare.gov*. The GAO has recommended several steps to make enforcement by CMS and the states more timely and effective, especially for SFFs. Medicare survey results, including fire safety reports and average nursing and nursing assistant staff hours per resident for each nursing home are posted on the Medicare website at *www.medicare.gov*. CMS has recently added a five-star quality rating system to the information concerning SNFs that it provides to consumers on its website. Ratings are from one to five stars, based on three factors that are separately rated health inspections from the last three years, the average number of hours of daily care provided to each resident by nursing staff, including nursing assistants, and selected physical and clinical measures related to quality of care. CMS issued a rule in August 2008 that requires older SNFs to install sprinkler systems within five years, by August 13, 2013. SNFs that do not have sprinklers or hard-wired smoke detectors are required to install battery powered smoke detectors in the interim. Currently all of our SNFs except five have sprinklers and we believe the five nursing homes without sprinklers are in compliance with the current requirements because they have a combination of hard wired and battery operated smoke detectors or hard wired smoke detector and a horn strobe system. When deficiencies under state licensing and Medicare and Medicaid standards are identified, sanctions and remedies such as denials of payment for new Medicare and Medicaid admissions, civil monetary penalties, state oversight, temporary management and loss of Medicare and Medicaid participation or licensure may be imposed on nursing home operators. Our communities incur sanctions and penalties from time to time. If we are unable to cure deficiencies which have been identified or that are identified in the future, or if appeals of proposed sanctions or penalties are not successful, additional sanctions or penalties may be imposed, and if imposed, may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

In 2000 and 2002, the Department of Health and Human Services and CMS issued reports linking nursing staffing levels with quality of care. CMS has indicated that it does not intend to impose minimum staffing levels or to increase Medicare or Medicaid rates to cover the costs of increased staffing; however, CMS publishes the nurse and nursing assistant staffing level at each nursing home on the internet at *www.medicare.gov* to create market pressure to improve nursing home operations.

Rehabilitation Hospital Regulation and Rate Setting. Our two rehabilitation hospitals are subject to federal, state and local regulation that affects their business activities and determines the rates they receive for services. These IRFs are subject to periodic inspection by governmental and non-governmental agencies to ensure continued compliance with various licensure and accreditation standards. In addition, these facilities are certified by CMS to participate in the Medicare program and receive a significant portion of their revenues from that program.

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On May 7, 2004, CMS issued a rule, known as the "75% Rule," establishing revised Medicare standards that IRFs are required to meet in order to participate as IRFs in the Medicare program. An IRF that failed to meet the requirements of the 75% Rule would be subject to reclassification as a different type of healthcare provider and the effect of such reclassification would be to lower Medicare payment rates. The rule is now known as the "60% Rule." Under the Medicare, Medicaid and SCHIP Extension Act of 2007, adopted in December 2007, for cost reporting periods starting on or after July 1, 2007, the 75% requirement for IRFs was reduced to 60%, and selected secondary medical conditions are included to qualify patients under the 60% requirement. The 60% Rule now generally provides that, to be considered an IRF and receive reimbursement for services under the IRF prospective payment system, at least 60% of a facility's total inpatient population must require intensive rehabilitation services associated with treatment of at least one of 13 designated medical conditions. Under the 60% Rule, to maintain their revenue levels many rehabilitation hospitals have needed to reduce the number of non-qualifying patients treated and replace them with qualifying patients, establish other sources of revenues or both. Before the 2007 amendment, the rule was being phased in over a four year period that began on July 1, 2004. For cost reporting periods starting on and after July 1, 2006, 60% of a facility's inpatient population must have required intensive rehabilitation services for one of CMS' designated medical conditions. For cost reporting periods starting on and after July 1, 2007, the requirement was 65%, and for cost reporting periods starting on and after July 1, 2008, the requirement was 75%. As a result of the rollback amendment, the requirement is now 60% for these and future cost reporting periods. We believe our hospitals have been and are operating in compliance with this rule and we are taking actions to assure continued compliance; however, we can provide no assurance that we will be able to continue to comply with this rule, or that CMS will not make a determination that we were non-compliant in a prior year. Also pursuant to the Medicare, Medicaid and SCHIP Extension Act of 2007, the annual inflation increase factor for Medicare payment rates for IRFs was set at zero percent for each of federal fiscal years 2008 and 2009, except for certain payments occurring before April 1, 2008. Our Medicare inflation increase factor for federal fiscal year 2008 had been set at approximately 3.5% effective October 1, 2007, and our rates were reduced by 3.2% effective as of April 1, 2008. Effective October 1, 2008 CMS adopted a rule updating the Medicare IRF prospective rate formulas. The rule recalculated the weights assigned to the 13 patient case mix groups that are used to calculate rates under the IRF prospective payment system and reset the outlier threshold to maintain estimated outlier payments at 3% of total estimated IRF payments for fiscal year 2009. CMS estimated that the changes contained in the rule would result in a decrease of 0.7% to total Medicare payments to IRFs for federal fiscal year 2009. Although the effects of the rate freeze and the recalibration were counterbalanced by the reduction of the prior law's 65% and 75% minimum percentage requirements to 60% under current law, the net effect of these changes adversely affected the profitability of our rehabilitation operations. Effective as of October 1, 2009, CMS has adopted rules that it estimates will increase aggregate Medicare payments to IRFs by approximately 2.5% in federal fiscal year 2010. CMS has set the outlier payments at 3% of total estimated IRF payments for the year. CMS has also adopted rules revising and clarifying the coverage criteria for Medicare patients in IRFs, effective as of January 1, 2010. These regulations include criteria for patient selection, treatment planning, coordination of care, and professional training and experience.

