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2019 Annual Report

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

CHECK ONE:

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

For the fiscal year ended December 31, 2019
OR

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

For the transition period from to

Commission file No.: 1-12996

Diversicare Healthcare Services, Inc.

(exact name of registrant as specified in its charter)

Delaware	**62-1559667**
(State or other jurisdiction of incorporation or organization)	**(IRS Employer Identification No.)**
1621 Galleria Boulevard, Brentwood, TN	**37027**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (615) 771-7575

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

Title of each class	**Name of each Exchange on which registered**
Common Stock, $0.01 par value per share	**OTCQX**

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 ☐ No ☑

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 ☐ No ☑

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 ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer”, “smaller reporting company,” and "emerging growth company" in Rule 12b-2 of the Exchange Act.
Large accelerated filer ☐ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☑
Emerging growth company ☐

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

The aggregate market value of Common Stock held by non-affiliates on June 30, 2019 (based on the closing price of such shares on the Nasdaq Capital Market) was approximately $16,647,000. For purposes of the foregoing calculation only, all directors, named executive officers and persons known to the registrant to be holders of 5% or more of the registrant's Common Stock have been deemed affiliates of the registrant.

On February 28, 2020, 6,676,054 shares of the registrant's $0.01 par value Common Stock were outstanding.

Documents Incorporated by Reference

Registrant's definitive proxy materials for its 2020 annual meeting of shareholders are incorporated by reference into Part III, Items 10, 11, 12, 13 and 14 of this Form 10-K.

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PART 1

ITEM 1. BUSINESS

Introductory Summary.

Diversicare Healthcare Services, Inc. provides post-acute care services to skilled nursing facilities, referred to as "skilled nursing centers," "nursing centers," or "centers," patients and residents in nine states, primarily in the Southeast, Midwest, and Southwest United States. Unless the context indicates otherwise, references herein to “Diversicare,” “the Company,” “we,” “us” and “our” include Diversicare Healthcare Services, Inc. and all of our consolidated subsidiaries. Diversicare Healthcare Services, Inc. was incorporated as a Delaware corporation in 1994.

The post-acute care profession encompasses a broad range of non-institutional and institutional services. For those among the aging, infirmed, or disabled requiring temporary or limited special services, a variety of home care options exist. As the need for assistance with activities of daily living develop, assisted living centers become the most viable and cost effective option. For those amongst the aging, disabled, or infirmed requiring more extensive assistance and intensive care, skilled nursing center care may become the only viable option. We have chosen to focus our business primarily on the skilled nursing centers sector and to specialize in this aspect of the post-acute care continuum.

Principal Address and Website.

Our principal executive offices are located at 1621 Galleria Boulevard, Brentwood, Tennessee 37027. Our telephone number at that address is 615.771.7575, and our facsimile number is 615.771.7409. Our website is located at www.dvcr.com. The information on our website does not constitute part of this Annual Report on Form 10-K.

Operating and Growth Strategy.

Our operating objective is to optimize market position in the delivery of health care and related services to the patients and residents in need of post-acute care in the communities in which we operate. Our strategic operations development plan focuses on (i) providing a broad range of high quality, cost-effective post-acute care services; (ii) improving skilled mix in our nursing centers via enhanced capabilities for rehabilitation and transitional care; (iii) building clinical competencies and programs consistent with marketplace needs; and (iv) clustering our operations on a regional basis. Interwoven into our objectives and operating strategy is our mission:

- Improve Every Life We Touch
- Provide Exceptional Healthcare
- Exceed Expectations
- Increase Shareholder Value

Strategic operating initiatives. Our key strategic operating initiatives include improving skilled mix in our nursing centers by enhancing our staffing complement to address the increased medical complexity of certain patients, increasing clinical competencies, and adding clinical programs. Our investments in nursing and clinical care have been implemented in concert with additional investments in nursing center-based sales representatives to cultivate referral and Managed Care relationships. These investments have positioned us and are expected to continue to position us to be a destination for patients covered by Medicare and Managed Care as well as certain private pay individuals. These enhancements and investments have positioned us to admit higher acuity patients.

To achieve our objectives, we:

Provide a broad range of quality cost-effective services. Our objective is to provide a variety of services to meet the needs of the increasing post-acute care population requiring skilled nursing and rehabilitation care. Our service offerings currently include skilled nursing, comprehensive rehabilitation services, programming for Life Steps and Memory Care units (described below) and other specialty programming. By addressing varying levels of acuity, we work to meet the needs of the population we serve. We seek to establish a reputation as the provider of choice in each of our markets. Furthermore, we believe we are able to deliver quality services cost-effectively, compared to other healthcare providers along the spectrum of care, thereby expanding the population base that can benefit from our services.

Improve skilled mix in our nursing centers. By enhancing our registered nurse coverage and adding specialized clinical care, we believe we can admit patients with more medically complex conditions, thereby improving skilled mix and reimbursement. The investments in nursing and clinical care are being conducted in concert with additional investments in nursing center-based sales representatives to develop referral and Managed Care relationships. These investments will better attract quality payor sources for patients covered by Medicare, Managed Care and Medicare replacement payors as well as certain private pay individuals. We will also continue our program for the renovation and improvement of our nursing centers to attract and retain patients and residents.

Cluster operations on a regional basis. We have developed regional concentrations of operations in order to achieve operating efficiencies, generate economies of scale and capitalize on marketing opportunities created by having multiple operations in a regional market area.

Key elements of our strategy are to:

Increase revenues and profitability at existing nursing centers. Our strategy includes increasing center revenues and profitability through improving payor mix, providing an increasing level of higher acuity care, obtaining appropriate reimbursement for the care we provide, and providing high quality patient care. Ongoing investments are being made in expanded nursing and clinical care. We continue to enhance center-based marketing initiatives to promote higher occupancy levels and improved skilled mix at our nursing centers.

Development of additional specialty services. Our strategy includes the development of additional specialty units and programming in nursing centers that could benefit from these services. The specialty programming will vary depending on the needs of the specific market, and may include complex medical and rehabilitation services, as well as memory care units and other specialty programming. These services allow our centers to meet market needs while improving census and payor mix. A center specific assessment of the market and the current programming being offered is conducted related to specialty programming to determine if unmet needs exist as a predictor of the success of particular niche offerings and services.

Strategic management of our portfolio of centers. We continue to pursue and investigate opportunities to acquire and lease new centers, focusing primarily on opportunities that can leverage our existing infrastructure. We routinely evaluate the performance of our existing centers within the markets in which we operate in order to determine whether continuing operations within certain centers or markets aligns with our strategic objectives.

Nursing Centers and Services.

Diversicare provides a broad range of post-acute care services to patients and residents including skilled nursing, ancillary health care services and assisted living. In addition to the nursing and social services usually provided in long-term care centers, we offer a variety of rehabilitative, nutritional, respiratory, and other specialized ancillary services. As of December 31, 2019, our continuing operations consist of 62 nursing centers with 7,329 licensed skilled nursing beds. Our nursing centers range in size from 50 to 320 licensed nursing beds. The licensed nursing bed count does not include 397 licensed assisted living beds. Our continuing operations include centers in Alabama, Florida, Indiana, Kansas, Mississippi, Missouri, Ohio, Tennessee, and Texas.

The following table summarizes certain information with respect to the nursing centers we own or lease as of December 31, 2019:

	Number of Centers	Licensed Nursing Beds [1]	Available Nursing Beds [1]
Operating Locations:			
Alabama	20	2,385	2,318
Florida	1	79	79
Indiana	1	158	158
Kansas	6	464	464
Mississippi	9	1,039	1,004
Missouri	3	339	339
Ohio	4	403	393
Tennessee	5	617	551
Texas	13	1,845	1,662
	62	7,329	6,968
Classification:			
Owned	15	1,365	1,250
Leased	47	5,964	5,718
Total	62	7,329	6,968

[1] The number of Licensed Nursing Beds is based on the regulatory licenses for the nursing center. The Company reports its occupancy based on licensed nursing beds. The number of Available Nursing Beds represents Licensed Nursing Beds reduced by beds removed from service. Available Nursing Beds is subject to change based upon the needs of the centers, including configuration of patient rooms, common usage areas and offices, status of beds (private, semi-private, ward, etc.) and renovations. The number of Licensed and Available Nursing Beds does not include 397 Licensed Assisted Living/Residential Beds, all of which are also available. These beds are excluded from the bed counts as our operating statistics such as occupancy are calculated using Nursing Beds only.

Our nursing centers provide skilled nursing health care services, including nutrition services, recreational therapy, social services, housekeeping and laundry services. Skilled nursing care is provided for post-acute patients and residents with comorbidities. This care includes assessment using evidence based tools; individualized care plan development based on identified areas of risk and care needs; and skilled interventions such as IV services. We also provide for the delivery of ancillary medical services at the nursing centers we operate. These specialty services include rehabilitation therapy services, such as audiology, speech, occupational and physical therapies, which are provided through licensed therapists and registered nurses, and the provision of medical supplies, nutritional support, infusion therapies and related clinical services. The majority of these services are provided using our internal resources and clinicians.

Within the framework of a nursing center, we may provide other specialty care, including:

Transitional Care Unit. Many of our nursing centers have units designated as transitional care units, our designation for patients requiring transitional care following an acute stay in the hospital. These units specialize in short-term nursing and rehabilitation with the goal of returning the patient to their highest potential level of functionality. These units provide enhanced services with emphasis on upgraded amenities. The design and programming of the units generally appeal to the clinical and hospitality needs of individuals as they progress to the next appropriate level of care. Specialized therapeutic treatment regimens include orthopedic rehabilitation, neurological rehabilitation and complex medical rehabilitation. While these patients generally have a shorter length of stay, the intensive level of nursing and rehabilitation required by these patients typically results in higher levels of reimbursement.

Memory Care Unit. Like our transitional care units, many of our nursing centers have memory care units, our designation for advanced care for dementia-related disorders including Alzheimer's disease. The goal of the units is to provide a safe, homelike and supportive environment for cognitively impaired patients, utilizing an interdisciplinary team approach. Family and community involvement complement structured programming in the secure environment, which is instrumental in fostering as much resident independence and purposeful quality of life as long as possible despite diminished capacity.

Enhanced Therapy Services. We have complemented our traditional therapy services with programs that provide electrotherapy, vital stimulation, ultrasound and shortwave diathermy therapy treatments that promote pain management, wound healing, muscle strengthening, and/or contractures management, improving outcomes for our patients and residents receiving therapy treatments.

Other Specialty Programming. We implement other specialty programming based on a center's specific needs. We have developed specialty programming for bariatric patients (generally, patients weighing more than 350 pounds) as these individuals have unique psychosocial and equipment needs.

Quality Assurance and Performance Improvement. We have in place a Quality Assurance and Performance Improvement ("QAPI") program, which is focused on monitoring and improving all aspects of the care provided in a center by identifying outcomes and acting on areas of improvement. The QAPI program in our centers addresses all systems of care and management practices. Key quality indicators are determined and performance goals and benchmarks are established based on industry research standards via a Balanced Scorecard. Gaps and opportunities in performance versus benchmarks are addressed with analysis and performance improvement plans. Outcomes from each center in the areas of quality, employee workplace, customer satisfaction, and stewardship are collected monthly and overseen by regional and company quality committees.

Utilization of Electronic Medical Records. Electronic Medical Records ("EMR") improves our ability to accurately record the care provided to our patients and quickly respond to areas of need. All of our nursing centers utilize EMR to improve Medicaid acuity capture, primarily in our states where the Medicaid payments are acuity based. By using EMR, we have increased our average Medicaid rate despite rate cuts in certain acuity based states by accurate and timely capture of care delivery. We believe the EMR system provides better support, efficiency, and improves the quality of care for our patients.

Organization. Our nursing centers are currently organized into seven regions, each of which is supervised by a regional vice president. The regional vice president is generally supported by specialists in several functions, including clinical, human resources, marketing, revenue cycle management and administration, all of whom are employed by us. The day-to-day operations of each of our nursing centers are led by an on-site, licensed administrator. The administrator of each nursing center is supported by other professional personnel, including a medical director, who assists in the medical management of the nursing center, and a director of nursing, who supervises a team of registered nurses, licensed practical nurses and nurse aides. Other personnel include those providing therapy, dietary, activities and social service, housekeeping, laundry, maintenance and office services. The majority of personnel at our nursing centers, including the administrators, are our employees.

Marketing.

We believe that skilled nursing care is fundamentally a local business in which both patients and their referral sources are typically based in the immediate geographic area in which the nursing center is located. Our marketing plan and related support activities emphasize the role and contributions of the administrators, admissions coordinators and clinical liaisons of each nursing center, all of whom are responsible for developing relationships with various referral sources such as doctors, hospitals, hospital case managers and discharge planners, and various healthcare and community organizations. Training, sales tools and job aids are provided for the sales and marketing teams for the product knowledge, market knowledge, and selling skills necessary to support their efforts in the field. As part of our business strategy, we have dedicated sales and marketing personnel who develop strong partnerships with physicians and hospital executives as well as Accountable Care Organizations ("ACO"), Bundled Payments for Care Improvement ("BPCI"), and Managed Care organizations. We believe these relationships will be mutually beneficial, providing the community with high quality healthcare while helping customers to navigate choices, manage transitions, and control costs.

At the local level, our sales and marketing efforts are designed to:

- Identify and develop strong healthcare partnerships
- Help facilitate smooth transitions between care settings
- Promote collaboration with ACOs, BPCIs, and healthcare organizations
- Educate referral sources and community on our key differentiators and capabilities
- Position ourselves as a valuable resource and healthcare partner
- Enhance the customer experience

- Contribute to a strong community presence
- Promote higher occupancy levels
- Foster optimal payor mix

In addition to soliciting admissions from current and potential referral sources, we emphasize involvement in community and healthcare events and opportunities to promote a public awareness of our nursing centers and services. Activities include ongoing family councils and community based “family night” functions, providing the opportunity to educate the public on various topics such as Medicare benefits, powers of attorney, and other topics of interest. We also promote a positive customer experience, best practices, strong surveys, and a high Star Rating; we seek feedback through third-party resident and family surveys. We host tour and “open house” opportunities, where members of the local community are invited to visit the center to see any improvements or to better understand our environment and services. We look for ways to offer increased clinical capabilities and services to better meet the needs of the community and referral sources. In addition, we have regional oversight to support the overall marketing strategies in each local center, in order to promote higher occupancy levels and improved payor and case mixes at our nursing centers. We offer the resources and metrics for strong healthcare partnerships with our referral sources, including ACOs and other Managed Care partners. Our support center marketing personnel support regional and local marketing personnel and efforts.

We have monthly marketing programs and ongoing marketing initiatives, developed internally, that focus on educating and meeting the needs of our customers while growing our business. Resources are also available to assist each nursing center administrator in analysis of local demographics and competition with a view toward complementary service development. We consider the primary referral area in long-term care to generally lie within a five-to-fifteen-mile radius of each nursing center depending on population density; consequently, we focus on local marketing efforts rather than broad-based advertising.

Significant Transactions.

Disposals

On December 1, 2018, the Company completed the sale of the assets and transfer of the operations of Diversicare of Fulton, LLC, Diversicare of Clinton, LLC and Diversicare of Glasgow, LLC (the “Kentucky Properties”) to Fulton Nursing and Rehabilitation LLC, Holiday Fulton Propco LLC, Birchwood Nursing and Rehabilitation LLC, Padgett Clinton Propco LLC, Westwood Nursing and Rehabilitation LLC, and Westwood Glasgow Propco for a purchase price of $18.7 million, On August 30, 2019, the Company terminated operations of ten centers in Kentucky and concurrently transferred operations to a new operator. These ten centers are collectively referred to as the "Kentucky Centers." The sale of the Kentucky Properties and the termination of operations at the Kentucky Centers are referred to collectively as the "Kentucky Exit." As a result of the Kentucky Exit, the Company no longer operates any skilled nursing centers in the State of Kentucky. The Kentucky Exit represents a strategic shift that has (or will have) a major effect on the Company's operations and financial results. In accordance with Accounting Standards Codification ("ASC") 205-40, *Presentation of Financial Statements- Discontinued Operations*, the Company's discontinued operating results have been reclassified on the face of the financial statements and the footnotes to reflect the discontinued status of these operations. Refer to Note 3, "Discontinued Operations" to the consolidated financial statements.

Lease Agreements

On October 1, 2018, the Company entered into a new Master Lease Agreement (the "Lease") with Omega Healthcare Investors (the "Lessor") to lease 34 centers currently owned by Omega and operated by Diversicare. The old Master Lease with Omega provided for its operation of 23 skilled nursing centers in Texas, Kentucky, Alabama, Tennessee, Florida, and Ohio. Additionally, Diversicare operated 11 centers owned by Omega under separate leases in Missouri, Kentucky, Indiana, and Ohio. The Lease entered into by Diversicare and Omega consolidated the leases for all 34 centers under one new Maser Lease. The Lease was subsequently amended on August 30, 2019 when the Company terminated operations of the Kentucky Centers and concurrently transferred operations to a new operator. The agreement effectively amended the Lease with the Lessor to remove the ten Kentucky facilities, reduce the annual rent expense, and release the Company from any further obligations arising under the Master Lease Agreement with respect to the Kentucky facilities. The remaining Lease terms remain unchanged with an initial term of twelve years and two optional 10-year extensions. The annual lease fixed escalator remains at 2.15% which began on October 1, 2019.

Nursing Center Industry.

We believe there are a number of significant trends within the post-acute care industry that will support the continued growth of the nursing center profession. These trends are also likely to impact our business. These factors include:

Demographic trends. The primary market for our post-acute health care services is comprised of persons aged 75 and older. This age group is one of the fastest growing segments of the United States population. As the number of persons aged 75 and over continues to grow, we believe that there will be corresponding increases in the number of persons who need skilled nursing care.

Cost containment pressures. In response to rapidly rising health care costs, governmental and other third-party payors have adopted cost-containment measures to reduce admissions and encourage reduced lengths of stays in hospitals and other acute care settings. As a result, hospitals are discharging patients earlier and referring elderly patients, who may be too sick or frail to manage their lives without assistance, to nursing centers where the cost of providing care is typically lower than hospital care.

Limited supply of centers. As the nation's population of seniors continues to grow and life expectancy continues to expand, there continues to be limitations on granting Certificates of Need ("CON") in most states for new skilled nursing centers. We believe that there will be continued demand for skilled nursing beds in the markets in which we operate. CON laws generally require a state agency to determine public need for any construction or expansion of healthcare facilities. We believe that the CON process tends to restrict the supply and availability of licensed skilled nursing center beds. High construction costs, limitations on state and federal government reimbursement for the full costs of construction, and start-up expenses also act to restrict growth in the supply for such centers.

Reduced reliance on family care. Historically, the family has been the primary provider of care for seniors. We believe that the increase in the percentage of dual income families, the reduction of average family size and the increased mobility in society will reduce the role of the family as the traditional care-giver for aging parents. We believe that this trend will make it necessary for many seniors to look outside the family for assistance as they age.

Competition.

The post-acute care business is highly competitive. We face direct competition for additional centers, and our centers face competition for employees and patients. Some of our present and potential competitors for acquisitions are significantly larger and have or may obtain greater financial and marketing resources. Competing companies may offer new or more modern centers or new or different services that may be more attractive to patients than some of the services we offer.

The nursing centers operated by us compete with other centers in their respective markets, including rehabilitation hospitals and other skilled and personal care residential centers. In the few urban markets in which we operate, some of the long-term care providers with which our centers compete are significantly larger and have or may obtain greater financial and marketing resources than our centers. Some of these providers are not-for-profit organizations with access to sources of funds not available to our centers. Construction of new long-term care centers near our existing centers could adversely affect our business. We believe that the most important competitive factors in the long-term care business are: a nursing center's local reputation with referral sources, such as acute care hospitals, physicians, religious groups, other community organizations, Managed Care organizations, and a patient's family and friends; physical plant condition; the ability to identify and meet particular care needs in the community; the availability of qualified personnel to provide the requisite care; and the rates charged for services. There is limited, if any, price competition with respect to Medicaid and Medicare patients, since revenues for services to such patients are strictly controlled and are based on fixed rates and cost reimbursement principles. Although the degree of success with which our centers compete varies from location to location, we believe that our centers generally compete effectively with respect to these factors.

Revenue Sources

We classify our revenues earned from patients and residents into four major categories: Medicaid, Medicare, managed care, and private pay and other. Medicaid revenues are those received under the traditional Medicaid program, which provides benefits to those in need of financial assistance in the securing of medical services. Medicare revenues include revenues received under both

Part A and Part B. Managed Care revenues are received from insurance entities, including third-party plans that administer Medicare benefits, known as Medicare Advantage plans. Private pay and other revenues are composed primarily of individuals or parties who directly pay for their services. Included in the private pay and other category are patients who are hospice beneficiaries as well as the recipients of Veterans Administration benefits. Veterans Administration payments are made pursuant to renewable contracts negotiated with these payors.

The following table set forth net patient revenues related to our continuing operations by payor source for the periods presented (dollar amounts in thousands): The amounts as reported for revenue in 2019 and 2018 differ from the method of accounting in prior years due to the implementation of ASC 606, *Revenues From Contracts with Customers*, the new revenue recognition standard. Refer to Note 4, "Revenue Recognition and Receivables" to the consolidated financial statements.

	Year Ended December 31,					
	2019		2018		2017	
	As reported		As reported		As reported	
Medicaid	$ 222,560	46.9%	$ 215,924	45.4%	$ 249,204	51.6%
Medicare	80,798	17.0%	84,959	17.8%	122,043	25.3%
Managed Care	50,323	10.6%	48,879	10.3%	39,162	8.1%
Private Pay and other	121,339	25.5%	126,360	26.5%	72,402	15.0%
Total	$ 475,020	100.0%	$ 476,122	100.0%	$ 482,811	100.0%

The following table sets forth average daily skilled nursing census, or average number of patients per day, by payor source for our continuing operations for the periods presented:

	Year Ended December 31,					
	2019		2018		2017	
Medicaid	3,912	68.9%	3,909	68.3%	3,954	68.4%
Medicare	529	9.3%	596	10.4%	630	10.9%
Managed Care	264	4.6%	257	4.5%	246	4.3%
Private Pay and other	973	17.2%	961	16.8%	954	16.4%
Total	5,678	100.0%	5,723	100.0%	5,784	100.0%

Consistent with the nursing center industry in general, changes in the mix of a center's patient population among Medicaid, Medicare, Managed Care, and private pay and other can significantly affect the profitability of the center's operations. However, private payors, including managed care payors, are increasingly demanding that providers accept discounted fees or assume all or a portion of the financial risk for the delivery of health care services. Such measures may include capitated payments, which can result in significant losses to health care providers if patients require expensive treatment not adequately covered by the capitated rate.

Medicare and Medicaid Reimbursement

A significant portion of our revenues are derived from government-sponsored health insurance programs, primarily Medicare and Medicaid. We employ third-party specialists in reimbursement and also use these services to monitor regulatory developments to comply with reporting requirements and to ensure that proper payments are made to our operated nursing centers.

Medicare

Medicare is a federally-funded and administered health insurance program for the aged and for certain chronically disabled individuals. Part A of the Medicare program covers certain services furnished by skilled nursing centers and other institutional providers and inpatient hospital services. Part B covers physician services, durable medical equipment, various outpatient services and certain ancillary services. Under the Managed Medicare program, also known as Medicare Part C, or Medicare Advantage, the federal government contracts with private health insurers to provide members with Medicare benefits. The plans may choose to offer supplemental benefits and impose higher premiums and cost-sharing obligations. An executive order issued in October 2019 seeks to accelerate the shift away from traditional fee-for-service Medicare to Managed Medicare plans.

Skilled nursing facilities. Medicare generally covers skilled nursing center services for beneficiaries who require nursing care or rehabilitation services after a qualifying hospital stay. Medicare pays a per diem rate for each beneficiary, adjusted for patient acuity and additional factors such as geographic differences in wage rates. The payment rates are set forth under a prospective payment system that uses nursing and therapy indexes to assign a payment rate to each beneficiary. The Centers for Medicare & Medicaid Services ("CMS") updates the rates annually. The payment rates cover all services to be provided to a beneficiary, including room and board, skilled nursing care, therapy, and medications.

In a final rule issued in July 2019, CMS set forth Medicare payment rates for skilled nursing facilities ("SNFs") for federal fiscal year 2020, estimating 2.4% increase in overall payments. This is based on a SNF market basket percentage increase of 2.8% with a negative 0.4 percentage point productivity adjustment. Effective October 1, 2019, CMS replaced the Resource Utilization Group ("RUG-IV") case-mix classification system with the Patient-Driven Payment Model ("PDPM"). The PDPM classifies residents in Medicare Part A-covered stays into payment groups based on clinically relevant factors using diagnosis codes, rather than by the volume of services. CMS has stated that it does not intend for the new model to change the aggregate amount of Medicare payments to SNFs. Rather, it intends the new model to more accurately reflect resource utilization.

The payment rates described above are reduced pursuant to ongoing sequestration. The Budget Control Act of 2011 ("BCA") requires automatic spending reductions to reduce the federal deficit, including Medicare spending reductions of up to 2% per fiscal year, with a uniform percentage reduction across all Medicare programs. CMS began imposing a 2% reduction on Medicare claims in April 2013, and these reductions have been extended through 2029.

CMS has implemented policies intended to shift Medicare to value-based payment methodologies, tying reimbursement to quality of care rather than quantity. For example, under the Quality Reporting Program, skilled nursing centers are required to report quality data to CMS or be subject to a 2% reduction to the annual market basket update. Beginning in federal fiscal year 2019, the Skilled Nursing Facility Value-Based Purchasing ("SNF VBP") Program makes incentive payments available to skilled nursing centers based on their past performance on a specified quality measure related to hospital readmissions. CMS funds the SNF VPB Program incentive payment pool by withholding 2% of skilled nursing center payments and then redistributing some of the withheld payments. Data collected from each performance period will affect Medicare payments two years later.

CMS publishes rankings based on performance scores on the Nursing Home Compare website, which is intended to assist the public in finding and comparing skilled care providers. The Nursing Home Compare website also publishes for each nursing home a rating between 1 and 5 stars as part of CMS's Five-Star Quality Rating System. An overall star rating is determined based on three components (information from the last three years of health inspections, staffing information, and quality measures), each of which also has its own five-star rating. The ratings are based, in part, on the quality data nursing centers are required to report. For example, nursing centers must report the rate of short-stay residents who are successfully discharged into the community and the percentage who had an outpatient emergency department visit. We remain diligent in continuing to provide outstanding patient care to achieve high rankings for our centers, as well as assuring that our rankings are correct and appropriately reflect our quality results.

Therapy Services. Reimbursement for physical therapy, occupational therapy, and speech-language pathology services covered under Medicare Part B is determined according to the Medicare Physician Fee Schedule ("MPFS"), which is updated annually. For 2020, CMS updated the conversion factor based on a budget neutrality adjustment of 0.14%. If a beneficiary receives multiple therapy treatments in one day, Medicare Part B pays the full rate for the therapy unit of service that has the highest Practice Expense ("PE") component. A multiple procedure payment reduction is applied to the second and subsequent therapy units, reducing reimbursement to 50% of the applicable PE component. Targeted medical reviews are performed when expenses for a beneficiary exceed a threshold of $3,000 for physical and speech therapy services combined or $3,000 for occupational therapy services alone. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit. Claims above the threshold may be subject to post-payment review of medical necessity documentation by Supplemental Medical Review Contractors.

CMS has implemented value-based programs that affect Medicare payments for physician and other clinician services. Under the Quality Payment Program ("QPP"), a payment methodology intended to reward high-quality patient care, physicians and certain other clinicians, including therapists, are required to participate in one of two QPP tracks. Under both tracks, performance data collected in each performance year will affect Medicare payments two years later. The Advanced Alternative Payment Model

("Advanced APM") track makes incentive payments available for participation in specific innovative payment models approved by CMS. A provider with sufficient participation in an Advanced APM is exempt from the reporting requirements and payment adjustments imposed under the second track, the Merit-Based Incentive Payment System ("MIPS"). Providers electing to participate in MIPS receive either payment incentives or are subject to payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meaningful use of electronic health records. MIPS consolidates components of previously established incentive programs, including the Value-Based Payment Modifier program and the Physician Quality Reporting System.

Medicaid

Medicaid is a medical assistance program for the indigent that is funded jointly by the federal and state governments and administered by the states. Federal law requires states to cover certain nursing center services for Medicaid-eligible individuals when other payment options are unavailable. However, Medicaid eligibility requirements and benefits vary by state, and states may impose limitations on nursing services. States may also establish levels of service or payment methodologies by acuity or specialization of a nursing center.

The Affordable Care Act requires states to expand Medicaid coverage by adjusting eligibility requirements such as income thresholds. However, the Presidential administration and certain members of Congress continue to attempt to repeal or significantly modify the Affordable Care Act, which may result in changes to Medicaid. Further, states may opt out of the Medicaid expansion. Some states use or have applied to use waivers granted by CMS to implement expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have indicated that they intend to increase state flexibility in the administration of Medicaid programs.

Medicaid reimbursement is often less than a skilled nursing center's cost of caring for patients. Some states make supplemental payments to Medicaid providers beyond the base payment for specific claims. Upper payment level ("UPL") supplemental payments are intended to address the difference between Medicaid fee-for-service payments and Medicare reimbursement rates. CMS has made and is considering making changes affecting supplemental payments. The Company receives supplemental payments, including through Indiana's UPL program, which provides supplemental Medicaid payments for skilled nursing centers that are licensed to non-state government entities such as county hospital districts. One skilled nursing center previously operated by the Company entered into a transaction with one such hospital district participating in the UPL program, providing for the transfer of the license from the Company to the hospital district. The Company's operating subsidiary retained the management of the center on behalf of the hospital district. The agreement between the hospital district and the Company is terminable by either party.

We receive the majority of our annual Medicaid rate increases during the third quarter of each year. The rate changes received in 2019 and 2018, along with increased Medicaid acuity in our acuity based states, were the primary contributor to our 1.4% increase in average rate per day for Medicaid patients in 2019 compared to 2018. Based on the rate changes received during the third quarter of 2019, we expect a favorable impact to our rate per day for Medicaid patients as we move into 2020 due to modest rate increases in many of the states in which we operate.

Several states in which we operate face budget shortfalls, which could result in reductions in Medicaid funding for nursing centers. Pressures on state budgets are expected to continue in the future. Certain of the states in which we 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. In addition, enrollment in managed Medicaid plans has increased in recent years as states seek to manage costs, utilization, and quality. Managed Medicaid programs enable states to contract with private entities for the delivery of Medicaid health benefits and to handle program responsibilities like care management and claims adjudication. Some states and managed care plans are promoting alternatives to nursing center care, such as community and home-based services.

Legislation and administrative actions at the federal and state levels may significantly alter the funding for, or structure of, Medicaid programs. CMS administrators have also signaled interest in changing Medicaid payment models, including through increased use of value-based care models. We are unable to predict what, if any, reform proposals or reimbursement limitations will be implemented in the future, or the effect such changes would have on our operations. For the year ended December 31, 2019, we derived 17.0% and 46.9% of our total patient revenues related to continuing operations from the Medicare and Medicaid

programs, respectively. Any health care reforms that significantly limit rates of reimbursement under these programs could, therefore, have a material adverse effect on our financial position and profitability.

