KINDRED HEALTHCARE, INC
Form 10-K
February 28, 2014

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2013

OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
Commission File Number: 001-14057

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

| | |
|---|---|
| Delaware | 61-1323993 |
| (State or other jurisdiction of incorporation or organization) | (I.R.S. Employer Identification Number) |
| 680 South Fourth Street | |
| Louisville, Kentucky | 40202-2412 |

(Address of principal executive offices) (Zip Code)

(502) 596-7300

(Registrant's telephone number, including area code)

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

| Title of Each Class | Name of Each Exchange on which Registered |
|---|---|
| Common Stock, par value $0.25 per share | New York Stock Exchange |

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes þ 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 þ

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 þ No ¨

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Annual Report on Form 10-K or any amendment of this Annual Report on Form 10-K. þ

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

Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨

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

The aggregate market value of the shares of the registrant held by non-affiliates of the registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2013, was approximately $681,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2014, there were 54,114,276 shares of the registrant's common stock, $0.25 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference from the registrant's 2014 definitive proxy statement, which will be filed no later than 120 days after December 31, 2013.

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PART I

All references in this Annual Report on Form 10-K to "Kindred," "Company," "we," "us," or "our" mean Kindred Healthcare, Inc. and, unless the context otherwise requires, our consolidated subsidiaries.

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS

Certain statements made in this Annual Report on Form 10-K and the documents we incorporate by reference in this Annual Report on Form 10-K include forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. All statements regarding our expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, plans and objectives of management and statements containing the words such as "anticipate," "approximate," "believe," "plan," "estimate," "expect," "project," "could "should," "will," "intend," "may" and other similar expressions, are forward-looking statements. Statements in this Annual Report on Form 10-K concerning the Company's business outlook or future economic performance, anticipated profitability, revenues, expenses or other financial items, and product or services line growth, together with other statements that are not historical facts, are forward-looking statements that are estimates reflecting our best judgment based upon currently available information.

Such forward-looking statements are inherently uncertain, and you must recognize that actual results may differ materially from our expectations as a result of a variety of factors, including, without limitation, those discussed below. Such forward-looking statements are based upon management's current expectations and include known and unknown risks, uncertainties and other factors, many of which we are unable to predict or control, that may cause our actual results or performance to differ materially from any future results or performance expressed or implied by such forward-looking statements. These statements involve risks, uncertainties and other factors discussed below and detailed from time to time in our filings with the Securities and Exchange Commission. Factors that may affect our plans, results or stock price include, without limitation:

the impact of healthcare reform, which will initiate significant changes to the United States healthcare system, including potential material changes to the delivery of healthcare services and the reimbursement paid for such services by the government or other third party payors, including reforms resulting from the Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, the "ACA") or future deficit reduction measures adopted at the federal or state level. Healthcare reform is affecting each of our businesses in some manner. Potential future efforts in the U.S. Congress to repeal, amend, modify or retract funding for various aspects of the ACA create additional uncertainty about the ultimate impact of the ACA on us and the healthcare industry. Due to the substantial regulatory changes that will need to be implemented by Centers for Medicare and Medicaid Services ("CMS") and others, and the numerous processes required to implement these reforms, we cannot predict which healthcare initiatives will be implemented at the federal or state level, the timing of any such reforms, or the effect such reforms or any other future legislation or regulation will have on our business, financial position, results of operations and liquidity,
the impact of the 2012 CMS Rules which, among other things, will reduce Medicare reimbursement to our transitional care hospitals in 2013 and beyond by imposing a budget neutrality adjustment and modifying the short-stay outlier rules,
the impact of the 2011 CMS Rules which significantly reduced Medicare reimbursement to our nursing centers and changed payments for the provision of group therapy services effective October 1, 2011,
the impact of the Budget Control Act of 2011 (as amended by the American Taxpayer Relief Act of 2012) which instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013,
our ability to adjust to the new patient criteria for long-term acute care hospitals under the Pathway for SGR Reform Act of 2013, which will reduce the population of patients eligible for our hospital services and change the basis upon

which we are paid,

the impact of the American Taxpayer Relief Act of 2012 which, among other things, reduces Medicare payments by an additional 25% for subsequent procedures when multiple therapy services are provided on the same day. At this time, we believe that the rules related to multiple therapy services will reduce our Medicare revenues by $25 million to $30 million on an annual basis,

changes in the reimbursement rates or the methods or timing of payment from third party payors, including commercial payors and the Medicare and Medicaid programs, changes arising from and related to the Medicare prospective payment system for long-term acute care hospitals, including potential changes in the Medicare payment rules, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and changes in Medicare and Medicaid reimbursement for our transitional care hospitals, nursing centers, inpatient rehabilitation facilities and home health and hospice operations, and the expiration of the Medicare Part B therapy cap exception process,

the effects of additional legislative changes and government regulations, interpretation of regulations and changes in the nature and enforcement of regulations governing the healthcare industry,

the ability of our hospitals and nursing centers to adjust to medical necessity reviews,

the costs of defending and insuring against alleged professional liability and other claims (including those related to pending whistleblower and wage and hour class action lawsuits against us) and our ability to predict the estimated costs and reserves related to such claims, including the impact of differences in actuarial assumptions and estimates compared to eventual outcomes,

the impact of our significant level of indebtedness on our funding costs, operating flexibility and ability to fund ongoing operations, development capital expenditures or other strategic acquisitions with additional borrowings,

our ability to successfully redeploy our capital and proceeds of asset sales in pursuit of our business strategy and pursue our development activities, including through acquisitions, and successfully integrate new operations, including the realization of anticipated revenues, economies of scale, cost savings and productivity gains associated with such operations, as and when planned, including the potential impact of unanticipated issues, expenses and liabilities associated with those activities,

our ability to pay a dividend as, when and if declared by the Board of Directors, in compliance with applicable laws and our debt and other contractual arrangements,

the failure of our facilities to meet applicable licensure and certification requirements,

the further consolidation and cost containment efforts of managed care organizations and other third party payors,

our ability to meet our rental and debt service obligations,

our ability to operate pursuant to the terms of our debt obligations, and comply with our covenants thereunder, and our ability to operate pursuant to our master lease agreements with Ventas, Inc.,

the condition of the financial markets, including volatility and weakness in the equity, capital and credit markets, which could limit the availability and terms of debt and equity financing sources to fund the requirements of our businesses, or which could negatively impact our investment portfolio,

our ability to control costs, particularly labor and employee benefit costs,

our ability to successfully reduce (by divestiture of operations or otherwise) our exposure to professional liability and other claims,

our obligations under various laws to self-report suspected violations of law by us to various government agencies, including any associated obligation to refund overpayments to government payors, fines and other sanctions,

national and regional economic, financial, business and political conditions, including their effect on the availability and cost of labor, credit, materials and other services,

increased operating costs due to shortages in qualified nurses, therapists and other healthcare personnel,

our ability to attract and retain key executives and other healthcare personnel,

our ability to successfully dispose of unprofitable facilities,

events or circumstances which could result in the impairment of an asset or other charges, such as the impact of the Medicare reimbursement regulations that resulted in us recording significant impairment charges in the last three fiscal years,

changes in generally accepted accounting principles or practices, and changes in tax accounting or tax laws (or authoritative interpretations relating to any of these matters),

our ability to maintain an effective system of internal control over financial reporting, and

each of the factors discussed in Item 1A – Risk Factors.

Many of these factors are beyond our control. We caution investors that any forward-looking statements made by us are not guarantees of future performance. We disclaim any obligation to update any such factors or to announce publicly the results of any revisions to any of the forward-looking statements to reflect future events or developments.

Item 1. Business

GENERAL

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates transitional care ("TC") hospitals, inpatient rehabilitation hospitals ("IRFs"), nursing centers, assisted living facilities, a contract rehabilitation services business and a home health and hospice business across the United States. At December 31, 2013, our hospital division operated 101 TC hospitals (certified as long-term acute care ("LTAC") hospitals under the Medicare program) and five IRFs in 22 states. Our nursing center division operated 100 nursing centers and six assisted living facilities in 23 states. Our rehabilitation division provided rehabilitation services primarily in hospitals and long-term care settings. Our care management division (formerly known as our home health and hospice division) primarily provided home health, hospice and private duty services from 159 locations in 13 states.

All financial and statistical information presented in this Annual Report on Form 10-K reflects the continuing operations of our businesses for all periods presented unless otherwise indicated.

Forward-Looking Statements. This Annual Report on Form 10-K includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). See also "Item 1A – Risk Factors."

Senior Home Care Acquisition. On December 1, 2013, we acquired Senior Home Care, Inc., a home health provider that operated 47 locations in Florida and Louisiana for $95 million in cash (the "Senior Home Care Acquisition"). The Senior Home Care Acquisition was financed through operating cash flows and proceeds from our ABL facility (as defined below).

HCP Acquisition. On November 5, 2013, we signed a definitive agreement with HCP, Inc. and its affiliates ("HCP") to acquire the real estate associated with nine nursing centers that we leased from HCP for approximately $83 million. The annual lease payments for these nursing centers were approximately $9 million. We completed the acquisition of seven of these nursing centers during 2013 for a total consideration of approximately $61 million. The two remaining facilities were acquired in February 2014.

IntegraCare Acquisition. On August 31, 2012, we acquired IntegraCare Holdings, Inc., a provider of home health, hospice and community services that operated 47 locations across Texas for $71 million in cash plus a potential $4 million cash earn out based on 2013 earnings growth (the "IntegraCare Acquisition"). The IntegraCare Acquisition was financed through operating cash flows and proceeds from our ABL Facility.

Professional Acquisition. On September 1, 2011, we acquired Professional HealthCare, LLC, a home health and hospice company that operated 27 locations in northern California, Arizona, Nevada and Utah for $51 million in cash (the "Professional Acquisition"). The Professional Acquisition was financed through operating cash flows and proceeds from our ABL Facility.

RehabCare Merger. On June 1, 2011, we completed the acquisition of RehabCare Group, Inc. and its subsidiaries ("RehabCare") (the "RehabCare Merger"). Upon consummation of the RehabCare Merger, each issued and outstanding share of RehabCare common stock was converted into the right to receive 0.471 of a share of our common stock and $26 per share in cash, without interest (the "Merger Consideration"). We issued approximately 12 million shares of our common stock in connection with the RehabCare Merger. The purchase price totaled $963 million and was comprised of $662 million in cash and $301 million of our common stock at fair value. We also assumed $356 million of long-term debt in the RehabCare Merger, of which $345 million was refinanced on June 1, 2011. The operating results of RehabCare have been included in our accompanying consolidated financial statements since June 1, 2011.