Certificates of Need. Most states limit the number of SNFs and hospitals by requiring developers to obtain certificates of need before new communities may be built and a few states also limit the number of assisted living facilities by requiring certificates of need. Also, states such as California and Texas that have eliminated certificate of need laws often have retained other means of limiting new development, such as the use of moratoria, licensing laws or limitations upon participation in the state Medicaid program. We believe that these governmental limitations may make existing SNFs and hospitals more valuable by limiting competition.

Other Matters. Federal and state efforts to target false claims, fraud and abuse and violations of anti-kickback, physician referral and privacy laws by Medicare and Medicaid providers and providers

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under other public and private programs have increased in recent years, as have civil monetary penalties, repayment requirements and criminal sanctions for noncompliance. In 2000, the U.S. Department of Health and Human Services Office of Inspector General, or OIG, issued compliance guidelines for SNFs to assist them in developing voluntary compliance programs to prevent fraud and abuse with supplemental guidance in 2008. The OIG issued compliance program guidance for hospitals in 1998 and supplemental guidance in 2005. CMS contractors are expanding the retroactive audits of Medicare claims submitted by IRFs, SNFs and other providers, and recouping alleged overpayments for services determined by auditors not to have been medically necessary or not to meet Medicare coverage criteria as billed. State Medicaid programs and other third party payors are conducting similar medical necessity and compliance audits.

Under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, rules governing the privacy, use and disclosure of individually identified health information took effect in 2003, and compliance with security rules for electronic personal health information was required by April 20, 2005 with civil monetary penalties and criminal sanctions for noncompliance. Compliance with expanded HIPAA privacy and security requirements recently enacted by Congress, and implementing regulations, was required on various dates between February 2009 and February 2010, and compliance with updated standards for electronic healthcare transactions and pharmacy transactions will be required on January 1, 2012.

Any adverse determination concerning any of our licenses or eligibility for Medicare or Medicaid reimbursement or any substantial penalties, repayments or sanctions, and the increasing costs of required compliance with applicable federal and state laws, may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006, Medicare beneficiaries may receive prescription drug benefits by enrolling in private health plans or managed care organizations, or if they remain in traditional Medicare, by enrolling in stand alone prescription drug plans. As a result of the implementation of this Medicare Part D drug program in 2006, the government's share of prescription drug expenditures has risen substantially from 28% in 2005 to 37% in 2008 (the most recent date for which this information is publicly available). Of the government funds spent for prescription drugs, Medicare's share was 7% in 2005 and 60% in 2008, while Medicaid's share was 68% in 2005 and 23% in 2008. As of January 2008, approximately 90% of Medicare beneficiaries had Medicare Part D drug coverage, according to the US Department of Health and Human Services. Due to Medicare's growing share of total prescription drug expenditures and increasing budget pressures on state and federal governments, we believe that government actions to control drug costs are likely to increase, reducing the profitability of providing pharmacy products and services.