Employees.

As of February 18, 2020, we employed approximately 6,800 employees, referred to as "team members," in connection with our continuing operations, approximately 4,900 of which are considered full-time team members. Approximately 700 of our team members are represented by a labor union.

Although we believe we are able to employ sufficient nurses and therapists to provide our services, a shortage of health care professional personnel in any of the geographic areas in which we operate could affect our ability to recruit and retain qualified team members and could increase our operating costs. We compete with other health care providers for both professional and non-professional team members and with non-health care providers for non-professional team members. This competition continues to contribute to a consistent increase in the salaries that we have to pay to hire and retain these team members. As is common in the health care industry, we expect the salary and wage increases for our skilled healthcare providers will continue to be higher than average salary and wage increases nationally.

Supplies and Equipment.

We purchase drugs, solutions and other materials and lease certain equipment required in connection with our business from many suppliers. We have not experienced, and do not anticipate that we will experience, any significant difficulty in purchasing supplies or leasing equipment from current suppliers. In the event that such suppliers are unable or fail to sell us supplies or lease equipment, we believe that other suppliers are available to adequately meet our needs at comparable prices. National purchasing contracts are in place for all major supplies, such as food, linens and medical supplies. These contracts assist in maintaining quality, consistency and efficient pricing. Based on contract pricing for food and other supplies, we expect cost increases in 2020 to be relatively the same or slightly lower than the increases we experienced in 2019.

Government Regulation.

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, quality of patient care and Medicare and Medicaid 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 a number of statutes and regulations, including those regulating fraud and abuse, false claims, patient privacy and quality of care issues. 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. The Company is involved in regulatory actions of this type from time to time.

Licensure and Certification.

All our nursing centers must be licensed by the state in which they are located in order to accept patients, regardless of payor source. In most states, nursing centers are subject to Certificate of Need ("CON") laws, which require us to obtain government approval for the construction of new nursing centers or the addition of new licensed beds to existing centers. Our nursing centers must comply with detailed statutory and regulatory requirements on an ongoing basis in order to qualify for licensure, as well as for certification as a provider eligible to receive payments from the Medicare and Medicaid programs. Generally, the requirements for licensure and Medicare/Medicaid certification are similar and relate to quality and adequacy of personnel, quality of medical care, record keeping, dietary services, patient rights, and the physical condition of the nursing center and the adequacy of the equipment used therein. Failure to comply with applicable laws and regulations could result in exclusion from the Medicare and Medicaid programs, which could have an adverse impact on our business, financial condition, or results of operations.

In 2016, CMS published a comprehensive update to the health and safety standards applicable to long-term care facilities participating in the Medicare or Medicaid programs. These revisions are aimed at improving quality of life, care and services in

long-term care facilities, optimizing resident safety, and reflecting current professional standards. For example, CMS added requirements related to infection prevention and control, compliance and ethics programs, staff training, and QAPI. We believe we have achieved substantial compliance with the requirements now existing and will achieve substantial compliance prior to the deadline for certain aspects of the program. In April 2019, CMS announced a comprehensive overview of regulations, guidelines, and processes related to safety and quality in nursing homes, including plans to enhance enforcement efforts and increase transparency through the Nursing Home Compare website. It is unclear how related initiatives will affect our operations.

Each center is subject to periodic inspections, known as "surveys" by health care regulators, to determine compliance with all applicable licensure and certification standards. Such requirements are both subjective and subject to change. If a survey concludes that there are deficiencies in compliance, the center will be subject to various sanctions, including but not limited to monetary fines and penalties, suspension of new admissions, non-payment for new admissions and loss of licensure or certification. Generally, however, once a center receives written notice of any compliance deficiencies, it may submit a written plan of correction and is given a reasonable opportunity to correct the deficiencies. There can be no assurance that, in the future, we will be able to maintain such licenses and certifications for our centers or that we will not be required to expend significant sums in order to comply with regulatory requirements.

Health care and health insurance reform.

In recent years, the U.S. Congress and some state legislatures have considered and enacted significant legislation concerning health care and health insurance. The most prominent of these efforts, the Affordable Care Act, affects how health care services are covered, delivered and reimbursed. The Affordable Care Act expands coverage through a combination of public program expansion and private sector reforms, provides for reduced growth in Medicare program spending, and promotes initiatives that tie reimbursement to quality and care coordination. Some of the provisions, such as the requirement that large employers provide health insurance benefits to full-time employees, have increased our operating expenses. The Affordable Care Act expands the role of home-based and community services, which may place downward pressure on our sustaining population of Medicaid patients. Reforms that we believe may have a material impact on the long-term care industry and on our business include, among others, possible modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. However, there is considerable uncertainty regarding the future of the Affordable Care Act. The Presidential administration and certain members of Congress have made significant changes to the law, its implementation or its interpretation. For example, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. In addition, effective January 1, 2019, Congress eliminated the financial penalty associated with the individual mandate. As a result of this change, a federal judge in Texas ruled in December 2018 that the individual mandate was unconstitutional and determined that the rest of the Affordable Care Act was, therefore, invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded for further consideration of how this affects the rest of the law. The law remains in place pending appeal.

Skilled nursing centers are required to bill Medicare on a consolidated basis for certain items and services that they furnish to patients, regardless of the cost to deliver these services. This consolidated billing requirement essentially makes the skilled nursing center responsible for billing Medicare for all care services delivered to the patient during the length of stay. CMS has instituted a number of test programs designed to extend the reimbursement and financial responsibilities under consolidated billing beyond the traditional discharge date to include a broader set of bundled services. Such examples may include, but are not exclusive to, home health, durable medical equipment, home and community based services, and the cost of re-hospitalizations during a specified bundled period. Currently, these test programs for bundled reimbursement are confined to a small set of clinical conditions, but CMS has indicated that it is developing additional bundled payment models. This bundled form of reimbursement could be extended to a broader range of diagnosis related conditions in the future. The potential impact on skilled nursing center utilization and reimbursement is currently unknown. The process for defining bundled services has not been fully determined by CMS and therefore is subject to change during the rule making process. CMS has indicated that it is working toward a unified payment system for post-acute care services, including those provided by skilled nursing centers.

Health Insurance Portability and Accountability Act of 1996 and Privacy and Security Requirements.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") has mandated an extensive set of regulations to standardize electronic patient health, administrative and financial data transactions and to protect the privacy and security of individually identifiable health information ("protected health information"). We have a HIPAA compliance committee and designated privacy and security officers.

The HIPAA transaction standards are intended to simplify the electronic claims process and other healthcare transactions by encouraging electronic transmission rather than paper submission. These regulations provide for uniform standards for data reporting, formatting and coding that we must use in certain transactions with health plans. The HIPAA security regulations establish requirements for safeguarding protected health information that is electronically transmitted or electronically stored. Some of the security regulations are technical in nature, while others are addressed through policies and procedures.

The HIPAA privacy regulations establish limits on the use and disclosure of protected health information, provide for patients' rights, including rights to access, to request amendment of, and to receive an accounting of certain disclosures of protected health information, and require certain safeguards for protected health information. In addition, each covered entity must contractually bind individuals and entities that furnish services to the covered entity or perform a function on its behalf, and to which the covered entity discloses protected health information, to restrictions on the use and disclosure of that protected health information. Covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay, but not to exceed 60 calendar days from the discovery of the breach. Notification must also be made to the Department of Health and Human Services and, in certain cases involving large breaches, to the media.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. We are subject to any federal and state laws that are more stringent or grant greater privacy rights to individuals. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches.

Although we believe that we are in material compliance with the HIPAA regulations and other federal and state laws and regulations related to privacy and security, inadvertent violations may occur in the course of our business. For this and other reasons, the HIPAA regulations and other federal and state laws are expected to continue to impact us operationally and financially and may pose increased regulatory risk.

Self-Referral and Anti-Kickback Legislation.

The health care industry is subject to state and federal laws that regulate the relationships of providers of health care services, physicians and other clinicians. These restrictions include self-referral laws that impose restrictions on physician referrals to any entity with which they have a financial relationship, which is a broadly defined term. We believe our relationships with physicians are in compliance with the self-referral laws. Failure to comply with self-referral laws could subject us to a range of sanctions, including civil monetary penalties and possible exclusion from government reimbursement programs. There are also federal and state laws making it illegal to offer anyone anything of value in return for referral of patients. These laws, generally known as "anti-kickback" laws, are broad and subject to interpretations that are highly fact dependent. Given the lack of clarity of these laws, there can be no absolute assurance that any health care provider, including us, will not be found in violation of the anti-kickback laws in any given factual situation. Strict sanctions, including fines and penalties, exclusion from the Medicare and Medicaid programs and criminal penalties, may be imposed for violation of the anti-kickback laws.

Secondary Coverage Reporting Obligations

As required by the Medicare Secondary Reporting Act and related laws and regulations, we report to CMS specific information regarding all claimants and claim settlements involving Medicare participants so CMS can recover Medicare funds expended to provide healthcare treatment to the claimant. The requirements are to ensure that CMS is notified so that it may recoup the amounts paid for services from the settlement proceeds. The requirements do not result in us making additional payments to CMS for these services provided and does not result in an incremental cost to us. Strict sanctions, including fines and penalties, exclusion from the Medicare and Medicaid programs and criminal penalties, may be imposed for non-compliance with these reporting obligations.

Available Information.

We file reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K. The SEC maintains electronic versions of the Company's reports on its website at www.sec.gov. We also make available, free of charge through our website, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and other materials filed with the SEC as soon as reasonably practical after such material is electronically filed with or furnished to the SEC via a link to the SEC's EDGAR system. Our website address is www.dvcr.com. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is otherwise specifically referenced elsewhere in this report.

In addition, copies of the Company's annual report will be made available, free of charge, upon written request.

Corporate Governance Principles.

The Company has adopted Corporate Governance Principles relating to the conduct and operations of the Board of Directors. The Corporate Governance Principles are posted on the Company's website (www.dvcr.com) and are available in print to any stockholder who requests a copy.

Committee Charters.

The Board of Directors has an Audit Committee, Compensation Committee, Corporate Governance Committee, Risk Management Committee, and Executive Committee. The Board of Directors has adopted written charters for each committee, except for the Executive Committee, which are posted on the Company's website (www.dvcr.com) and are available in print to any stockholder who requests a copy.

ITEM 1A. RISK FACTORS

There have been a number of material developments both within the Company and the long-term care industry. These developments have had and are likely to continue to have a material impact on us. This section summarizes these developments, as well as other risks that should be considered by our shareholders and prospective investors.

Risks Related to our Operations

We are substantially self-insured and have significant potential professional liability exposure.

The provision of health care services entails an inherent risk of liability. Participants in the health care industry are subject to an increasing number of lawsuits alleging malpractice, negligence, product liability or related legal theories, many of which involve large claims and significant defense costs. Like many other companies engaged in the long-term care profession in the United States, we have numerous pending liability claims, disputes and legal actions for professional liability and other related issues. We expect to continue to be subject to such suits as a result of the nature of our business. We have professional liability insurance coverage for our nursing centers that, based on historical claims experience, is likely to be substantially less than the amount required to satisfy claims that are expected to be incurred. See "Item 3. Legal Proceedings" for further descriptions of pending claims and see "Item 7. Management's Discussion and Analysis of Financial Condition - Accounting Policies and Judgments - Professional Liability and Other Self-Insurance Reserves" for discussion of our reserve for self-insured claims and of our ability to meet our anticipated cash needs.

We may have substantial adjustments to our accrual for professional liability claims which could cause significant changes in our net earnings.

Each year, we record adjustments to our accrual for self-insured risks associated with professional liability claims. While these adjustments to the accrual result in changes to reported expenses and income, they are not directly related to changes in cash because the accrual is not funded. These self-insurance reserves are assessed on a quarterly basis, with changes in estimated losses being recorded in the consolidated statements of operations in the period identified. Any increase in the accrual decreases income in the period, and any reduction in the accrual increases income during the period. Our actual professional liabilities may vary significantly from the accrual due to an increase in the number of

claims asserted or claim costs in excess of estimates, and the amount of the accrual has and may continue to fluctuate by a material amount in any given quarter. For the years ended December 31, 2019, 2018 and 2017, we recorded professional liability expense from continuing operations of $7.0 million, $6.5 million and $8.0 million, respectively.

We continue to have significant potential professional liability exposure related to our discontinued operations.

Effective August 30, 2019, we terminated our operations in Kentucky. Even though we no longer have on-going operations in Kentucky, the Company is required to continue to defend, and make cash payments related to, professional liability claims asserted against our previously operated nursing centers for events occurring prior to August 30, 2019. The Company has approximately 46 pending law suits related to its operations in Kentucky as of December 31, 2019, and the Company expects additional claims to be filed. We also have one remaining action related to our former operations in Arkansas. Our professional liability insurance coverage for these claims is likely to be substantially less than the amount required to satisfy these claims, and the cash expenditures associated with these claims could have a material adverse effect on our on-going business, results of operations and financial condition. See “Item 3. Legal Proceedings” for further descriptions of pending claims and see “Item 7. Management's Discussion and Analysis of Financial Condition - Accounting Policies and Judgments - Professional Liability and Other Self-Insurance Reserves” for discussion of our reserve for self-insured claims and of our ability to meet our anticipated cash needs.

Our outstanding indebtedness is subject to various financial covenants and floating rates of interest which could be subject to fluctuations based on changing interest rates.

We have long-term indebtedness of $74.1 million at December 31, 2019. Certain of our debt agreements contain various financial covenants, the most restrictive of which relate to minimum cash deposits, cash flow and fixed charge coverage ratios. Our failure to comply with those covenants could result in an event of default, which, if not cured or waived, could result in the acceleration of some or all of our debts. Such non-compliance could result in a material adverse impact to our financial position, results of operations and cash flows. We are in compliance with all such covenants, exclusive of the guarantor minimum fixed charge coverage ratio related to the Amended Mortgage Loan and Amended Revolver, which was due to the Kentucky Exit and the related impacts on the Company's financial results. We obtained a waiver of this covenant from our syndicate of banks for the period ending December 31, 2019 in connection with an amendment to the Company's credit facility effective February 25, 2020. See “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources” for additional discussion of our covenants.

In connection with the refinancing transaction in February 2016 discussed in “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources,” we entered into an interest rate swap with respect to a portion of the mortgage loan to mitigate the floating interest rate risk of such borrowing. The interest rate swap converted the variable rate on our mortgage indebtedness to a fixed interest rate for the five year term of this indebtedness, decreasing our exposure to risks of variable rates of interest. While limiting our risk to increases in interest rates by utilizing the interest rate swap, we forgo benefits that might result from downward fluctuations in interest rates. We also are exposed to the risk that our counterpart to the swap agreement will default on its obligations. The February 2020 amendment to our Credit Facility had no impact on our interest rate swap.

Changes in the method of determining LIBOR, or the replacement of LIBOR with an alternative reference rate, may adversely affect interest rates on our current or future indebtedness and may otherwise adversely affect our financial condition and results of operations.

In 2017, the United Kingdom’s Financial Conduct Authority announced that after 2021 it would no longer compel banks to submit the rates required to calculate the London Interbank Offered Rate ("LIBOR"). This announcement indicates that the continuation of LIBOR on the current basis cannot and will not be guaranteed after 2021. We have a significant number of debt instruments with attributes that are dependent on LIBOR. The transition from LIBOR to an alternative reference rate could have a material adverse effect on our liquidity, financial condition and results of operations.

Our accrual for professional liability claims is not funded, and if a material judgment is entered against us in any lawsuit, we may lack adequate cash to pay the judgment.

As of December 31, 2019, we are engaged in 95 professional liability lawsuits, including 46 of which related to centers we no longer operate. Although we work diligently to limit the cash required to settle and defend professional liability claims, a significant judgment entered against us in one or more legal actions could have a material adverse impact on our cash flows and could result in our being unable to meet all of our cash needs as they become due.

We have entered a settlement agreement with the U.S. Department of Justice that requires substantial future payments.

In February 2020, we entered into a settlement agreement with the U.S. Department of Justice and the State of Tennessee of actions alleging violations of the federal False Claims Act in connection with our provision of therapy and the completion of certain resident admission forms. This agreement requires material annual payments for a period of five years ending in February 2025 and also requires a contingent payment in the event the Company sells any of its owned facilities during the five year payment period. Failure to make timely any of these payments could result in rescission of the settlement and result in the government having a very large claim against us, including penalties, and/or make us ineligible to participate in certain government funded healthcare programs, any of which could in turn significantly harm our business and financial condition. See Legal Proceedings for further information regarding this investigation and the terms of the settlement.

We are subject to the terms of a Corporate Integrity Agreement.

In February 2020, in conjunction with the settlement of the government investigation related to our therapy practices, we entered into a corporate integrity agreement ("CIA") with the Office of the Inspector General of CMS. This agreement has a term of five years and imposes material burdens on the Company, its officers and directors to take actions designed to insure compliance with applicable healthcare laws, including requirements to maintain specific compliance positions within the Company, to report any non-compliance with the terms of the agreement, to return any overpayments received, to submit annual reports and for an annual audit of submitted claims by an independent review organization. The CIA sets forth penalties for non-compliance by the Company with the terms of the agreement, including possible exclusion from federally funded healthcare programs for material violations of the agreement.

Our operational and strategic flexibility is limited due to the number of our centers that are leased from third parties.

A substantial majority of our centers are leased from third parties including 24 centers leased from Omega and 20 centers leased from Golden Living. The loss or deterioration of our relationship with either of these landlords may adversely affect our business. The terms of such leases generally require us to operate such centers as skilled nursing centers, and generally do not allow us to assign the lease to a third party without the applicable landlord’s consent. Therefore, our ability to divest such leased properties is limited, and we may be forced to continue operating such centers as skilled nursing centers even if doing so becomes unprofitable.

While we expect to renew or extend our leases in the normal course of business, there can be no assurance that these rights will be exercised in the future or that we will be able to satisfy the conditions precedent to exercising any such renewal or extension, to the extent that such provisions exist in our leases. In addition, if we are unable to renew or extend any of our master leases, we may lose all of the facilities subject to that master lease agreement. If we are not able to renew or extend our leases at or prior to the end of the existing lease terms, or if the terms of such options are unfavorable or unacceptable to us, our business, financial condition and results of operation could be adversely affected.

Our failure to pay rent or otherwise comply with the provisions of any of our Master Lease Agreements could materially adversely affect our business, financial position, results of operations, and liquidity.

Many of our facilities are under a Master Lease Agreement. Our failure to pay the rent or otherwise comply with the provisions of any of our lease agreements could result in an “event of default” under such lease agreement and also could result in a cross default under other master lease agreements and the agreements for our indebtedness. Upon an event of default, remedies available to our landlords generally include, without limitation, terminating such lease agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such lease agreement, including the difference between the rent under such lease agreement and the rent payable as a

result of reletting the leased properties, or requiring us to pay the net present value of the rent due for the balance of the term of such lease agreement. The exercise of such remedies would have a material adverse effect on our business, financial position, results of operations and liquidity. An event of default under any of our Master Lease Agreements could result in a default under the Credit Facilities and, if repayment of the borrowings under the Credit Facilities were accelerated, the payments under the indentures governing our outstanding notes could also be accelerated. The exercise of remedies by any of our landlords could have a material adverse effect on our business, financial position, results of operations, and liquidity.

We are highly dependent on reimbursement by third-party payors, and we may be negatively impacted by changes to third-party payor programs and any delays in reimbursement.

Substantially all of our nursing center revenues are directly or indirectly dependent upon reimbursement from third-party payors, including the Medicare and Medicaid programs and private insurers. For the year ended December 31, 2019, our patient revenues from continuing operations derived from Medicaid, Medicare, Managed Care and private pay (including private insurers) sources were approximately 46.9%, 17.0%, 10.6%, and 25.5%, respectively. Changes in the mix of our patients among Medicare, Medicaid, Managed Care and private pay categories and among different types of private pay sources may affect our net revenues and profitability. For example, we may be adversely affected by increasing enrollment in Managed Medicare and Managed Medicaid programs. Our net revenues and profitability are also affected by the continuing efforts of all payors to contain or reduce the costs of health care. Efforts to impose reduced payments, greater discounts and more stringent cost controls by government and other payors are expected to continue.

The federal government makes frequent changes to the reimbursement provided under the Medicare program. Effective October 2019, CMS changed the case-mix model used under the SNF prospective payment system. The new model, known as the Patient-Driven Payment Model, shifts the focus to the patient's condition and resulting care needs rather than the amount of care provided in order to determine Medicare reimbursement. Future changes to payment rates or methodology could significantly reduce the reimbursement we receive. For example, CMS has indicated that it is working toward a unified payment system for post-acute care services, including those provided by SNFs, home health agencies, and other long-term care providers.

In addition, there may be changes to Medicaid reimbursement rates and methodologies, supplemental payment programs, or provider assessment programs. CMS is considering Medicaid financing limitations that, if finalized as currently proposed, would negatively impact revenues received in connection with supplemental payment programs, among other effects. Further, a number of state governments, including several of the states in which we operate, face projected budget shortfalls and/or deficit spending situations. Because Medicaid is typically a substantial part of a state's budget, many states are considering or have implemented strategies to reduce Medicaid spending or decrease spending growth. Some states are exploring or implementing alternatives to traditional long-term care, including community and home-based nursing services.

Any changes in reimbursement levels or in the timing of payments under Medicare, Medicaid or private pay programs and any changes in applicable government regulations could have a material adverse effect on our net revenues, net income (loss) and cash flows. We are limited in our ability to reduce the direct costs of providing care. We are unable to predict the nature and success of future financial or delivery system reforms or the effect such changes will have on our operations. No assurance can be given that such reforms will not have a material adverse effect on us. See "Item 1. Business - Government Regulation and Reimbursement."

If we have problems with our information systems that affect payment or if other issues arise with Medicare, Medicaid or other payors that affect the amount or timeliness of reimbursements, we may encounter delays in our payment cycle. Any significant payment timing delay could cause us to experience working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in our consolidated results of operations and liquidity. Our working capital management procedures may not successfully mitigate the effects of any delays in our receipt of payments or reimbursements. Accordingly, such delays could have an adverse effect on our liquidity and financial condition.

We operate in an industry that is highly competitive.

The long-term care industry generally, and the nursing home business particularly, is highly competitive. We face direct competition for the acquisition of centers, and our centers face competition for patients. Our ability to compete is based on several factors including, but not limited to, building age and appearance, reputation, relationships with referral sources, availability of patients, survey history and CMS rankings. Some of our present and potential competitors are significantly larger and have or may obtain greater financial and marketing resources than we can. In addition, some competitors are implementing vertical alignment strategies. For example, some hospitals provide long-term care services and some providers are aligned or are pursuing alignment strategies with payors. Certain of our competitors are operated by not-for-profit, non-taxpaying or governmental agencies that can finance capital expenditures on a tax exempt basis and receive funds and charitable contributions unavailable to us. In addition, we may encounter substantial competition from new market entrants. Consequently, there can be no assurance that we will not encounter increased competition in the future, which could limit our ability to attract patients or expand our business, and could materially and adversely affect our business or decrease our market share.

We may have difficulty attracting and retaining qualified nurses, therapists, healthcare professionals and other key personnel, which, along with a growing number of minimum wage and compensation related regulations, may increase our costs related to these employees.

Our team members are essential to our business. We rely on our ability to attract and retain qualified nurses, therapists and other healthcare professionals. The market for these key personnel is highly competitive, and we could experience significant increases in our operating costs due to shortages in their availability. Like other healthcare providers, we have at times experienced difficulties in attracting and retaining qualified personnel. We may continue to experience increases in our labor costs, primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel, and such increases may adversely affect our profitability. Furthermore, while we attempt to manage overall labor costs in the most efficient way, our efforts to manage them through wage freezes and similar means may have limited effectiveness and may lead to increased turnover and other challenges.

Tight labor markets and high demand for such team members can contribute to high turnover among clinical professional staff. A shortage of qualified personnel at a facility could result in significant increases in labor costs and increased reliance on overtime and expensive temporary staffing agencies, and could otherwise adversely affect operations at the affected centers. If we are unable to attract and retain qualified professionals, our ability to adequately provide services to our residents and patients may decline and our ability to grow may be constrained.

Our cost of labor may be influenced by unanticipated factors in certain markets or, with respect to collective bargaining agreements that we are a party to, we may experience above-market increases. A substantial number of our team members are hourly team members whose wage rates are affected by increases in the federal or state minimum wage rate. As collective bargaining agreements are renegotiated or minimum wage rates increase we may need to increase the wages paid to team members. This may be applicable to not only minimum wage team members but also to team members at wage rates which are currently above the minimum wage.

The Department of Labor issued rule changes to the Fair Labor Standards Act that increased the minimum salary threshold for team members exempt from overtime along with an automatic annual increase to this salary threshold. The future of these rule changes, as well as other potential changes, remains uncertain given the recent change in Presidential administrations. However, these rule changes could increase our cost of services provided.

Because we are largely funded by government programs according to predetermined, nonnegotiable rates, we do not have an ability to pass such wage increases through to revenue sources. Any such mandated wage increases could have a material adverse effect on our results of operations, liquidity and financial condition.

Possible changes in the acuity of residents and patients, as well as payor mix and payment methodologies, may significantly affect our profitability.

The sources and amount of our revenues are determined by a number of factors, including the occupancy rates of our facilities, the length of stay, the payor mix of residents and patients, rates of reimbursement, and patient acuity. These

factors may be impacted by continued efforts to shift patients from institutional care settings to home and community-based services. Changes in patient acuity as well as payor mix among private pay, Medicare, and Medicaid may significantly affect our profitability. In particular, any significant decrease in our population of high-acuity patients or any significant increase in our Medicaid population could have a material adverse effect on our business, financial position, results of operations, and liquidity, especially if state Medicaid programs continue to limit, or more aggressively seek limits on, reimbursement rates or service levels.

The industry trend toward value-based purchasing may negatively impact our revenues.

There is a growing trend in the healthcare industry among both government and commercial payors toward value-based purchasing of healthcare services. Value-based purchasing programs emphasize quality and efficiency of services, rather than volume of services. For example, the SNF VBP program makes incentive payments available based on past performance on specified quality measures related to hospital readmissions. Failure to report quality data or poor performance may negatively impact the amount of reimbursement received.

Other initiatives aimed at improving quality and cost of care include alternative payment models, such as ACOs and bundled payment arrangements. It is unclear whether alternative models will successfully coordinate care and reduce costs or whether they will decrease overall reimbursement. Additionally, commercial payors have expressed intent to shift toward value-based reimbursement arrangements.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. While we believe we are adapting our business strategies to compete in a value-based reimbursement environment, we are unable at this time to predict how this trend will affect our results of operations. If we are unable to meet or exceed quality performance standards under any applicable value-based purchasing program, perform at a level below the outcomes demonstrated by our competitors, or otherwise fail to effectively provide or coordinate the efficient delivery of quality healthcare services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts, and we may owe repayments to payors, causing our revenues to decline.

Our systems are subject to security breaches and other cybersecurity incidents.

While we maintain information technology security and safeguards, complex medical systems have been and may continue to be targeted for cyber-attacks, which may result in unauthorized parties obtaining access to our computer systems and networks. Cyber-attacks could result in the misappropriation of our patient information that is protected by law, private employee information, proprietary business information and technology or result in interruptions to our business. The reliability and security of our information technology infrastructure is critical to our business. To the extent that any disruptions or security breaches result in significant loss or damage to our data, or inappropriate use or disclosure of patient, employee or proprietary information, we could be required to notify affected individuals, state and federal agencies and the media of the breach, could experience damage to our reputation and patient relationships and be subject to civil and/or criminal fines and penalties or related class action litigation, any of which could have a material adverse effect on our business, results of operations and financial condition. In addition, we may be at increased risk because we outsource certain services or functions to, or have systems that interface with, third parties. Some of these third parties may store or have access to our data and may not have effective controls, processes, or practices to protect our information from attack, damage, or unauthorized access. A breach or attack affecting any of these third parties could harm our business.

The success of previous and future acquisitions cannot be guaranteed and such acquisitions may consume substantial capital and other resources and could expose us to unforeseen liabilities and integration risks.

We have in the past and plan to in the future make investments in additional centers, whether by opening new centers or acquiring existing centers. Such acquisitions may involve significant cash expenditures, debt incurrence, operating losses and additional expenses that could have a material adverse effect on our financial position, results of operations and liquidity. Acquisitions involve numerous risks, including:

- difficulties integrating acquired operations, personnel and accounting and information systems, or in realizing projected efficiencies and cost savings;
- diversion of management's attention from other business concerns;
- potential loss of key team members or customers of acquired companies;
- entry into markets in which we may have limited or no experience;
- increased indebtedness and reduced ability to access additional capital when needed;
- assumption of unknown liabilities or regulatory issues of acquired companies, including failure to comply with healthcare regulations or to establish internal financial controls; and
- straining of our resources, including internal controls relating to information and accounting systems, regulatory compliance, logistics and others.

Furthermore, certain of the foregoing risks could be exacerbated when combined with other growth measures that we may pursue.

We have significant participation in the Texas Quality Incentive Payment Program ("QIPP") and changes to the program by the state of Texas could cause changes in our net earnings.

During 2019, the Company expanded its participation in QIPP as administered by the Texas Health and Human Services Commission. QIPP provides supplemental Medicaid payments for skilled nursing centers that achieve certain quality measures. Effective September 1, 2019, twelve of the Company's centers participate in the QIPP and the Company received approximately $1.5 million in additional revenue as a result of the QIPP program in 2019. If the State of Texas should decide to terminate QIPP, reduce the payments pursuant to the program or determine that the Company can no longer participate in QIPP, such action could have a material adverse effect on our business, financial position, results of operations, and liquidity.

Investing in our business initiatives and development could adversely impact our results of operations and financial condition.

We plan to invest in business initiatives and development that could increase our operating expenses. These initiatives may or may not be successful in growing our census or revenues. A part of our business initiative is to emphasize our skilled nursing facilities' care on patients with shorter stays but higher acuities. Shorter stays may result in decreased census during certain periods. In addition, there is typically a time delay between incurring such expenses and the attaining of revenues and cash flows expected from these initiatives and development. As a result, our revenue and operating cash flow may not increase enough during a reporting period to cover these increased expenses. Such additional revenues may not materialize to the level we anticipate, if at all.

We may be unable to reduce costs to offset decreases in our patient census levels or other expenses completely.

We depend on implementing adequate cost management initiatives in response to fluctuations in levels of patient census in our centers in order to maintain our current cash flow and earnings levels. Fluctuation in our patient census levels may become more common as we continue our emphasis in our skilled nursing facilities on patients with shorter stays but higher acuities. With the average length of stay decreasing for a skilled nursing patient, as well as the increased availability of assisted living facilities and home and community-based services, the challenge of maintaining desirable patient census levels has been amplified. A decline in patient census levels would likely result in decreased revenue. If we are unable to put in place corresponding reductions in costs in response to decreases in our patient census or other revenue shortfalls, our financial condition and operating results would be adversely affected. There are limits in our ability to reduce the costs of our centers because we must maintain required staffing levels.