At the RehabCare Merger date, we acquired 32 TC hospitals, five IRFs, approximately 1,200 rehabilitation therapy sites of service and 102 hospital-based inpatient rehabilitation units. The RehabCare Merger expanded our service offerings, positioned us for future growth and provided opportunities for significant operating synergies.

Credit Facilities and Notes. In connection with the RehabCare Merger, we entered into a new $650 million senior secured asset-based revolving credit facility (the "ABL Facility") and a new $700 million senior secured term loan facility (the "Term Loan Facility") (collectively, the "Credit Facilities"). We also completed the private placement of $550 million of senior notes due 2019 (the "Notes"). In 2011, we used proceeds from the Credit Facilities and the Notes to pay the Merger Consideration, repay all amounts outstanding under our and RehabCare's previous credit facilities and to pay transaction costs. The amounts outstanding under our and RehabCare's former credit facilities that were repaid at the RehabCare Merger closing were $390 million and $345 million, respectively.

The Credit Facilities also included an option to increase the credit capacity in an aggregate amount between the two facilities by $200 million. We exercised this option to increase the credit capacity by $200 million in October 2012. In May 2013, we completed an amendment and restatement of our Term Loan Facility to reduce our annual interest costs. In August 2013, we completed amendments and restatements to the Credit Facilities to modify certain covenants to improve our financial flexibility. See "Part II – Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity" and note 12 of the notes to consolidated financial statements for additional information on the Credit Facilities and the Notes.

Vista Acquisition. On November 1, 2010, we completed the acquisition of five TC hospitals from Vista Healthcare, LLC ("Vista") for a purchase price of $179 million in cash (the "Vista Acquisition"). The Vista Acquisition was financed through operating cash flows and proceeds from our former revolving credit facility. The Vista Acquisition included four freestanding hospitals and one hospital-in-hospital with a total of 250 beds, all of which are located in southern California. We did not acquire the working capital of Vista or assume any of its liabilities. All of the Vista hospitals are leased.

Spin-off from Ventas. On May 1, 1998, Ventas, Inc. ("Ventas") completed the spin-off of its healthcare operations to its stockholders through the distribution of our former common stock. Ventas retained ownership of substantially all of its real property and leases a portion of such real property to us. In anticipation of the spin-off from Ventas, we were incorporated on March 27, 1998 as a Delaware corporation. For accounting purposes, the consolidated historical financial statements of Ventas became our historical financial statements following the spin-off.

Discontinued Operations

We have completed several strategic divestitures to improve our future operating results. Certain of these divestitures are described below. For accounting purposes, the operating results of these businesses and the losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2013 have been measured at the lower of carrying value or estimated fair value less costs of disposal and have been classified as held for sale in the accompanying consolidated balance sheet. See notes 2 and 3 of the notes to consolidated financial statements.

Vibra Sale. In September 2013, we completed the sale of 15 non-strategic hospitals and one nursing center (the "Vibra Facilities") for approximately $187 million to an affiliate of Vibra Healthcare, LLC ("Vibra"). The net proceeds of approximately $180 million from this transaction were used to reduce the borrowings under our ABL Facility.

Signature Sale. In July 2013, we completed the sale of seven non-strategic nursing centers (the "Signature Facilities") for approximately $47 million to affiliates of Signature Healthcare, LLC ("Signature"). The proceeds from this transaction were used to reduce the borrowings under our ABL Facility.

Ventas Divestitures. On September 30, 2013, we entered into agreements to renew early our leases with Ventas for 22 TC hospitals and 26 nursing centers (collectively, the "2013 Renewal Facilities") and to exit 60 nursing centers (collectively, the "2013 Expiring Facilities"). Under the terms of the agreements, the lease term for the 2013 Expiring Facilities will now expire on September 30, 2014. For accounting purposes, the 2013 Expiring Facilities qualified as assets held for sale and we reflected the operating results as discontinued operations in the accompanying consolidated statement of operations for all historical periods.

In April 2012, we announced that we would not renew 54 nursing centers (the "2012 Expiring Facilities") under operating leases with Ventas that were scheduled to expire on April 30, 2013. We transferred the operations of all of the 2012 Expiring Facilities to new operators during the nine months ended September 30, 2013 and we reclassified the results of operations and losses associated with the 2012 Expiring Facilities to discontinued operations, net of

income taxes, for all periods presented.

See "– Master Lease Agreements" and note 11 of the notes to consolidated financial statements for additional information on the 2013 Renewal Facilities, the 2013 Expiring Facilities and the 2012 Expiring Facilities.

HEALTHCARE OPERATIONS

We are organized into four operating divisions: the hospital division, the nursing center division, the rehabilitation division and the care management division. The expansion of our home health and hospice operations and changes to our organizational structure led us to segregate our home health and hospice business into a separate division on December 31, 2011 (now known as the care management division). Our home health and hospice business was included in the rehabilitation division prior to such date. For more information about our operating divisions, as well as financial information, see "Part II – Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations" and note 7 of the notes to consolidated financial statements.

The hospital division operates TC hospitals and IRFs. The nursing center division operates nursing centers and assisted living facilities. The rehabilitation division provides rehabilitation services primarily in hospitals and long-term care settings. The care management division primarily provides home health, hospice and private duty services to patients in a variety of settings, including homes, nursing centers and other residential settings. We believe that the independent focus of each division on the unique aspects of its business enhances its ability to improve the quality of its operations and achieve operating efficiencies.

Based upon the authoritative guidance for business segments, our operating divisions represent five reportable operating segments, including (1) hospitals, (2) nursing centers, (3) skilled nursing rehabilitation services ("SRS"), (4) hospital rehabilitation services ("HRS") and (5) home health and hospice services. The SRS and HRS operating segments are both contained within the rehabilitation division, while home health and hospice services are contained within the care management division.

COMPETITIVE STRENGTHS

We believe that several competitive strengths support our business strategy, including:

Well-diversified service offerings allow us to Continue the Care® across the post-acute continuum. We have a well-diversified portfolio of service offerings including TC hospitals, IRFs, nursing centers, contract rehabilitation services, home health and hospice operations. We are concentrating our service offerings through the development of Integrated Care Markets which allows us to coordinate and manage the continuum of care for our patients, reduce lengths of stay, implement physician services strategies, prevent avoidable re-hospitalizations and reduce costs. In addition, this array of services across our four operating divisions creates multiple earnings streams and avenues for growth and development.

Uniquely positioned for bundled or episodic payment environment. As healthcare reform continues to be implemented, we believe that healthcare providers that can operate with scale across the continuum of care will have a competitive advantage in an episodic payment environment. Our diversified service offerings across our four operating divisions enable us to do this effectively and to participate with other healthcare providers in determining the most appropriate setting for patients as they continue their care throughout a post-acute episode. As a leading provider in four critical segments of the post-acute continuum, we are uniquely positioned to deliver the right care at the right site of service. We also are positioned to become a valuable partner to short-term acute care hospitals and managed care organizations, which are seeking to increase care coordination, reduce re-hospitalizations, reduce lengths of stay, more effectively manage healthcare costs and develop new care delivery and payment models.

Strong asset base including owned real estate. We have been focused on adding high quality assets to our balance sheet through opportunistic acquisitions and the development of TC hospitals and transitional care centers (licensed as nursing centers). We own the real estate of 17 TC hospitals, one IRF, 26 nursing centers and two assisted living facilities, a significant increase from the 16 facilities we owned in 2006. We also have taken steps to reduce our lease

portfolio by exiting 114 leased nursing centers through the recent transactions with Ventas. We believe that over time increased facility ownership and reduced lease obligations will significantly improve our future growth and profitability.

Strong cash flow generation. We have demonstrated the ability to generate strong operating cash flows in a highly regulated environment. Our operating cash flows offer opportunities to fund our acquisition and development strategies, as well as reduce our leverage over time. In addition, we initiated a cash dividend to our shareholders in 2013 which reflects our ability to generate meaningful and sustainable free cash flows.

OUR STRATEGY

We believe that we are the largest diversified post-acute healthcare provider in the United States, and accordingly, are well-positioned to grow and succeed in what will be an increasingly integrated healthcare delivery system. Our core strategy is to provide superior clinical outcomes and quality care with an approach that is patient-centered and focused on lowering costs by reducing lengths of stay in short-term acute care hospitals and transitioning patients to their homes at the highest possible level of function, thereby preventing avoidable re-hospitalizations.

The key elements of our business strategy include:

Providing quality, clinical-based care with a focus on operating efficiency. We are committed to maintaining and improving the quality of our patient care by dedicating appropriate resources at each site of service and continuing to refine our clinical initiatives and objectives. We are implementing technology enhancements and clinical protocols that will promote best practices and improve the operating efficiency of our caregivers. We are continuing our Company-wide program to re-engineer processes, improve efficiencies and focus on the provision of shared services across our divisions that will help us reduce costs while maintaining quality patient care.

Repositioning our assets and management time to higher margin growth businesses. During 2013, we accelerated our strategy of exiting unprofitable and non-strategic facilities outside of our Integrated Care Markets through asset sales and the expiration of leases. We transferred the operations of 54 Ventas nursing centers during 2013 and entered into agreements that will facilitate the early exit of 60 additional non-strategic nursing centers in 2014. We also completed the sale of 14 TC hospitals, one IRF and eight nursing centers which generated $227 million in net sale proceeds. We intend to reinvest these proceeds in higher margin businesses such as home health and hospice and contract rehabilitation. In addition, we continue to allocate capital to the development of TC hospitals, IRFs and transitional care centers, particularly in our Integrated Care Markets.

Expanding presence in home health and hospice business. We continue to expand our presence in the home health and hospice business, and now provide services in 159 locations in 13 states. In December 2013, we completed the Senior Home Care Acquisition, which added 47 home health locations in Florida and Louisiana. In August 2012, we completed the IntegraCare Acquisition, which significantly expanded the scope of our operations into Texas. In addition, we have committed significant resources to develop a senior management team for these growing operations and are implementing a standardized information technology platform across all sites of services, both of which will enable and support future growth. We intend to continue expanding our home health and hospice operations through additional acquisitions, joint ventures and de novo site development, particularly in our Integrated Care Markets.