The U.S. House of Representatives and U.S. Senate have each recently passed comprehensive, but different, national healthcare reform bills that would, if adopted, dramatically change the country's healthcare system. We are unable to predict whether healthcare reform legislation will be adopted after negotiations between the House and Senate, the form of the legislation if adopted, or if adopted, the impact it will have on our business or financial condition. The pending bills include healthcare insurance reforms, payment systems reforms, and healthcare delivery systems reforms, with the goals of expanding access to health insurance coverage and simultaneously reducing the growth of healthcare expenditures. Included in the bills or under consideration by Congress are mandates that most individuals purchase health insurance, tax credits to assist those with low incomes to acquire health insurance, expansion of Medicaid eligibility to more people, mandates that most employers pay part of the cost of health insurance for their employees, statewide insurance exchanges to expand access to health insurance, reducing or freezing Medicare and Medicaid provider payment rates including rates of SNFs and IRFs, and various pilot projects intended to reduce or slow the growth of healthcare costs. The pending legislation includes a pilot program under which acute care hospitals and post acute care

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providers such as SNFs, IRFs and rehabilitation clinics would receive a single bundled Medicare payment for acute hospital and post-acute care provided to a patient. The pending legislation also includes provisions for individuals to purchase government sponsored long term care insurance, which would entitle participating individuals after five or more years to receive insurance benefits for long term care services such as SNF or home health care services if needed.

Other legislative proposals that have been introduced in Congress, proposed by federal or state agencies or are being considered by some state governments, include the option of block grants for states rather than federal matching money for certain state Medicaid services, additional policies encouraging state Medicaid programs to use home and community based long term care services rather than SNFs, laws authorizing or directing Medicare to negotiate rate reductions for prescription drugs, additional Medicare and Medicaid enforcement procedures and federal and state cost containment measures, such as freezing Medicare or Medicaid nursing home and rehabilitation hospital payment rates at their current levels and reducing or eliminating annual Medicare or Medicaid inflation allowances or gradually reducing rates for SNFs and rehabilitation hospitals.

The recent recession and current difficult economic conditions are causing budget shortfalls in most states, increasing the likelihood of Medicaid rate reductions, freezes or increases that are insufficient to offset increasing operating costs. Pursuant to the American Recovery and Reinvestment Act of 2009, adopted February 17, 2009, federal payments to states for Medicaid programs have been temporarily increased retroactively from October 1, 2008 through December 31, 2010, with greater increases for states with more unemployment. Payments to states for Medicaid expenditures on hospitals, SNFs and other specified providers are conditioned on states paying those providers promptly. However, most states project continuing fiscal deficits. The magnitude of the potential Medicare and Medicaid rate reductions and the impact of the failure of these programs to increase rates to match increasing expenses, as well as the impact on us of potential healthcare reform laws and Medicare and Medicaid policy changes proposed by members of Congress cannot currently be estimated, but they may be material to our operations and may adversely affect our future results of operations.

INSURANCE

Litigation against senior living and healthcare companies has increased during the past few years. As a result, liability insurance costs have risen. Also, our insurance costs for workers compensation and employee healthcare have increased. To partially offset these insurance cost increases, we have taken a number of actions including the following:

- we have become fully self insured for all health related claims of covered employees;
- we have increased the deductible or retention amounts for which we are liable under our liability insurance;
- we have established offshore captive insurance companies which participate in our liability and worker compensation insurance programs. These programs may allow us to reduce our net insurance costs by allowing us to retain the earnings on our reserves, provided that our claims experience is as projected by various statutory and actuarial formulas;
- we have increased the amounts which some of our employees are required to pay for health insurance coverage and as co-payments for health services and pharmaceutical prescriptions and decreased the amount of certain healthcare benefits. In October 2008, we added a high deductible health insurance plan as an option for our employees;
- we have hired professional advisors to help us establish programs to reduce our insured workers compensation and professional and general liabilities, including a program to monitor and proactively settle liability claims and to reduce workplace injuries;

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we have hired insurance and other professionals to help us establish appropriate reserves for our retained liabilities and captive insurance programs; and

in order to obtain more control over our insurance costs, we and other companies to which RMR provides management services have recently organized a new insurance company which will soon begin to underwrite certain of our insurance requirements.

We partially self insure up to certain limits for workers compensation and professional liability. Claims in excess of these limits are insured with third party insurance providers up to contractual limits, over which we are self insured. Our current insurance arrangements are generally renewable in June 2010. We do not know if our insurance charges and self insurance reserve requirements will increase, and we cannot now predict the amount of any such increase, or to what extent, if at all, we may be able to offset any increase through use of higher deductibles, retention amounts, self insurance or other means in the future. For more information about our new insurance initiative see Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations Related Person Transactions" of this Annual Report on Form 10-K.