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

Our affiliated facilities located in Alabama, Mississippi, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result

in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations.

Disasters and similar events may seriously harm our business.

Natural and man-made disasters, pandemics or epidemics, such as the COVID-19 coronavirus outbreak and similar events, including terrorist attacks and acts of nature such as hurricanes, tornados, earthquakes and wildfires, may cause damage or disruption to us, our employees and our centers, which could have an adverse impact on our patients and our business. Our affiliated facilities in Kansas, Missouri, Mississippi, Florida, Alabama and Texas may be more susceptible to damage caused by natural disasters including hurricanes, tornadoes and flooding. In order to provide care for our patients, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our centers, and the availability of employees to provide services at our centers. If the delivery of goods or the ability of employees to reach our centers were interrupted in any material respect due to a natural disaster, pandemic or other reasons, it would have a significant impact on our centers and our business. Furthermore, the impact, or impending threat, of a natural disaster has in the past and may in the future require that we evacuate one or more centers, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters, pandemics and similar events is inherently uncertain. Such events could harm our patients and employees, severely damage or destroy one or more of our centers, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

Failure to maintain effective internal control over our financial reporting could have an adverse effect on our ability to report our financial results on a timely and accurate basis.

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"), and is required to evaluate the effectiveness of these controls and procedures on a periodic basis and publicly disclose the results of these evaluations and related matters in accordance with the requirements of Section 404 of the Sarbanes-Oxley Act of 2002. Effective internal control over financial reporting is necessary for us to provide reliable financial reports, to help mitigate the risk of fraud and to operate successfully. However, testing and maintaining our internal control over financial reporting can be expensive and divert our management's attention from other business matters. Any failure to implement and maintain effective internal controls could result in material weaknesses or material misstatements in our consolidated financial statements.

If we fail to maintain effective internal control over financial reporting, we may be required to take corrective measures or restate the affected historical financial statements. In addition, we may be subjected to investigations and/or sanctions by federal and state securities regulators, and/or civil lawsuits by security holders. Any of the foregoing could also cause investors to lose confidence in our reported financial information and in our company and would likely result in a decline in the market price of our stock and in our ability to raise additional financing if needed in the future.

Certain events or circumstances could result in the impairment of our assets that result in material charges to earnings.

We review the carrying value of certain long-lived assets, finite-lived intangible assets and indefinite-lived intangible assets with respect to any events or circumstances that indicate an impairment or an adjustment to the amortization period may be necessary. If circumstances suggest that the recorded amounts of any of these assets cannot be recovered based upon estimated future cash flows, the carrying values of such assets are reduced to fair value. If the carrying value of any of these assets is impaired, we may incur a material charge to earnings. Any such impairment charges could have a material adverse effect on our business, financial position and results of operations.

Risks Related to Government Regulations

We are subject to significant government regulation.

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, protection of patient health information, reimbursement for patient services,

quality of patient care, Medicare and Medicaid fraud and abuse, debt collection and communications with consumers. Various federal and state laws regulate relationships among providers of services, including employment or service contracts and investment relationships. The operation of long-term care centers and the provision of services are also subject to extensive federal, state, and local laws relating to, among other things, the adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, environmental compliance, compliance with the Americans with Disabilities Act, fire prevention and compliance with building codes.

Long-term care facilities are subject to periodic inspection to assure continued compliance with various standards and licensing requirements under state law, as well as with Medicare and Medicaid conditions of participation. The failure to obtain or renew any required regulatory approvals or licenses could prevent us from offering our existing or additional services, subject us to penalties, and adversely affect our growth. In addition, health care is an area of extensive and frequent regulatory change. Changes in the laws or new interpretations of existing laws can have a significant effect on methods and costs of doing business and amounts of payments received from governmental and other payors. Our operations could be adversely affected by, among other things, regulatory developments such as mandatory increases in the scope and quality of care to be afforded patients and revisions in licensing and certification standards. We attempt at all times to comply with all applicable laws; however, there can be no assurance that we will remain in compliance at all times with all applicable laws and regulations or that new legislation or administrative or judicial interpretation of existing laws or regulations will not have a material adverse effect on our operations or financial condition. Federal or state proceedings seeking to impose fines and penalties for violations of applicable laws and regulations, as well as federal and state changes in these laws and regulations, may negatively impact us. See "Item 1. Business - Government Regulation." See also "Item 3. Legal Proceedings."

We are the subject of governmental audits, investigations, claims and litigation, which could have an adverse effect on our business or financial position.

Healthcare companies are subject to high levels of regulatory scrutiny. Various government agencies and their agents may conduct audits of our operations, including the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG"), which is tasked with combating fraud, waste and abuse within the Medicare and Medicaid programs. The OIG's enforcement priorities are outlined in a work plan that is updated monthly. These priorities include life safety reviews, compliant billing, quality of care, poorly performing nursing facilities, hospitalizations, criminal background checks, Medicare part B services, accuracy of clinical data collected by nursing facilities, transparency of ownership, and civil monetary penalty funds. We cannot predict the likelihood, scope or outcome of any OIG investigations of our centers.

The costs associated with potential litigation or the public announcement that we are being investigated, even if a dispute is resolved in our favor, or any determination that we have violated laws or regulations could have an adverse effect on our business, financial position or results of operations. In particular, government investigations, as well as qui tam lawsuits, may lead to significant penalties, including fines, damages payments or exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely involve both financial penalties and corporate integrity agreements, either of which could have an adverse effect on our business, financial position or results of operations.

Payments we receive from Medicare and Medicaid are subject to audits. Such audits could result in an obligation to refund amounts previously paid to us.

Payments we receive from Medicare and Medicaid can be retroactively adjusted after examination during the claims settlement process or as a result of post-payment audits. Private pay sources also reserve the right to conduct audits. Payors may disallow our requests for reimbursement, or recoup amounts previously reimbursed, based on determinations by the payors or their third-party audit contractors that certain costs are not reimbursable because either adequate or additional documentation was not provided or because certain services were not covered or deemed to not be medically necessary. We believe that billing and reimbursement errors and disagreements are common in our industry. Significant adjustments, recoupments or repayments of our Medicare or Medicaid revenue could adversely affect our business, financial condition or results of operations.

We are subject to claims under false claims, self-referral and anti-kickback prohibitions.

We are subject to numerous federal and state laws intended to prevent fraud, waste and abuse within the healthcare industry. Violations of these laws may result in substantial damage awards, civil or criminal penalties for individuals or entities, including large civil monetary penalties and exclusion from participation in the Medicare or Medicaid programs. Such awards, exclusion or penalties, if applied to us, could have a material adverse effect on our financial position and profitability.

In the United States, various federal laws regulate the relationships between providers of health care services, physicians, and other clinicians. These laws impose restrictions on physician referrals for designated health services to entities with which they have financial relationships. These laws also prohibit the offering, payment, solicitation or receipt of any form of remuneration in return for the referral of Medicare or Medicaid patients or patient care opportunities for the purchase, lease or order of any item or service that is covered by the Medicare and Medicaid programs. Many states in which we operate have similar anti-kickback and self-referral laws that may apply to all payors or a broader range of services. To the extent that we, any of our centers through which we do business, or any of the owners or directors have a financial relationship with each other or with other health care entities providing services to long-term care patients, such relationships could be subject to increased scrutiny.

Federal and state laws prohibit the submission of false claims for reimbursement and prohibit the making of false claims or statements. The submission of false claims or false statements may lead to the imposition of significant civil monetary penalties, significant criminal fines and imprisonment, and/or exclusion from participation in state and federally-funded healthcare programs, including the Medicare and Medicaid programs. Under the FCA, actions against a provider can be initiated by the federal government or by a private party on behalf of the federal government. These private parties, who are often referred to as "qui tam relators" or "relators," are entitled to share in any amounts recovered by the government. Both direct enforcement activity by the government and qui tam relator actions have increased significantly in recent years.

A FCA violation occurs when a provider knowingly submits a claim for items or services not provided. Liability also arises for the known failure to report and refund an overpayment received from the government. Some courts have held that providers who allegedly have violated other statutes, such as self-referral or kickback laws, have thereby submitted false claims under the FCA. Allegations of poor quality of care can also lead to FCA actions under a theory of worthless services, which contends that care provided was so deficient that it was tantamount to no service at all.

The implied certification theory expands the scope of the FCA. Under the implied certification theory, a violation of the FCA occurs when a provider's request for payment implies a certification of compliance with the applicable statutes, regulations or contract provisions that are preconditions to payment. The recognition of this theory has increased the risk that a healthcare company will have to defend a false claims action, pay fines and treble damages or settlement amounts or be excluded from federal and state healthcare programs as a result of an investigation arising out of the FCA. Many states have enacted similar laws providing for imposition of civil and criminal penalties for the filing of fraudulent claims.

Because we submit thousands of claims to Medicare each year and there is a relatively long statute of limitations under the FCA, there is a risk that intentionally, or even negligently or recklessly submitted claims that prove to be incorrect, or billing errors, cost reporting errors or lapses in statutory or regulatory compliance with regard to the provision of healthcare services (including, without limitation the Anti-Kickback Statue and the self-referral laws discussed above), could result in significant civil or criminal penalties against us. We recently settled one such false claims act case, and there can be no assurance that our operations will not be subject to review, scrutiny, penalties or enforcement actions under these laws, or that these laws will not change in the future. Any penalties or allegations involving false claims, whether valid or not, could have a significant impact on our business.

We are subject to laws governing the confidentiality of patient health information.

Both federal and state laws impose certain requirements regarding maintaining the confidentiality of patient health information and other personal information. In particular, HIPAA regulations require us to protect the medical records

and other personal health information of our patients, limit our use of and ability to disclose such information, give patients a right to access and amend their personal health information, and notify affected patients, HHS, and, in the case of large breaches, the media of breaches involving unsecure patient health information. A violation of HIPAA or any other federal or state laws regarding the confidentiality or use of personal information could subject us to civil or criminal penalties, and could in turn damage our reputation, affect our ability to attract or retain patients, and thereby have a material adverse effect on our revenues, financial position, results of operations and cash flows.

We cannot predict the effects that healthcare reform initiatives, including possible repeal or invalidation of or changes to the Affordable Care Act, and other changes in government programs may have on our business, financial condition or results of operations.

In recent years, there have been initiatives on the federal and state levels for comprehensive reforms affecting the availability, payment and reimbursement of healthcare services in the United States. The most prominent of these efforts is the Affordable Care Act, which affects how healthcare services are covered, delivered and reimbursed. However, there is significant uncertainty regarding the future of the Affordable Care Act. The law has been subject to legislative and regulatory changes and court challenges. For example, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. Effective January 1, 2019, Congress eliminated the penalty associated with the individual mandate to maintain health insurance. As a result of this change, a federal judge in Texas ruled in December 2018 that the individual mandate was unconstitutional and determined that the rest of the Affordable Care Act was, therefore, invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded the case for further consideration of how this affects the rest of the law. The law remains in place pending the appeals process. The elimination of the individual mandate penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

It is difficult to predict the impact of the Affordable Care Act and related regulations or the impact of its modification on our operations in light of the uncertainty regarding whether, when or how the law will be further changed, and the ultimate impact of court challenges. There is also uncertainty regarding whether, when, and what other health reform initiatives will be adopted and the impact of such efforts on providers and other healthcare industry participants. For example, some members of Congress have proposed significantly expanding the coverage of government-funded programs, including single payor proposals. CMS administrators have indicated that they intend to grant states additional flexibility in the administration of state Medicaid programs, including expanding the scope of waivers under which states may impose different eligibility or enrollment restrictions or otherwise implement programs that vary from federal standards. CMS administrators have also signaled interest in changing Medicaid payment models, including adopting value-based care models. We are unable to predict the nature and success of future financial or delivery system reforms that may be implemented by other, non-governmental industry participants, such as private payors. Healthcare reform initiatives, including changes to or repeal or invalidation of the Affordable Care Act, could materially and adversely affect our business, financial condition and results of operations.

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

Some states require healthcare providers to obtain prior approval, known as a CON, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

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

the acquisition of a facility being operated by a non-profit organization requires the approval of the state Attorney General.

Our ability to acquire or construct new facilities or expand or provide new services at existing facilities would be adversely affected if we are unable to obtain the necessary approvals, if there are changes in the standards applicable to those approvals, or if we experience delays and increased expenses associated with obtaining those approvals. We may not be able to obtain licensure, CON approval, Medicaid certification, Attorney General approval or other necessary approvals for future expansion projects. Conversely, the elimination or reduction of state regulations that limit the construction, expansion or renovation of new or existing facilities could result in increased competition to us or result in overbuilding of facilities in some of our markets. If overbuilding in the healthcare industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

Changes to federal and state income tax laws and regulations as well as accounting guidance could adversely affect our position on income taxes, estimated income liabilities and deferred tax assets.

We are subject to both state and federal income taxes in the U.S. and our operations, plans and results are affected by tax and other initiatives. On December 22, 2017, a law commonly known as the Tax Cuts and Jobs Act (“Tax Act") was enacted in the United States. Among other things, the Tax Act reduced the U.S. corporate income tax rate to 21 percent, which resulted in changes in the valuation of our deferred tax assets and liabilities.

Accounting guidance requires that deferred tax assets be reduced by a valuation allowance, when it is more likely than not that a tax benefit will not be realized. As of December 31, 2019, we had net deferred tax assets of approximately $21.8 million, against which we have applied a full valuation allowance. We continually assess the realizability of our deferred tax assets.

Any such change in valuation could have a material impact on our income tax expense and net deferred tax assets.We are also subject to regular reviews, examinations, and audits by the Internal Revenue Service ("IRS") and other taxing authorities with respect to our taxes. There are uncertainties and ambiguities in the application of the Tax Act and it is possible that the IRS could issue subsequent guidance or take positions on audit that differ from our interpretations and assumptions. Although we believe our tax estimates are reasonable, if a taxing authority disagrees with the positions we have taken, we could face additional tax liability, including interest and penalties. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in tax laws and regulations, changes in our interpretations of tax laws, including the Tax Act. Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability. There can be no assurance that payment of such additional amounts upon final adjudication of any disputes will not have a material impact on our results of operations and financial position.

We may be subject to liability for environmental damages.

Under various federal, state and local environmental laws, ordinances and regulations, a current or previous owner or operator of real estate may be required to investigate and clean up hazardous or toxic substances or petroleum product releases at the property, and may be held liable to a governmental entity or to third parties for property damage and for investigation and clean-up costs incurred by those parties in connection with the contamination. These laws typically impose clean-up responsibility and liability without regard to whether the owner or operator knew of or caused the presence of the contaminants, and liability under these laws has been interpreted to be joint and several unless the harm is divisible and there is a reasonable basis for allocation of responsibility. The costs of investigation, remediation or removal of the substances may be substantial. In addition, under our leases with Omega and Golden Living, we have agreed to indemnify the landlord for any such liabilities related to the properties that we lease from them. Persons who arrange for the disposal or treatment of hazardous or toxic substances also may be liable for the costs of removal or remediation of the substances at the disposal or treatment facility, whether or not the facility is owned or operated by the person. Finally, the owner of a site may be subject to common law claims by third parties based on damages and costs resulting from environmental contamination emanating from a site. If we become subject to any of these claims,

the costs involved could be significant and could have a material adverse effect on our business, financial condition, cash flows, and results of operations.

The proposed Medicaid Fiscal Accountability Regulation ("MFAR") could adversely impact our federal Medicaid revenue in some of our facilities.

On November 18, 2019, CMS published a proposed rule, MFAR, that could impact our federal Medicaid revenue in some of our facilities. Specifically, some states' Medicaid programs allow for UPL payments to be made to SNFs that are owned and operated by a non-state government ("NSG") provider, such as a city or county hospital. These supplemental UPL payments are paid through federal Medicaid funds, but administered through the state. The Company currently has twelve centers in Texas and one center in Indiana that have entered into UPL arrangements (Texas QIPP). Of these centers five have entered into agreements with a NSG hospital in which operations have been transferred to the NSG hospital, but Diversicare manages these facilities. This has allowed these facilities to obtain supplemental UPL funds from the federal Medicaid program.

The proposed MFAR rule, if enacted as currently written, would institute sweeping changes to the UPL program, including changes to: (i) the calculations related to the UPL payments; (ii) the definition of "public funds" that can be used for intergovernmental transfers ("IGT") (which would negatively impact the available revenue for UPL payments); and (iii) the definition of a "non-state government" provider (making fewer entities eligible to participate). Additionally, the proposed MFAR rule requires additional and detailed reporting by states related to the UPL payments and suggests that CMS will increase scrutiny of hospitals/ facilities that are part of such arrangements.

In addition to changes to the UPL program, the proposed MFAR rule would disallow states from receiving federal funds for provider taxes that impose undue burden on the Medicaid program. Such burdens include: (i) taxing providers that provide less Medicaid services at lower rates than those that provide relatively more Medicaid services; (ii) Medicaid services, in general, being taxed more than non-Medicaid services (except when excluding Medicare/Medicaid revenue); (iii) Not taxing, or taxing at a lower rate, groups of providers with no Medicaid services compared to other groups. States would have three years to comply with the MFAR requirements once a rule is finalized.

If the proposed MFAR rule goes into effect, without change, the number or our facilities participating in the UPL program, and/or the amount of reimbursement we receive through the UPL program, could drastically decrease or even cease. Such would have a significant and adverse effect on our Medicaid revenue, and as a result could have a material and adverse effect on our business, financial condition or results of operations.

Risks Related to our Common Stock

We do not intend to pay dividends on our common stock.

Although we paid cash dividends from the second quarter of 2009 through the third quarter of 2018, we do not anticipate paying cash dividends on our common stock in the foreseeable future. We currently anticipate that we will retain all of our available cash, if any, for use as working capital and for other general purposes, including to service or repay our debt and lease obligations as well as to fund the operations of our business. Any payment of future dividends will be at the discretion of our board of directors and will depend on, among other things, our earnings, financial condition, capital requirements, level of indebtedness, lease obligations, statutory and contractual restrictions applying to the payment of dividends and other considerations that our board of directors deems relevant.

Our common stock is no longer listed on the NASDAQ Capital Market and is quoted only in the Pink Sheets, making them subject to additional "penny stock" rules, which could negatively affect our stock price and liquidity.

On August 27, 2019, the Company was notified by Nasdaq that it denied the Company’s appeal and determined to delist the Company’s Common Stock from the Nasdaq Capital Market. Accordingly, the trading of the Company’s Common Stock was suspended on the Nasdaq Capital Market at the opening of business on August 29, 2019.

On October 11, 2019, Nasdaq filed a Form 25 with the Securities & Exchange Commission to effect the formal delisting of the Company’s common stock from the Nasdaq Capital Market, which became effective October 21, 2019. The Form

25 filing did not cause the removal of any shares of the Company's common stock from registration under the Exchange Act and the Company remains subject to the periodic reporting requirements of the Exchange Act. The Company believes that the delisting of its common stock from the Nasdaq Capital Market, as well as the related process leading up to delisting, has had a negative impact on the Company's common stock market price as well as on the liquidity of its common stock.

Delisting from Nasdaq may adversely affect our ability to raise additional financing through the public or private sale of equity securities, may affect the ability of investors to trade our securities and may negatively affect the value and liquidity of our common stock. Delisting also could have other negative results, including the potential loss of employee confidence and the loss of institutional investor interest and business development opportunities.

Since the suspension of trading on Nasdaq on August 29, 2019, the Company's Common stock began trading on the OTCQX under the trading symbol "DVCR." However, there is no assurance that an active market will be maintained for the Company's Common Stock. An investor would likely find it less convenient to sell, or to obtain accurate quotations in seeking to buy, our common stock on an over-the-counter market, and many investors would likely not buy or sell our common stock due to difficulty in accessing over-the-counter markets, policies preventing them from trading in securities not listed on a national exchange or other reasons. In addition, as a delisted security, our common stock is subject to SEC rules as a "penny stock," which impose additional disclosure requirements on broker-dealers. The regulations relating to penny stocks, coupled with the typically higher cost per trade to the investor of penny stocks due to factors such as broker commissions generally representing a higher percentage of the price of a penny stock than of a higher-priced stock, would further limit the ability of investors to trade in our common stock. For these reasons and others, delisting could adversely affect the liquidity, trading volume and price of our common stock, causing the value of an investment in us to decrease and having an adverse effect on our business, financial condition and results of operations, including our ability to attract and retain qualified employees, to raise capital, and execute on a strategic alternative.

Our securities are now and have historically been thinly traded. An active trading market in our equity securities may cease to exist, which would adversely affect the market price and liquidity of our common stock, in addition our stock price has been subject to fluctuating prices.

Shares of our common stock are now and have been thinly traded, meaning that the number of persons interested in purchasing our common stock at or near ask prices at any given time may be relatively small or non-existent. As a consequence, our stock price may not reflect an actual or perceived value of the business. Also, there may be periods of several days or more when trading activity in our shares is minimal or non-existent, as compared to an issuer that has a large and steady volume of trading activity that will generally support continuous sales without an adverse effect on share price. We cannot predict the actions of market makers, investors or other market participants, and can offer no assurances that the market for our securities will be stable. If there is no active trading market in our equity securities, the market price and liquidity of the securities will be adversely affected. The market price of our common stock could decline as a result of sales of a large number of shares of our common stock in the market or the perception that these sales could occur. Due to these conditions, you may not be able to sell your shares at or near ask prices or at all if you need money or otherwise desire to liquidate your shares. These conditions also might make it more difficult for us to sell equity securities in the future at a time and at a price that we deem appropriate.

We have a number of policies in place that could be considered anti-takeover protections.

Our Certificate of Incorporation (the "Certificate") requires the approval of the holders of two-thirds of the outstanding shares to amend certain provisions of the Certificate. Section 203 of the Delaware General Corporate Law restricts the ability of a Delaware corporation to engage in any business combination with an interested shareholder. We are also authorized to issue up to 0.8 million shares of preferred stock, the rights of which may be fixed by our Board without shareholder approval. Provisions in certain of our executive officers' employment agreements provide for post-termination compensation, including payment of amounts up to two times their annual salary, following certain changes in control (as defined in such agreements). Our stock incentive plans provide for the acceleration of the vesting of options in the event of certain changes in control (as defined in such plans). Certain changes in control also constitute an event

of default under our bank credit facility. The foregoing matters may, together or separately, have the effect of discouraging or making more difficult an acquisition or change of control of the company.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

We own 15 and lease 47 long-term care centers as discussed in “Item 1 Business - Nursing Centers and Services.” See further details below.

Our current operations include 47 nursing centers subject to operating leases, including 24 owned by Omega Health Investors ("Omega"), 20 owned by Golden Living and three owned by other parties. In our role as lessee, we are responsible for the day-to-day operations of all operated centers. These responsibilities include recruiting, hiring and training all nursing and other personnel, and providing patient care, nutrition services, marketing, quality improvement, accounting, and data processing services for each center. The lease agreements pertaining to our 47 leased centers are “triple net” leases, requiring us to maintain the premises, provide insurance, pay taxes and pay for all utilities. See the table below for a summary of owned and leased beds operated by the Company.

State	Centers	Leased Beds	Owned Beds	Total Operational Beds [1]
Alabama	20	2,079	306	2,385
Florida	1	79	—	79
Indiana	1	172	—	172
Kansas	6	—	483	483
Mississippi	9	1,039	—	1,039
Missouri	3	455	—	455
Ohio	4	651	—	651
Tennessee	5	497	120	617
Texas	13	1,370	475	1,845
Total	62	6,342	1,384	7,726

(1) The number of Operational Beds includes 397 Licensed Assisted Living/Residential Beds.

Brentwood Support Center and Regional Offices

We lease approximately 29,000 square feet of office space in Brentwood, Tennessee that houses our executive offices and centralized management support functions. Lease periods on these centers range up to three years. Regional executives for Kansas work from an office of approximately 922 square feet. We believe that our leased properties are adequate for our present needs and that suitable additional or replacement space will be available as required.

ITEM 3. LEGAL PROCEEDINGS

The provision of health care services entails an inherent risk of liability. Participants in the health care industry are subject to lawsuits alleging malpractice, negligence, violations of false claims acts, product liability, or related legal theories, many of which involve large claims and significant defense costs. Like many other companies engaged in the long-term care profession in the United States, we have numerous pending liability claims, disputes and legal actions for professional liability and other related issues. It is expected that we will continue to be subject to such suits as a result of the nature of our business. Further, as with all health care providers, we are periodically subject to regulatory actions seeking fines and penalties for alleged violations of health care laws and are potentially subject to the increased scrutiny of regulators for issues related to compliance with health care fraud and abuse laws and with respect to the quality of care provided to residents of our center. Like other health care providers, in the ordinary course of our business, we are also subject to claims made by employees and other disputes and litigation arising from the conduct of our business.

As of December 31, 2019, we are engaged in 95 professional liability lawsuits, including those related centers we no longer operate. Twenty-three lawsuits are currently scheduled for trial or arbitration during the next twelve months, and it is expected that additional cases will be set for trial or hearing. The ultimate results of any of our professional liability claims and disputes cannot be predicted. We have limited, and sometimes no, professional liability insurance with regard to most of these claims. A significant judgment entered against us in one or more of these legal actions could have a material adverse impact on our financial position and cash flows.

In February 2020, we entered into a settlement agreement with the U.S. Department of Justice and the State of Tennessee of actions alleging violations of the federal False Claims Act in connection with our provision of therapy and the completion of certain resident admission forms. This settlement resolved an investigation that had begun in 2012 and covers the time period from January 1, 2010 through December 31, 2015. This agreement requires material annual payments for a period of five years ending in February 2025 and also requires a contingent payment in the event the Company sells any of its owned facilities during the five year payment period. Failure to make timely any of these payments could result in rescission of the settlement and result in the government having a very large claim against us, including penalties, and/or make us ineligible to participate in certain government funded healthcare programs, any of which could in turn significantly harm our business and financial condition.

In conjunction with the settlement of the government investigation related to our therapy practices, we entered into a corporate integrity agreement with the Office of the Inspector General of CMS. This agreement has a term of five years and imposes material burdens on the Company, its officers and directors to take actions designed to insure compliance with applicable healthcare laws, including requirements to maintain specific compliance positions within the Company, to report any non-compliance with the terms of the agreement, to return any overpayments received, to submit annual reports and for an annual audit of submitted claims by an independent review organization. The CIA sets forth penalties for non-compliance by the Company with the terms of the agreement, including possible exclusion from federally funded healthcare programs for material violations of the agreement.

In January 2009, a purported class action complaint was filed in the Circuit Court of Garland County, Arkansas against the Company and certain of its subsidiaries and Garland Nursing & Rehabilitation Center (the "Center"). The Company answered the original complaint in 2009, and there was no other activity in the case until May 2017. At that time, plaintiff filed an amended complaint asserting new causes of action. The amended complaint alleges that the defendants breached their statutory and contractual obligations to the patients of the Center over a multi-year period by failing to meet minimum staffing requirements, failing to otherwise adequately staff the Center and failing to provide a clean and safe living environment in the Center. The Company has filed an answer to the amended complaint denying plaintiffs' allegations and has asked the Court to dismiss the new causes of action asserted in the amended complaint because the Company was prejudiced by plaintiff's long delay in filing the amended complaint. The Court has not yet ruled on the motion to dismiss, so the lawsuit remains in its early stages and has not yet been certified by the court as a class action. The Company intends to defend the lawsuit vigorously.

We cannot currently predict with certainty the ultimate impact of any of the above cases on our financial condition, cash flows or results of operations. An unfavorable outcome in any of these lawsuits or any of our professional liability actions, any regulatory action, any investigation or lawsuit alleging violations of fraud and abuse laws or of elderly abuse laws or any state or Federal False Claims Act case could subject us to fines, penalties and damages, including exclusion from the Medicare or Medicaid programs, and could have a material adverse impact on our financial condition, cash flows or results of operations.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information. Our common stock is traded on the OTCQX Market and began trading there on August 29, 2019. The Company's OTCQX ticker symbol is "DVCR."

Our common stock has been traded since May 10, 1994. On February 28, 2020, the closing price for our common stock was $2.28, as reported by OTCMarkets.com.

Holders. On February 28, 2020, there were approximately 260 holders of record. Most of our shareholders have their holdings in the street name of their broker/dealer.

ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Overview

Diversicare Healthcare Services, Inc. provides long-term care services to nursing center patients in nine states, primarily in the Southeast, Midwest and Southwest. Our centers provide a range of health care services to their patients and residents. In addition to the nursing, personal care and social services usually provided in long-term care centers, we offer a variety of comprehensive rehabilitation services as well as nutritional support services. As of December 31, 2019, our continuing operations consist of 62 nursing centers with 7,329 licensed skilled nursing beds and 397 assisted-living and other residential beds. We own 15 and lease 47 of our nursing centers included in continuing operations. The Company's continuing operations include centers in Alabama, Florida, Indiana, Kansas, Mississippi, Missouri, Ohio, Tennessee, and Texas.

Key Performance Metrics

Skilled mix. Skilled mix represents the number of days our Medicare and Managed Care patients are receiving services at the skilled nursing facilities divided by the total number of days (less days from assisted living patients).

Average rate per day. Average rate per day is the revenue by payor source for a period at the skilled nursing facility divided by actual patient days for the revenue source for a given period.

Average daily skilled nursing census. Average daily skilled nursing census is the average number of patients who are receiving skilled nursing care.

Strategic Operating Initiatives

We identified several key strategic objectives to increase shareholder value through improved operations and business development. These strategic operating initiatives include: improving our facilities' quality metrics, improving skilled mix in our nursing centers, improving our average Medicare rate, maintaining Electronic Medical Records to improve Medicaid capture, and completing strategic acquisitions and divestitures. We have experienced success in these initiatives and expect to continue to build on these improvements.

Improving skilled mix and average Medicare rate:

One of our key performance indicators is skilled mix. We believe that our skilled mix is an important indicator of our success in attracting high-acuity patients because it represents the percentage of our patients who are reimbursed by Medicare, managed care and other skilled payors, for whom we receive higher reimbursement rates. Our strategic operating initiatives of improving our skilled mix and our average Medicare rate required investing in nursing and clinical care to treat more acute patients along with nursing center-based marketing representatives to attract these patients. These initiatives developed referral and Managed Care relationships that have attracted and are expected to continue to attract payor sources for patients covered by Medicare and

Managed Care. The Company's skilled mix for the years ended December 31, 2019, 2018 and 2017 was 13.9%, 14.9% and 15.2%, respectively. For the past several years, census and skilled mix trends have been affected by healthcare reforms resulting in lower lengths of stay among our skilled patient population and lower admissions caused by initiatives among acute care providers, managed care payors and conveners to divert certain skilled nursing referrals to home health or other community-based care settings.

Utilizing Electronic Medical Records to improve Medicaid acuity capture:

As another part of our strategic operating initiatives, all of our nursing centers utilize EMR to improve Medicaid acuity capture, primarily in our states where the Medicaid payments are acuity based. By using EMR, we have increased our average Medicaid rate despite rate cuts in certain acuity based states by accurate and timely capture of care delivery.