Developing care management capabilities. In August 2013, we announced the creation of a new care management division to improve care transitions and patient outcomes by further developing capabilities to deliver integrated care across various care settings. Our care management division will develop programs that will enable us and our partners to better manage episodes of care, create more seamless transitions between care settings and improve patient satisfaction, thereby reducing lengths of stay and re-hospitalizations at a lower cost to Medicare and other payors. Our care management division includes our home health and hospice business, and is responsible for expanding this business, as well as leveraging our service offerings as we develop and support care models, including medical homes and accountable care organizations that meet consumer preference and support integrated care delivery. The new division will grow our home health and hospice business, test new delivery and payment models and develop capabilities to support our Integrated Care Markets and Continue the Care® strategy. These capabilities will include (1) physician coverage across sites of service, (2) care managers to improve care transitions, (3) information sharing and information technology connectivity, (4) tools to ensure appropriate patient placement and (5) condition-specific clinical programs and outcome measures.

Grow through development of Integrated Care Markets. Our operating divisions are increasingly focused on enabling our patients to Continue the Care® during an episode of care at a Kindred facility or site of service in markets where we operate multiple facilities or sites of service. We have designated 24 markets across the country as current or potential Integrated Care Markets. These Integrated Care Markets allow our caregivers to coordinate and manage the continuum of care for our patients, as well as implement physician services strategies. The Integrated Care Markets provide opportunities to improve quality and patient satisfaction, lower hospital re-admissions, increase volumes and lower costs.

During the last few years, we have focused our development activities on expanding our Integrated Care Markets. In addition to the significant expansion of our home health and hospice operations discussed above, we continue to grow our transitional care centers and hospital-based sub-acute units. During 2013, we began constructions of a new 120-bed transitional care center in Phoenix, Arizona, a 100-bed transitional care center in Indianapolis, Indiana and a 160-bed transitional care center in Las Vegas, each of which should open in the second half of 2014. Also during 2013, we opened a TC hospital that is co-located within a host hospital (a “HIH”) in St. Louis, Missouri with 54 beds. In 2012, we opened a 30 bed co-located sub-acute unit in our Seattle TC hospital, completed the construction of a new freestanding IRF with 46 licensed beds in Humble, Texas and opened a newly constructed, freestanding replacement IRF with 50 licensed beds in Austin, Texas.

Improve capital structure and enhance shareholder returns. We seek to improve our capital structure through the purchase of our leased facilities which enhances our operating flexibility, reduces our more expensive leased obligations and allows us to dispose of non-strategic or underperforming assets. During 2013, we acquired the real estate related to our Tampa TC hospital and our Indianapolis transitional care center for an aggregate consideration of $35 million. We also signed a definitive agreement to acquire nine additional leased nursing centers for $83 million, seven of which were acquired in the fourth quarter of 2013. In addition, we also re-priced and amended our Credit Facilities on favorable terms in 2013, resulting in significant interest savings, extended maturity of the ABL Facility and an option to increase our aggregate credit capacity by $250 million. Finally, we initiated a quarterly dividend of $0.12 per share in the third quarter of 2013 that reflects our ability to generate meaningful and sustainable free cash flows.

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 101 TC hospitals with 7,315 licensed beds and five IRFs with 215 licensed beds in 22 states as of December 31, 2013. We operate the second largest network of TC hospitals and IRFs in the United States based upon number of facilities. Our TC hospitals are certified as LTAC hospitals under the Medicare program.

As a result of our commitment to the hospital business, we have developed a comprehensive program of care for medically complex patients that allows us to deliver high quality care in a cost-effective manner. A number of our hospitals also provide skilled nursing, sub-acute and outpatient services. Outpatient services may include diagnostic services, rehabilitation therapy, CT scanning, one-day surgery and laboratory tests.

In our TC hospitals, we treat medically complex patients, including the critically ill, suffering from multiple organ system failures, most commonly of the cardiovascular, pulmonary, kidney, gastro-intestinal and cutaneous (skin) systems. In particular, we have a core competency in treating patients with cardio-pulmonary disorders, skin and wound conditions, and life-threatening infections. Prior to being admitted to one of our TC hospitals, many of our patients have undergone a major surgical procedure or developed a neurological disorder following head and spinal cord injury, cerebrovascular incident or metabolic instability. Our expertise lies in the ability to simultaneously deliver comprehensive and coordinated medical interventions directed at all affected organ systems, while maintaining a patient-centered, integrated care plan. Medically complex patients are characteristically dependent on technology for continued life support, including mechanical ventilation, total parenteral nutrition, respiratory or cardiac monitors and kidney dialysis machines. During 2013, the average length of stay for patients in our hospitals was approximately 27 days.

Our TC hospital patients generally have conditions that require a high level of monitoring and specialized care, yet may not need the services of a traditional intensive care unit. These patients are not clinically appropriate for admission to other post-acute settings because their severe medical conditions are periodically or chronically unstable. By providing a range of services required for the care of medically complex patients, we believe that our TC hospitals provide our patients with high quality, cost-effective care.

Our TC hospitals employ a comprehensive program of care for their patients that draws upon the talents of interdisciplinary teams, including physician specialists. The teams evaluate patients upon admission to determine treatment programs. Our hospital division has developed specialized treatment programs focused on the needs of medically complex patients. In addition to traditional medical services, our TC hospital patients receive individualized treatment plans, which may include rehabilitation, skin integrity management and clinical pharmacology services. Where appropriate, the treatment programs may involve the services of several disciplines, such as pulmonary medicine, infectious disease and physical medicine.

Our IRFs provide services to patients who require intensive inpatient rehabilitative care. Our IRF patients typically experience significant physical disabilities due to various medical and physical conditions, such as head injury, spinal cord injury, stroke, hip fractures, certain orthopedic problems, and neuromuscular disease, and require rehabilitative healthcare services in an inpatient setting. Our nurses and physical, occupational, and speech therapists work with physicians with the goal of returning patients to home and work. Patient care is provided by nursing and therapy staff as directed by physician orders. Our IRFs provide an interdisciplinary approach to treatment that leads to a higher level of care and superior outcomes. The medical, nursing, therapy, and ancillary services provided by our IRFs comply with local, state, and federal regulations, as well as other accreditation standards.

Selected Hospital Division Operating Data

The following table sets forth certain operating and financial data for the hospital division (dollars in thousands, except statistics):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| Revenues | $2,521,649 | $2,604,925 | $2,265,106 |
| Operating income | $523,156 | $562,224 | $457,867 |
| Hospitals in operation at end of period | 106 | 106 | 107 |
| Licensed beds at end of period | 7,530 | 7,484 | 7,474 |
| Admissions | 56,602 | 59,462 | 52,105 |
| Patient days | 1,534,651 | 1,596,108 | 1,425,148 |
| Average length of stay | 27.1 | 26.8 | 27.4 |
| Revenues per admission | $44,551 | $43,808 | $43,472 |
| Revenues per patient day | $1,643 | $1,632 | $1,589 |
| Medicare case mix index (discharged patients only) | 1.17 | 1.17 | 1.18 |
| Average daily census | 4,205 | 4,361 | 3,905 |
| Occupancy % | 63.0 | 65.6 | 65.5 |
| Annualized employee turnover % | 20.8 | 19.7 | 18.0 |
| Assets at end of period | $1,776,728 | $2,129,303 | $2,048,598 |
| Capital expenditures: | | | |
| Routine | $28,571 | $38,272 | $46,393 |
| Development | 11,817 | 42,265 | 67,321 |

The term “operating income” is defined as earnings before interest, income taxes, depreciation, amortization, rent and corporate overhead. Segment operating income excludes impairment charges and transaction costs. A reconciliation of “operating income” to our consolidated results of operations is included in note 7 of the notes to consolidated financial statements. The term “licensed beds” refers to the maximum number of beds permitted in a facility under its license regardless of whether the beds are actually available for patient care. “Patient days” refers to the total number of days of patient care provided for the periods indicated. “Average length of stay” is computed by dividing each facility’s patient days by the number of admissions in the respective period. “Medicare case mix index” is the sum of the individual patient diagnostic related group weights for the period divided by the sum of the discharges for the same period. “Average daily census” is computed by dividing each facility’s patient days by the number of calendar days in the respective period. “Occupancy %” is computed by dividing average daily census by the number of operational licensed beds, adjusted for the length of time each facility was in operation during each respective period. “Annualized employee turnover %” is calculated by dividing full-time and part-time terminations by the active employee count at the beginning of the year. Routine capital expenditures include expenditures at existing facilities that generally do not result in the expansion of services. Development capital expenditures include expenditures for the development of new facilities or the expansion of services or capacity at existing facilities.

Sources of Hospital Revenues

The hospital division receives payment for its services from third party payors, including government reimbursement programs such as Medicare and Medicaid and non-government sources such as Medicare Advantage, commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. Patients covered by non-government payors generally are more profitable to the hospital division than those covered by the Medicare and Medicaid programs. The following table sets forth the approximate percentages of our hospital

division admissions, patient days and revenues derived from the payor sources indicated:

| Year ended December 31, | Medicare | | | Medicaid | | | Medicare Advantage | | | Commercial insurance and other | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Admissions | Patient days | Revenues | Admissions | Patient days | Revenues | Admissions | Patient days | Revenues | Admissions | Patient days | Revenues |
| 2013 | 69 % | 63 % | 61 % | 5 % | 8 % | 6 % | 11 % | 11 % | 11 % | 15 % | 18 % | 22 % |
| 2012 | 68 | 63 | 62 | 6 | 8 | 6 | 10 | 11 | 10 | 16 | 18 | 22 |
| 2011 | 67 | 62 | 61 | 8 | 10 | 7 | 9 | 10 | 10 | 16 | 18 | 22 |

For the year ended December 31, 2013, revenues of the hospital division totaled approximately $2.5 billion or 49% of our total revenues (before eliminations). For more information regarding the reimbursement for our hospital services, see “– Governmental Regulation – Hospital Division – Overview of Hospital Division Reimbursement.”