COMPETITION

The senior living services, pharmacy and the rehabilitation hospital businesses are highly competitive. We compete with service providers offering alternate types of services, such as home healthcare services, as well as other companies providing facility based services and rehabilitation services. We have large lease obligations and limited financeable assets. Many of our competitors have greater financial resources than we do. We may expand our business with SNH and our relationships with SNH and RMR may provide us with competitive advantages; however, SNH is not obligated to provide us with opportunities to lease additional properties. Some of our competitors are operated by not for profit entities which have endowment income and may not have the same financial pressures that we experience. For all of these reasons and others, we cannot provide any assurance that we will be able to compete successfully for business.

ENVIRONMENTAL AND CLIMATE CHANGE MATTERS

Under various laws, owners as well as tenants and operators of real estate may be required to investigate and clean up or remove hazardous substances present at or migrating from properties they own, lease or operate and may be held liable for property damage or personal injuries that result from hazardous substances. These laws also expose us to the possibility that we may become liable to reimburse governments for damages and costs they incur in connection with hazardous substances. Under our leases with SNH, we have also agreed to indemnify SNH for any such liabilities related to the properties we lease from SNH. In addition, some environmental laws create a lien on a contaminated site in favor of the government for damages and costs it incurs in connection with the contamination, which lien may be senior in priority to our debt obligations or our leases. We have reviewed environmental surveys of all of our leased and owned communities. Based upon that review we do not believe that there are environmental conditions at any of our properties that have had or will have a material adverse effect on us. However, no assurances can be given that conditions are not present at our properties or that costs we may be required to incur in the future to remediate contamination will not have a material adverse effect on our business or financial condition.

The current political debates about world climate changes has resulted in various existing and proposed treaties, laws and regulations which are intended to limit carbon emissions. We believe treaties, laws and regulations which may limit carbon emissions may cause energy costs at our communities to increase. In the longer term, we believe any such increased costs will be passed through and paid by our patients, residents and other customers in higher charges for our services. However, in the short term, these increased costs, if material in amount, could materially and adversely affect our financial condition and results of operations.

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INTERNET WEBSITES

Our internet website address is www.fivestarseniorliving.com. Copies of our governance guidelines, or Governance Guidelines, code of business conduct and ethics, or Code of Conduct, and the charters of our audit, quality of care, compensation and nominating and governance committees are posted on our website and may be obtained free of charge by writing to our Secretary, Five Star Quality Care, Inc., 400 Centre Street, Newton, Massachusetts, 02458 or at our website. We make available, free of charge, on our website, our Annual Reports on Form 10-K, our Quarterly Reports on Form 10-Q, our Current Reports on Form 8-K and amendments to these reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, or the Exchange Act, as soon as reasonably practicable after these forms are filed with, or furnished to, the Securities and Exchange Commission, or SEC. Any shareholder or other interested party who desires to communicate with our Independent Directors, individually or as a group, may do so by filling out a report on our website. Our Board of Directors also provides a process for our security holders to send communications to our entire Board of Directors. Information about the process for sending communications to our Board of Directors can be found on our website. Our website address and website addresses of one or more unrelated third parties are included several times in this Annual Report on Form 10-K as textual references only and none of the information on any such websites is incorporated by reference into this Annual Report on Form 10-K.

Item 1A. Risk Factors

Our business faces many risks. The risks described below may not be the only risks we face. Additional risks that we do not yet know of, or that we currently think are immaterial, may also impair our business operations or financial results. If any of the events or circumstances described in the following risks occurs, our business, financial condition or results of operations would suffer and the trading price of our securities could decline. Investors and prospective investors should consider the following risks and the information contained under the heading "Warning Concerning Forward Looking Statements" before deciding whether to invest in our securities.

RISKS RELATED TO OUR BUSINESS

A small percentage decline in our revenues or increase in our expenses could have a material negative impact upon our operating results.

For the year ended December 31, 2009, our revenues were $1.19 billion and our operating expenses were $1.18 billion. A small percentage decline in our revenues or increase in our expenses could have a material negative impact upon our operating results.

Circumstances that adversely affect the ability of seniors, or their families, to pay for our services could have a material adverse effect on us.

Our residents paid approximately 69% of our senior living revenues during the year ended December 31, 2009 from their private resources. We expect to continue to rely on the ability of our residents to pay for our services from their own financial resources. Inflation, a devalued stock market, rising unemployment, or other circumst