Completing strategic transactions:

Our strategic operating initiatives include a renewed focus on completing strategic acquisitions and divestitures. We continue to pursue and investigate opportunities to acquire or lease new centers, focusing primarily on opportunities within our existing geographic areas of operation. As part of our strategic efforts, we have also performed thorough analysis on our existing centers in order to determine whether continuing operations within certain markets or regions is in line with the short-term and long-term strategy of the business.

On December 1, 2018, the Company completed the sale of the assets and transfer of the operations of Diversicare of Fulton, LLC, Diversicare of Clinton, LLC and Diversicare of Glasgow, LLC (the “Kentucky Properties”) with Fulton Nursing and Rehabilitation LLC, Holiday Fulton Propco LLC, Birchwood Nursing and Rehabilitation LLC, Padgett Clinton Propco LLC, Westwood Nursing and Rehabilitation LLC, and Westwood Glasgow Propco for a purchase price of $18.7 million. On August 30, 2019, the Company terminated operations of ten centers in Kentucky and concurrently transferred operations to a new operator. These ten centers are collectively referred to as the "Kentucky Centers." The sale of the Kentucky Properties and the termination of operations at the Kentucky Centers are referred to collectively as the "Kentucky Exit." As a result of the Kentucky Exit, the Company no longer operates any skilled nursing centers in the State of Kentucky. The Kentucky Exit represents a strategic shift that has (or will have) a major effect on the Company's operations and financial results. In accordance with Accounting Standards Codification ("ASC 205"), the Company's discontinued operating results have been reclassified on the face of the financial statements and the footnotes to reflect the discontinued status of these operations. Refer to Note 3, "Discontinued Operations" to the consolidated financial statements.

On October 1, 2018, the Company entered into a New Master Lease Agreement (the "Lease") with Omega Healthcare Investors (the "Lessor") to lease 34 centers currently owned by Omega and operated by Diversicare. The old Master Lease with Omega provided for its operation of 23 skilled nursing centers in Texas, Kentucky, Alabama, Tennessee, Florida, and Ohio. Additionally, Diversicare operated 11 centers owned by Omega under separate leases in Missouri, Kentucky, Indiana, and Ohio. The Lease entered into by Diversicare and Omega consolidated the leases for all 34 centers under one New Maser Lease. The Lease was subsequently amended on August 30, 2019 when the Company terminated operations of ten centers in Kentucky and concurrently transferred operations to a new operator. The agreement effectively amended the Master Lease Agreement with the Lessor to remove the ten Kentucky Centers, reduce the annual rent expense, and release the Company from any further obligations arising under the Lease with respect to the Kentucky facilities. The remaining Lease terms remain unchanged with an initial term of twelve years and two optional 10-year extensions. The annual lease fixed escalator remains at 2.15% which began on October 1, 2019.

Basis of Financial Statements.

Our patient revenues consist of the fees charged for the care of patients in the nursing centers we own and lease. Our operating expenses include the costs, other than lease, depreciation and amortization expenses, incurred in the operation of the nursing centers we own and lease. Our general and administrative expenses consist of the costs of the corporate office and regional support functions. Our interest, depreciation and amortization expenses include all such expenses across the range of our operations.

Selected Financial and Operating Data

The following table summarizes the Diversicare statements of continuing operations for the years ended December 31, 2019, 2018 and 2017, and sets forth this data as a percentage of revenues for the same year:

	Year Ended December 31, (Dollars in thousands)					
	2019		2018		2017	
Revenues:						
Patient revenues, net	$ 475,020	100.0 %	$ 476,122	100.0 %	$ 482,811	100.0 %
Expenses:						
Operating	380,870	80.2 %	381,178	80.1 %	389,916	80.8 %
Lease and rent expense	52,990	11.2 %	49,231	10.3 %	48,248	10.0 %
Professional liability	6,996	1.5 %	6,498	1.4 %	7,992	1.7 %
Litigation contingency expense	3,100	0.7 %	6,400	1.3 %	—	— %
General & administrative	28,009	5.9 %	30,237	6.4 %	31,342	6.5 %
Depreciation and amortization	9,122	1.9 %	9,991	2.1 %	9,252	1.9 %
Lease termination receipts	—	— %	—	— %	(180)	— %
	481,087	101.4 %	483,535	101.6 %	486,570	100.9 %
Operating loss	(6,067)	(1.4)%	(7,413)	(1.6)%	(3,759)	(0.9)%
Other income (expense):						
Other income	281	0.1 %	160	— %	472	0.1 %
Gain on bargain purchase	—	— %	—	— %	925	0.2 %
Gain on sale of investment in unconsolidated affiliate	—	— %	308	0.1 %	733	0.2 %
Hurricane costs	—	— %	—	— %	(232)	— %
Interest expense, net	(5,994)	(1.3)%	(5,533)	(1.2)%	(5,353)	(1.1)%
Debt retirement costs	—	— %	(267)	(0.1)%	—	— %
	(5,713)	(1.2)%	(5,332)	(1.2)%	(3,455)	(0.6)%
Loss from continuing operations before income taxes	(11,780)	(2.6)%	(12,745)	(2.8)%	(7,214)	(1.5)%
Benefit (provision) for income taxes	(15,694)	(3.3)%	1,481	0.3 %	(2,534)	(0.5)%
Loss from continuing operations	$ (27,474)	(5.9)%	$ (11,264)	(2.5)%	$ (9,748)	(2.0)%

The following table presents data about the centers we operated as part of our operations as of the dates:

	December 31,		
	2019	2018	2017
Licensed Nursing Center Beds:			
Owned	1,365	1,365	1,607
Leased	5,964	6,849	6,849
Total	7,329	8,214	8,456
Facilities:			
Owned	15	15	18
Leased	47	57	58
Total	62	72	76

Critical Accounting Policies and Judgments

A "critical accounting policy" is one which is both important to the understanding of our financial condition and results of operations and requires management's most difficult, subjective or complex judgments, often of the need to make estimates about the effect of matters that are inherently uncertain. Actual results could differ from those estimates and cause our reported net income (loss) to vary significantly from period to period. Our accounting policies that fit this definition include the following:

Revenues

Patient Revenues, Net

The Company adopted ASC 606, Revenue from Contracts with Customers, effective January 1, 2018, using the modified retrospective transition method. The Company uses an estimate of variable considerations to arrive at the transaction price, including methods and assumptions used to determine settlements with Medicare and Medicaid payors. Results for reporting periods beginning after January 1, 2018 are presented under ASC 606, while comparative information has not been restated and continues to be reported under the accounting standards in effect for those periods. See Note 4, "Revenue Recognition and Receivables."

Professional Liability and Other Self-Insurance Reserves

Accrual for Professional and General Liability Claims

The Company has professional liability insurance coverage for its nursing centers that, based on historical claims experience, is likely to be substantially less than the claims that are expected to be incurred. Effective July 1, 2013, the Company established a wholly-owned, consolidated offshore limited purpose insurance subsidiary, SHC Risk Carriers, Inc. ("SHC"), which has issued a policy insuring claims made against all of the Company's nursing centers in Florida and Tennessee, several of the Company's nursing centers in Alabama, Ohio, and Texas and several of the Company's prior nursing centers in Kentucky for claims prior to the transfer of such operation. The insurance coverage provided for these centers under the SHC policy include coverage limits of $1.0 million or $3.0 million per medical incident with a sublimit per center of $3.0 million and total annual aggregate policy limits of $5.0 million. All other centers within the Company's portfolio are covered through various commercial insurance policies which provide coverage limits of $1.0 million per claim and have sublimits of $3.0 million per center, with varying aggregate policy limits and deductibles. The deductibles for these policies vary in amount and are covered through the insurance subsidiary.

Because our actual liability for existing and anticipated professional liability and general liability claims will exceed our limited insurance coverage, we have recorded total liabilities for reported professional liability claims and estimates for incurred but unreported claims of $27.4 million and $1.0 million of estimated insurance recovery receivables as of December 31, 2019, including $2.2 million for settlements that are expected to be paid in 2020, estimates of liability for incurred but not reported claims, estimates of liability for reported but unresolved claims, and estimates of related legal costs incurred and expected to be incurred. All losses are projected on an undiscounted basis. The payments due under the government settlement agreement are not included in this reserve.

The Company evaluates the adequacy of this liability on a quarterly basis. Semi-annually, the Company retains a third-party actuarial firm to assist in the evaluation of this reserve. Since May 2012, the actuary has assisted management in the preparation of the appropriate accrual for incurred but not reported general and professional liability claims based on data furnished as of May 31 and November 30 of each year. The actuary primarily utilizes historical data regarding the frequency and cost of the Company's past claims over a multi-year period, industry data and information regarding the number of occupied beds to develop its estimates of the Company's ultimate professional liability cost for current periods.

On a quarterly basis, we obtain reports of asserted claims and lawsuits from our insurers and a third party claims administrator. These reports contain information relevant to the liability actually incurred to date with that claim as well as the third-party administrator's estimate of the anticipated total cost of the claim. This information is reviewed by us quarterly and provided to the actuary semi-annually. We use this information to determine the timing of claims reporting and the development of reserves and compare the information obtained to our previously recorded estimates of liability. Based on the actual claim information obtained, on the semi-annual estimates received from the actuary and on estimates regarding the number and cost of additional

claims anticipated in the future, the reserve estimate for a particular period may be revised upward or downward on a quarterly basis. Final determination of our actual liability for claims incurred in any given period is a process that takes years.

The Company's cash expenditures for self-insured professional liability costs from continuing operations were $4.6 million, $6.5 million and $6.6 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Although we retain a third-party actuarial firm to assist us, professional and general liability claims are inherently uncertain, and the liability associated with anticipated claims is very difficult to estimate. Professional liability cases have a long cycle from the date of an incident to the date a case is resolved, and final determination of our actual liability for claims incurred in any given period is a process that takes years. As a result, our actual liabilities may vary significantly from the accrual, and the amount of the accrual has and may continue to fluctuate by a material amount in any given quarter due to the significance of judgments and estimates.

Professional liability costs are material to our financial position, and changes in estimates, as well as differences between estimates and the ultimate amount of loss, may cause a material fluctuation in our reported results of operations. Our professional liability expense was $7.0 million, $6.5 million and $8.0 million for the years ended December 31, 2019, 2018 and 2017, respectively. These amounts are material in relation to our reported loss from continuing operations for the related periods of $27.5 million, $11.3 million and $9.7 million, respectively. The total liability recorded at December 31, 2019 was $27.4 million, compared to current assets of $72.3 million and total assets of $440.4 million.

Accrual for Other Self-Insured Claims

With respect to workers' compensation insurance, substantially all of our employees are covered under either a prefunded deductible policy or state-sponsored programs. We have been and remain a non-subscriber to the Texas workers' compensation system and are, therefore, completely self-insured for employee injuries with respect to our Texas operations. From June 30, 2003 until June 30, 2007, our workers' compensation insurance programs provided coverage for claims incurred with premium adjustments depending on incurred losses. For the period from July 1, 2008 through December 31, 2019, we are covered by a prefunded deductible policy. Under this policy, we are self-insured for the first $0.5 million per claim, subject to an aggregate maximum of $3.0 million. We fund a loss fund account with the insurer to pay for claims below the deductible. We account for premium expense under this policy based on its estimate of the level of claims subject to the policy deductibles expected to be incurred.

We are self-insured for health insurance benefits for certain employees and dependents for amounts up to $0.2 million per individual annually. We provide reserves for the settlement of outstanding self-insured health claims at amounts believed to be adequate, based on known claims and estimates of unknown claims based on historical information. The differences between actual settlements and reserves are included in expense in the period finalized. Our reserves for health insurance benefits can fluctuate materially from one year to the next depending on the number of significant health issues of our covered employees and their dependents.

Asset Impairment

We evaluate our property, equipment, right-of-use assets, and other long-lived assets on a quarterly basis to determine if facts and circumstances suggest that the assets may be impaired or that the estimated depreciable life of the asset may need to be changed for significant physical changes in the property, or significant adverse changes in general economic conditions, and significant deteriorations of the underlying cash flows or fair values of the property if impairment indicators exist. The need to recognize impairment is based on estimated undiscounted future cash flows from an asset compared to the carrying value of that asset. If recognition of impairment is necessary, it is measured as the amount by which the carrying amount of the asset exceeds the fair value of the asset.

No impairment of long lived assets was recognized during 2019, 2018, or 2017. If our estimates or assumptions with respect to an asset change in the future, we may be required to record impairment charges for our assets.

Business Combinations

For business combination transactions, we recognize and measure the identifiable assets acquired, the liabilities assumed, any noncontrolling interest in the acquiree, as well as the goodwill acquired or gain recognized in a bargain purchase, and we make certain valuations to determine the acquisition date fair value of assets acquired and the liabilities assumed. These valuations are subject to adjustments during the measurement period, not to exceed twelve-months from the acquisition date. Such valuations require us to make significant estimates, judgments and assumptions, including projections of future events and operating performance.

Stock-Based Compensation

We recognize compensation cost for all share-based payments granted on a straight-line basis over the vesting period. For restricted shares, we utilize the market price at the grant date in order to calculate the stock-based compensation expense to be recognized during the vesting period. During the years ended December 31, 2019, 2018, and 2017, we recorded charges of approximately $0.6 million, $1.1 million and $1.0 million in stock-based compensation, respectively. Stock-based compensation expense is a non-cash expense and such amounts are included as a component of general and administrative expense or operating expense based upon the classification of cash compensation paid to the related employees.

Income Taxes

Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities at tax rates 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.

In determining the need for a valuation allowance 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.

Contractual Obligations and Commercial Commitments

We have certain contractual obligations of continuing operations as of December 31, 2019, summarized by the period in which payment is due, as follows (dollar amounts in thousands):

Contractual Obligations	Total	Less than 1 year	1 to 3 Years	3 to 5 Years	After 5 Years
Long-term debt obligations [1]	$ 81,239	$ 7,905	$ 73,283	$ 51	$ —
Settlement obligations [2]	2,230	2,230	—	—	—
Operating leases [3]	463,724	50,819	104,600	107,700	200,605
Required capital expenditures under operating leases [4]	18,698	2,081	4,162	4,161	8,294
Total	$ 565,891	$ 63,035	$ 182,045	$ 111,912	$ 208,899

(1) Long-term debt obligations include scheduled future payments of principal and interest of long-term debt and amounts outstanding on our finance lease obligations. Our long-term debt obligations decreased $3.6 million between December 31, 2018 and December 31, 2019. See Note 7, "Long-Term Debt, Interest Rate Swap and Finance Lease Obligations" to the consolidated financial statements included in this report for additional information.

(2) Settlement obligations relate to professional liability cases that are expected to be paid within the next twelve months. The professional liabilities are included in our current portion of self-insurance reserves.

(3) Represents minimum annual lease payments (exclusive of taxes, insurance, and maintenance costs) under our operating lease agreements, which does not include renewals. Our operating lease obligations decreased $161.2 million between December 31, 2018 and December 31, 2019, which was due to scheduled rent payments, as well as the exit from the State of Kentucky. See Note 6, "Leases" to the consolidated financial statements included in this report for additional information.

(4) Includes annual expenditure requirements under operating leases. Our required capital expenditures decreased $7.9 million between December 31, 2018 and December 31, 2019. The decrease is due to the exit from the State of Kentucky.

Employment Agreements

We have employment agreements with certain members of management that provide for the payment to these members of amounts up to two times their annual salary in the event of a termination without cause, a constructive discharge (as defined), or upon a change of control of the Company (as defined). The maximum contingent liability under these agreements is approximately $1.7 million as of December 31, 2019. The terms of such agreements are for one year and automatically renew for one year if not terminated by us or the employee.

Civil Investigative Demand

In February 2020, we entered into a settlement agreement in the amount of $9.5 million with the U.S. Department of Justice and the State of Tennessee of actions alleging violations of the federal False Claims Act in connection with our provision of therapy and the completion of certain resident admission forms. This settlement resolved an investigation that had begun in 2012 and covers the time period from January 1, 2010 through December 31, 2015. This agreement requires material annual payments for a period of five years ending in February 2025 and also requires a contingent payment in the event the Company sells any of its owned facilities during the five year payment period. Failure to make timely any of these payments could result in rescission of the settlement and result in the government having a very large claim against us, including penalties, and/or make us ineligible to participate in certain government funded healthcare programs, any of which could in turn significantly harm our business and financial condition.

In conjunction with the settlement of the government investigation related to our therapy practices, we entered into a corporate integrity agreement with the Office of the Inspector General of CMS. This agreement has a term of five years and imposes material burdens on the Company, its officers and directors to take actions designed to insure compliance with applicable healthcare laws, including requirements to maintain specific compliance positions within the Company, to report any non-compliance with the terms of the agreement, to return any overpayments received, to submit annual reports and for an annual audit of submitted claims by an independent review organization. The CIA sets forth penalties for non-compliance by the Company with the terms of the agreement, including possible exclusion from federally funded healthcare programs for material violations of the agreement.

Results of Operations

As discussed in the overview at the beginning of Management's Discussion and Analysis of Financial Condition and Results of Operations, we have completed certain divestitures, acquisitions and entered several new lease agreements. We have reclassified our Consolidated Financial Statements to present certain divestitures as discontinued operations for all periods presented. The following discussion only relates to our continuing operations.

(in thousands)	Year Ended December 31,			
	2019	2018	Change	%
PATIENT REVENUES, net	$ 475,020	$ 476,122	$ (1,102)	(0.2)%
EXPENSES:				
Operating	380,870	381,178	(308)	(0.1)%
Lease and rent expense	52,990	49,231	3,759	7.6 %
Professional liability	6,996	6,498	498	7.7 %
Litigation contingency expense	3,100	6,400	(3,300)	(51.6)%
General and administrative	28,009	30,237	(2,228)	(7.4)%
Depreciation and amortization	9,122	9,991	(869)	(8.7)%
Total expenses	481,087	483,535	(2,448)	(0.5)%
OPERATING LOSS	(6,067)	(7,413)	1,346	18.2 %
OTHER INCOME (EXPENSE):				
Other income	281	160	121	75.6 %
Gain on sale of investment in unconsolidated affiliate	—	308	(308)	(100.0)%
Interest expense, net	(5,994)	(5,533)	(461)	(8.3)%
Debt retirement costs	—	(267)	267	100.0 %
	(5,713)	(5,332)	(381)	(7.1)%
LOSS FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	(11,780)	(12,745)	965	7.6 %
BENEFIT (PROVISION) FOR INCOME TAXES	(15,694)	1,481	(17,175)	*N/M*
LOSS FROM CONTINUING OPERATIONS	$ (27,474)	$ (11,264)	$ (16,210)	(143.9)%
NET LOSS PER COMMON SHARE:				
Continuing operations per common share - basic	$ (4.25)	$ (1.77)	$ (2.48)	(140.1)%
Continuing operations per common share - dilutive	$ (4.25)	$ (1.77)	$ (2.48)	(140.1)%
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING:				
Basic	6,459	6,372		
Dilutive	6,459	6,372		

N/M = Not Meaningful

(in thousands)	Year Ended December 31,			
	2018	2017	Change	%
PATIENT REVENUES, net	$ 476,122	$ 482,811	$ (6,689)	(1.4)%
EXPENSES:				
Operating	381,178	389,916	(8,738)	(2.2)%
Lease and rent expense	49,231	48,248	983	2.0 %
Professional liability	6,498	7,992	(1,494)	(18.7)%
Litigation contingency expense	6,400	—	6,400	100 %
General and administrative	30,237	31,342	(1,105)	(3.5)%
Depreciation and amortization	9,991	9,252	739	8.0 %
Lease termination receipts	—	(180)	180	100.0 %
Total expenses	483,535	486,570	(3,035)	(0.6)%
OPERATING LOSS	(7,413)	(3,759)	(3,654)	(97.2)%
OTHER INCOME (EXPENSE):				
Other income	160	472	(312)	(66.1)%
Gain on bargain purchase	—	925	(925)	(100.0)%
Gain on sale of investment in unconsolidated affiliate	308	733	(425)	(58.0)%
Hurricane costs	—	(232)	232	100.0 %
Interest expense, net	(5,533)	(5,353)	(180)	(3.4)%
Debt retirement costs	(267)	—	(267)	(100.0)%
	(5,332)	(3,455)	(1,877)	(54.3)%
LOSS FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	(12,745)	(7,214)	(5,531)	(76.7)%
BENEFIT (PROVISION) FOR INCOME TAXES	1,481	(2,534)	4,015	158.4 %
LOSS FROM CONTINUING OPERATIONS	$ (11,264)	$ (9,748)	$ (1,516)	(15.6)%
NET LOSS PER COMMON SHARE:				
Continuing operations per common share - basic	$ (1.77)	$ (1.55)	$ (0.22)	(14.2)%
Continuing operations per common share - dilutive	$ (1.77)	$ (1.55)	$ (0.22)	(14.2)%
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING:				
Basic	6,372	6,279		
Dilutive	6,372	6,279		

Year Ended December 31, 2019 Compared With Year Ended December 31, 2018

Patient Revenues

Patient revenues were $475.0 million in 2019 and $476.1 million in 2018, a decrease of $1.1 million or 0.2%.

Our average Medicaid, Private and Medicare rates per patient day for the twelve months ended December 31, 2019 increased compared to the twelve months ended December 31, 2018, by 1.4%, 2.3%, and 2.2%, respectively, resulting in increases in revenue of $3.5 million, $0.8 million, and $2.2 million, respectively. Our Hospice and Managed Care average daily census for the twelve months ended December 31, 2019 increased 16.2% and 2.7%, respectively, resulting in $4.5 million and $1.0 million in additional revenue, respectively. Conversely, our Medicare and Private average daily census for the twelve months ended December 31, 2019 decreased 11.1% and 10.9%, respectively, resulting in revenue losses of $10.9 million and $4.0 million, respectively. The QIPP and IGT resulted in $1.2 million in additional revenues for the twelve months ended December 31, 2019

The following table summarizes key revenue and census statistics for continuing operations for each period:

	Year Ended December 31,	
	2019	**2018**
Skilled nursing occupancy	77.5%	78.1%
As a percent of total census:		
Medicaid census	68.9%	68.3%
Medicare census	9.3%	10.4%
Managed Care census	4.6%	4.5%
As a percent of total revenues:		
Medicaid revenues	46.9%	45.4%
Medicare revenues	17.0%	17.8%
Managed Care revenues	10.6%	10.3%
Average rate per day:		
Medicare	$ 462.39	$ 451.21
Medicaid	$ 179.25	$ 176.79
Managed Care	$ 392.94	$ 390.64

Operating Expense

Operating expense decreased to $380.9 million in 2019 from $381.2 million in 2018. Operating expense increased to 80.2% of revenue in 2019, compared to 80.1% of revenue in 2018.

The decrease in operating expenses is mostly attributable to a decrease in nursing and ancillary costs of $2.8 million for the twelve months ended December 31, 2019 compared to the twelve months ended December 31, 2018. This was offset by increases in health insurance costs of $2.4 million for the twelve months ended December 31, 2019 compared to the twelve months ended December 31, 2018.

One of the largest components of operating expenses is wages, which increased from $229.0 million for the twelve months ended December 31, 2018 to $229.3 million for the twelve months ended December 31, 2019.

Lease Expense

Lease expense increased to $53.0 million in 2019 from $49.2 million in 2018, an increase of $3.8 million, or 7.6%. The increase in lease expense was due to rent increases resulting from the New Master Lease Agreement with Omega Healthcare Investors and the impact of straight line rent expense. See Note 11, "Commitments and Contingencies" to the consolidated financial statements for further discussion of the New Master Lease Agreement.

Professional Liability

Professional liability expense was $7.0 million in 2019 compared to $6.5 million in 2018, an increase of $0.5 million, or 7.7%. Our cash expenditures for professional liability costs, including the State of Kentucky, were $4.6 million and $6.5 million for 2019 and 2018, respectively. Professional liability expense and cash expenditures fluctuate from year to year based respectively on the results of our third-party professional liability actuarial studies, the premium costs of purchased insurance, and on the costs incurred in defending and settling existing claims. See “Liquidity and Capital Resources” for further discussion of the accrual for professional liability.

Litigation Contingency Expense

In June 2019, the Company and the U.S. Department of Justice reached an agreement in principle on the financial terms of a settlement regarding a civil investigative demand. In anticipation of the execution of final agreements and payment of a settlement amount of $9.5 million, the Company recorded an additional contingent liability related to the DOJ investigation of $3.1 million during the twelve months ended December 31, 2019 to increase our previously estimated and recorded liability related to this investigation. Refer to Note 11, "Commitments and Contingencies" to the consolidated financial statements for further discussion.

General and Administrative Expense

General and administrative expenses were approximately $28.0 million in 2019 compared to $30.2 million in 2018, a decrease of $2.2 million, or 7.4%. The decrease in general and administrative expense is mainly attributable to $1.2 million of executive severance expense for the twelve months ended December 31, 2018. The remaining change is due to a decrease in salaries and related taxes of $0.6 million for the twelve months ended December 31, 2019 as compared to the twelve months ended December 31, 2018.

Depreciation and Amortization

Depreciation and amortization expense was approximately $9.1 million in 2019 and $10.0 million in 2018, a decrease of $0.9 million, or 8.7%. The decrease in depreciation and amortization expense relates to a decrease in capital expenditures.

Interest Expense, Net

Interest expense has increased to $6.0 million in 2019 compared to $5.5 million in 2018, an increase of $0.5 million. The increase was primarily attributable to outstanding borrowings on our loan facilities.

Loss from Continuing Operations before Income Taxes; Loss from Continuing Operations per Common Share

As a result of the above, continuing operations reported a loss before taxes of $11.8 million in 2019, as compared to a loss before taxes of $12.7 million in 2018. The provision for income taxes was $15.7 million in 2019, resulting in an effective rate of 133.2%. The benefit for income taxes was $1.5 million in 2018, resulting in an effective rate of 11.6%. The fluctuation is attributable to a full valuation allowance of $21.9 million in 2019. The basic and diluted loss per common share from continuing operations were $4.25 and $4.25 in 2019, respectively, compared to a basic and diluted loss per common share from continuing operations of $1.77 and $1.77 in 2018, respectively.

Year Ended December 31, 2018 Compared With Year Ended December 31, 2017

Patient Revenues

Patient revenues were $476.1 million in 2018 and $482.8 million in 2017, a decrease of $6.7 million or 1.4%. The difference between patient revenues for 2018 is primarily due to the implementation of ASC 606. Refer to Note 4, "Revenue Recognition and Receivables" to the consolidated financial statements. The following table summarizes the revenue fluctuations attributable to our portfolio growth (in thousands):

	Year Ended December 31,		
	2018	2017	
	As reported	As reported	Change
Same-store revenue	$ 466,826	$ 472,910	$ (6,084)
2017 acquisition revenue	9,296	4,553	4,743
2017 disposition revenue	—	5,348	(5,348)
Total revenue	$ 476,122	$ 482,811	$ (6,689)

Revenue increased by $6.7 million, which is primarily attributable to revenue contributions from the acquisition of a center in Alabama ("Park Place") during the third quarter of 2017 of $4.7 million. The increase from the acquisition activity was offset by a decrease in revenues attributable to the 2017 disposition of a center in Mississippi ("Carthage") of $5.3 million. Refer to Note 2, "Business Developments" to the consolidated financial statements. The increase in same store revenue of $6.1 million is explained in more detail below.

The following table summarizes key revenue and census statistics for continuing operations for each period:

	Year Ended December 31,	
	2018	2017
	As reported	As reported
Skilled nursing occupancy	78.1%	78.7%
As a percent of total census:		
Medicaid census	68.3%	68.4%
Medicare census	10.4%	10.9%
Managed Care census	4.5%	4.3%
As a percent of total revenues:		
Medicaid revenues	51.8%	51.6%
Medicare revenues	24.1%	25.3%
Managed Care revenues	8.7%	8.1%
Average rate per day:		
Medicare	$ 451.21	$ 452.52
Medicaid	$ 176.79	$ 172.62
Managed Care	$ 390.64	$ 378.15

The average Medicaid rate per patient day for same-store nursing centers in 2018 increased 2.4% compared to 2017, resulting in an increase in revenue of $5.9 million. This average rate per day for Medicaid patients is the result of rate increases in certain states and increasing patient acuity levels. The average Managed Care, Hospice, and Private rate per patient day for same-store nursing centers in 2018 increased 3.4%, 4.5%, and 3.1%, respectively, compared to 2017, resulting in an increase in revenue of $1.2 million, $1.0 million, and $1.2 million, respectively.

Our total average daily census decreased by approximately 2.6% compared to 2017. On a same-store basis, our Medicare, Medicaid and Private average daily census for 2018 decreased compared to 2017, resulting in decreases in revenue of $5.8

million, $2.9 million and $3.4 million, respectively. Conversely, our Managed Care and Hospice average daily census increased in 2018 compared to 2017 by $1.5 million and $3.7 million, respectively. Additionally, our ancillary revenue increased by $2.3 million in 2018 compared to 2017.

Operating Expense

Operating expense decreased to $381.2 million in 2018 from $389.9 million in 2017. The difference between operating expenses for 2018 is primarily due to the implementation of ASC 606. Refer to Note 4, "Revenue Recognition and Receivables" to the consolidated financial statements. Operating expense decreased from 80.8% of revenue in 2017 to 80.1% of revenue in 2018. The following table summarizes the operating expense fluctuations attributable to our portfolio growth (in thousands):

	Year Ended December 31,		
	2018	2017	
	As reported	As reported	Change
Same-store operating expenses	$ 374,356	$ 382,134	$ (7,778)
2017 acquisition operating expenses	6,822	3,640	$ 3,182
2017 disposition operating expenses	—	4,142	$ (4,142)
Total operating expenses	$ 381,178	$ 389,916	(8,738)

The difference between operating expenses for 2018 is primarily due to the implementation of ASC 606. Refer to Note 4, "Revenue Recognition and Receivables" to the consolidated financial statements. Same-store operating expenses decreased by $7.8 million, which is primarily attributable to the implementation of ASC 606. Same-store operating salaries and related taxes increased by $2.3 million. Our same-store legal and accounting fees increased by $1.1 million.

Lease Expense

Lease expense increased to $49.2 million in 2018 from $48.2 million in 2017, an increase of $1.0 million, or 2.0%. The increase in lease expense was due to rent increases resulting from the New Master Lease Agreement with Omega Healthcare Investors and the impact of straight line rent expense. See Note 11, "Commitments and Contingencies" to the consolidated financial statements for further discussion of the New Master Lease Agreement.

Professional Liability

Professional liability expense was $6.5 million in 2018 compared to $8.0 million in 2017, a decrease of $1.5 million, or 18.7%. Our cash expenditures for professional liability costs, including the State of Kentucky, were $6.5 million and $6.6 million for 2018 and 2017, respectively. Professional liability expense and cash expenditures fluctuate from year to year based respectively on the results of our third-party professional liability actuarial studies, the premium costs of purchased insurance, and on the costs incurred in defending and settling existing claims. See “Liquidity and Capital Resources” for further discussion of the accrual for professional liability.