Hospital Facilities

The following table lists by state the number of TC hospitals and IRFs and related licensed beds we operated as of December 31, 2013:

| | | Number of facilities | | | |
|---|---|---|---|---|---|
| State | Licensed beds | Owned by us | Leased from Ventas (2) | Leased from other parties | Total |
| Arizona | 167 | – | 2 | 1 | 3 |
| California | 1,058 | 4 | 5 | 5 | 14 |
| Colorado | 105 | – | 1 | 1 | 2 |
| Florida (1) | 745 | 3 | 6 | 1 | 10 |
| Georgia (1) | 117 | – | – | 2 | 2 |
| Illinois (1) | 575 | – | 4 | 2 | 6 |
| Indiana | 221 | 1 | 1 | 2 | 4 |
| Kentucky (1) | 414 | – | 1 | 1 | 2 |
| Louisiana | 168 | – | 1 | – | 1 |
| Massachusetts (1) | 220 | 1 | 2 | 1 | 4 |
| Michigan (1) | 77 | – | – | 1 | 1 |
| Missouri (1) | 389 | 1 | 2 | 3 | 6 |
| Nevada | 254 | 1 | 1 | 1 | 3 |
| New Jersey (1) | 117 | – | – | 3 | 3 |
| New Mexico | 61 | – | 1 | – | 1 |
| North Carolina (1) | 124 | – | 1 | – | 1 |
| Ohio | 309 | 2 | – | 3 | 5 |
| Oklahoma | 93 | – | 1 | 1 | 2 |
| Pennsylvania | 332 | 1 | 2 | 4 | 7 |
| Tennessee (1) | 109 | – | 1 | 1 | 2 |
| Texas | 1,735 | 2 | 6 | 17 | 25 |
| Washington (1) | 140 | 2 | – | – | 2 |
| Totals | 7,530 | 18 | 38 | 50 | 106 |

(1) These states have certificate of need regulations. See "– Governmental Regulation – Federal, State and Local Regulations."
(2) See "– Master Lease Agreements."

Quality Assessment and Improvement

The hospital division maintains a clinical outcomes and customer service program which includes a review of its patient population measured against utilization and quality standards, clinical outcomes data collection and patient/family, employee and physician satisfaction surveys. In addition, our hospitals have integrated quality assurance and improvement programs administered by a director of quality management, which encompass quality improvement, infection control and risk management. The objective of these programs is to ensure that patients are managed appropriately in our hospitals and that quality healthcare is provided in a cost-effective manner.

The hospital division has implemented a program whereby its TC hospitals and IRFs are reviewed by internal quality auditors for compliance with standards of the Joint Commission or the American Osteopathic Association (the "AOA").

The purposes of this internal review process are to: (1) ensure ongoing compliance with industry recognized standards for hospitals, (2) assist management in analyzing each hospital's operations and (3) provide consulting and educational programs for each hospital to identify opportunities to improve patient care.

Hospital Division Management and Operations

Each of our TC hospitals has a fully credentialed, multi-specialty medical staff to meet the needs of the medically complex, long-term acute patient. Our TC hospitals offer a broad range of physician services including pulmonology, internal medicine, infectious diseases, neurology, nephrology, cardiology, radiology and pathology. In addition, our TC hospitals have a multi-disciplinary team of healthcare professionals, including a professional nursing staff trained to care for long-term acute patients, respiratory, physical, occupational and speech therapists, pharmacists, registered dietitians and social workers, to address the needs of medically complex patients.

Each TC hospital utilizes a pre-admission assessment system to evaluate clinical needs and other information in determining the appropriateness of each potential patient admission. After admission, each patient's case is reviewed by the TC hospital's

interdisciplinary team to determine a care plan. Typically, and where appropriate, the care plan involves the services of several disciplines, such as pulmonary medicine, infectious disease and physical medicine.

A hospital chief executive officer or administrator supervises and is responsible for the day-to-day operations at each of our hospitals. Each hospital (or network of hospitals) also employs a chief financial or accounting officer who monitors the financial matters of such hospital or network. In addition, each hospital (or network of hospitals) employs a chief clinical officer to oversee the clinical operations and a director of quality management to oversee our quality assurance programs. We provide centralized administrative services in the areas of information systems, reimbursement guidance, state licensing and Medicare and Medicaid certification and maintenance support, as well as legal, finance, accounting, purchasing, human resources management and facilities management support to each of our hospitals. We believe that this centralization improves efficiency, promotes the standardization of certain processes and allows staff in our hospitals to focus more attention on quality patient care.

A division president, chief operating officer and a chief financial officer manage the hospital division. The operations of the hospital division are divided into three regions, each headed by a senior officer of the division who reports to the division president. The clinical issues and quality concerns of the hospital division are managed by the division's chief medical officer and senior vice president of clinical operations. The sales and marketing efforts for the division are led by district and regional sales leaders, who in turn report to our senior vice president of enterprise sales.

Hospital Division Competition

In each geographic market that we serve, there are generally several competitors that provide similar services to those provided by our hospital division. In addition, several of the markets in which the hospital division operates have other LTAC hospitals and IRFs that provide services comparable to those offered by our hospitals. Certain competing hospitals are operated by not-for-profit, non-taxpaying or governmental agencies, which can finance capital expenditures on a tax-exempt basis and receive funds and charitable contributions unavailable to our hospital division.

Competition for patients covered by non-government reimbursement sources is intense. The primary competitive factors in the LTAC hospital and IRF business include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies have entered the LTAC hospital and IRF business with licensed hospitals that compete with our hospitals. The competitive position of any LTAC hospital and IRF also is affected by the ability of its management to negotiate contracts with purchasers of, and to receive referrals from, group healthcare services, including managed care companies, preferred provider organizations and health maintenance organizations. Such organizations attempt to obtain discounts from established charges, as well as to limit their overall expenditures by compressing average lengths of stay. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations and other organizations that finance healthcare varies from market to market, depending on the number and market strength of such organizations.

NURSING CENTER DIVISION

Our nursing center division provides quality, cost-effective care through the operation of a national network of 100 nursing centers (12,638 licensed beds) and six assisted living facilities (341 licensed beds) located in 23 states as of December 31, 2013. Through our nursing centers, we provide short stay patients and long stay residents with a full range of medical, nursing, rehabilitative, pharmacy and routine services, including daily dietary, social and recreational services.

Consistent with industry trends, patients and residents admitted to our nursing centers arrive with greater medical complexity and require a more extensive and costly level of care. This is particularly true with our Medicare population for whom the average length of stay in 2013 was 31 days. To appropriately care for a higher acuity short

stay patient population and a more frail and unstable long stay resident population, we have improved the delivery of the clinical and hospitality services offered to our patients and residents by adjusting the level of clinical and hospitality staffing, assisting physician oversight through the selective use of nurse practitioners, enhancing nursing skills via ongoing education and competency evaluations and improving clinical case management through the employment of clinical case managers.

We also monitor and enhance the quality of care and customer service at our nursing centers through the use of performance improvement committees and family satisfaction surveys. Our performance improvement committees oversee resident healthcare needs and resident and staff safety. Physician medical directors serve on these committees and advise on healthcare policies and practices. We regularly conduct surveys of residents and their families, and these surveys are reviewed by our performance improvement committees at each center to promote quality care and customer service. We also have established initiatives to reduce potentially avoidable re-hospitalizations. The clinical leadership of each center is actively engaged in improving nursing competencies and communication skills, developing specific clinical programs to address acute care needs that may arise on site and working collaboratively with the medical community to coordinate monitoring and treatment.

Substantially all of our nursing centers are certified to provide services under the Medicare and Medicaid programs. Our nursing centers have been certified because the quality of our services, accommodations, equipment, safety, personnel, physical environment and policies and procedures meet or exceed the standards of certification set by those programs.

We operate transitional care units at 13 of our nursing centers. These units within our nursing centers typically consist of 20 to 50 beds offering skilled nursing services and provide a range of rehabilitation services including physical, occupational and speech therapy to patients recovering from a variety of surgical procedures as well as medical conditions such as stroke and cardiac and respiratory ailments. Our transitional care units enhance our ability to care for the higher acuity short-term patients typically associated with Medicare, Medicare Advantage and commercial insurance payors.

Our nursing center division also manages seven hospital-based sub-acute units (244 licensed beds) in five states. These units, co-located within TC hospitals owned and operated by our hospital division, typically consist of 20 to 50 beds offering skilled nursing services and provide a range of rehabilitation services including physical, occupational, speech and ventilator or other respiratory therapy to patients recovering from a variety of surgical procedures as well as medical conditions such as stroke and cardiac ailments. Our nursing center division also manages five sub-acute units (237 licensed beds) in California for an unaffiliated company. These five sub-acute units are certified as either hospital-based or nursing center sub-acute units, and specialize in providing respiratory and ventilator therapy.

Several of our nursing centers provide higher level clinical services focused primarily upon patients arriving for recovery, recuperation and rehabilitation. We refer to these patients as transitional care patients and the nursing centers capable of providing these higher intensity clinical services as transitional care centers. We currently classify 48 of our nursing centers as transitional care centers. These transitional care patients are typically associated with Medicare, Medicare Advantage and commercial insurance payors.

At a number of our nursing centers, we offer specialized programs for residents with Alzheimer’s disease and other dementias through our Reflections units. We have developed specific certification criteria for these units. These units are operated by teams of professionals that are dedicated to addressing the unique problems experienced by residents with Alzheimer’s disease or other dementias. We believe that we are a leading provider of nursing care to residents with Alzheimer’s disease and dementia based upon the specialization and size of our program.

Selected Nursing Center Division Operating Data

The following table sets forth certain operating and financial data for the nursing center division (dollars in thousands, except statistics):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| Revenues | $1,089,760 | $1,092,416 | $1,107,976 |
| Operating income | $135,362 | $141,258 | $155,672 |
| Facilities in operation at end of period: | | | |
| Nursing centers: | | | |
| Owned or leased | 96 | 96 | 97 |
| Managed | 4 | 4 | 4 |
| Assisted living facilities | 6 | 6 | 6 |
| Licensed beds at end of period: | | | |
| Nursing centers: | | | |
| Owned or leased | 12,153 | 12,153 | 12,159 |
| Managed | 485 | 485 | 485 |
| Assisted living facilities | 341 | 341 | 413 |
| Patient days (a) | 3,804,676 | 3,914,321 | 3,971,758 |
| Revenues per patient day (a) | $287 | $279 | $279 |
| Average daily census (a) | 10,424 | 10,695 | 10,882 |
| Admissions (a) | 41,442 | 41,917 | 41,080 |
| Occupancy % (a) | 81.4 | 83.3 | 84.8 |
| Medicare average length of stay (a,b) | 31.0 | 31.0 | 31.9 |
| Annualized employee turnover % | 42.8 | 39.6 | 37.9 |
| Assets at end of period | $552,336 | $626,016 | $644,553 |
| Capital expenditures: | | | |
| Routine | $23,023 | $20,764 | $34,304 |
| Development | 7 | 8,057 | 19,167 |

(a) Excludes managed facilities.
(b) Computed by dividing total Medicare discharge patient days by total Medicare discharges.