Litigation Contingency Expense

The Company recorded a contingent liability related to the DOJ investigation for $6.4 million in 2018. In June 2019, the Company and the U.S. Department of Justice reached an agreement in principle on the financial terms of a settlement regarding the civil investigative demand. Refer to Note 11, "Commitments and Contingencies" to the consolidated financial statements for further discussion of the investigation.

General and Administrative Expense

General and administrative expenses were approximately $30.2 million in 2018 compared to $31.3 million in 2017, a decrease of $1.1 million, or 3.5%. The overall decrease in general and administrative expenses was attributable to a $1.1 million decrease in salaries and related expenses.

Depreciation and Amortization

Depreciation and amortization expense was approximately $10.0 million in 2018 and $9.3 million in 2017, an increase of $0.7 million, or 8.0%. The increase in depreciation and amortization expense relates to capital expenditures.

Lease termination receipts

The Company ceased operations at our Carthage, Mississippi, center in September 2017, which resulted in a $0.2 million cash termination receipt, net of legal costs.

Gain on bargain purchase

The Company acquired the operations and assets of a center in Selma, Alabama in July 2017. In connection with the business combination, we recognized $0.9 million gain on bargain purchase.

Gain on sale of investment in unconsolidated affiliate

Gain on the sale of investment in unconsolidated affiliate was $0.3 million and $0.7 million for 2018 and 2017, respectively. The additional gains recognized in 2018 and 2017 are related to the final liquidation of remaining net assets affiliated with the partnership.

Hurricane costs

Hurricane costs of $0.2 million were incurred in 2017, which related to Hurricanes Harvey and Irma.

Interest Expense, Net

Interest expense increased to $5.5 million in 2018 compared to $5.4 million in 2017, an increase of $0.1 million. The increase was primarily attributable to outstanding borrowings on our loan facilities.

Debt retirement costs

Debt retirement costs were $0.3 million in 2018 as a result of a reduction of the debt balances for the Mortgage Loan and Revolver in connection with the latest amendments to our financing agreements. See Note 7, "Long-Term Debt, Interest Rate Swap and Finance Lease Obligations" to the consolidated financial statements for further discussion on the amended debt agreement.

Loss from Continuing Operations before Income Taxes; Loss from Continuing Operations per Common Share

As a result of the above, continuing operations reported a loss before taxes of $12.7 million in 2018, as compared to income before taxes of $7.2 million in 2017. The benefit for income taxes was $1.5 million in 2018, resulting in an effective rate of 11.6%. The provision for income taxes was $2.5 million in 2017, resulting in an effective rate of 35.1%. The higher effective tax rate in 2017 reflects the impact of a revaluation of our net deferred tax assets of $5.5 million as a result of the Tax Act. The basic and diluted loss per common share from continuing operations were $1.77 and $1.77 in 2018, respectively, compared to a basic and diluted loss per common share from continuing operations of $1.55 and $1.55 in 2017, respectively.

Liquidity and Capital Resources

Liquidity

Our primary source of liquidity is the net cash flows provided by the operating activities of our centers. These internally generated cash flows are used to service existing debt obligations, fund required capital expenditures as well as provide cash flows for investing opportunities. In determining priorities for our cash flow, we evaluate alternatives available to us and select the ones that we believe will most benefit us over the long term. Options for our cash include, but are not limited to, capital improvements, acquisitions, and payment of existing debt obligations, as well as initiatives to improve nursing center performance. We review these potential uses and align them to our cash flows with a goal of achieving long-term success.

Net cash provided by operating activities of continuing operations totaled $12.3 million, $5.7 million, and $2.1 million in 2019, 2018, and 2017, respectively. The increase in cash provided by operating activities between 2019 and 2018 is due to increased collections of accounts receivable, which was slightly offset by an increase in accounts payable and accrued expenses.

Additionally, we recognized a decrease of $3.3 million in loss contingency expense period over period. The cash provided by continuing operations increased $3.6 million from $5.7 million in 2017 to $2.1 million in 2018. Operating activities of discontinued operations used cash of $7.0 million and $0.1 million in 2019 and 2018, respectively, and provided cash of $10.0 million in 2017.

Our cash expenditures related to professional liability claims were $4.6 million, $6.5 million and $6.6 million for 2019, 2018 and 2017, respectively. Although we work diligently to limit the cash required to settle and defend professional liability claims, a significant judgment entered against us in one or more legal actions could have a material adverse impact on our cash flows and could result in our being unable to meet all of our cash needs as they become due.

Investing activities of continuing operations used cash of $5.0 million, $7.2 million, $16.1 million in 2019, 2018, and 2017, respectively. The decrease in cash used in continuing operations was due to a decrease in capital expenditures. The change in our cash from investing activities between 2018 and 2017 is attributable to the asset purchase of Park Place in Selma, Alabama in July 2017 for $8.8 million. Net cash provided by investing activities of discontinued operations in 2018 totaled $17.7 million and used cash of $1.3 million in 2017. The cash provided by investing activities of discontinued operations during 2018 is due to the sale of Diversicare of Fulton, LLC, Diversicare of Clinton, LLC and Diversicare of Glasgow, LLC (the "Kentucky Properties") on December 1, 2018 for $18.7 million. The proceeds from the sale were immediately applied to our outstanding borrowings on our mortgage and revolver facilities, which is in accordance with our debt agreements. We have used $5.0 million, $7.5 million, and $8.4 million in 2019, 2018 and 2017, respectively, for capital expenditures of continuing operations.

Net cash used in financing activities of continuing operations were $0.3 million and $16.9 million in 2019 and 2018, respectively, compared to net cash provided by financing activities of continuing operations of $4.6 million in 2017. The decrease in cash used in financing activities between 2019 and 2018 is due to the decrease in net repayments of $14.9 million. The significant decrease in net repayments of debt obligations is due to the proceeds received from the sale of three Kentucky centers of $18.7 million, which was immediately used to relieve debt on our mortgage and revolver facilities in 2018. See Note 7, "Long-Term Debt, Interest Rate Swap and Finance Lease Obligations" to the consolidated financial statements for further discussion on the amended debt agreement related to the sale of the Kentucky centers. Cash provided by financing activities in 2017 is primarily due to draws on the Company's revolving credit facility of $21.0 million, acquisition revolver of $8.5 million and amending our credit facility resulting in proceeds of $7.5 million. The proceeds received were offset by repayments of $30.2 million. Financing activities reflect dividends on common stock of $1.1 million in 2018, and $1.4 million in 2017.

Professional Liability

The Company has professional liability insurance coverage for its nursing centers that, based on historical claims experience, is likely to be substantially less than the claims that are expected to be incurred. Effective July 1, 2013, the Company established a wholly-owned, consolidated offshore limited purpose insurance subsidiary, SHC, which has issued a policy insuring claims made against all of the Company's nursing centers in Florida and Tennessee, and several of the Company's nursing centers in Alabama, Kentucky, Ohio, and Texas. The insurance coverage provided for these centers under the SHC policy include coverage limits of $1.0 million or $3.0 million per medical incident with a sublimit per center of $3.0 million and total annual aggregate policy limits of $5.0 million. All other centers within the Company's portfolio are covered through various commercial insurance policies which provide coverage limits of $1.0 million per claim and have sublimits of $3.0 million per center, with varying aggregate policy limits and deductibles. The deductibles for these policies are covered through the insurance subsidiary.

As of December 31, 2019, we have recorded total liabilities for reported professional liability claims and estimates for incurred, but unreported claims of $27.4 million. Our calculation of this estimated liability is based on the Company's best estimates of the likelihood of adverse judgments with respect to any asserted claim; however, a significant judgment could be entered against us in one or more of these legal actions, and such a judgment could have a material adverse impact on our financial position and cash flows.

Capital Resources

As of December 31, 2019, we had $75.0 million of outstanding long-term debt and capital lease obligations. The $75.0 million total includes $0.9 million in capital lease obligations. The balance of the long-term debt is comprised of $49.7 million owed on

our collateralized mortgage debt, $14.0 million currently outstanding on a revolving credit facility, $1.0 million on an affiliated revolver, and $9.4 million on the acquisition loan facility.

Under the terms of the agreements, a syndicate of banks provided a mortgage loan with an original balance of $80.0 million with a five year maturity through February 26, 2021, consisting of $67.5 million term and $12.5 million acquisition loan facilities ("Amended Mortgage Loan"), and a $42.3 million revolver through February 26, 2021 ("Amended Revolver"). The Amended Mortgage Loan has a term of five years, with principal and interest payable monthly based on a 25 year amortization. Interest on the term and acquisition loan facilities are based on LIBOR plus 4.0% and 4.75%, respectively. A portion of the Amended Mortgage Loan is effectively fixed at 5.79% pursuant to an interest rate swap with an initial notional amount of $30.0 million. The Amended Mortgage Loan balance was $59.1 million as of December 31, 2019, consisting of $49.7 million on the term loan facility with an interest rate of 5.8% and $9.4 million on the acquisition loan facility with an interest rate of 6.5%. The Amended Mortgage Loan is secured by 15 owned nursing centers, related equipment and a lien on the accounts receivable of these centers. The Amended Mortgage Loan and the revolvers are cross-collateralized and cross-defaulted. The Company's revolvers have an interest rate of LIBOR plus 4.0% and are secured by accounts receivable and are subject to limits on the maximum amount of loans that can be outstanding under the revolvers based on borrowing base restrictions. Eligible accounts receivable are calculated as defined and consider 80% of certain net receivables while excluding receivables from private pay patients, those pending approval by Medicaid and receivables greater than 120 days.

As of December 31, 2019, the Company had $15.0 million in borrowings outstanding under its revolvers compared to $15.0 million outstanding as of December 31, 2018. The interest rate related to the revolvers was 5.75% as of December 31, 2019. The outstanding borrowings on the revolvers were used primarily for temporary working capital requirements. Annual fees for letters of credit issued under the Amended Revolver are 3.0% of the amount outstanding. The Company has 4 letters of credit with a total value of $12.1 million outstanding as of December 31, 2019. Considering the balance of eligible accounts receivable, the letters of credit, the amounts outstanding under the revolvers and the maximum loan amount of $31.6 million, the balance available for borrowing under the revolvers was $5.8 million at December 31, 2019.

Our lending agreements contain various financial covenants, the most restrictive of which relate to debt service coverage ratios. We are in compliance with all such covenants, exclusive of the minimum guarantor fixed charge coverage ratio related to the Amended Revolver and the Amended Mortgage Loan, which was due to the exit from the State of Kentucky and the related impact on our operating activities. We obtained a waiver of this covenant from our syndicate of banks for the period ending December 31, 2019 in connection with an amendment to our credit facility effective February 25, 2020. See Note 13, "Subsequent Events" to the consolidated financial statements for further discussion on the amended debt agreement.

Our calculated compliance with financial covenants is presented below:

	Requirement	Level at December 31, 2019
Credit Facility:		
Minimum fixed charge coverage ratio	1.01:1.00	Waived
Minimum adjusted EBITDA	$9.5 million	$10.0 million
Current ratio (as defined in agreement)	1.00:1.00	1.20:1.00
Mortgaged Centers:		
EBITDAR (mortgaged centers)	$10.0 million	$13.9 million
Affiliated Revolver:		
Minimum fixed charge coverage ratio	1:00:1:00	1.30:1:00
Minimum adjusted EBITDA	$0.8 million	$0.9 million

As part of the debt agreements entered into in February 2016, the Company entered into an interest rate swap agreement with a member of the bank syndicate as the counterparty. The interest rate swap agreement has the same effective date and maturity date as the Amended Mortgage Loan, and carries an initial notional amount of $30.0 million. The interest rate swap agreement requires the Company to make fixed rate payments to the bank calculated on the applicable notional amount at an annual fixed rate of

5.79% while the bank is obligated to make payments to us based on LIBOR on the same notional amounts. We entered into the interest rate swap agreement to mitigate the variable interest rate risk on our outstanding mortgage borrowings.

Exchange Listing

As previously disclosed, on June 19, 2019, the Company received written notification from Nasdaq stating that the Company's Common Stock was subject to delisting from Nasdaq, pending the Company's opportunity to request a hearing before the Nasdaq Hearings Panel. The Company appealed the Notification on August 22, 2019. On August 27, 2019, the Company was notified by the Panel that it denied the Company's appeal and determined to delist the Company's Common Stock from the Nasdaq Capital Market. Accordingly, the trading of the Company's Common Stock was suspended on the Nasdaq Capital Market at the opening of business on August 29, 2019 and the Company's Common stock began trading on the OTCQX under the trading symbol "DVCR." On October 11, 2019 Nasdaq filed a Form 25 with the Securities & Exchange Commission to effect the formal delisting of the Company's common stock from the Nasdaq Capital Market, which became effective October 21, 2019. The Form 25 filing did not cause the removal of any shares of the Company's common stock from registration under the Exchange Act. The Company remains subject to the periodic reporting requirements of the Exchange Act. Delisting from Nasdaq may adversely affect our ability to raise additional financing through the public or private sale of equity securities.

Finance Lease Obligations

Upon acquisition of certain centers, we assume certain leases, primarily related to equipment, that constitute capital leases. Additionally, the Company leases certain technology equipment that supports the clinical systems, including electronic medical records, at our nursing centers that constitute capital leases.

As a result of the lease agreements above, we have recorded the underlying lease assets and finance lease obligations of $0.9 million, $0.9 million, and $1.4 million as of December 31, 2019, 2018, and 2017, respectively. These lease agreements provide terms of three to five years.

Receivables

Our operations could be adversely affected if we experience significant delays in reimbursement from Medicare, Medicaid and other third-party revenue sources. Our future liquidity will continue to be dependent upon the relative amounts of current assets (principally cash, accounts receivable and inventories) and current liabilities (principally accounts payable and accrued expenses). In that regard, accounts receivable can have a significant impact on our liquidity. Continued efforts by governmental and third-party payors to contain or reduce the acceleration of costs by monitoring reimbursement rates, by increasing medical review of bills for services, or by negotiating reduced contract rates, as well as any delay by us in the processing of our invoices, could adversely affect our liquidity and financial position.

Net accounts receivable attributable to patient services of continuing operations totaled $60.5 million at December 31, 2019 compared to $66.3 million at December 31, 2018, representing approximately 54 days and 50 days revenue in accounts receivable, respectively. The decrease in net accounts receivable was due to the exit from the State of Kentucky. We continue to evaluate and implement additional procedures to strengthen our collection efforts and reduce the incidence of uncollectible accounts.

Inflation

Based on contract pricing for food and other supplies and recent market conditions, we expect cost increases in 2020 to be relatively the same or slightly lower than the increases in 2019. We expect salary and wage increases for our skilled health care providers to continue to be higher than average salary and wage increases, as is common in the healthcare industry.

Off-Balance Sheet Arrangements

We have four letters of credit outstanding totaling approximately $12.1 million as of December 31, 2019. The letters of credit serve as security deposits for certain center leases. The letters of credit were issued under our revolving credit facility. Our accounts receivable serve as the collateral for this revolving credit facility.

Forward-Looking Statements

The foregoing discussion and analysis provides information deemed by management to be relevant to an assessment and understanding of our consolidated results of operations and financial condition. This discussion and analysis should be read in conjunction with our consolidated financial statements included herein. Certain statements made by or on behalf of us, including those contained in this “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and elsewhere, are forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Actual results could differ materially from those contemplated by the forward-looking statements made herein. Forward-looking statements are predictive in nature and are frequently identified by the use of terms such as "may," "will," "should," "expect," "believe," "estimate," "intend," and similar words indicating possible future expectations, events or actions. In addition to any assumptions and other factors referred to specifically in connection with such statements, other factors, many of which are beyond our ability to control or predict, could cause our actual results to differ materially from the results expressed or implied in any forward-looking statements including, but not limited to:

- our ability to successfully operate all of our centers,
- our ability to increase census and occupancy rates at our centers,
- changes in governmental reimbursement, including the new Patient-Driven Payment Model that was implemented in October 2019,
- our ability to comply with the Settlement Agreement entered with the Department of Justice and the State of Tennessee,
- our ability to comply with the Corporate Integrity Agreement entered in conjunction with the Settlement Agreement with the government, including the results of annual claims audits required thereunder.
- government regulation,
- the impact of the Affordable Care Act, efforts to repeal or further modify the Affordable Care Act, and other health care reform initiatives,
- any increases in the cost of borrowing under our credit agreements,
- our ability to comply with covenants contained in those credit agreements,
- our ability to extend or replace our current credit facility,
- our ability to comply with the terms of our master lease agreements,
- our ability to renew or extend our leases at or prior to the end of the existing lease terms,
- the outcome of professional liability lawsuits and claims, including claims related to our discontinued operations,
- our ability to control ultimate professional liability costs,
- the accuracy of our estimate of our anticipated professional liability expense,
- the impact of future licensing surveys,
- laws and regulations governing quality of care or other laws and regulations applicable to our business including HIPAA and laws governing reimbursement from government payors,
- the costs of investing in our business initiatives and development,
- our ability to control costs,
- our ability to attract and retain qualified healthcare professionals,
- changes to our valuation of deferred tax assets,
- changing economic and competitive conditions,
- changes in anticipated revenue and cost growth,
- changes in the anticipated results of operations,
- the effect of changes in accounting policies as well as others.

Investors also should refer to the risks identified in this “Management's Discussion and Analysis of Financial Condition and Results of Operations” as well as risks identified in “Part I. Item 1A. Risk Factors” for a discussion of various risk factors of the Company and that are inherent in the health care industry. Given these risks and uncertainties, we can give no assurances that

these forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. These assumptions may not materialize to the extent assumed, and risks and uncertainties may cause actual results to be different from anticipated results. These risks and uncertainties also may result in changes to the Company's business plans and prospects. Such cautionary statements identify important factors that could cause our actual results to materially differ from those projected in forward-looking statements. In addition, we disclaim any intent or obligation to update these forward-looking statements.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The chief market risk factor affecting our financial condition and operating results is interest rate risk. As of December 31, 2019, we had outstanding borrowings of approximately $74.1 million, $47.4 million of which were subject to variable interest rates. In connection with February 2016 financing agreement, we entered into an interest rate swap with respect to one half of the Amended Mortgage Loan to mitigate the floating interest rate risk of such borrowing. In the event that interest rates were to change 1%, the impact on future pre-tax cash flows would be approximately $0.5 million annually, representing the impact of increased or decreased interest expense on variable rate debt.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Audited financial statements are contained on pages F-1 through F-35 of this Annual Report on Form 10-K and are incorporated herein by reference. Audited supplemental schedule data is contained on pages S-1 through S-2 of this Annual Report on Form 10-K and is incorporated herein by reference.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Diversicare, with the participation of our principal executive and financial officers, has evaluated the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15d-15(e) promulgated under the Securities Exchange Act of 1934, as amended, as of December 31, 2019. Based on this evaluation, the principal executive and financial officers have determined that such disclosure controls and procedures are effective to ensure that information required to be disclosed in our filings under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported within the time periods specified in the Securities Exchange Commission's rules and forms.

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended). Our management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on this evaluation, management concluded that our internal control over financial reporting was effective as of December 31, 2019. Management reviewed the results of its assessment with our Audit Committee.

Changes in Internal Control over Financial Reporting

There has been no change (including corrective actions with regard to significant deficiencies or material weaknesses) in our internal control over financial reporting that has occurred during our fiscal quarter ended December 31, 2019 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Our management does not expect that our disclosure controls and procedures or our internal controls will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefit of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that

all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision making can be faulty and that breakdowns can occur because of simple error or mistake. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Information concerning our Directors, Executive Officers and Corporate Governance is incorporated herein by reference to our definitive proxy statement for our 2020 Annual Meeting of Shareholders, which we will file within 120 days of the end of the fiscal year to which this Report relates.

ITEM 11. EXECUTIVE COMPENSATION

Information concerning Executive Compensation is incorporated herein by reference to our definitive proxy statement for our 2020 Annual Meeting of Shareholders, which we will file within 120 days of the end of the fiscal year to which this Report relates.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Information concerning Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters is incorporated herein by reference to our definitive proxy statement for our 2020 Annual Meeting of Shareholders, which we will file within 120 days of the end of the fiscal year to which this Report relates.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information concerning Certain Relationships and Related Transactions, and Director Independence is incorporated herein by reference to our definitive proxy statement for our 2020 Annual Meeting of Shareholders, which we will file within 120 days of the end of the fiscal year to which this Report relates.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

Information concerning the fees and services provided by our principal accountant is incorporated herein by reference to our definitive proxy statement for our 2020 Annual Meeting of Shareholders, which we will file within 120 days of the end of the fiscal year to which this Report relates.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

The Financial statements and schedule for us and our subsidiaries required to be included in Part II, Item 8 are listed below.

Exhibits

The exhibits filed as part of this Report on Form 10-K are listed in the Exhibit Index below.

ITEM 16. FORM 10-K SUMMARY

None.

Exhibit Number		Description of Exhibits
3.1		Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement No. 33-76150 on Form S-1, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T)
3.2		Certificate of Designation of Registrant (incorporated by reference to Exhibit 3.5 to the Company's quarterly report on Form 10-Q for the quarter ended September 30, 2006).
3.3		Bylaws of the Company (incorporated by reference to Exhibit 3.2 to the Company's Registration Statement No. 33-76150 on Form S-1, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T)
3.4		Bylaw Amendment adopted November 5, 2007 (incorporated by reference to Exhibit 3.4 to the Company's annual report on Form 10-K for the year ended December 31, 2007).
3.5		Amendment to Certificate of Incorporation dated March 23, 1995 (incorporated by reference to Exhibit A of Exhibit 1 to the Company's Form 8-A filed March 30, 1995, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T).
3.6		Certificate of Designation of Registrant (incorporated by reference to Exhibit 3.4 to the Company's quarterly report on Form 10-Q for the quarter ended March 31, 2001).
3.7		Certificate of Ownership and Merger of Diversicare Healthcare Services, Inc. with and into Advocat Inc. (incorporated by reference to Exhibit 3.1 to the Company's current report on Form 8-K filed March 14, 2013).
3.8		Amendment to Certificate of Incorporation dated June 9, 2016 (incorporated by reference to Exhibit 3.8 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2016).
3.9		Bylaw Second Amendment adopted April 14, 2016 (incorporated by reference to Exhibit 3.9 to the Company's quarterly report on Form 10-Q for the quarter ended March 31, 2017.
4.1		Form of Common Stock Certificate (incorporated by reference to Exhibit 4 to the Company's Registration Statement No. 33-76150 on Form S-1, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T)
4.2		Description of each class of securities registered under Section 12 of the Exchange Act.
*10.1		Master Agreement and Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.6 to the Company's Registration Statement No. 33-76150 on Form S-1, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T).
10.2		Form of Director Indemnification Agreement (incorporated by reference to Exhibit 10.8 to the Company's Registration Statement No. 33-76150 on Form S-1, filed in paper - hyperlink is not required pursuant to Rule 105 of Regulation S-T)
10.3		Management Agreement effective October 1, 2000, between Diversicare Leasing Corp. and Diversicare Management Services Co. (incorporated by reference to Exhibit 10.85 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2000).
*10.4		Advocat Inc. 2005 Long-Term Incentive Plan (incorporated by reference to Appendix A to the Company's Definitive Proxy Statement on Schedule 14A filed on April 20, 2006).
*10.5		First Amendment to the Advocat Inc. 2005 Long-Term Incentive Plan (incorporated by reference to Exhibit 10.63 to the Company's annual report on Form 10-K for the year ended December 31, 2008).
*10.6		Advocat Inc. 2010 Long-Term Incentive Plan (incorporated by reference to Appendix A to the Company's Definitive Proxy Statement on Schedule 14A filed on April 28, 2010).
*10.7		First Amendment to the Diversicare Healthcare Services, Inc. 2010 Long-Term Incentive Plan (incorporated by reference to Appendix A to the Company's Definitive Proxy Statement on Schedule 14A filed on April 26, 2017).

*10.8		Advocat Inc. 2008 Stock Purchase Plan for Key Personnel (incorporated by reference to Appendix A to the Company's Definitive Proxy Statement on Schedule 14A filed May 2, 2008).
*10.9		Employment Agreement effective January 1, 2013, between Leslie Campbell and Advocat Inc. (incorporated by reference to Exhibit 10.49 to the Company's annual report on Form 10-K for the year ended December 31, 2012).
10.10		Second Amended and Restated Term Loan and Security Agreement dated February 26, 2016 (incorporated by reference to exhibit 10.1 to the Company's quarterly report on Form 10-Q for the quarter ended March 31, 2016).
10.11		Second Amended and Restated Guaranty (Revolver) dated as of February 26, 2016, by the Company to and for the benefit of The PrivateBank in its capacity as administrative agent (incorporated by reference to Exhibit 10.29 to the Company's Annual Report of Form 10-K for the year ended December 31, 2018).
10.12		Second Amended and Restated Guaranty (Term) dated as of February 26, 2016, by the Company to and for the benefit of The PrivateBank in its capacity as administrative agent(incorporated by reference to Exhibit 10.30 to the Company's Annual Report of Form 10-K for the year ended December 31, 2018).
10.13		Third Amended and Restated Revolving Loan and Security Agreement dated February 26, 2016 (incorporated by reference to exhibit 10.2 to the Company's quarterly report on Form 10-Q for the quarter ended March 31, 2016).
*10.14		Amendment to Diversicare Healthcare Services, Inc. 2008 Employee Stock Purchase Plan for Key Personnel (incorporated by reference to exhibit 10.1 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2016).
10.15		First Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated August 3, 2016 (incorporated by reference to exhibit 10.12 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2016).
10.16		First Amendment to Second Amended and Restated Term Loan and Security Agreement dated August 3, 2016 (incorporated by reference to exhibit 10.3 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2016).
10.17		Second Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated October 3, 2016 (incorporated by reference to exhibit 10.3 to the Company's quarterly report on Form 10-Q for the quarter ended September 30, 2016).
10.18		Third Amendment to the Third Amended and Restated Revolving Loan and Security Agreement dated December 29, 2016 (incorporated by reference to Exhibit 10.55 to the Company's Annual Report of Form 10-K for the year ended December 31, 2016).
**10.19		Amended and Restated Golden Living Master Lease Agreement dated November 1, 2016 (incorporated by reference to Exhibit 10.57 to the Company's Annual Report of Form 10-K for the year ended December 31, 2016).
10.20		Fourth Amendment to the Third Amended and Restated Revolving Loan And Security Agreement dated June 30, 2017 (incorporated by reference to exhibit 10.1 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2017).
10.21		Second Amendment to the Second Amended and Restated Term Loan and Security Agreement dated June 30, 2017 (incorporated by reference to exhibit 10.2 to the Company's quarterly report on Form 10-Q for the quarter ended June 30, 2017).
10.22		Fifth Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated February 27, 2018 (incorporated by reference to Exhibit 10.61 to the Company's Annual Report of Form 10-K for the year ended December 31, 2017).
10.23		Third Amendment to Second Amended and Restated Term Loan and Security Agreement dated February 27, 2018 (incorporated by reference to Exhibit 10.62 to the Company's Annual Report on Form 10-K for the year ended December 31, 2017).
*10.24		Kelly Gill Separation Agreement (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018).
*10.25		Employment Agreement effective September 10, 2018, between Kerry D. Massey and Diversicare Healthcare Services, Inc. (incorporated by reference to Exhibit 10.1 to the Company's current report on Form 8-K filed September 5, 2018).

*10.26		Amended Employment Agreement effective July 6, 2018, between James R. McKnight, Jr. and Diversicare Healthcare Services, Inc. (incorporated by reference to Exhibit 10.1 to the Company's current report on Form 8-K filed September 20, 2018)
**10.27		Master Lease Agreement Effective October 1, 2018 by and between the Company and Omega Healthcare Investors (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018)
10.28		Amended and Restated Guaranty in favor of Omega Healthcare Investors, Inc. dated October 1, 2018. (incorporated by reference to Exhibit 10.46 to the Company's Annual Report on Form 10-K for the year ended December 31, 2018).
10.29		Amended and Restated Security Agreement dated October 1, 2018 by and among the Company and a syndicate of financial institutions and banks (incorporated by reference to Exhibit 10.48 to the Company's Annual Report on Form 10-K for the year ended December 31, 2018).
10.30		Asset Purchase Agreement dated October 30, 2018 by and between Diversicare of Fulton, LLC, Diversicare of Fulton Properties, LLC, Diversicare of Clinton, LLC, Diversicare of Clinton Properties, LLC, Diversicare of Glasgow, LLC and Fulton Nursing and Rehabilitation LLC, Holiday Fulton Propco LLC, Birchwood Nursing and Rehabilitation LLC, Padgett Clinton Propco LLC and Westwood Nursing and Rehabilitation LLC (incorporated by reference to Exhibit 10.47 to the Company's Annual Report on Form 10-K for the year ended December 31, 2018)
10.31		Fourth Amendment to Second Amended and Restated Term Loan and Security Agreement dated December 1, 2018 (incorporated by reference to Exhibit 10.49 to the Company's Annual Report on Form 10-K for the year ended December 31, 2018).
10.32		Sixth Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated December 1, 2018 (incorporated by reference to Exhibit 10.50 to the Company's Annual Report on Form 10-K for the year ended December 31, 2018).
10.33		Seventh Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated May 13, 2019 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019).
10.34		Fifth Amendment to Second Amended and Restated Term Loan and Security Agreement dated May 13, 2019 (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019).
10.35		First Amendment to Omega Master Lease Agreement dated August 20, 2019 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019).
10.36		Eighth Amendment to Third Amended and Restated Revolving Loan and Security Agreement dated February 25, 2020.
10.37		Sixth Amendment to Second Amended and Restated Term Loan and Security Agreement dated February 25, 2020.
10.38		First Amendment to Revolving Loan and Security Agreement dated February 25, 2020.
10.39		Settlement Agreement with the U.S. Department of Justice and the State of Tennessee dated February 14, 2020.
10.40		Corporate Integrity Agreement with the Office of the Inspector General of CMS dated February 14, 2020.
21		Subsidiaries of the Registrant.
23.1		Consent of BDO USA, LLP.
31.1		Certification of Chief Executive Officer pursuant to Rule 13a-14(a) or Rule 15d-14(a).
31.2		Certification of Chief Financial Officer pursuant to Rule 13a-14(a) or Rule 15d-14(a).

32		Certification of Chief Executive Officer and Chief Financial Officer pursuant to Rule 13a-14(b) or Rule 15d-14(b).
101.INS		XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document
101.SCH		Inline XBRL Taxonomy Extension Schema Document
101.CAL		Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.LAB		Inline XBRL Taxonomy Extension Labels Linkbase Document
101.PRE		Inline XBRL Taxonomy Extension Presentation Linkbase Document
104		Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101

* Indicates management contract or compensatory plan or arrangement.

** Confidential treatment has been requested for portions of this exhibit

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

DIVERSICARE HEALTHCARE SERVICES, INC.

/s/ Chad A. McCurdy
Chad A. McCurdy
Chairman of the Board
March 5, 2020

/s/ James R. McKnight, Jr.
James R. McKnight, Jr.
President and Chief Executive Officer
(Principal Executive Officer)
March 5, 2020

/s/ Kerry D. Massey
Kerry D. Massey
Executive Vice President and Chief Financial Officer
(Principal Financial and Accounting Officer)
March 5, 2020

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

/s/ Chad A. McCurdy
Chad A. McCurdy
Chairman of the Board and Director
March 5, 2020

/s/ Robert Z. Hensley
Robert Z. Hensley
Director
March 5, 2020

/s/ James R. McKnight, Jr.
James R. McKnight, Jr.
President and Chief Executive Officer
Director
March 5, 2020

/s/ Leslie K. Morgan
Leslie K. Morgan
Director
March 5, 2020

/s/ Robert A. McCabe, Jr.
Robert A. McCabe, Jr.
Director
March 5, 2020

/s/ Richard M. Brame
Richard M. Brame
Director
March 5, 2020

/s/ Ben R. Leedle, Jr.
Ben R. Leedle, Jr.
Director
March 5, 2020

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES

Consolidated Financial Statements
For the Years Ended December 31, 2019, 2018 and 2017
Together with Report of Independent Registered Public Accounting Firm

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Shareholders and Board of Directors
Diversicare Healthcare Services, Inc.
Brentwood, Tennessee

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Diversicare Healthcare Services, Inc. (the "Company") as of December 31, 2019 and 2018, the related consolidated statements of operations, comprehensive loss, shareholders' equity (deficit), and cash flows for each of the three years in the period ended December 31, 2019, and the related notes and financial statement schedule listed in the accompanying index (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019**,** in conformity with accounting principles generally accepted in the United States of America.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, the Company has changed its method of accounting for leases effective January 1, 2019. The Company adopted FASB Accounting Standards Update 2016-02, *Leases* (ASC 842).

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's consolidated financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ BDO USA, LLP

We have served as the Company's auditor since 2002.

Nashville, Tennessee
March 5, 2020

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2019 AND 2018
(in thousands, except per share amounts)

ASSETS	2019	2018
CURRENT ASSETS:		
Cash	$ 2,710	$ 2,685
Receivables	60,521	66,257
Self-insurance receivables	1,011	4,475
Other receivables	2,534	1,191
Prepaid expenses and other current assets	5,056	4,659
Income tax refundable	484	1,115
Current assets of discontinued operations	—	155
Total current assets	72,316	80,537
PROPERTY AND EQUIPMENT, at cost	132,775	127,644
Less accumulated depreciation and amortization	(85,020)	(76,801)
Property and equipment, net	47,755	50,843
OTHER ASSETS:		
Operating lease right-of-use assets	310,238	—
Deferred income taxes, net	—	15,851
Deferred leasehold costs	—	206
Other noncurrent assets	4,323	3,244
Acquired leasehold interest, net	5,736	6,307
Noncurrent assets of discontinued operations	—	2,256
Total other assets	320,297	27,864
	$ 440,368	$ 159,244

LIABILITIES AND SHAREHOLDERS' DEFICIT	2019	2018
CURRENT LIABILITIES:		
Current portion of long-term debt and finance lease obligations	$ 3,498	$ 12,449
Current portion of operating lease liability	23,736	—
Trade accounts payable	14,641	15,659
Current liabilities of discontinued operations	—	86
Accrued expenses:		
Payroll and employee benefits	16,780	19,471
Self-insurance reserves, current portion	13,829	13,158
Other current liabilities	11,545	9,522
Total current liabilities	84,029	70,345
NONCURRENT LIABILITIES:		
Long-term debt and finance lease obligations, less current portion and deferred financing costs, net	70,637	60,984
Operating lease liability, less current portion	295,636	—
Self-insurance reserves, less current portion	16,291	16,057
Litigation contingency	9,000	6,400
Other noncurrent liabilities	1,691	6,656
Total noncurrent liabilities	393,255	90,097
COMMITMENTS AND CONTINGENCIES		
SHAREHOLDERS' DEFICIT:		
Common stock, authorized 20,000 shares, $.01 par value, 6,908 and 6,751 shares issued, and 6,676 and 6,519 shares outstanding, respectively	69	68
Treasury stock at cost, 232 shares of common stock	(2,500)	(2,500)
Paid-in capital	24,026	23,413
Accumulated deficit	(59,079)	(23,016)
Accumulated other comprehensive income	568	837
Total shareholders' deficit	(36,916)	(1,198)
	$ 440,368	$ 159,244

The accompanying notes are an integral part of these consolidated financial statements.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(in thousands, except per share amounts)

	Years Ended December 31,		
	2019	2018	2017
PATIENT REVENUES, net	$ 475,020	$ 476,122	$ 482,811
EXPENSES:			
Operating	380,870	381,178	389,916
Lease and rent expense	52,990	49,231	48,248
Professional liability	6,996	6,498	7,992
Litigation contingency expense	3,100	6,400	—
General and administrative	28,009	30,237	31,342
Depreciation and amortization	9,122	9,991	9,252
Lease termination receipts	—	—	(180)
Total expenses	481,087	483,535	486,570
OPERATING LOSS	(6,067)	(7,413)	(3,759)
OTHER INCOME (EXPENSE):			
Other income	281	160	472
Gain on bargain purchase	—	—	925
Gain on sale of investment in unconsolidated affiliate	—	308	733
Hurricane costs	—	—	(232)
Interest expense, net	(5,994)	(5,533)	(5,353)
Debt retirement costs	—	(267)	—
Total other income (expense)	(5,713)	(5,332)	(3,455)
LOSS FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	(11,780)	(12,745)	(7,214)
BENEFIT (PROVISION) FOR INCOME TAXES	(15,694)	1,481	(2,534)
LOSS FROM CONTINUING OPERATIONS	(27,474)	(11,264)	(9,748)
INCOME (LOSS) FROM DISCONTINUED OPERATIONS:			
Operating income (loss), net of income tax provision of ($517), ($731) and ($4,209), respectively	(9,322)	(957)	4,921
Gain on lease modification, net of tax	733	—	—
Gain on sale of assets, net of tax	—	4,825	—
INCOME (LOSS) FROM DISCONTINUED OPERATIONS	(8,589)	3,868	4,921
NET LOSS	$ (36,063)	$ (7,396)	$ (4,827)
NET INCOME (LOSS) PER COMMON SHARE:			
Per common share – basic			
Continuing operations	$ (4.25)	$ (1.77)	$ (1.55)
Discontinued operations	(1.33)	0.61	0.78
	$ (5.58)	$ (1.16)	$ (0.77)
Per common share – diluted			
Continuing operations	$ (4.25)	$ (1.77)	$ (1.55)
Discontinued operations	(1.33)	0.61	0.78
	$ (5.58)	$ (1.16)	$ (0.77)
DIVIDENDS DECLARED PER SHARE OF COMMON STOCK	$ —	$ 0.17	$ 0.22
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING:			
Basic	6,459	6,372	6,279
Diluted	6,459	6,372	6,279

The accompanying notes are an integral part of these consolidated financial statements.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
(in thousands)

	Years Ended December 31,		
	2019	**2018**	**2017**
NET LOSS	$ (36,063)	$ (7,396)	$ (4,827)
OTHER COMPREHENSIVE INCOME (LOSS):			
Change in fair value of cash flow hedge, net of tax	(269)	279	976
Less: reclassification adjustment for amounts recognized in net loss	—	(151)	(462)
Total other comprehensive income (loss)	(269)	128	514
COMPREHENSIVE LOSS	$ (36,332)	$ (7,268)	$ (4,313)

The accompanying notes are an integral part of these consolidated financial statements.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY (DEFICIT)
(in thousands)

	Common Stock		Treasury Stock				Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity (Deficit)
	Shares Issued	Amount	Shares	Amount	Paid-in Capital	Accumulated Deficit		
BALANCE, DECEMBER 31, 2016	6,592	$ 66	232	$ (2,500)	$ 21,935	$ (8,276)	$ 195	$ 11,420
Net loss	—	—	—	—	—	(4,827)	—	(4,827)
Common stock dividends declared	—	—	—	—	47	(1,431)	—	(1,384)
Issuance/redemption of equity grants, net	95	1	—	—	(95)	—	—	(94)
Interest rate cash flow hedge	—	—	—	—	—	—	514	514
Stock based compensation	—	—	—	—	833	—	—	833
BALANCE, DECEMBER 31, 2017	6,687	67	232	(2,500)	22,720	(14,534)	709	6,462
Net loss	—	—	—	—	—	(7,396)	—	(7,396)
Common stock dividends declared	—	—	—	—	31	(1,086)	—	(1,055)
Issuance/redemption of equity grants, net	64	1	—	—	(218)	—	—	(217)
Interest rate cash flow hedge	—	—	—	—	—	—	128	128
Stock based compensation	—	—	—	—	880	—	—	880
BALANCE, DECEMBER 31, 2018	6,751	68	232	(2,500)	23,413	(23,016)	837	(1,198)
Net loss	—	—	—	—	—	(36,063)	—	(36,063)
Issuance/redemption of equity grants, net	157	1	—	—	40	—	—	41
Interest rate cash flow hedge	—	—	—	—	—	—	(269)	(269)
Stock based compensation	—	—	—	—	573	—	—	573
BALANCE, DECEMBER 31, 2019	6,908	$ 69	232	$ (2,500)	$ 24,026	$ (59,079)	$ 568	$ (36,916)

The accompanying notes are an integral part of these consolidated financial statements.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Years Ended December 31,		
	2019	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net loss	$ (36,063)	$ (7,396)	$ (4,827)
Income (loss) from discontinued operations	(8,589)	3,868	4,921
Loss from continuing operations	(27,474)	(11,264)	(9,748)
Adjustments to reconcile loss from continuing operations to net cash provided by operating activities:			
Depreciation and amortization	9,122	9,991	9,252
Provision for doubtful accounts	—	—	8,202
Deferred income tax provision (benefit)	15,421	(926)	2,040
Provision for self-insured professional liability, net of cash payments	4,739	2,325	1,342
Stock based and deferred compensation	573	1,127	1,027
Debt retirement costs	—	267	—
Provision for leases, net of cash payments	3,897	(106)	(936)
Amortization of right-of-use assets	21,890	—	—
Litigation contingency expense	3,100	6,400	—
Gain on sale of assets and unconsolidated affiliate	—	(308)	(733)
Gain on bargain purchase	—	—	(925)
Deferred bonus	—	—	761
Other	1,507	415	524
Changes in other assets and liabilities affecting operating activities:			
Receivables	9,200	(2,289)	(10,721)
Prepaid expenses and other assets	(6,693)	(5,926)	385
Trade accounts payable and accrued expenses	(1,793)	6,010	1,589
Operating lease liabilities	(21,154)	—	—
Net cash provided by continuing operations	12,335	5,716	2,059
Net cash provided by (used in) discontinued operations	(7,003)	(65)	10,001
Net cash provided by operating activities	5,332	5,651	12,060
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of property and equipment	(4,980)	(7,531)	(8,423)
Acquisition of property and equipment through business combination	—	—	(8,750)
Proceeds from unconsolidated affiliate	—	308	1,100
Net cash used in continuing operations	(4,980)	(7,223)	(16,073)
Net cash provided by (used in) discontinued operations	6	17,653	(1,307)
Net cash provided by (used in) investing activities	(4,974)	10,430	(17,380)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Repayment of debt and finance lease obligations	(12,541)	(36,684)	(30,154)
Proceeds from issuance of debt	12,500	21,689	37,067
Financing costs	(333)	(146)	(195)
Issuance and redemption of employee equity awards	41	(217)	(94)
Payment of common stock dividends	—	(1,054)	(1,384)
Payment for preferred stock restructuring	—	(508)	(659)
Net cash provided by (used in) continuing operations	(333)	(16,920)	4,581
Net cash provided by (used in) discontinued operations	—	—	—
Net cash provided by (used in) financing activities	(333)	(16,920)	4,581

(Continued)

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)
(continued)

	Years Ended December 31,		
	2019	2018	2017
NET INCREASE (DECREASE) IN CASH	$ 25	$ (839)	$ (739)
CASH, beginning of period	2,685	3,524	4,263
CASH, end of period	$ 2,710	$ 2,685	$ 3,524
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:			
Cash payments of interest, net of amounts capitalized	$ 5,390	$ 6,074	$ 5,404
Cash payments of income taxes	$ 432	$ 498	$ 847
SUPPLEMENTAL INFORMATION ON NON-CASH INVESTING AND FINANCING TRANSACTIONS:			
Acquisition of equipment through finance lease	$ 483	$ 689	$ 507
Acquisition of operating leases through adoption of ASC Topic 842	$ 389,403	$ —	$ —
Lease modification	$ (48,877)	$ —	$ —

The accompanying notes are an integral part of these consolidated financial statements.

1. BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Diversicare Healthcare Services, Inc. ("Diversicare" or the "Company") provides a broad range of post-acute care services to patients and residents including skilled nursing, ancillary health care services and assisted living. In addition to the nursing and social services usually provided in long-term care centers, we offer a variety of rehabilitative, nutritional, respiratory, and other specialized ancillary services. The Company operates and reports one reportable operating segment. The Company believes that this structure reflects its current operational and financial management.

As of December 31, 2019, our continuing operations consist of 62 nursing centers with 7,329 licensed skilled nursing beds. Our nursing centers range in size from 50 to 320 licensed nursing beds. The licensed nursing bed count does not include 397 licensed assisted living and other residential beds. Our continuing operations include centers in Alabama, Florida, Indiana, Kansas, Mississippi, Missouri, Ohio, Tennessee, and Texas. The number of centers and beds denoted in these consolidated financial statements are unaudited.

Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the financial position, operations and accounts of Diversicare and its subsidiaries, all wholly-owned. All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenue Recognition

On January 1, 2018, the Company adopted Accounting Standards Codification 606, *Revenues From Contracts with Customers*, ("ASC 606"), using the modified retrospective method for all contracts as of the date of adoption. The reported results for 2019 and 2018 reflect the application of ASC 606 guidance while the reported results for 2017 were prepared under the guidance in ASC 605, *Revenue Recognition* (ASC 605). The adoption of ASC 606 represents a change in accounting principle that more closely aligns revenue recognition with the delivery of the Company's services. The amount of revenue recognized reflects the consideration to which the Company expects to be entitled to receive in exchange for these services.

Performance obligations are promises made in a contract to transfer a distinct good or service to the customer. A contract's transaction price is allocated to each distinct performance obligation and recognized as revenue when, or as, the performance obligation is satisfied. The Company has concluded that the contracts with patients and residents represent a bundle of distinct services that are substantially the same, with the same pattern of transfer to the customer. Accordingly, the promise to provide quality care is accounted for as a single performance obligation.

The Company performed analyses using the application of the portfolio approach as a practical expedient to group patient contracts with similar characteristics, such that revenue for a given portfolio would not be materially different than if it were evaluated on a contract-by-contract basis. These analyses incorporated consideration of reimbursements at varying rates from Medicaid, Medicare, Managed Care, Private Pay, Assisted Living, Hospice, and Veterans for services provided in each corresponding state. It was determined that the contracts are not materially different for the following groups: Medicaid, Medicare, Managed Care and Private Pay and other (Assisted Living, Hospice and Veterans).

In order to determine the transaction price, the Company estimates the amount of variable consideration at the beginning of the contract using the expected value method. The estimates consider (i) payor type, (ii) historical payment trends, (iii) the maturity of the portfolio, and (iv) geographic payment trends throughout a class of similar payors. The Company typically enters into agreements with third-party payors that provide for payments at amounts different from the established charges. These arrangement terms provide for subsequent settlement and cash flows that may occur well after the service is provided. The Company constrains (reduces) the estimates of variable consideration such that it is probable that a significant reversal of previously recognized revenue will not occur throughout the life of the contract. Changes in the Company's expectation of the amount it will receive from the patient or third-party payors will be recorded in revenue unless there is a specific event that suggests the patient or third-party payor no longer has the ability and intent to pay the amount due and, therefore, the changes in its estimate of variable consideration better represent an impairment, or bad debt. These estimates are re-assessed each reporting period, and any amounts allocated to a satisfied performance obligation are recognized as revenue or a reduction of revenue in the period in which the transaction price changes.

The Company satisfies its performance obligation by providing quality of care services to its patients and residents on a daily basis until termination of the contract. The performance obligation is recognized on a time elapsed basis, by day, for which the services are provided. For these contracts, the Company has the right to consideration from the customer in an amount that directly corresponds with the value to the customer of the Company's performance to date. Therefore, the Company recognizes revenue based on the amount billable to the customer in accordance with the practical expedient in ASC 606-10-55-18. Additionally, because the Company applied ASC 606 using certain practical expedients, the Company elected not to disclose the aggregate amount of the transaction price for unsatisfied, or partially unsatisfied, performance obligations for all contracts with an original expected length of one year or less.

The Company incurs costs related to patient/resident contracts, such as legal and advertising expenses. The contract costs are expensed as incurred. They are not expected to be recovered and are not chargeable to the patient/resident regardless of whether the contract is executed. See Note 4, “Revenue Recognition and Receivables.”

Lease Expense

As of December 31, 2019, the Company operates 47 nursing centers under operating leases, including 24 owned by Omega, 20 owned by Golden Living and three owned by other parties. The Company's operating leases generally require the Company to pay stated rent, subject to increases based on changes in the Consumer Price Index or a minimum percentage increase. The Company's Master Leases with Omega and Golden Living require the Company to pay certain scheduled rent increases. Such scheduled rent increases are recorded as additional lease expense on a straight-line basis recognized over the term of the related leases and the difference between the amounts recorded for rent expense as compared to rent payments is recorded as an accrued liability.

See Note 2, "Business Development and Other Significant Transactions" and Note 11, "Commitments and Contingencies" for a discussion regarding the Company's Master Leases with Omega and Golden Living and the addition of certain leased centers.

Classification of Expenses

The Company classifies all expenses (except lease, interest, depreciation and amortization expenses) that are associated with its corporate and regional management support functions as general and administrative expenses within continuing operations. All other expenses (except lease, professional liability, interest, depreciation and amortization expenses) incurred by the Company at the center level for continuing operations are classified as operating expenses.

Property and Equipment

Property and equipment are recorded at cost or at fair value determined on the respective dates of acquisition for assets obtained in a business combination, with depreciation and amortization being provided over the shorter of the remaining lease term (where applicable) or the assets' estimated useful lives on the straight-line basis as follows:

Buildings and improvements	-	5 to 40 years
Leasehold improvements	-	2 to 10 years
Furniture, fixtures and equipment	-	2 to 15 years

Interest incurred during construction periods for qualifying expenditures is capitalized as part of the building cost. Maintenance and repairs are expensed as incurred, and major betterments and improvements are capitalized.

The Company routinely evaluates the recoverability of the carrying value of its long-lived assets, including property and equipment and right of use assets. The evaluation for recoverability includes when significant adverse changes in the general economic conditions and significant deteriorations of the underlying undiscounted cash flows or fair values of the asset group indicate that the carrying amount of the asset group may not be recoverable. If circumstances suggest that the recorded amounts are not recoverable based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

Cash

Cash and cash equivalents include cash on deposit with banks and all highly liquid investments with original maturities of three months or less when purchased. Our cash on deposit with banks was subject to the Federal Deposit Insurance Corporation ("FDIC") minimum insurance levels.

Deferred Financing and Other Costs

The Company records deferred financing and lease costs for direct and incremental expenditures related to entering into or amending debt and lease agreements. These expenditures include lenders' and attorneys' fees. Financing costs are amortized using the effective interest method over the term of the related debt. The amortization is reflected as interest expense in the accompanying consolidated statements of operations. Deferred lease costs are amortized on a straight-line basis over the term of the related leases. See Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations" for further discussion.

Acquired Leasehold Interest

The Company has recorded an acquired leasehold interest intangible asset related to an acquisition completed during 2007. The intangible asset is accounted for in accordance with the Financial Accounting Standards Board's ("FASB") guidance on goodwill and other intangible assets, and is amortized on a straight-line basis over the remaining life of the acquired lease. As discussed in Note 2, "Business Developments and Other Significant Transactions," the Company entered into a new Master Lease agreement with Omega Healthcare Investors ("Omega" or the "Lessor") on October 1, 2018, which was subsequently modified on August 30, 2019. The new Master Lease includes the seven centers to which the intangible asset relates. As such, the intangible asset is now being amortized over an adjusted remaining life, consistent with the term of the new Master Lease, which goes through September 30, 2030. Amortization expense of approximately $571, $384 and $384 related to this intangible asset was recorded during each of the years ended December 31, 2019, 2018 and 2017, respectively.

The carrying value of the acquired leasehold interest intangible and the accumulated amortization are as follows:

	December 31,	
	2019	**2018**
Acquired leasehold interest, gross	$ 10,652	$ 10,652
Accumulated amortization	(4,916)	(4,345)
Acquired leasehold interest, net	$ 5,736	$ 6,307

The Company evaluates the recoverability of the carrying value of the acquired leasehold intangible in accordance with the FASB's guidance on accounting for the impairment or disposal of long-lived assets. Included in this evaluation is whether significant adverse changes in general economic conditions, and significant deteriorations of the underlying cash flows or fair values of the intangible asset indicate that the carrying amount of the intangible asset may not be recoverable. The need to recognize an impairment charge is based on estimated future undiscounted cash flows from the asset compared to the carrying value of that asset. If recognition of an impairment charge is necessary, it is measured as the amount by which the carrying amount of the intangible asset exceeds the fair value of the intangible asset.

The expected amortization expense for the acquired leasehold interest intangible asset is as follows:

2020	$ 534
2021	534
2022	534
2023	534
2024	534
Thereafter	3,066
	$ 5,736

Self-Insurance

Self-insurance liabilities primarily represent the unfunded accrual for self-insured risks associated with general and professional liability claims, employee health insurance and workers' compensation. The Company's health insurance liability is based on known claims incurred and an estimate of incurred but unreported claims determined by an analysis of historical claims paid. The Company's workers' compensation liability relates primarily to periods of self insurance and consists of an estimate of the future costs to be incurred for the known claims.

Final determination of the Company's actual liability for incurred general and professional liability claims is a process that may take years. The Company evaluates the adequacy of this liability on a quarterly basis. Semi-annually, the Company retains a third-party actuarial firm to assist in the evaluation of this unfunded accrual. Since May 2012, Merlinos & Associates, Inc. (“Merlinos”) has assisted management in the preparation of the appropriate accrual for incurred but not reported general and professional liability claims based on data furnished by the Company. Merlinos primarily utilizes historical data regarding the frequency and cost of the Company's past claims over a multi-year period, industry data and information regarding the number of occupied beds to develop its estimates of the Company's ultimate professional liability cost for current periods.

On a quarterly basis, the Company obtains reports of asserted claims and lawsuits incurred. These reports, which are provided by the Company's insurers and a third party claims administrator, contain information relevant to the actual expense already incurred with each claim as well as the third-party administrator's estimate of the anticipated total cost of the claim. This information is reviewed by the Company quarterly and provided to the actuary semi-annually. Based on the Company's evaluation of the actual claim information obtained, the semi-annual estimates received from the third-party actuary, the amounts paid and committed for settlements of claims and on estimates regarding the number and cost of additional claims anticipated in the future, the reserve estimate for a particular period may be revised upward or downward on a quarterly basis. Any increase in the accrual has an unfavorable impact on results of operations in the period and any reduction in the accrual increases results of operations during the period.

All losses are projected on an undiscounted basis. The self-insurance liabilities include estimates of liability for incurred but not reported claims, estimates of liability for reported but unresolved claims, actual liabilities related to settlements, including settlements to be paid over time, and estimates of related legal costs incurred and expected to be incurred.

One of the key assumptions in the actuarial analysis is that historical losses provide an accurate forecast of future losses. Changes in legislation such as tort reform, changes in our financial condition, changes in our risk management practices and other factors may affect the severity and frequency of claims incurred in future periods as compared to historical claims.

The facts and circumstances of each claim vary significantly, and the amount of ultimate liability for an individual claim may vary due to many factors, including whether the case can be settled by agreement, the quality of legal representation, the individual jurisdiction in which the claim is pending, and the views of the particular judge or jury deciding the case.

Although the Company adjusts its unfunded accrual for professional and general liability claims on a quarterly basis and retains a third-party actuarial firm semi-annually to assist management in estimating the appropriate accrual, professional and general liability claims are inherently uncertain, and the liability associated with anticipated claims is very difficult to estimate. Professional liability cases have a long cycle from the date of an incident to the date a case is resolved, and final determination of the Company's actual liability for claims incurred in any given period is a process that takes years. As a result, the Company's

actual liabilities may vary significantly from the unfunded accrual, and the amount of the accrual has and may continue to fluctuate by a material amount in any given period. Each change in the amount of this accrual will directly affect the Company's results of operations and financial position for the period in which the change in accrual is made.

Income Taxes

The Company follows the FASB's guidance on Income Taxes, which requires the asset and liability method of accounting for income taxes whereby deferred income taxes are recorded for the future tax consequences attributable to differences between the financial statement and tax bases of assets and liabilities. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. Valuation allowances are provided against any estimated non-realizable deferred tax assets where necessary.

Where the Company believes that a tax position is supportable for income tax purposes, the item is included in its income tax returns. Where treatment of a position is uncertain, liabilities are recorded based upon the Company's evaluation of the "more likely than not" outcome considering the technical merits of the position. While the judgments and estimates made by the Company are based on management's evaluation of the technical merits of a matter, historical experience and other assumptions that management believes are appropriate and reasonable under current circumstances, actual resolution of these matters may differ from recorded estimated amounts, resulting in charges or credits that could materially affect future financial statements. See Note 10, "Income Taxes" for additional information related to the provision for income taxes.

Disclosure of Fair Value of Financial Instruments

Fair value is defined as the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants. In calculating fair value, a company must maximize the use of observable market inputs, minimize the use of unobservable market inputs and disclose in the form of an outlined hierarchy the details of such fair value measurements. The carrying amounts of cash, receivables, trade accounts payable and accrued expenses approximate fair value because of the short-term nature of these accounts. The Company's self-insurance liabilities are reported on an undiscounted basis as the timing of estimated settlements cannot be determined.

The Company follows the FASB's guidance on *Fair Value Measurements and Disclosures* which provides rules for using fair value to measure assets and liabilities as well as a fair value hierarchy that prioritizes the information used to develop the measurements. It applies whenever other guidance requires (or permits) assets or liabilities to be measured at fair value and gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

A summary of the fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels is described below:

Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets or liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

Level 2: Observable prices that are based on inputs not quoted on active markets, but corroborated by market data.

Level 3: Unobservable inputs are used when little or no market data is available. The fair value hierarchy gives the lowest priority to Level 3 inputs.

As further discussed in Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations", in conjunction with the debt agreements entered into in February 2016, the Company entered into an interest rate swap agreement with a member of the bank syndicate as the counterparty. The applicable guidance requires companies to recognize all derivative instruments as either assets or liabilities at fair value in a company's balance sheets.

As the Company's interest rate swap, a cash flow hedge, is not traded on a market exchange, the fair value is determined using a valuation model based on a discounted cash flow analysis. This analysis reflects the contractual terms of the interest rate swap agreement and uses observable market-based inputs, including estimated future LIBOR interest rates. The fair value of the Company's interest rate swap is the net difference in the discounted future fixed cash payments and the discounted expected

variable cash receipts. The variable cash receipts are based on the expectation of future interest rates and are observable inputs available to a market participant. The interest rate swap valuation is classified in Level 2 of the fair value hierarchy. The debt balances as presented in the consolidated balance sheets approximate the fair value of the respective instruments as the debt is at a variable rate, the estimates of which are considered Level 2 fair value calculations within the fair value hierarchy.

The following table presents by level, within the fair value hierarchy, assets and liabilities measured at fair value on a recurring basis as of December 31, 2019 and 2018:

December 31, 2019	Fair Value Measurements - Assets (Liabilities)			
	Total	Level 1	Level 2	Level 3
Interest rate swap	$ (57)	$ —	$ (57)	$ —

December 31, 2018	Fair Value Measurements - Assets (Liabilities)			
	Total	Level 1	Level 2	Level 3
Interest rate swap	$ 384	$ —	$ 384	$ —

The change in fair value of the Company's cash flow hedge is detailed in the Company's Consolidated Statements of Comprehensive Loss.

Net Loss per Common Share

The Company follows the FASB's guidance on *Earnings Per Share* for the financial reporting of net loss per common share. Basic earnings per common share excludes dilution and restricted shares and is computed by dividing income available to common shareholders by the weighted-average number of common shares, excluding restricted shares, outstanding for the period. Diluted earnings per common share reflects the potential dilution that could occur if securities or other contracts to issue common stock were exercised or converted into common stock or otherwise resulted in the issuance of common stock that then shared in the earnings of the Company. See Note 9, "Net Loss per Common Share" for additional disclosures about the Company's Net Loss per Common Share.

Stock Based Compensation

The Company follows the FASB's guidance on *Stock Compensation* to account for share-based payments granted to team members and recorded non-cash stock based compensation expense of $573, $1,127 and $1,027 during the years ended December 31, 2019, 2018 and 2017, respectively. Such amounts are included as components of general and administrative expense or operating expense based upon the classification of cash compensation paid to the related employees. See Note 8, "Shareholders' Equity, Stock Plans and Preferred Stock" for additional disclosures about the Company's stock based compensation plans.

Accumulated Other Comprehensive Income

Accumulated other comprehensive income consists of other comprehensive income (loss). Comprehensive income (loss) is a more inclusive financial reporting method that includes disclosure of financial information that historically has not been recognized in the calculation of net income (loss). Currently, the Company's other comprehensive income (loss) consists of the change in fair value of the Company's interest rate swap transaction accounted for as a cash flow hedge.

Recent Accounting Standards Adopted by the Company

In February 2016, the FASB issued Accounting Standards Update ("ASU") No. 2016-02, Leases (Topic 842). The standard establishes a right-of-use ("ROU") model that requires a lessee to record a ROU asset and a lease liability on the balance sheet. Leases are classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. For short-term leases (those with a term of 12 months or less and that do not include a lessee purchase option that is reasonably certain to be exercised), a lessee is permitted to make (and the Company chose to utilize) an accounting policy election by asset class not to recognize ROU assets and lease liabilities, which would generally result in lease expense for these short term leases being recognized on a straight-line basis over the lease term. The Company adopted the requirements of this standard

effective January 1, 2019. In July 2018, the FASB issued ASU 2018-11, Leases - Targeted Improvements, which allows lessees and lessors to recognize and measure existing leases at the beginning of the period of adoption without modifying the comparative period financial statements (which therefore will remain under prior GAAP, Topic 840, Leases). The Company elected to reflect adoption in the period of adoption (January 1, 2019) rather than the earliest period presented. The Company also elected the package of practical expedients upon transition, which includes retaining the lease classification for any leases that exist prior to adoption of the standard. The adoption of the new standard resulted in the recording of net right-of-use assets and lease liabilities of $384,187 and $389,403, respectively, as of January 1, 2019. The standard did not materially impact our consolidated net earnings and had no impact on cash flows. See Note 6, "Leases" for a discussion regarding leases under the new standard.