Sources of Nursing Center Revenues

Nursing center revenues are derived principally from the Medicare and Medicaid programs and private and other payors. Consistent with the nursing center industry, changes in the mix of the patient and resident population among these categories significantly affect the profitability of our nursing center operations. Although higher acuity patients generally produce the most revenue per patient day, profitability with respect to higher acuity patients is impacted by the costs associated with the higher level of nursing care and other services generally required. In addition, these patients usually have a significantly shorter length of stay.

The following table sets forth the approximate percentages of nursing center patient days and revenues derived from the payor sources indicated:

| | Medicare | Medicaid | Medicare Advantage | Private and other |
|---|---|---|---|---|

| Year ended December 31, | Patient days | Revenues | Patient days | Revenues | Patient days | Revenues | Patient days | Revenues |
|---|---|---|---|---|---|---|---|---|
| 2013 | 17% | 34 % | 55% | 37 % | 5 % | 8 % | 23% | 21 % |
| 2012 | 18 | 35 | 54 | 36 | 5 | 8 | 23 | 21 |
| 2011 | 18 | 38 | 54 | 35 | 5 | 7 | 23 | 20 |

For the year ended December 31, 2013, revenues of the nursing center division totaled approximately $1.1 billion or 21% of our total revenues (before eliminations). For more information regarding the reimbursement for our nursing center services, see “– Governmental Regulation – Nursing Center Division – Overview of Nursing Center Division Reimbursement.”

Nursing Center Facilities

The following table lists by state the number of nursing centers and assisted living facilities and related licensed beds we operated as of December 31, 2013:

| | | Number of facilities | | | | |
|---|---|---|---|---|---|---|
| | | Owned | | | | |
| State | Licensed beds | by us | Leased from Ventas (2) | Leased from other parties | Managed | Total |
| Alabama (1) | 135 | – | – | 1 | – | 1 |
| Arizona | 100 | – | – | 1 | – | 1 |
| California | 2,211 | 5 | 5 | 9 | – | 19 |
| Colorado | 108 | – | 1 | – | – | 1 |
| Connecticut (1) | 108 | – | 1 | – | – | 1 |
| Georgia (1) | 162 | – | 1 | – | – | 1 |
| Idaho | 584 | 1 | 6 | – | – | 7 |
| Indiana | 2,337 | 7 | 8 | 1 | – | 16 |
| Kentucky (1) | 319 | 2 | 1 | – | – | 3 |
| Maine | 102 | – | – | 2 | – | 2 |
| Massachusetts (1) | 2,313 | 1 | 4 | 11 | 3 | 19 |
| Montana (1) | 276 | – | 2 | – | – | 2 |
| New Hampshire (1) | 290 | – | 1 | – | – | 1 |
| North Carolina (1) | 309 | – | 3 | – | – | 3 |
| Ohio (1) | 979 | 7 | – | – | – | 7 |
| Tennessee (1) | 668 | 2 | – | 3 | – | 5 |
| Texas | 405 | 3 | – | – | – | 3 |
| Utah | 193 | – | 2 | – | – | 2 |
| Vermont (1) | 294 | – | 1 | – | 1 | 2 |
| Virginia (1) | 432 | – | 3 | – | – | 3 |
| Washington (1) | 268 | – | 3 | – | – | 3 |
| Wisconsin (1) | 97 | – | – | 1 | – | 1 |
| Wyoming | 289 | – | 3 | – | – | 3 |
| Totals | 12,979 | 28 | 45 | 29 | 4 | 106 |

(1) These states have certificate of need regulations. See "– Governmental Regulation – Federal, State and Local Regulations."
(2) See "– Master Lease Agreements." These totals do not include the 2013 Expiring Facilities.

Nursing Center Division Management and Operations

Each of our nursing centers is managed by a state-licensed executive director who is supported by other professional personnel, including, but not limited to, a director of nursing, nursing assistants, licensed practical nurses, staff development coordinator, activities director, social services director, clinical liaisons, admissions coordinator and business office manager. The directors of nursing are state-licensed nurses who supervise our nursing staffs that include but are not limited to, registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing center, the types of services provided and the acuity level of the patients and residents. The nursing centers contract with physicians who provide medical director services and serve on performance improvement committees. We provide our nursing centers with centralized

administrative services in the areas of information systems, reimbursement guidance, state licensing, care management, dietary and nutrition services, and Medicare and Medicaid certification and maintenance support, as well as legal, finance, accounting, purchasing, human resources management and facilities management support. The centralization of these services improves operating efficiencies, promotes the standardization of certain processes and permits our healthcare staff to focus on the delivery of quality care.

Our nursing center division is managed by a division president and a chief financial officer. Our nursing center operations are divided into two geographic regions, each of which is headed by an operational executive vice president. These two operational executive vice presidents report to the division president. The clinical issues and quality concerns of the nursing center division are overseen by the division's chief medical officer and senior vice president of clinical operations with assistance from our regional and district teams. The sales and marketing efforts for the division are led by district and regional sales leaders, who in turn report to our senior vice president of enterprise sales.

Quality Assessment and Improvement

Quality of care is monitored and enhanced by our clinical operations personnel, as well as our performance improvement committees and family satisfaction surveys. Our performance improvement committees oversee resident healthcare needs and resident and staff safety. Additionally, physician medical directors serve on these committees and advise on healthcare policies and procedures.

Regional and district nursing professionals visit our nursing centers periodically to review practices and recommend improvements where necessary in the level of care provided and to ensure compliance with requirements under applicable Medicare and Medicaid regulations. Surveys of residents' families are conducted on a regular basis and provide an opportunity for families to rate various aspects of our service and the physical condition of our nursing centers. These surveys are reviewed by performance improvement committees at each nursing center to promote and improve resident care and safety.

The nursing center division provides training programs for nursing center executive directors, business office and other department managers, nurses and nursing assistants. These programs are designed to maintain high levels of quality patient and resident care, with an orientation towards federal and state regulatory compliance.

Nursing Center Division Competition

Our nursing centers compete with other nursing centers and similar long-term care facilities primarily on the basis of quality of care, reputation, location and physical appearance and, in the case of private payment residents, the charges for our services. Our nursing centers also compete on a local and regional basis with other facilities providing similar services, including hospitals, extended care centers, assisted living facilities, home health agencies and similar institutions. Some competitors may operate newer facilities and may provide services that we do not offer. Our competitors include government-owned, religious organization-owned, secular not-for-profit and for-profit institutions. Many of these competitors have greater financial and other resources than we do. Although there is limited, if any, price competition with respect to Medicare and Medicaid residents (since revenues received for services provided to these residents are generally based on pre-established rates), there is substantial price competition for private payment residents.

REHABILITATION DIVISION

Our rehabilitation division provides rehabilitation services, including physical and occupational therapies and speech pathology services, to residents and patients of nursing centers, acute and LTAC hospitals, outpatient clinics, home health agencies, assisted living facilities, school districts and hospice providers under the name "RehabCare." We are organized into two reportable operating segments: skilled nursing rehabilitation services (SRS) and hospital rehabilitation services (HRS). Our SRS operations provide contract therapy services primarily to freestanding nursing centers. As of December 31, 2013, our SRS segment provided rehabilitative services to 1,806 nursing centers in 45 states. Our HRS operations provide program management and therapy services on an inpatient basis in hospital-based inpatient rehabilitation units, LTAC hospitals, sub-acute (or skilled nursing) units, as well as on an outpatient basis to hospital-based and other satellite programs. As of December 31, 2013, our HRS segment operated 104 hospital-based inpatient rehabilitation units and provided rehabilitation services in 121 LTAC hospitals,10 sub-acute (or skilled nursing) units, and 144 outpatient clinics.

SRS Operations

Our SRS operations involve therapy management services provided primarily to freestanding nursing centers allowing our customers to fulfill their continuing need for therapists on a full-time or part-time basis without the need to hire and retain full-time staff. As of December 31, 2013, SRS managed 1,806 contract therapy programs. We are the largest contract therapy company in the United States based upon fiscal 2013 revenues of approximately $1.0 billion.

SRS provides specialized rehabilitation programs designed to meet the individual needs of the residents and patients we serve. Our specialized care programs address complex medical needs, such as wound care, pain management, and cognitive retraining, in addition to programs for neurologic, orthopedic, cardiac and pulmonary conditions such as stroke, fractures and other orthopedic conditions. We also provide clinical education and programming which is

developed and supported by our clinical experts. These programs are implemented in an effort to ensure that clinical practices support the provision of quality rehabilitation services in accordance with applicable standards of care.

SRS recruits and retains qualified professionals with the clinical expertise to provide quality patient care and measurable rehabilitation outcomes. Our rehabilitation division also provides regulatory guidance and compliance support that benefits our customers and their residents and patients.

HRS Operations

Our HRS operations provide program management and therapy services on an inpatient basis in hospital-based inpatient rehabilitation units, LTAC hospitals, sub-acute (or skilled nursing) units, as well as on an outpatient basis to hospital-based and other satellite programs.

Hospital-based inpatient rehabilitation units. We are a leading operator of hospital-based inpatient rehabilitation units on a contract basis. As of December 31, 2013, we managed or operated 104 hospital-based inpatient rehabilitation units. The hospital-based

inpatient rehabilitation units we operate provide high acuity rehabilitation for patients recovering from strokes, orthopedic conditions, traumatic brain injuries and other neurological disease processes. We establish hospital-based inpatient rehabilitation units in acute care hospitals that have vacant space and/or unmet rehabilitation needs in their markets. We also work with acute care hospitals that currently operate hospital-based inpatient rehabilitation units to improve the delivery of clinical services to patients by implementing our scheduling, clinical protocol and outcome systems, as well as time management training for existing staff. In the case of acute care hospitals that do not operate hospital-based inpatient rehabilitation units, we review their historical and existing hospital population, as well as the demographics of the geographic region, to determine the optimal size of the proposed hospital-based inpatient rehabilitation units and the potential of the new facility under our management to attract patients and generate revenues sufficient to cover anticipated expenses. Our relationships with these hospitals are customarily in the form of contracts for management services which typically have a term of three to five years.