In August 2017, the FASB issued ASU No. 2017-12, Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities, which is intended to simplify and amend the application of hedge accounting to more clearly portray the economics of an entity's risk management strategies in its financial statements. The new guidance will make more financial and nonfinancial hedging strategies eligible for hedge accounting and reduce complexity in fair value hedges of interest rate risk. The new guidance also changes how companies assess effectiveness and amends the presentation and disclosure requirements. The new guidance eliminates the requirement to separately measure and report hedge ineffectiveness and generally the entire change in the fair value of a hedging instrument will be required to be presented in the same income statement line as the hedged item. The new guidance also eases certain documentation and assessment requirements and modifies the accounting for components excluded from the assessment of hedge effectiveness. The Company adopted the requirements of this standard effective January 1, 2019. The adoption did not have a material impact on our consolidated financial statements and related disclosures. In October 2018, the FASB issued ASU No. 2018-16, Derivatives and Hedging (Topic 805): Inclusion of the Secured Overnight Financing Rate ("SOFR") Overnight Index Swap ("OIS") Rate as a Benchmark Interest Rate for Hedge Accounting Purposes. The ASU amends ASC 815 to add the OIS rate based on the SOFR as a fifth US benchmark interest rate. The Company adopted the requirements of this standard effective January 1, 2019. The adoption did not have a material impact on our consolidated financial statements and related disclosures.

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606), which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. For public companies, Topic 606 is effective for annual and interim reporting periods beginning after December 15, 2017. The Company adopted the requirements of this standard effective January 1, 2018. The Company elected to apply the modified retrospective approach with the cumulative transition effect recognized in beginning retained earnings as of the date of adoption. The impact of the implementation to the consolidated financial statements for periods subsequent to the adoption is not material. See Note 4, "Revenue Recognition and Receivables" for a discussion regarding revenue recognition under the new standard.

Accounting Standards Recently Issued But Not Yet Adopted by the Company

In June 2016, the FASB issued ASU No. 2016-13, Financial Instruments-Credit Losses (Topic 326): Measurement of Credit Loses on Financial Instruments. This update is intended to improve financial reporting by requiring timelier recognition of credit losses on loans and other financial instruments that are not accounted for at fair value through net income, including loans held for investment, held-to-maturity debt securities, trade and other receivables, net investment in leases and other such commitments. This update requires that financial statement assets measured at an amortized cost be presented at the net amount expected to be collected, through an allowance for credit losses that is deducted from the amortized cost basis. This standard is effective for the fiscal year beginning after December 15, 2022 with early adoption permitted. The Company is in the initial stages of evaluating the impact from the adoption of this new standard on the consolidated financial statements and related notes.

In August 2018, the FASB issued ASU No. 2018-13, Fair Value Measurements (Topic 820): Disclosure Framework — Changes to the Disclosure Requirements for Fair Value Measurement. The amendments in this update modify the disclosure requirements on fair value measurements in Topic 820. The standard is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted. The Company does not expect the adoption of this standard to have a material impact on the consolidated financial statements.

2. BUSINESS DEVELOPMENTS AND OTHER SIGNIFICANT TRANSACTIONS

2018 New Master Lease Agreement

On October 1, 2018, the Company entered into a New Master Lease Agreement (the "Lease") with Omega to lease 34 centers currently owned by the Lessor and operated by Diversicare. The old Master Lease with the Lessor provided for its operation of 23 skilled nursing centers in Texas, Kentucky, Alabama, Tennessee, Florida, and Ohio. Additionally, Diversicare operated 11 centers owned by the Lessor under separate leases in Missouri, Kentucky, Indiana, and Ohio. The Lease entered into by Diversicare and the Lessor consolidated the leases for all 34 centers under one New Master Lease. The Lease has an initial term of twelve years with two optional 10-year extensions. The Lease has a common date of annual lease fixed escalators of 2.15% beginning on October 1, 2019.

On August 30, 2019, the Company terminated operations of ten centers in Kentucky and concurrently transferred operations to a new operator. The agreement effectively amended the Lease with the Lessor to remove the ten Kentucky facilities, reduce the annual rent expense, and release the Company from any further obligations arising under the Master Lease Agreement with respect to the Kentucky facilities. The remaining Lease terms remain unchanged with an initial term of twelve years and two optional 10-year extensions. The annual lease fixed escalator remains at 2.15% beginning on October 1, 2019.

Quality Incentive Payment Program

The Company recently expanded its participation in a Quality Incentive Payment Program ("QIPP ") as administered by the Texas Health and Human Services Commission. QIPP provides supplemental Medicaid payments for skilled nursing centers that achieve certain quality measures. The Company previously had one of its Texas skilled nursing centers participating in the QIPP. During April 2019, the Company enrolled an additional eleven of its Texas skilled nursing centers in the program, such that twelve of the Company’s centers participate in the QIPP effective September 1, 2019. To allow four of these centers to meet the QIPP participation requirements, the Company entered into a transaction with a Texas medical district already participating in the QIPP, providing for the transfer of the provider license from the Company to the medical district. The Company’s operating subsidiary retained the management of the centers on behalf of the medical district.

3. DISCONTINUED OPERATIONS

Kentucky Disposition

On October 30, 2018, the Company entered into an Asset Purchase Agreement (the "Agreement") with Fulton Nursing and Rehabilitation, LLC, Holiday Fulton Propco LLC, Birchwood Nursing and Rehabilitation LLC, Padgett Clinton Propco LLC, Westwood Nursing and Rehabilitation LLC, and Westwood Glasgow Propco (the "Buyers") to sell the assets and transfer the operations of Diversicare of Fulton, LLC, Diversicare of Clinton, LLC and Diversicare of Glasgow, LLC (the "Kentucky Properties"). On December 1, 2018, the Company completed the sale of the Kentucky Properties with the Buyers for a purchase price of $18,700. The carrying value of these centers' assets was $13,331, resulting in a gain net of miscellaneous closing costs of $4,825. The proceeds were used to relieve debt, as required under the terms of the Company's Amended Mortgage Loan and Amended Revolver. Refer to Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations" for more information on this transaction.

On May 22, 2019, the Company announced that it entered into an agreement with Omega to amend its master lease to terminate operations of ten nursing facilities, totaling approximately 885 skilled nursing beds, located in Kentucky and to concurrently transfer operations to an operator selected by Omega. These ten centers are collectively referred to as the "Kentucky Centers." The sale of the Kentucky Properties and the termination of operations at the Kentucky Centers are referred to collectively as the "Kentucky Exit." On August 30, 2019, the Company completed the transaction and no longer operates any skilled nursing centers in the State of Kentucky. The Company's exit from the state represents a strategic shift that has (or will have) a major effect on the Company's operations and financial results. In accordance with ASC 205-40, *Presentation of Financial Statements-Discontinued Operations*, the Company's discontinued financial position, results of operations and cash flows have been reclassified on the face of the financial statements and footnotes for all periods presented to reflect the discontinued status of these operations.

The transaction resulted in a gain on the modification of the Lease, which is presented within Discontinued Operations on the Consolidated Statements of Operations. The net gain on the transaction was $733.

These centers contributed revenues of $46,019, $87,338 and $91,727 and net income (loss) of $(8,589), $3,868 and $4,921 during the years ended December 31, 2019, 2018 and 2017, respectively. The net income or loss for the nursing centers included in discontinued operations does not reflect any allocation of corporate general and administrative expense. The Company considered these additional costs along with the centers' future prospects based upon operating history when determining the contribution of the skilled nursing centers to its operations.

The Company did not transfer the accounts receivable or liabilities, inclusive of the reserves for professional liability and workers' compensation, to the new operator. The Company expects to collect the balance of the accounts receivable and pay the remaining liabilities in the ordinary course of business through its future operating cash flows.

4. REVENUE RECOGNITION AND RECEIVABLES

The Company's revenue is derived from providing quality healthcare services to its patients. The amount of revenue recognized reflects the consideration to which the Company expects to be entitled to receive in exchange for these services. The promise to provide quality care is accounted for as a single performance obligation satisfied at a point in time, when those services are rendered.

The Company performed analyses using the application of the portfolio approach as a practical expedient to group patient contracts with similar characteristics, such that revenue for a given portfolio would not be materially different than if it were evaluated on a contract-by-contract basis. These analyses incorporated consideration of reimbursements at varying rates from Medicaid, Medicare, Managed Care, Private Pay, Assisted Living, Hospice, and Veterans for services provided in each corresponding state. It was determined that the contracts are not materially different for the following groups: Medicaid, Medicare, Managed Care and Private Pay and other (Assisted Living, Hospice and Veterans).

Disaggregation of Revenue and Accounts Receivable

The following table set forth net patient revenues related to our continuing operations by payor source for the periods presented (dollar amounts in thousands): The amounts as reported for revenue in 2019 and 2018 differ from the method of accounting in prior years due to the implementation of ASC 606.

	Twelve Months Ended December 31,					
	2019		2018		2017	
	As reported		As reported		As reported	
Medicaid	$ 222,560	46.9%	$ 215,924	45.4%	$ 249,204	51.6%
Medicare	80,798	17.0%	84,959	17.8%	122,043	25.3%
Managed Care	50,323	10.6%	48,879	10.3%	39,162	8.1%
Private Pay and other	121,339	25.5%	126,360	26.5%	72,402	15.0%
Total	$ 475,020	100.0%	$ 476,122	100.0%	$ 482,811	100.0%

Accounts receivable as of December 31, 2019 and 2018 is summarized in the following table:

	December 31,	
	2019	2018
Medicaid	$ 21,998	$ 27,532
Medicare	11,811	15,706
Managed Care	9,103	8,126
Private Pay and other	17,609	14,893
Total accounts receivable	$ 60,521	$ 66,257

5. PROPERTY AND EQUIPMENT

Property and equipment, at cost, consists of the following:

	December 31, 2019	December 31, 2018
Land	$ 5,265	$ 5,283
Buildings and leasehold improvements	84,544	82,111
Furniture, fixtures and equipment	42,966	40,250
	132,775	127,644
Less: accumulated depreciation	(85,020)	(76,801)
Net property and equipment	$ 47,755	$ 50,843

As discussed further in Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations", the property and equipment of certain skilled nursing centers are pledged as collateral for mortgage debt obligations. In addition, the Company has assets recorded as finance leased assets purchased through finance lease obligations. The Company capitalizes leasehold improvements which will revert back to the lessor of the property at the expiration or termination of the lease, and depreciates these improvements over the shorter of the remaining lease term or the assets' estimated useful lives.

6. LEASES

The Company has operating and finance leases for facilities, corporate offices, and certain equipment. The Company recognizes lease expense for these operating leases on a straight-line basis over the lease term. Leases with an initial term of one year or less are not recorded on the consolidated balance sheet. The Company's other leases have original lease terms of one to twelve years, some of which include options to extend the lease for up to twenty years, and some of which include options to terminate the leases within one year. The exercise of lease renewal options is at our sole discretion. The Company's lease agreements do not contain any material residual value guarantees or material restrictive covenants. Upon adoption of Topic 842, the Company elected the practical expedient to not separate lease and non-lease components for all of its leases as the non-lease components are not significant to the overall lease costs.

Leases

	Classification	December 31, 2019
Assets		
Operating lease assets	Operating lease right-of-use assets	$ 310,238
Finance lease assets	Property and equipment, net [(a)]	906
Total leased assets		$ 311,144
Liabilities		
Current		
Operating	Current portion of operating lease liability	$ 23,736
Finance	Current portion of long-term debt and finance lease obligations, net	231
Noncurrent		
Operating	Operating lease liability, less current portion	295,636
Finance	Long-term debt and finance lease obligations, less current portion and deferred financing costs, net	445
Total lease liabilities		$ 320,048

[(a)] Finance lease assets are recorded net of accumulated amortization of $1,522 as of December 31, 2019.

Lease Cost

	Classification	Year Ended December 31,
Operating lease cost [(a)]	Lease and rent expense	$ 52,990
Finance lease cost:		
Amortization of finance lease	Depreciation and	263
Interest on finance lease	Interest expense, net	48
Short term lease cost	Operating expense	649
Net lease cost		$ 53,950

[(a)] Includes variable lease costs, which are immaterial

Maturity of Lease Liabilities

	As of December 31, 2019		
	Operating Leases [(a)]	Finance Leases [(a)]	Total
2020	$ 50,819	$ 269	$ 51,088
2021	51,788	242	52,030
2022	52,812	179	52,991
2023	53,857	37	53,894
2024	53,843	14	53,857
After 2024	200,605	—	200,605
Total lease payments	$ 463,724	$ 741	$ 464,465
Less: Interest	(144,352)	(65)	(144,417)
Present value of lease liabilities	$ 319,372	$ 676	$ 320,048

[(a)] Operating and Finance lease payments exclude options to extend lease terms that are not reasonably certain of being exercised.

The Company's future minimum lease commitments for continuing operations as of December 31, 2018, under Topic 840, predecessor to Topic 842, are as follows:

	As of December 31, 2018		
	Operating Leases [(a)]	Finance Leases [(a)]	Total
2019	$ 48,701	$ 454	$ 49,155
2020	49,595	174	49,769
2021	50,570	173	50,743
2022	51,587	127	51,714
2023	52,624	—	52,624
After 2023	245,225	—	245,225
Total lease payments	$ 498,302	$ 928	$ 499,230

[(a)] Operating and Finance lease payments exclude option to extend lease terms that are not reasonably certain of being exercised.

The measurement of right-of-use assets and lease liabilities requires the Company to estimate appropriate discount rates. To the extent the rate implicit in the lease is readily determinable, such rate is utilized. However, based on information available at lease commencement for the majority of our leases, the rate implicit in the lease is not known. In these instances, the Company utilizes an incremental borrowing rate, which represents the rate of interest that it would pay to borrow on a fully collateralized basis over a similar term.

Lease Term and Discount Rate

	December 31, 2019
Weighted-average remaining lease term (years)	
Operating leases	8.81
Finance leases	3.00
Weighted-average discount rate	
Operating leases	8.9%
Finance leases	6.1%

Other Information

	Year Ended December 31, 2019
Cash paid for amounts included in the measurement of lease liabilities	
Operating cash flows for operating leases	$ 55,485
Operating cash flows for finance leases	48
Financing cash flows for finance leases	471
Acquisition of operating leases though adoption of Topic 842	389,403
Lease modification	$ (48,877)

7. LONG-TERM DEBT, INTEREST RATE SWAP AND FINANCE LEASE OBLIGATIONS

Long-term debt consists of the following:

	December 31,	
	2019	2018
Mortgage loan	$ 49,743	$ 51,730
Acquisition loan	9,400	6,900
Revolver	14,000	15,000
Affiliated revolver	1,000	—
	74,143	73,630
Plus finance lease obligations	857	928
Less current portion	(3,498)	(12,449)
	71,502	62,109
Less deferred financing costs, net	(865)	(1,125)
Long-term debt and finance lease obligation, net	$ 70,637	$ 60,984

On February 26, 2016, the Company executed an Amended and Restated Credit Agreement (the "Credit Agreement") with a syndicate of banks, which consists of a $80,000 mortgage loan subsequently amended ("Amended Mortgage Loan") and a $52,250 revolver subsequently amended ("Amended Revolver"). The Amended Mortgage Loan and Amended Revolver both have a five-year maturity through February 26, 2021. The Amended Mortgage Loan consists of $67,500 term and $12,500 acquisition loan facilities. The Amended Mortgage Loan has a term of five years, with principal and interest payable monthly based on a 25-year amortization. Interest on the term and acquisition loan facilities are based on LIBOR plus 4.0% and 4.75%, respectively. A portion of the Amended Mortgage Loan is effectively fixed at 5.79% pursuant to an interest rate swap with an initial notional amount of $30,000. The Amended Mortgage Loan balance was $59,143 as of December 31, 2019, consisting of $49,743 on the term loan facility with an interest rate of 5.75% and $9,400 on the acquisition loan facility with an interest rate of 6.5%. The Amended Mortgage Loan is secured by 15 owned nursing centers, related equipment and a lien on the accounts receivable of these centers. The Amended Mortgage Loan and the Amended Revolver are cross-collateralized and cross-defaulted. The Company's Amended Revolver has an interest rate of LIBOR plus 4.0% and is secured by accounts receivable and is subject to limits on the maximum amount of loans that can be outstanding under the revolver based on borrowing base restrictions.

As of December 31, 2019, the Company's weighted average interest rate on long-term debt, including the impact of the interest rate swap, was approximately 5.86%.

In connection with the sale of the Kentucky Properties the Company entered into the Sixth Amendment ("Sixth Revolver Amendment") to amend the Amended Revolver effective December 1, 2018. The Sixth Amendment decreased the Amended Revolver capacity from $52,250 to $42,250. The Company also applied $4,947 of net proceeds from the sale of the Kentucky Properties to the outstanding borrowings under the Amended Revolver.

Also effective December 1, 2018, the Company executed a Fourth Amendment (the "Fourth Term Amendment") to amend the Amended Mortgage Loan. The Company applied $11,100 and $2,100 of net proceeds from the sale of the Kentucky Properties to the term and acquisition loans, respectively. Additionally, the related acquisition loan availability was reduced by a reserve of $2,100, and therefore, our borrowing capacity is $10,400. For further discussion of the sale of the Kentucky centers, refer to Note 3, "Discontinued Operations."

The Company is participating in the Texas Quality Incentive Payment Program ("QIPP"). Effective May 13, 2019, the Company entered into a Fifth Amendment (the “Fifth Term Amendment”) to amend the Amended Mortgage Loan to release the operators of three of the QIPP centers in Texas from the Amended Mortgage Loan and a Seventh Amendment (the “Seventh Revolver Amendment”) to amend the Amended Revolver to remove the operators of four of the QIPP centers in Texas from the Amended Revolver and to permanently reduce the amount available under the Amended Revolver by $2,000. At the same time, the operators of these four facilities entered into a separate revolving loan (the "affiliated revolver") with the same syndicate of banks to provide for the temporary working capital requirements of the four QIPP centers. The affiliated revolver, which is guaranteed by the Company, has an initial capacity of $5,000, which amount is reduced by $1,000 on each of January 1, 2020, April 1, 2020 and July 1, 2020. The affiliated revolver has the same maturity date as the Amended Revolver and the Amended Mortgage Loan of February 26, 2021. The affiliated revolver is cross-defaulted with the Amended Revolver and the Amended Mortgage Loan. For further discussion of the QIPP centers in Texas, refer to Note 2, "Business Development and Other Significant Transactions." As of December 31, 2019, the Company had $1,000 borrowings outstanding under the affiliated revolver. The interest rate related to the affiliated revolver was 5.75% as of December 31, 2019. The balance available for borrowing under the affiliated revolver was $339 at December 31, 2019.

As of December 31, 2019, the Company had $15,000 in borrowings outstanding under its revolvers compared to $15,000 outstanding as of December 31, 2018. The interest rate related to the revolvers was 5.75% as of December 31, 2019. The outstanding borrowings on the revolvers were used primarily for temporary working capital requirements. Annual fees for letters of credit issued under the Amended Revolver are 3.0% of the amount outstanding. The Company has 4 letters of credit with a total value of $12,143 outstanding as of December 31, 2019. Considering the balance of eligible accounts receivable, the letter of credit, the amounts outstanding under the revolvers and the maximum loan amount of $31,579, the balance available for borrowing under the revolvers was $5,774 at December 31, 2019.

Our lending agreements contain various financial covenants, the most restrictive of which relate to fixed charge coverage ratios. We are in compliance with all such covenants at December 31, 2019, exclusive of the minimum guarantor fixed charge coverage ratio related to the Amended Mortgage Loan and Amended Revolver, which was due to the exit from the State of Kentucky and the related impact on our operating activities. The Company obtained a waiver of this covenant from our syndicate of banks in connection with an amendment to its credit facility that was effective February 25, 2020. See Note 13, "Subsequent Events" to the consolidated financial statements for further discussion on the amended debt agreement.

In connection with the Company's loan agreements, the Company recorded the following amounts related to deferred loan costs, with such costs classified as a reduction of the debt balances discussed above:

	2019	2018
Write-off of deferred financing costs	$ —	$ 267
Deferred financing costs capitalized	$ 333	$ 146

The deferred financing costs included in the long-term debt balances were $865 at December 31, 2019 and $1,125 at December 31, 2018.

Scheduled principal payments of long-term debt are as follows:

2020	$	3,085
2021		71,058
Total	$	74,143

Interest Rate Swap Cash Flow Hedge

As part of the debt agreements entered into in April 2013, the Company entered into an interest rate swap agreement with a member of the bank syndicate as the counterparty. The Company entered into the interest rate swap agreement to mitigate the variable interest rate risk on its outstanding mortgage borrowings. The Company designated its interest rate swap as a cash flow hedge and the effective portion of the hedge, net of taxes, is reflected as a component of other comprehensive income (loss). In conjunction with the aforementioned amendment to the Credit Agreement that occurred in February 2016, the Company retained the previously agreed upon interest rate swap modifying the terms of the swap to reflect the amended Credit Agreement. The Company redesignated the interest rate swap as a cash flow hedge. The interest rate swap agreement has the same effective date and maturity date as the Amended Mortgage Loan, and has an amortizing notional amount that was $26,785 as of December 31, 2019. The interest rate swap agreement requires the Company to make fixed rate payments to the bank calculated on the applicable notional amount at an annual fixed rate of 5.79% while the bank is obligated to make payments to the Company based on LIBOR on the same notional amounts. The applicable guidance requires companies to recognize all derivative instruments as either assets or liabilities at fair value in a company's balance sheets.

The Company assesses the effectiveness of its interest rate swap on a quarterly basis and at December 31, 2019, the Company determined that the interest rate swap was effective. The interest rate swap valuation model indicated a net liability of $57 at December 31, 2019. The fair value of the interest rate swap is included in “other noncurrent liabilities” on the Company's consolidated balance sheets. The liability related to the change in the interest rate swap included in accumulated other comprehensive income at December 31, 2019 is $44, net of income tax benefit of $13. As the Company's interest rate swap is not traded on a market exchange, the fair value is determined using a valuation model based on a discounted cash flow analysis. This analysis reflects the contractual terms of the interest rate swap agreement and uses observable market-based inputs, including estimated future LIBOR interest rates. The fair value of the Company's interest rate swap is the net difference in the discounted future fixed cash payments and the discounted expected variable cash receipts. The variable cash receipts are based on the expectation of future interest rates and are observable inputs available to a market participant. The interest rate swap valuation is classified in Level 2 of the fair value hierarchy, in accordance with the FASB's guidance on *Fair Value Measurements and Disclosures*.

Finance Lease Obligations

Upon acquisition of some centers, we assumed certain leases, primarily related to equipment, that constitute finance leases. As a result, we have recorded the underlying lease liabilities and financed lease obligations of $857 and $928 as of December 31, 2019 and 2018, respectively. These lease agreements provide three to five year terms.

Scheduled payments of the financed lease obligations are as follows:

2020	$	461
2021		242
2022		178
2023		37
2024		15
Total		933
Amounts related to interest		(76)
Principal payments on finance lease obligation	$	857

8. SHAREHOLDERS' EQUITY, STOCK PLANS AND PREFERRED STOCK

Stock Based Compensation Plans

The Company follows the FASB's guidance on *Stock Compensation* to account for stock-based payments granted to employees and non-employee directors.

Overview of Plans

In June 2008, the Company adopted the Advocat Inc. 2008 Stock Purchase Plan for Key Personnel ("Stock Purchase Plan"). The Stock Purchase Plan provides for the granting of rights to purchase shares of the Company's common stock to directors and officers and 150 shares of the Company's common stock has been reserved for issuance under the Stock Purchase Plan. The Stock Purchase Plan allows participants to elect to utilize a specified portion of base salary, annual cash bonus, or director compensation to purchase restricted shares or restricted share units ("RSU's") at 85% of the quoted market price of a share of the Company's common stock on the date of purchase. The restriction period under the Stock Purchase Plan is generally two years from the date of purchase and during which the shares will have the rights to receive dividends, however, the restricted share certificates will not be delivered to the shareholder and the shares cannot be sold, assigned or disposed of during the restriction period and are subject to forfeiture. In June 2016, our shareholders approved an amendment to the Stock Purchase Plan to increase the number of shares of our common stock authorized under the Plan from 150 shares to 350 shares. No grants can be made under the Stock Purchase Plan after April 25, 2028.

In April 2010, the Compensation Committee of the Board of Directors adopted the 2010 Long-Term Incentive Plan ("2010 Plan"), followed by approval by the Company's shareholders in June 2010. The 2010 Plan allows the Company to issue stock appreciation rights, stock options and other share and cash based awards. In June 2017, our shareholders approved an amendment to the Long-Term Incentive Plan to increase the number of shares of our common stock authorized under the Plan from 380 shares to 680 shares. No grants can be made under the 2010 Plan after May 31, 2027.

Equity Grants and Valuations

During 2019 and 2018, the Compensation Committee of the Board of Directors approved grants totaling approximately 151 and 90, respectively, shares of restricted common stock to certain employees and members of the Board of Directors. These restricted shares vest one-third on the first, second and third anniversaries of the grant date. Unvested shares may not be sold or transferred. During the vesting period, dividends accrue on the restricted shares, but are paid in additional shares of common stock upon vesting, subject to the vesting provisions of the underlying restricted shares. The restricted shares are entitled to the same voting rights as other common shares. Upon vesting, all restrictions are removed. Our policy is to account for forfeitures of share-based compensation awards as they occur.

The Company recorded non-cash stock-based compensation expense from continuing operations for equity grants and RSU's issued under the Plans of $573, $1,127, and $1,027 during the years ended December 31, 2019, 2018, and 2017, respectively. Such amounts are included as components of general and administrative expense or operating expense based upon the classification of cash compensation paid to the related employees. As of December 31, 2019, there was $406 in unrecognized compensation costs related to stock-based compensation to be recognized over the applicable remaining vesting periods. The Company estimated the total recognized and unrecognized compensation for all options and SOSARs using the Black-Scholes-Merton equity grant valuation model. Restricted stock awards are valued using the market price on the grant date.

The table below shows the weighted average assumptions the Company used to develop the fair value estimates under its option valuation model:

	Year Ended December 31,		
	2019	2018	2017
Expected volatility (range)	N/A[1]	47%-49%	N/A[1]
Risk free interest rate (range)	N/A[1]	2.68%-2.75%	N/A[1]
Expected dividends	N/A[1]	2.70%	N/A[1]
Weighted average expected term (years)	N/A[1]	6	N/A[1]

(1) The Company did not issue any options or other equity grants that would require application of the Black-Scholes-Merton equity grant valuation model during the years ended December 31, 2019 and 2017. All equity grants during these periods were restricted common shares which are valued using an intrinsic valuation method based on market price.

In computing the fair value estimates using the Black-Scholes-Merton valuation model, the Company took into consideration the exercise price of the equity grants and the market price of the Company's stock on the date of grant. The Company used an expected volatility that equals the historical volatility over the most recent period equal to the expected life of the equity grants. The risk free interest rate is based on the U.S. treasury yield curve in effect at the time of grant. The Company used the expected dividend yield at the date of grant, reflecting the level of annual cash dividends currently being paid on its common stock.

In computing the fair value of these equity grants, the Company estimated the equity grants' expected term based on the average of the vesting term and the original contractual terms of the grants.

The table below describes the resulting weighted average grant date fair values calculated as well as the intrinsic value of options exercised under the Company's equity awards during each of the following years:

	Year Ended December 31,		
	2019[1]	2018	2017[1]
Weighted average grant date fair value	$ —	$ 3.05	$ —
Total intrinsic value of exercises	$ 3	$ 115	$ 2

(1) The Company did not issue any options or other equity grants that would require application of the Black-Scholes-Merton equity grant valuation model during the years ended December 31, 2019 and 2017. All equity grants during this period were restricted common shares which are valued using an intrinsic valuation method based on market price.

The following table summarizes information regarding stock options and SOSAR grants outstanding as of December 31, 2019:

Range of Exercise Prices	Weighted Average Exercise Prices	Grants Outstanding	Intrinsic Value-Grants Outstanding	Grants Exercisable	Intrinsic Value-Grants Exercisable
$8.14 to $10.21	$ 8.83	45	$ —	35	$ —
$5.45 to $5.86	$ 5.71	31	$ —	31	$ —
		76		66	

As of December 31, 2019, the outstanding equity grants have a weighted average remaining life of 5.14 years and those outstanding equity grants that are exercisable have a weighted average remaining life of 4.7 years. During the year ended December 31, 2019, approximately 2 stock option and SOSAR grants were exercised under these plans. All of the equity grants exercised were net settled. The net payments from equity grants exercised in 2019 was $41.

Summarized activity of the equity compensation plans is presented below:

	SOSARs/ Options	Weighted Average Exercise Price
Outstanding, December 31, 2018	122	$ 7.29
Granted	—	—
Exercised	(2)	2.37
Expired or cancelled	(44)	7.06
Outstanding, December 31, 2019	76	$ 7.55
Exercisable, December 31, 2019	66	$ 7.46

	Restricted Shares	Weighted Average Grant Date Fair Value
Outstanding, December 31, 2018	120	$ 8.77
Granted	151	3.93
Dividend Equivalents	—	—
Vested	(57)	8.91
Cancelled	(7)	5.97
Outstanding, December 31, 2019	207	$ 5.28

Summarized activity of the Restricted Share Units for the Stock Purchase Plan is as follows:

	Restricted Share Units	Weighted Average Grant Date Fair Value
Outstanding, December 31, 2018	43	$ 9.26
Granted	36	3.93
Dividend Equivalents	—	—
Vested	(31)	9.54
Cancelled	—	—
Outstanding December 31, 2019	48	$ 5.08

Preferred Stock

The Company is authorized to issue up to 195 shares of Preferred Stock. The Company's Board of Directors is authorized to establish the terms and rights of each series, including the voting powers, designations, preferences, and other special rights, qualifications, limitations, or restrictions thereof.

9. NET LOSS PER COMMON SHARE

Information with respect to the calculation of basic and diluted net income (loss) per common share is presented below:

	Years Ended December 31,		
	2019	2018	2017
Numerator: Loss:			
Loss from continuing operations	$ (27,474)	$ (11,264)	$ (9,748)
Income (loss) from discontinued operations, net of income taxes	(8,589)	3,868	4,921
Net loss	$ (36,063)	$ (7,396)	$ (4,827)
Denominator: Basic Weighted Average Common Shares Outstanding:	6,459	6,372	6,279
Basic net loss per common share			
Loss from continuing operations	$ (4.25)	$ (1.77)	$ (1.55)
Income (loss) from discontinued operations			
Operating income (loss), net of taxes	(1.33)	0.61	0.78
Discontinued operations, net of taxes	(1.33)	0.61	0.78
Basic net loss per common share	$ (5.58)	$ (1.16)	$ (0.77)

	2019	2018	2017
Numerator: Loss from continuing operations	$ (27,474)	$ (11,264)	$ (9,748)
Income (loss) from discontinued operations, net of income taxes	(8,589)	3,868	4,921
Net loss	$ (36,063)	$ (7,396)	$ (4,827)
Basic weighted average common shares outstanding	6,459	6,372	6,279
Denominator: Diluted Weighted Average Common Shares Outstanding:	6,459	6,372	6,279
Diluted net loss per common share			
Loss from continuing operations	$ (4.25)	$ (1.77)	$ (1.55)
Income (loss) from discontinued operations			
Operating income (loss), net of taxes	(1.33)	0.61	0.78
Discontinued operations, net of taxes	(1.33)	0.61	0.78
Diluted net loss per common share	$ (5.58)	$ (1.16)	$ (0.77)

The dilutive effects of the Company's stock options, SOSARs, Restricted Shares and Restricted Share Units are included in the computation of diluted income per common share during the periods they are considered dilutive.