A hospital-based acute rehabilitation unit within a hospital allows the hospital to offer rehabilitation services to patients who might otherwise be discharged to a setting outside the acute care hospital, thus improving the hospital's ability to provide a full continuum of care and consistency in clinical services and outcomes. A hospital-based acute rehabilitation unit within a hospital typically consists of 20 beds and is staffed with a program director, a rehabilitation physician or medical director, and clinical staff, which may include a psychologist, physical and occupational therapists, speech/language pathologists, a social worker, a case manager and other appropriate support personnel. Additionally, compliance, clinical education and clinical programming are supported by our clinical compliance experts in an effort to ensure that clinical practices support the provision of quality rehabilitation services.

LTAC hospitals. We also provide rehabilitation and program management services, including physical and occupational therapies and speech pathology services, to LTAC hospitals. We provide specialized care programs that support patients with complex medical needs, such as wound care, pain management and cognitive deficits, in addition to programs for neurologic, orthopedic, cardiac and pulmonary recovery. As of December 31, 2013, we operated therapy programs in 121 LTAC hospitals. We also provide LTAC hospitals with clinical education and programming supported by our clinical experts in an effort to ensure that clinical practices support the provision of quality rehabilitation services in accordance with applicable standards of care.

Sub-acute units. As of December 31, 2013, we managed therapy programs in 10 sub-acute (or skilled nursing) units. These hospital-based units provide lower intensity rehabilitation for medically complex patients. Patients' diagnoses cover approximately 60 clinical conditions, including stroke, post-surgical conditions, pulmonary disease, cancer, congestive heart failure, burns and wounds. These sub-acute units enable patients to remain in a hospital setting where emergency medical needs can be met quickly as opposed to having to be transported from a nursing center. These types of units are typically located within the acute care hospital and are separately licensed or under the hospital's license as permitted by applicable laws. The hospital benefits by retaining patients who otherwise would be discharged to another setting and by utilizing idle space.

Outpatient therapy programs. We also manage or operate outpatient therapy programs that provide therapy services to patients with a variety of orthopedic and neurological conditions that may be related to work or sports injuries. As of December 31, 2013, we managed or operated 144 hospital-based and satellite outpatient therapy programs. An outpatient therapy program complements the hospital's occupational medicine initiatives and allows therapy to be continued for patients discharged from inpatient rehabilitation facilities and medical/surgical beds. An outpatient therapy program also attracts patients into the hospital and is operated either on the hospital's campus or in satellite locations controlled by the hospital.

We believe our management of outpatient therapy programs enables the efficient delivery of therapy services through our scheduling, clinical protocol and outcome systems, as well as through time management training for our therapy personnel. We also provide our customers with guidance on compliance and quality assurance objectives.

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Selected Rehabilitation Division Operating Data

The following table sets forth certain operating and financial data for the rehabilitation division (dollars in thousands, except statistics):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| SRS: | | | |
| Revenues | $991,790 | $1,003,002 | $762,128 |
| Operating income | $36,696 | $67,960 | $49,833 |
| Revenue mix %: | | | |
| Company-operated | 12 | 11 | 14 |
| Non-affiliated | 88 | 89 | 86 |
| Sites of service (at end of period) | 1,806 | 1,726 | 1,774 |
| Revenue per site | $565,883 | $580,357 | $535,398 |
| Therapist productivity % | 80.2 | 80.4 | 80.4 |
| Assets at end of period | $339,103 | $336,445 | $426,529 |
| Routine capital expenditures | $2,608 | $2,274 | $1,700 |

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| HRS: | | | |
| Revenues | $286,613 | $293,580 | $200,824 |
| Operating income | $73,925 | $69,745 | $43,731 |
| Revenue mix %: | | | |
| Company-operated | 33 | 33 | 37 |
| Non-affiliated | 67 | 67 | 63 |
| Sites of service (at end of period): | | | |
| Inpatient rehabilitation units | 104 | 105 | 102 |
| LTAC hospitals | 121 | 123 | 115 |
| Sub-acute units | 10 | 21 | 25 |
| Outpatient units | 144 | 119 | 115 |
| Other | – | 5 | 8 |
| | 379 | 373 | 365 |
| Revenue per site | $831,914 | $799,585 | $783,412 |
| Assets at end of period | $348,968 | $340,668 | $347,491 |
| Routine capital expenditures | $273 | $348 | $238 |
| Annualized employee turnover % (SRS and HRS combined) | 13.7 | 16.9 | 16.5 |

“Therapist productivity %” is computed by dividing labor minutes related to patient care by total labor minutes for the period.

Sources of Rehabilitation Division Revenues

Our rehabilitation division receives payment for the rehabilitation and program management services it provides to residents, patients and customers. The basis for payment varies depending upon the type of service provided. Customers in the SRS segment generally pay on the basis of a negotiated patient per diem rate or a negotiated fee

schedule based upon the type of service rendered. In the HRS segment, our hospital-based acute rehabilitation unit customers generally pay us on the basis of a negotiated fee per discharge. Our LTAC hospital customers pay based upon a negotiated per patient day rate. Our sub-acute rehabilitation customers pay based upon a flat monthly fee or a negotiated fee per patient day. Our outpatient therapy clients typically pay on the basis of a negotiated fee per unit of service. For the year ended December 31, 2013, revenues of the SRS segment totaled approximately $1.0 billion or 19% of our total revenues (before eliminations). For the year ended December 31, 2013, revenues of the HRS segment totaled approximately $287 million or 6% of our total revenues (before eliminations). Approximately 16% of our rehabilitation division revenues (before eliminations) in 2013 were generated from services provided to hospitals and nursing centers that we operated.

As a provider of services to healthcare providers, trends and developments in healthcare reimbursement will impact our revenues and growth. Changes in the reimbursement provided by Medicare or Medicaid to our customers can impact the demand and pricing for our services. For more information regarding the reimbursement for our rehabilitation services, see "– Governmental Regulation – Rehabilitation Division – Overview of Rehabilitation Division Revenues," "– Governmental Regulation – Hospital Division – Overview of Hospital Division Reimbursement," and "– Governmental Regulation – Nursing Center Division – Overview of Nursing Center Division Reimbursement."

Geographic Coverage

The following table lists by state the number of SRS contracts we serviced as of December 31, 2013:

| State | Company-operated | Non-affiliated | Total |
|---|---|---|---|
| Alabama | 2 | 8 | 10 |
| Arizona | 2 | 6 | 8 |
| Arkansas | – | 5 | 5 |
| California | 20 | 49 | 69 |
| Colorado | 7 | 35 | 42 |
| Connecticut | 4 | 7 | 11 |
| Delaware | – | 1 | 1 |
| Florida | – | 51 | 51 |
| Georgia | 2 | 9 | 11 |
| Idaho | 7 | 3 | 10 |
| Illinois | 2 | 249 | 251 |
| Indiana | 13 | 29 | 42 |
| Iowa | – | 27 | 27 |
| Kansas | – | 63 | 63 |
| Kentucky | 10 | 35 | 45 |
| Louisiana | – | 6 | 6 |
| Maine | 1 | 25 | 26 |
| Maryland | – | 45 | 45 |
| Massachusetts | 33 | 28 | 61 |
| Michigan | – | 33 | 33 |
| Minnesota | – | 60 | 60 |
| Missouri | – | 257 | 257 |
| Montana | 2 | 4 | 6 |
| Nebraska | – | 4 | 4 |
| Nevada | – | 3 | 3 |
| New Hampshire | 2 | 2 | 4 |
| New Jersey | – | 3 | 3 |
| New Mexico | – | 5 | 5 |
| New York | – | 22 | 22 |
| North Carolina | 14 | 61 | 75 |
| North Dakota | – | 4 | 4 |
| Ohio | 11 | 54 | 65 |
| Oklahoma | – | 21 | 21 |
| Oregon | 1 | 2 | 3 |

| | | | |
|---|---|---|---|
| Pennsylvania | 1 | 69 | 70 |
| Rhode Island | 2 | 2 | 4 |
| South Carolina | – | 5 | 5 |
| Tennessee | 6 | 39 | 45 |
| Texas | 7 | 192 | 199 |
| Utah | 2 | – | 2 |
| Vermont | 2 | 3 | 5 |
| Virginia | 3 | 39 | 42 |
| Washington | 5 | 16 | 21 |
| Wisconsin | 9 | 52 | 61 |
| Wyoming | 3 | – | 3 |
| Totals | 173 | 1,633 | 1,806 |

The following table lists by state the number of HRS contracts we serviced as of December 31, 2013:

| State | Hospital-based inpatient rehab units | LTAC hospitals | Sub-acute units | Outpatient units | Total |
|---|---|---|---|---|---|
| Arizona | – | 3 | – | – | 3 |
| Arkansas | 7 | – | 1 | 12 | 20 |
| California | 10 | 16 | – | – | 26 |
| Colorado | 1 | 2 | – | 5 | 8 |
| Delaware | 1 | – | – | – | 1 |
| Florida | – | 10 | – | 5 | 15 |
| Georgia | 4 | 2 | 2 | – | 8 |
| Illinois | 7 | 6 | – | 7 | 20 |
| Indiana | 7 | 6 | – | 7 | 20 |
| Iowa | 4 | – | – | 2 | 6 |
| Kansas | 4 | – | – | 3 | 7 |
| Kentucky | – | 2 | – | – | 2 |
| Louisiana | 6 | 2 | 1 | 16 | 25 |
| Massachusetts | 1 | 6 | – | 3 | 10 |
| Michigan | 8 | 2 | – | 4 | 14 |
| Minnesota | 2 | – | – | – | 2 |
| Mississippi | 5 | – | – | 7 | 12 |
| Missouri | 6 | 4 | 1 | 7 | 18 |
| Nevada | – | 3 | – | 1 | 4 |
| New Jersey | – | 2 | 1 | 8 | 11 |
| New Mexico | – | 1 | – | – | 1 |
| New York | – | – | – | 10 | 10 |
| North Carolina | – | 1 | – | 4 | 5 |
| North Dakota | 1 | 2 | – | – | 3 |
| Ohio | 6 | 7 | 1 | 17 | 31 |
| Oklahoma | 3 | 3 | – | – | 6 |
| Pennsylvania | 7 | 8 | 2 | 4 | 21 |
| Puerto Rico | 1 | – | – | – | 1 |
| Rhode Island | 1 | – | – | 2 | 3 |
| South Carolina | 1 | 1 | – | 4 | 6 |
| Tennessee | 3 | 1 | – | – | 4 |
| Texas | 6 | 27 | – | 13 | 46 |
| Virginia | – | 1 | – | – | 1 |
| Washington | 1 | 2 | – | 1 | 4 |
| West Virginia | – | – | – | 2 | 2 |
| Wisconsin | – | 1 | – | – | 1 |
| Wyoming | 1 | – | 1 | – | 2 |
| Totals | 104 | 121 | 10 | 144 | 379 |

Sales and Marketing

The rehabilitation division's sales and marketing efforts are tailored to each of its operating segments. SRS primarily focuses on the outsourcing needs of freestanding skilled nursing facilities, while HRS focuses on the provision of therapy services to IRFs and therapy program management for hospitals. Both SRS and HRS emphasize the broad range of rehabilitation programs, clinical expertise, and competitive pricing that we provide. SRS's new business efforts are led by a divisional vice president of business development and eight directors of business development in geographically defined regions. HRS's new business efforts are led by a divisional vice president of business development and four directors of business development in geographically defined regions.