The following table reflects the weighted average outstanding SOSARs and Options that were excluded from the computation of diluted earnings per share, as they would have been anti-dilutive:

	2019	2018	2017
SOSARs/Options Excluded	76,000	114,000	45,000

The weighted average common shares for basic and diluted earnings for common shares was the same due to the losses in 2019, 2018 and 2017.

10. INCOME TAXES

Overview

Effective January 1, 2018, the Tax Act reduced the corporate rate from 35% to 21%. The Company has adopted ASU No. 2018-05, Income Taxes (Topic 740): Amendments to SEC Paragraph Pursuant to SEC Staff Accounting Bulletin No. 118 (SAB 118), which allows the Company to record provisional amounts during the period of enactment. Any change to the provisional amounts are recorded as an adjustment to the provision for income taxes in the period the amounts are determined. During the year ended December 31, 2017, the company recognized a provisional net deferred income tax expense of $5,476 to reflect the revaluation of the Company's net deferred tax assets based on the U.S. federal tax rate of 21%. In accordance with SAB 118, the Tax Act related income tax effects that were initially reported as provisional estimates were refined as additional analysis was performed.

The provision (benefit) for income taxes on continuing operations for the years ended December 31, 2019, 2018 and 2017 is summarized as follows:

	Year Ended December 31,		
	2019	2018	2017
Current provision (benefit) :			
Federal	$ 197	$ (143)	$ 272
State	76	(412)	222
	273	(555)	494
Deferred provision (benefit):			
Federal	12,439	(529)	2,544
State	2,982	(397)	(504)
	15,421	(926)	2,040
Provision (benefit) for income taxes of continuing operations	$ 15,694	$ (1,481)	$ 2,534

A reconciliation of taxes computed at statutory income tax rates on income (loss) from continuing operations is as follows:

	Year Ended December 31,		
	2019	2018	2017
Provision (benefit) for federal income taxes at statutory rates	$ (2,469)	$ (2,676)	$ (2,453)
Provision (benefit) for state income taxes, net of federal benefit	(106)	(564)	322
Valuation allowance changes affecting the provision for income taxes	19,002	(147)	(498)
Employment tax credits	(210)	(49)	(173)
Nondeductible expenses	122	1,899	401
Stock based compensation expense	80	15	(29)
Effect of Tax Cuts and Jobs Creation Act	—	—	4,514
Rate actualization	(1,349)	—	(36)
Other	624	41	486
Provision (benefit) for income taxes of continuing operations	$ 15,694	$ (1,481)	$ 2,534

Deferred Taxes

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Deferred tax assets are reduced by a valuation allowance if, based upon the weight of available evidence, it is more likely than not that we will realize only some portion of the deferred tax assets. The net deferred tax assets and liabilities, at the respective income tax rates, are as follows:

	December 31,	
	2019	**2018**
Deferred tax assets (liabilities):		
Net operating loss and other carryforwards	$ 859	$ 324
Credit carryforwards	3,118	2,878
Accounts receivable	4,852	4,570
Prepaid expenses	(1,015)	(1,022)
Interest rate limitation	971	148
Right-of-use lease	2,351	—
Depreciation	1,863	1,318
Tax goodwill and intangibles	(1,066)	(1,079)
Stock-based compensation	183	197
Accrued liabilities	504	896
Accrued rent	380	1,914
Kentucky and Kansas acquisition costs	—	3
Impairment of long-lived assets	176	191
Interest rate swap	(4)	(152)
Hedge Ineffectiveness	(155)	(168)
Noncurrent self-insurance liabilities	6,363	5,997
Restitution	2,445	—
Other	30	64
	21,855	16,079
Less valuation allowance	(21,855)	(228)
	$ —	$ 15,851

Deferred Tax Valuation Allowance

The assessment of the amount of value assigned to our deferred tax assets under the applicable accounting standards is highly judgmental. We are required to consider all available positive and negative evidence in evaluating the likelihood that we will be able to realize the benefit of our deferred tax assets in the future. Such evidence includes scheduled reversals of deferred tax assets and liabilities, projected future taxable income, tax-planning strategies, and the results of recent operations. Since this evaluation requires consideration of historical and future events, there is significant judgment involved, and our conclusion could be materially different should certain of our expectations not transpire.

When assessing all available evidence, we consider the weight of the evidence, both positive and negative, based on the objectivity of the underlying evidence and the extent to which it can be verified. For the three-year period ended December 31, 2019, the Company has a cumulative pre-tax loss from continuing operations of $31,739, which includes $11,780 of loss attributable to the year ended December 31, 2019. Additionally, the Company recognized governmental and regulatory changes have put downward revenue pressure on the long-term care industry as a piece of negative evidence in the analysis. In 2019 and 2018 combined, the Company recognized a total expense of $9.5 million related to the CID settlement. Additionally, in 2017 it recorded an additional $5.5 million of income tax expense related to the revaluation of deferred tax assets in accordance with the Tax Cuts and Jobs Act. Because of these items and other financial results, the Company entered a cumulative loss for the 36 preceding months ended June 30, 2019 and performed a thorough assessment of the available positive and negative evidence in order to ascertain whether it is more likely than not that in future periods the Company will generate sufficient pre-tax income to utilize all of its federal deferred tax assets and its net operating loss and other carryforwards and credits.

The Company also identified several pieces of positive evidence that were considered and weighed in the analysis performed regarding the valuation of deferred tax assets. The evidence included the termination of operations for 10 nursing facilities in Kentucky completed in the third quarter of 2019, the related corporate and regional restructuring and other cost saving initiatives already in process. The evidence also included consideration of participation in revenue incentive programs that are expected to generate additional revenue, the long-term expiration dates of a majority of the net operating losses and credits, and the Company's history of not having carryforwards or credits expire unutilized.

In performing the analysis, the Company contemplated utilization of the recorded deferred tax assets under multiple scenarios. After consideration of these factors, the Company determined that a full valuation allowance of $20.0 million was necessary as of June 30, 2019. As of December 31, 2019, the Company has a valuation allowance in the amount of $21.9 million. The Company will continue to periodically assess the realizability of its future deferred tax assets.

At December 31, 2019, the Company had $8,655 of federal net operating losses, which expire at various dates beginning in 2020. The use of a portion of these loss carryforwards is limited by change in ownership provisions of the Federal tax code to a maximum of approximately $3,336. The Company has reduced the deferred tax asset and the corresponding valuation allowances for net operating loss deductions permanently lost as a result of the change in ownership provisions.

Under the Work Opportunity Tax Credit ("WOTC") program, the Company recorded $210, $64 and $210 in Work Opportunity Tax Credits during 2019, 2018 and 2017, respectively.

The Company is not currently under examination by any major income tax jurisdiction. During 2019, the statutes of limitations lapsed on the Company's 2015 Federal tax year and certain 2014 and 2015 state tax years. The Company does not believe the Federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months.

11. COMMITMENTS AND CONTINGENCIES

Lease Commitments

The Company is committed under long-term operating leases with various expiration dates and varying renewal options. Under these lease agreements, the Company's lease payments are subject to periodic annual escalations as described below and in Note 1, "Business and Summary of Significant Accounting Policies". Total lease expense for continuing operations was $52,990, $49,231 and $48,248 for 2019, 2018 and 2017, respectively. The accrued liability related to straight line rent was $9,325 and $6,877 at December 31, 2019 and 2018, respectively, and is recorded as an offset to the right-of-use asset on the accompanying consolidated balance sheets.

Omega Master Lease

On October 1, 2018, the Company entered into a New Master Lease Agreement (the "Omega Master Lease") with Omega Healthcare Investors (the "Lessor") to lease 34 centers currently owned by Omega and operated by Diversicare. The old Master Lease with Omega provided for its operation of 23 skilled nursing centers in Texas, Kentucky, Alabama, Tennessee, Florida, and Ohio. Additionally, Diversicare operates 11 centers owned by Omega, previously under separate leases in Missouri, Kentucky, Indiana, and Ohio. The Omega Master Lease entered into by Diversicare and Omega consolidated the leases for all 34 centers under one New Master Lease. The Omega Master Lease has an initial term of twelve years with the option of two ten year extensions at the Company's election. The Omega Master Lease has annual rent escalators of 2.15% beginning on October 1, 2019.

On August 30, 2019, the Company terminated operations of 10 centers in Kentucky and concurrently transferred operations to a new operator. The agreement effectively amended the Master Lease Agreement with Omega Healthcare Investors to remove the 10 Kentucky facilities, reduce the annual rent expense, and release the Company from any further obligations arising under the Master Lease Agreement with respect to the Kentucky facilities. The remaining Lease terms remain unchanged with an initial term of twelve years and two optional 10-year extensions. The annual lease fixed escalator remains at 2.15% beginning on October 1, 2019.

Under generally accepted accounting principles, the Company is required to report these scheduled rent increases on a straight line basis over the term of the lease. These scheduled increases had no effect on cash rent payments at the start of the lease term and only result in additional cash outlay as the annual increases take effect each year.

The Omega Master Lease requires the Company to fund annual capital expenditures related to the leased centers at an amount currently equal to four-hundred dollars per licensed bed. These amounts are subject to adjustment for increases in the Consumer Price Index. The Company is in compliance with the capital expenditure requirements. Total required capital expenditures during the remaining lease term are $12,294. These capital expenditures are being depreciated on a straight-line basis over the shorter of the asset life or the appropriate lease term.

Upon expiration of the Omega Master Lease or in the event of a default under the Omega Master Lease, the Company is required to transfer all of the leasehold improvements, equipment, furniture and fixtures of the leased centers to Omega. The assets to be transferred to Omega are being amortized on a straight-line basis over the shorter of the remaining lease term, excluding the renewal options, or estimated useful life, and will be fully depreciated upon the expiration of the lease. All of the equipment, inventory and other related assets of the centers leased pursuant to the Omega Master Lease have been pledged as security under the Omega Master Lease. In addition, the Company has a letter of credit of $5,332 as a security deposit for the Company's leases with Omega, as described in Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations".

Golden Living Master Lease

The Company leases 20 nursing centers from Golden Living. On October 1, 2016, the Company and Golden Living entered into a Master Lease ("Golden Living Lease") agreement to lease eight centers located in Mississippi. On November 1, 2016, the Company and Golden Living entered into an Amended and Restated Master Lease ("Amended Lease") to extend the term of its centers leased from Golden Living and lease an additional twelve centers located in Alabama. The Amended Lease is triple net and has an initial term of ten years with two separate five year options to extend the term. Base rent for the amended lease is $24,675 for the first year and escalates 2% annually thereafter. Under generally accepted accounting principles, the Company is required to report these scheduled rent increases on a straight line basis over the term of the lease including the 10 year term of the renewal period. These scheduled increases had no effect on cash rent payments at the start of the lease term and only result in additional cash outlay as the annual increases take effect each year.

The Golden Living Lease requires the Company to fund annual capital expenditures related to the leased centers at an amount currently equal to five hundred and twenty dollars per licensed bed. These amounts are subject to adjustment for increases in the Consumer Price Index. The Company is in compliance with the capital expenditure requirements. Total required capital expenditures during the remaining lease term and renewal options are $6,404. These capital expenditures are being depreciated on a straight-line basis over the shorter of the asset life or the appropriate lease term.

Upon expiration of the Golden Living Lease or in the event of a default under the Golden Living Lease , the Company is required to transfer all of the leasehold improvements, equipment, furniture and fixtures of the leased centers to Golden Living. The assets to be transferred to Golden Living are being amortized on a straight-line basis over the shorter of the remaining lease term or estimated useful life, and will be fully depreciated upon the expiration of the lease. All of the equipment, inventory and other related assets of the center leased pursuant to the Golden Living Lease have been pledged as security under the Golden Living Lease. In addition, the Company has a letter of credit of $6,481 as a security deposit for the Company's leases with Golden Living, as described in Note 7, "Long-term Debt, Interest Rate Swap and Finance Lease Obligations".

Insurance Matters

Professional Liability and Other Liability Insurance

The Company has professional liability insurance coverage for its nursing centers that, based on historical claims experience, is likely to be substantially less than the claims that are expected to be incurred. Effective July 1, 2013, the Company established a wholly-owned, offshore limited purpose insurance subsidiary, SHC Risk Carriers, Inc. (“SHC”), to replace some of the expiring commercial policies. SHC covers losses up to specified limits per occurrence. All of the Company's nursing centers in Florida and Tennessee are now covered under the captive insurance policies along with most of the nursing centers in Alabama, Kentucky, and Texas. The insurance coverage provided for these centers under the SHC policy includes coverage limits of at least $1,000

per medical incident with a sublimit per center of $3,000 and total annual aggregate policy limits of $5,000. All other centers within the Company's portfolio are covered through various commercial insurance policies which provide similar coverage limits per medical incident, per location, and on an aggregate basis for covered centers. The deductibles for these policies vary in amount are covered through the insurance subsidiary.

The Company follows the FASB Accounting Standards Update, "Presentation of Insurance Claims and Related Insurance Recoveries," that clarifies that a health care entity should not net insurance recoveries against a related professional liability claim and that the amount of the claim liability should be determined without consideration of insurance recoveries. Accordingly, the estimated insurance recovery receivables are included within "Other Current Assets" on the Consolidated Balance Sheet. As of December 31, 2019 and 2018, there are $1,011 and $5,478, respectively, estimated insurance recovery receivables.

Reserve for Estimated Self-Insured Professional Liability Claims

Because the Company's actual liability for existing and anticipated professional liability and general liability claims will likely exceed the Company's limited insurance coverage, the Company has recorded total liabilities for reported and estimated future claims of $27,390 and $27,201 as of December 31, 2019 and 2018, respectively. This accrual includes estimates of liability for incurred but not reported claims, estimates of liability for reported but unresolved claims, actual liabilities related to settlements, including settlements to be paid over time, and estimates of legal costs related to these claims. All losses are projected on an undiscounted basis and are presented without regard to any potential insurance recoveries. Amounts are added to the accrual for estimates of anticipated liability for claims incurred during each period, and amounts are deducted from the accrual for settlements paid on existing claims during each period.

The Company evaluates the adequacy of this liability on a quarterly basis. Semi-annually, the Company retains a third-party actuarial firm to assist in the evaluation of this reserve. Since May 2012, the actuary has assisted management in the preparation of the appropriate accrual for incurred but not reported general and professional liability claims based on data furnished as of May 31 and November 30 of each year. The actuary primarily utilizes historical data regarding the frequency and cost of the Company's past claims over a multi-year period, industry data and information regarding the number of occupied beds to develop its estimates of the Company's ultimate professional liability cost for current periods.

On a quarterly basis, the Company obtains reports of asserted claims and lawsuits incurred. These reports, which are provided by the Company's insurers and a third party claims administrator, contain information relevant to the actual expense already incurred with each claim as well as the third-party administrator's estimate of the anticipated total cost of the claim. This information is reviewed by the Company quarterly and provided to the actuary semi-annually. Based on the Company's evaluation of the actual claim information obtained, the semi-annual estimates received from the third-party actuary, the amounts paid and committed for settlements of claims and on estimates regarding the number and cost of additional claims anticipated in the future, the reserve estimate for a particular period may be revised upward or downward on a quarterly basis. Any increase in the accrual decreases results of operations in the period and any reduction in the accrual increases results of operations during the period.

The Company's cash expenditures for self-insured professional liability costs were $4,578, $6,540, and $6,593 for the years ended December 31, 2019, 2018 and 2017, respectively.

Although the Company adjusts its accrual for professional and general liability claims on a quarterly basis and retains a third-party actuarial firm semi-annually to assist management in estimating the appropriate accrual, professional and general liability claims are inherently uncertain, and the liability associated with anticipated claims is very difficult to estimate. Professional liability cases have a long cycle from the date of an incident to the date a case is resolved, and final determination of the Company's actual liability for claims incurred in any given period is a process that takes years. As a result, the Company's actual liabilities may vary significantly from the accrual, and the amount of the accrual has and may continue to fluctuate by a material amount in any given period. Each change in the amount of this accrual will directly affect the Company's reported earnings and financial position for the period in which the change in accrual is made.

Other Insurance

With respect to workers' compensation insurance, substantially all of our employees are covered under either a prefunded deductible policy or state-sponsored program. The Company has been and remains a non-subscriber to the Texas workers'

compensation system and is, therefore, completely self-insured for employee injuries with respect to its Texas operations. From June 30, 2003 until June 30, 2007, the Company's workers' compensation insurance programs provided coverage for claims incurred with premium adjustments depending on incurred losses. For the period from July 1, 2008 through December 31, 2019, the Company is covered by a prefunded deductible policy. Under this policy, the Company is self-insured for the first $500 per claim, subject to an aggregate maximum of $3,000. The Company funds a loss fund account with the insurer to pay for claims below the deductible. The Company accounts for premium expense under this policy based on its estimate of the level of claims subject to the policy deductibles expected to be incurred. The liability for workers' compensation claims is $921 and $618 at December 31, 2019 and 2018, respectively. The Company has a non-current receivable for workers' compensation policies covering previous years of $1,575 and $1,258 as of December 31, 2019 and 2018, respectively. The non-current receivable is a function of payments paid to the Company's insurance carrier in excess of the estimated level of claims expected to be incurred.

As of December 31, 2019, the Company is self-insured for health insurance benefits for certain employees and dependents for amounts up to $200 per individual annually. The Company provides reserves for the settlement of outstanding self-insured health claims at amounts believed to be adequate. The liability for reported claims and estimates for incurred but unreported claims is $1,810 and $1,396 at December 31, 2019 and 2018, respectively. The differences between actual settlements and reserves are included in expense in the period finalized.

Employment Agreements

The Company has employment agreements with certain members of management that provide for the payment to these members of amounts up to 2.0 times their annual salary in the event of a termination without cause, a constructive discharge (as defined in each employee agreement), or upon a change in control of the Company (as defined in each employee agreement). The maximum contingent liability under these agreements is $1,692 as of December 31, 2019. The terms of such agreements are from 1 to 3 years and automatically renew for 1 year if not terminated by the employee or the Company.

No amounts have been accrued for these contingent liabilities for members of management the Company currently employs.

Health Care Industry and Legal Proceedings

The provision of health care services entails an inherent risk of liability. Participants in the health care industry are subject to lawsuits alleging malpractice, violations of false claims acts, product liability, or related legal theories, many of which involve large claims and significant defense costs. Like many other companies engaged in the long-term care profession in the United States, we have numerous pending liability claims, disputes and legal actions for professional liability and other related issues. Further, as with all health care providers, we are periodically subject to regulatory actions seeking fines and penalties for alleged violations of health care laws and are potentially subject to the increased scrutiny of regulators for issues related to compliance with health care fraud and abuse laws and with respect to the quality of care provided to residents of our center. Like other health care providers, in the ordinary course of our business, we are also subject to claims made by employees and other disputes and litigation arising from the conduct of our business.

As of December 31, 2019, we are engaged in 95 professional liability lawsuits, of which 46 relate to centers we no longer operate, which are reserved for as discussed above. Twenty-three lawsuits are currently scheduled for trial or arbitration during the next twelve months, and it is expected that additional cases will be set for trial or hearing. The ultimate results of any of our professional liability claims and disputes cannot be predicted. We have limited, and sometimes no, professional liability insurance with regard to most of these claims. A significant judgment entered against us in one or more of these legal actions could have a material adverse impact on our financial position and cash flows.

In February 2020, the Company entered into a settlement agreement with the U.S. Department of Justice and the State of Tennessee of actions alleging violations of the federal False Claims Act in connection with our provision of therapy and the completion of certain resident admission forms. This settlement of $9,500 resolved an investigation that had begun in 2012 and covers the time period from January 1, 2010 through December 31, 2015. This agreement requires an initial payment of $500 within ten days of the effective date, which was February 14, 2020, and material annual payments for a period of five years thereafter ending in February 2025, and also requires a contingent payment in the event the Company sells any of its owned facilities during the five year payment period. Failure to make timely any of these payments could result in rescission of the settlement and result in the government having a very large claim against us, including penalties, and/or make us ineligible to

participate in certain government funded healthcare programs, any of which could in turn significantly harm our business and financial condition.

In conjunction with the settlement of the government investigation related to our therapy practices, the Company entered into a corporate integrity agreement with the Office of the Inspector General of CMS. This agreement has a term of five years and imposes material burdens on the Company, its officers and directors to take actions designed to insure compliance with applicable healthcare laws, including requirements to maintain specific compliance positions within the Company, to report any non-compliance with the terms of the agreement, to return any overpayments received, to submit annual reports and for an annual audit of submitted claims by an independent review organization. The CIA sets forth penalties for non-compliance by the Company with the terms of the agreement, including possible exclusion from federally funded healthcare programs for material violations of the agreement.

In January 2009, a purported class action complaint was filed in the Circuit Court of Garland County, Arkansas against the Company and certain of its subsidiaries and Garland Nursing & Rehabilitation Center (the "Center"). The complaint alleges that the defendants breached their statutory and contractual obligations to the patients of the Center over the five-year period prior to the filing of the complaints. The lawsuit remains in its early stages and has not yet been certified by the court as a class action. The Company intends to defend the lawsuit vigorously.

We cannot currently predict with certainty the ultimate impact of any of the above cases on our financial condition, cash flows or results of operations. Our reserve for professional liability expenses does not include the amounts that will be owed under the settlement agreement with the DOJ and State of Tennessee or the purported class action against the Arkansas centers. An unfavorable outcome in any of these lawsuits or any of our professional liability actions, any regulatory action, any investigation or lawsuit alleging violations of fraud and abuse laws or of elderly abuse laws or any state or Federal False Claims Act case could subject us to fines, penalties and damages, including exclusion from the Medicare or Medicaid programs, and could have a material adverse impact on our financial condition, cash flows or results of operations.

12. QUARTERLY FINANCIAL INFORMATION (UNAUDITED)

Selected quarterly financial information for each of the quarters in the years ended December 31, 2019 and 2018 is as follows:

	Quarter			
2019	**First**	**Second**	**Third**	**Fourth**
Patient revenues, net	$ 117,550	$ 117,967	$ 118,630	$ 120,873
Professional liability expense [1]	1,851	1,594	1,737	1,814
Loss from continuing operations	(1,574)	(22,616)	(1,916)	(1,368)
Loss from discontinued operations	(1,772)	(1,980)	(2,958)	(1,879)
Net loss [2]	$ (3,346)	$ (24,596)	$ (4,874)	$ (3,247)
Basic net loss per common share:				
Loss from continuing operations	$ (0.24)	$ (3.49)	$ (0.30)	$ (0.22)
Loss from discontinued operations	(0.28)	(0.31)	(0.45)	(0.29)
Net loss per common share	$ (0.52)	$ (3.80)	$ (0.75)	$ (0.51)
Diluted net loss per common share:				
Loss from continuing operations	$ (0.24)	$ (3.49)	$ (0.30)	$ (0.22)
Loss from discontinued operations	(0.28)	(0.31)	(0.45)	(0.29)
Net loss per common share	$ (0.52)	$ (3.80)	$ (0.75)	$ (0.51)

(1) The Company's quarterly results are significantly affected by the amounts recorded for professional liability expense, as discussed further in Note 11, "Commitments and Contingencies". The amount of expense recorded for professional liability in each quarter of 2019 is set forth in the table above.

(2) The loss in the second quarter of 2019 is inclusive of a full valuation allowance of $20.0 million.

	Quarter			
2018	**First**	**Second**	**Third**	**Fourth**
Patient revenues, net	$ 119,043	$ 119,327	$ 119,036	$ 118,716
Professional liability expense [1]	1,539	1,755	1,604	1,600
Loss from continuing operations	(738)	(327)	(7,512)	(2,687)
Income from discontinued operations	635	17	114	3,102
Net income (loss)	$ (103)	$ (310)	$ (7,398)	$ 415
Basic net income (loss) per common share:				
Loss from continuing operations	$ (0.12)	$ (0.05)	$ (1.18)	$ (0.42)
Income from discontinued operations	0.11	—	0.02	0.48
Net income (loss) per common share	$ (0.01)	$ (0.05)	$ (1.16)	$ 0.06
Diluted net income (loss) per common share:				
Loss from continuing operations	$ (0.12)	$ (0.05)	$ (1.18)	$ (0.42)
Income from discontinued operations	0.11	—	0.02	0.48
Net income (loss) per common share	$ (0.01)	$ (0.05)	$ (1.16)	$ 0.06

(1) The Company's quarterly results are significantly affected by the amounts recorded for professional liability expense, as discussed further in Note 11, "Commitments and Contingencies". The amount of expense recorded for professional liability in each quarter of 2018 is set forth in the table above.

13. SUBSEQUENT EVENTS

Debt Amendment

Effective February 25, 2020, the Company entered into a Sixth Amendment to amend the Amended Mortgage Loan, an Eighth Amendment to amend the Amended Revolver and a First Amendment to the affiliated revolver. The amendments extend the maturity date of the facilities to September 30, 2021. Also, in connection with these amendments, the Company obtained a waiver from our syndicate of banks for the minimum guarantor fixed charge coverage ratio covenant applicable to the Amended Mortgage Loan and the Amended Revolver for the period ending December 31, 2019 and made certain changes to the financial covenants of these loan agreements, as follows.

Pursuant to the amendments, the Company's Fixed Charge Coverage Ratio, as defined under the Amended Mortgage Loan and the Amended Revolver, should not be less than 1.01 to 1.00, for the Fiscal Quarter (i) ending March 31, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing three month basis, (ii) ending June 30, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing six month basis, (iii) ending September 30, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing nine month basis, and (iv) ending December 31, 2020 and for each Fiscal Quarter thereafter, each measured on the last day of the applicable Fiscal Quarter on a trailing twelve month basis.

The minimum Adjusted EBITDA should not be less than (i) $9,500,000 for the Fiscal Quarter ending December 31, 2019 on a trailing Twelve month basis, (ii) $3,250,000 for the Fiscal Quarter ending March 31, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing three month basis, (iii) $6,500,000 for the Fiscal Quarter ending June 30, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing six month basis, (iv) $9,750,000 for the Fiscal Quarter ending September 30, 2020, measured on the last day of the applicable Fiscal Quarter on a trailing nine month basis, and (v) $13,000,000 for the Fiscal Quarter ending December 31, 2020 and for each Fiscal Quarter thereafter, each measured on the last day of the applicable Fiscal Quarter on a trailing twelve month basis.

Civil Investigative Demand

Effective February 14, 2020, the Company entered into a settlement agreement in the amount of $9.5 million with the U.S. Department of Justice and the State of Tennessee of actions alleging violations of the federal False Claims Act in connection with our provision of therapy and the completion of certain resident admission forms. This settlement resolved an investigation that had begun in 2012 and covers the time period from January 1, 2010 through December 31, 2015. This agreement requires material annual payments for a period of five years ending in February 2025 and also requires a contingent payment in the event the Company sells any of its owned facilities during the five year payment period. Failure to make timely any of these payments could result in rescission of the settlement and result in the government having a very large claim against us, including penalties, and/or make us ineligible to participate in certain government funded healthcare programs, any of which could in turn significantly harm our business and financial condition.

In conjunction with the settlement of the government investigation related to our therapy practices, we entered into a corporate integrity agreement with the Office of the Inspector General of CMS. This agreement has a term of five years and imposes material burdens on the Company, its officers and directors to take actions designed to insure compliance with applicable healthcare laws, including requirements to maintain specific compliance positions within the Company, to report any non-compliance with the terms of the agreement, to return any overpayments received, to submit annual reports and for an annual audit of submitted claims by an independent review organization. The CIA sets forth penalties for non-compliance by the Company with the terms of the agreement, including possible exclusion from federally funded healthcare programs for material violations of the agreement.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
SCHEDULE II - VALUATION AND QUALIFYING ACCOUNTS
OF CONTINUING OPERATIONS
(in thousands)

Description	Balance at Beginning of Period	Impact of ASC 606 Adoption [1]	Additions Charged to Costs and Expenses	Deductions	Balance at End of Period
Year ended December 31, 2019: Allowance for doubtful accounts	$—	$—	$—	$—	$—
Year ended December 31, 2018: Allowance for doubtful accounts	$14,235	$(14,235)	$—	$—	$—
Year ended December 31, 2017: Allowance for doubtful accounts	$10,326	$—	$8,958	$(5,049)	$14,235

(1) Subsequent to the adoption of ASC 606 on January 1 2018, the allowance for doubtful accounts related to bad debt expense has been incorporated as an implicit price concession factored into net revenue and accounts receivable.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
SCHEDULE II - VALUATION AND QUALIFYING ACCOUNTS
(in thousands)

Column A	Column B	Column C			Column D	Column E
		Additions			Deductions	
Description	Balance at Beginning of Period	Charged to Costs and Expenses	Charged to Other Accounts [2]	Other	Payments [1]	Balance at End of Period
Year ended December 31, 2019:						
Professional Liability Reserve	$27,201	$10,435	$—	$(3,020)	$(7,226)	$27,390
Workers Compensation Reserve	$618	$400	$—	$—	$(97)	$921
Health Insurance Reserve	$1,396	$16,733	$—	$—	$(16,319)	$1,810
Year ended December 31, 2018:						
Professional Liability Reserve	$20,057	$8,865	$—	$5,475	$(7,196)	$27,201
Workers Compensation Reserve	$867	$(18)	$—	$—	$(231)	$618
Health Insurance Reserve	$1,326	$14,369	$—	$—	$(14,299)	$1,396
Year ended December 31, 2017:						
Professional Liability Reserve	$19,977	$7,935	$—	$—	$(7,855)	$20,057
Workers Compensation Reserve	$171	$995	$—	$—	$(299)	$867
Health Insurance Reserve	$1,019	$13,769	$—	$—	$(13,462)	$1,326

(1) Payments for the Professional Liability Reserve include amounts paid for claims settled during the period as well as payments made under structured arrangements for claims settled in earlier periods.

(2) The Company has presented the results of certain divestiture and lease termination transactions as discontinued operations. The amounts charged to Other Accounts represent the amounts charged to discontinued operations.

DIVERSICARE HEALTHCARE SERVICES, INC. AND SUBSIDIARIES
SCHEDULE II - VALUATION AND QUALIFYING ACCOUNTS
OF CONTINUING OPERATIONS
(in thousands)

Description	Balance at Beginning of Period	Additions Charged to Costs and Expenses [1]	Deductions	Balance at End of Period
Year ended December 31, 2019: Deferred Tax Valuation Allowance	$228	$21,657	$—	$21,885
Year ended December 31, 2018: Deferred Tax Valuation Allowance	$377	$—	$(149)	$228
Year ended December 31, 2017: Deferred Tax Valuation Allowance	$732	$—	$(355)	$377

(1) The Company initially recorded a full valuation allowance of $20.0 million during the second quarter of 2019.

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