Rehabilitation Division Management and Operations

A division president and a chief financial officer manage our rehabilitation division. Our operations are divided between the SRS and HRS lines of business. The SRS segment is divided into two geographic areas led by senior vice presidents who report to the division senior vice president. These senior vice presidents have six regional vice presidents reporting to them. The HRS segment is led by a senior vice president who reports to the division president. Our HRS operations are led by a division vice president of operations who manages six regional vice presidents. In both the SRS and HRS segments, area directors of operations report to the regional vice presidents. Each area director of operations is responsible for the overall management of 15 to 30 on-site program directors. Each of our rehabilitation customers has an on-site program director responsible for managing the therapy operations at such facility. There are two senior vice presidents of clinical operations that manage the clinical education for our therapists and implement quality care initiatives.

We provide our program staff with centralized administrative services in the areas of information systems, clinical operations, regulatory compliance, reimbursement guidance, professional licensing support, as well as legal, finance, accounting, purchasing, recruiting and human resources management support. The centralization of these services improves operating efficiencies, promotes the standardization of certain processes and permits program staff to focus on the delivery of quality, medically necessary rehabilitation services.

Rehabilitation Division Competition

In the geographic markets that we serve, there are national, regional and local rehabilitation services providers that offer rehabilitation services comparable to ours. A number of our competitors may have greater financial and other resources than we do, may be more established in the markets in which we compete and may be willing to provide services at lower prices. In addition, a number of nursing centers and hospitals may elect not to outsource rehabilitation services thereby reducing our potential customer base. While there are several large rehabilitation providers, the market generally is highly fragmented and is primarily comprised of smaller independent providers.

We believe our rehabilitation division generally competes based upon its reputation for providing quality rehabilitation services, state of the art therapy programs, qualified therapists, competitive pricing, outcome management and technology systems.

CARE MANAGEMENT DIVISION

On August 1, 2013, we announced the creation of our care management division, which includes within its scope the activities and services formerly provided and reported under our home health and hospice division. Our care management division primarily provides home health, hospice and private duty services, typically using the name “Kindred at Home,” to patients in a variety of settings, including homes, nursing centers and other residential settings. We established the care management division to continue to grow our home care and hospice business and to test and develop new service delivery and payment models. While minor in scope at this time, we intend to use our care management division to develop (1) physician coverage across sites of service, (2) care manager roles to smooth care transitions, (3) information sharing and technology connectivity, (4) patient placement tools, and (5) condition-specific clinical programs and outcome measures. As of December 31, 2013, our care management division operated 159 locations in the states of Arizona, California, Colorado, Florida, Illinois, Indiana, Louisiana, Massachusetts, Nevada, Ohio, Texas, Utah and Virginia. The care management division generated revenues of approximately $225 million in 2013 or 5% of our total revenues (before eliminations).

Our home health operations offer medical care and other services to patients in their homes or other residential settings. Experienced nurses, therapists and home health aides work with the patient and his or her family members to

maximize the patient's ability to handle a wide variety of daily activities and to educate the patient regarding medications and medical conditions. Our services include nursing, physical, occupational and speech therapies, and medical social work.

Our hospice operations provide a family-oriented model of care designed to meet the spiritual, emotional and physical needs of terminally ill patients and their families. Hospice services are provided in the home or in other settings such as nursing centers, assisted living facilities and hospitals. Working in conjunction with a patient's attending physician, our hospice team of professionals develops a plan of care designed to support the patient's individual needs, which may include pain and symptom management, emotional and spiritual counseling, homemaking and dietary services.

Our private duty services include personal care (bathing and grooming), meal preparation, light housekeeping, respite care and transportation.

In key markets, we also provide physician services focused on delivering primary and urgent care to patients in home-based settings such as assisted living facilities, independent living facilities and homes, as well as care transition managers to follow patients with specific diagnoses and/or risk factors through the entire care continuum.

Selected Care Management Division Operating Data

The following table sets forth certain operating and financial data for the care management division (dollars in thousands, except statistics):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| Revenues | $224,927 | $143,340 | $60,736 |
| Operating income | $9,963 | $13,708 | $3,103 |
| Locations (at end of period) | 159 | 101 | 51 |
| Annualized employee turnover % | 38.0 | 29.5 | 32.4 |
| Assets at end of period | $244,123 | $202,156 | $104,374 |
| Capital expenditures: | | | |
| Routine | $1,523 | $1,616 | $164 |
| Development | – | – | 1,167 |

Sources of Care Management Division Revenues

Care management division revenues are derived principally from the Medicare and Medicaid programs, private insurers and private pay patients. Medicare reimburses both home health and hospice services under prospective payment systems, which are subject to numerous qualifications, standards and adjustments. Medicaid reimburses home health and hospice service providers using a number of state specific systems. We often negotiate contract rates of reimbursement with private insurers.

The following table sets forth the approximate percentages of care management division revenues derived from the payor sources indicated:

| Year ended December 31, | Medicare | Medicaid | Private insurance | Private pay |
|---|---|---|---|---|
| 2013 | 70 % | 9 % | 5 % | 16 % |
| 2012 | 67 | 9 | 3 | 21 |
| 2011 | 69 | 9 | 6 | 16 |

For more information regarding the reimbursement of our care management division, see "– Governmental Regulation – Care Management Division – Overview of Care Management Division Reimbursement."

Care Management Division Management and Operations

The care management division is headed by a president, overseeing a chief financial officer, a senior vice president of quality integrated care, two physician vice presidents of medical development and medical affairs, respectively, a chief operating officer and a chief clinical officer with respect to home health and hospice activities, and a vice president for each of the four geographic regions of the care management division. In addition, the care management division has division level compliance, clinical services, finance, operations and human resources executives. The sales and marketing efforts for the care management division are led by three divisional vice presidents, who in turn report to our senior vice president of enterprise sales.

We provide our care management division with centralized administrative support in the areas of information systems, reimbursement guidance, licensing support as well as legal, finance, accounting, purchasing and human resources management. The centralization of these services improves operating efficiencies, promotes standardization of processes and enables our healthcare professionals to focus on delivering quality care to our patients.

Care Management Division Competition

Our care management division operates in a highly competitive and significantly fragmented industry. Our competitors include relatively large providers of home health and hospice services, both for profit and non-profit and smaller independent local operators. There often are no significant barriers to entry in many of the markets in which our care management division operates and new providers of home health and/or hospice services may enter into our current and future markets. Many of our competitors may have greater financial and other resources than we do.

Although there is limited, if any, price competition with respect to Medicare and Medicaid patients (since revenues received for services provided to these patients are based generally on fixed rates), there is substantial price competition for private payment patients. We believe our care management division competes based upon its reputation for providing quality services, competitive prices and for being consistently responsive to the needs of our patients and their families and physicians.

GOVERNMENTAL REGULATION

Medicare and Medicaid

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over and certain disabled persons. Medicaid is a medical assistance program administered by each state funded with federal and state funds pursuant to which healthcare benefits are available to certain indigent or disabled patients. Within the Medicare and Medicaid statutory framework, there are substantial areas subject to administrative rulings, interpretations and discretion that may affect payments made under Medicare and Medicaid. A substantial portion of our revenues are derived from patients covered by the Medicare and Medicaid programs.

We could be affected adversely by the continuing efforts of governmental and private third party payors to contain healthcare costs. We cannot assure you that reimbursement payments under governmental and private third party payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Medicare reimbursement in LTAC hospitals, IRFs, nursing centers, home health and hospice is subject to fixed payments under the Medicare prospective payment systems. In accordance with Medicare laws, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems under what is commonly known as a “market basket update.” Each year, the Medicare Payment Advisory Commission, a commission chartered by Congress to advise it on Medicare payment issues (“MedPAC”), makes payment policy recommendations to Congress for a variety of Medicare payment systems. Congress is not obligated to adopt MedPAC recommendations, and, based upon outcomes in previous years, there can be no assurance that Congress will adopt MedPAC’s recommendations in a given year. Medicaid reimbursement rates in many states in which we operate nursing centers also are based upon fixed payment systems. Generally, these rates are adjusted annually for inflation. However, these adjustments may not reflect the actual increase in the costs of providing healthcare services. In addition, Medicaid reimbursement can be impacted negatively by state budgetary pressures, which may lead to reduced reimbursement or delays in receiving payments. Moreover, we cannot assure you that the facilities operated by us, or the provision of goods and services offered by us, will meet the requirements for participation in such programs.

The Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act (enacted on March 23, 2010) and the Healthcare Education and Reconciliation Act (enacted on March 30, 2010) (which we refer to as the ACA). The reforms contained in the ACA have affected each of our businesses in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. These reforms include the 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.

The ACA also provides for: (1) reductions to the annual market basket payment updates for LTAC hospitals, IRFs, home health agencies and hospice providers which could result in lower reimbursement than in the preceding year; (2) additional annual “productivity adjustment” reductions to the annual market basket payment update as determined by CMS for LTAC hospitals, IRFs, and nursing centers (beginning in federal fiscal year 2012), home health agencies (beginning in federal fiscal year 2015) and hospice providers (beginning in federal fiscal year 2013); (3) new transparency, reporting and certification requirements for skilled nursing facilities, including disclosures regarding organizational structure, officers, directors, trustees, managing employees and financial, clinical and other related data; (4) a quality reporting system for hospitals (including LTAC hospitals and IRFs) beginning in federal fiscal year 2014; and (5) reductions in Medicare payments to hospitals (including LTAC hospitals and IRFs) beginning in federal

fiscal year 2014 for failure to meet certain quality reporting standards or to comply with standards in new value based purchasing demonstration project programs.

The healthcare reforms and changes resulting from the ACA, as well as other similar healthcare reforms, could have a material adverse effect on our business, financial position, results of operations and liquidity.

Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. We cannot predict the adjustments to Medicare payment rates that Congress or CMS may make in the future. Any downward adjustment to rates for the types of services we provide could have a material adverse effect on our business, financial position, results of operations and liquidity.

Congress continues to discuss additional deficit reduction measures, leading to a high degree of uncertainty regarding potential reforms to governmental healthcare programs, including Medicare and Medicaid. These discussions, along with other continuing efforts to reform governmental healthcare programs, could result in major changes in healthcare delivery and reimbursement systems on a national and state level, including changes directly impacting the government and private reimbursement systems for each of our businesses. Healthcare reform, future healthcare legislation or other changes in the administration or interpretation of governmental

healthcare programs, whether resulting from deficit reduction measures or otherwise, could have a material adverse effect on our business, financial position, results of operations and liquidity.

See “Item 1A – Risk Factors – Risk Factors Relating to Reimbursement and Regulation of Our Business – Changes in the reimbursement rates or methods or timing of payment from third party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a substantial reduction in our revenues and operating margins.”

Recent Regulatory Changes

LTAC Legislation

As part of the Pathway for SGR Reform Act of 2013 enacted on December 26, 2013 (the “SGR Reform Act”), Congress adopted various legislative changes impacting LTAC hospitals (the “LTAC Legislation”). The LTAC Legislation creates new Medicare criteria and payment rules for LTAC hospitals. Under the new criteria, LTAC hospitals treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under the Long-Term Acute Care Prospective Payment System (“LTAC PPS”), a prospective payment system specifically for LTAC hospitals. Other patients will continue to have access to LTAC care, whether they are admitted to LTAC hospitals from acute care hospitals or directly from other settings or the community. LTAC hospitals will be paid at a “site-neutral” rate for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under the prospective payment system for general short-term acute care hospitals (“IPPS”) or LTAC costs.

The effective date of the new patient criteria is October 1, 2015, followed by a two-year phase-in period tied to each LTAC hospital’s cost reporting period. During the phase-in period, payment for patients receiving the site neutral rate will be based 50% on the current LTAC PPS and 50% on the new site neutral rate. Approximately 70% of our LTAC hospitals have a cost reporting period starting on or after July 1 of each year. Accordingly, the phase-in will not begin for most of our hospitals until after July 1, 2016 and full implementation of the new criteria will not begin until after July 1, 2018.

We continue to analyze Medicare and internal data to estimate the number of our cases that will continue to be paid under the LTAC PPS rate. At this time, we estimate that approximately 40% of our current LTAC patients will be paid at the site neutral rate under the new criteria once it is fully phased-in. The site-neutral payment rates will be based on LTAC costs or a Medicare per diem rate paid for patients with the same diagnoses under IPPS. There can be no assurance that these site neutral payments will not be materially less than the payments currently provided under LTAC PPS.

The additional patient criteria imposed by the LTAC Legislation will reduce the population of patients eligible for LTAC PPS and change the basis upon which we are paid for other patients. These changes could have a material adverse effect on our business, financial position, results of operations and liquidity.

The LTAC Legislation extends the moratorium on the expansion of the “25 Percent Rule” to LTAC hospitals certified prior to October 1, 2004 for four years. LTAC hospitals certified after October 1, 2004 continue to be ineligible for relief from the “25 Percent Rule.” Freestanding LTAC hospitals will not be subject to the “25 Percent Rule” payment adjustment until cost reporting periods beginning on or after July 1, 2016. In addition, for cost reporting periods beginning before October 1, 2016: (1) LTAC hospitals may admit up to 50% of their patients from a co-located hospital and still be paid according to LTAC PPS; and (2) LTAC hospitals that are co-located with an urban single hospital or a hospital that generates more than 25% of the Medicare discharges in a metropolitan statistical area (“MSA Dominant hospital”) may admit up to 75% of their patients from such urban single or MSA Dominant hospital and still

be paid according to LTAC PPS. The LTAC Legislation further provides that co-located LTAC hospitals certified on or before September 30, 1995 are exempt from the provisions of the "25 Percent Rule." The LTAC Legislation also mandates that the Secretary of the Health and Human Services report to Congress by July 1, 2015 on whether the "25 Percent Rule" should continue to be applied.

The LTAC Legislation also will change the 25-day average length of stay requirement for LTAC hospitals. To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be greater than 25 days. Medicare Advantage patients are included with Medicare fee-for-service patients in order to determine compliance with the 25-day average length of stay requirements. Under the LTAC Legislation, the average Medicare 25-day length of stay rule will remain in effect for patients paid for under the new Medicare LTAC payment system. However, for cost reporting periods beginning on or after October 1, 2015, the 25-day requirement will not apply to patients receiving the site neutral rate or to Medicare Advantage patients treated in LTAC hospitals.

Beginning in 2020, the LTAC Legislation requires that at least 50% of our patients must be paid under the new LTAC payment system to maintain Medicare certification as a LTAC hospital. Under the new criteria, LTAC hospitals treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTAC PPS.

The failure of one or more of our LTAC hospitals to maintain its Medicare certification as a LTAC hospital could have a material adverse effect on our business, financial position, results of operations and liquidity.

The LTAC Legislation also will impose a new moratorium beginning on January 1, 2015 and continuing through September 30, 2017 on the establishment and classification of new LTAC hospitals, LTAC satellite facilities and LTAC beds in existing LTAC hospitals or satellite hospitals. This moratorium will limit our ability to increase LTAC bed capacity, expand into new areas or increase bed capacity in existing markets that we serve.

The Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012

The Budget Control Act of 2011, enacted on August 2, 2011, initiated $1.2 trillion in domestic and defense spending reductions automatically on February 1, 2013, split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. As discussed below, the American Taxpayer Relief Act of 2012 (the "Taxpayer Relief Act") subsequently delayed by two months the automatic budget sequestration cuts established by the Budget Control Act of 2011. The automatic 2% reduction on each claim submitted to Medicare began on April 1, 2013.

The Taxpayer Relief Act was enacted on January 2, 2013. This Act delayed by two months the automatic budget sequestration cuts established by the Budget Control Act of 2011. The Taxpayer Relief Act also: (1) reduced Medicare payments by an additional 25% for subsequent procedures when multiple therapy services are provided on the same day; (2) extended the Medicare Part B outpatient therapy cap exception process to December 31, 2013; (3) suspended until December 31, 2013 the sustainable growth rate adjustment ("SGR") reduction applicable to the Medicare Physician Fee Schedule ("MPFS") for certain services provided under Medicare Part B; and (4) increased the statute of limitations to recover Medicare overpayments from three years to five years. We believe that the new rules related to multiple therapy services will reduce the Company's Medicare revenues by $25 million to $30 million on an annual basis.

The SGR Reform Act subsequently modified the Budget Control Act of 2011 and the Taxpayer Relief Act by (1) extending the Medicare Part B outpatient therapy cap exception process to March 31, 2014; and (2) suspending until March 31, 2014 the SGR reduction applicable to the MPFS for certain services provided under Medicare Part B.

Federal, state and local regulations

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, and the privacy and security of health-related information. In addition, various anti-fraud and abuse laws, including physician self-referral laws, anti-kickback laws and laws regarding filing of false claims, codified under the Social Security Act and other statutes, prohibit certain business practices and relationships in connection with healthcare services for patients whose care will be paid by Medicare, Medicaid or other governmental programs. Sanctions for violating these anti-fraud and abuse laws include criminal penalties, civil penalties and possible exclusion from government programs such as Medicare and Medicaid.

In the ordinary course of our business, we are subject regularly to inquiries, investigations and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. Audits may include enhanced medical necessity review of hospital cases pursuant to the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "SCHIP Extension Act") and audits under the CMS Recovery Audit Contractor ("RAC") program.

We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory penalties, including demands for refund of

overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. These enforcement policies, along with the costs incurred to respond to and defend reviews, audits and investigations, could have a material adverse effect on our business, financial position, results of operations and liquidity. We vigorously contest such penalties where appropriate; however, these cases can involve significant legal and other expenses and consume our resources.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," provides that a physician may not refer a Medicare or Medicaid patient for a "designated health service" to an entity with which the physician or an immediate family member has a financial relationship unless the financial arrangement meets an exception under the Stark Law or its regulations. Designated health services include inpatient and outpatient hospital services, physical, occupational, and speech therapy, durable medical equipment, prosthetics, orthotics and supplies, diagnostic imaging, enteral and parenteral feeding and supplies, home health services, and clinical laboratory services. Under the Stark Law, a "financial relationship" is defined as an ownership or investment interest or a compensation arrangement. If such a financial relationship exists and does not meet a Stark Law exception, the entity is prohibited from submitting or claiming payment under the Medicare or Medicaid programs or from collecting from the patient or other payor. Many of the compensation arrangements exceptions permit referrals if, among other things, the arrangement is set forth in a written agreement signed by the parties, the compensation to be paid is set in advance, is consistent with fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. Exceptions may have other requirements. Any funds collected for an item or service resulting from a referral that violates the Stark Law must be repaid to Medicare or Medicaid, any other third party payor and the patient. In addition, a civil monetary penalty of up to $15,000 for each service may be imposed for presenting or causing to be presented, a claim for a service rendered in violation of the Stark Law. Many states have enacted healthcare provider referral laws that go beyond physician self-referrals or apply to a greater range of services than just the designated health services under the Stark Law.

The Anti-Kickback Statute, Section 1128B of the Social Security Act (the "Anti-Kickback Statute") prohibits the knowing and willful offer, payment, solicitation or receipt of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of an individual, in return for recommending, or to arrange for, the referral of an individual for any item or service payable under any federal healthcare program, including Medicare or Medicaid. The U.S. Department of Health and Human Services Office of Inspector General ("OIG") has issued regulations that create "safe harbors" for certain conduct and business relationships that are deemed protected under the Anti-Kickback Statute. In order to receive safe harbor protection, all of the requirements of a safe harbor must be met. The fact that a given business arrangement does not fall within one of these safe harbors, however, does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria, if investigated, will be evaluated based upon all facts and circumstances and risk increased scrutiny and possible sanctions by enforcement authorities. The Anti-Kickback Statute is a criminal statute, with penalties of up to $25,000, up to five years in prison, or both. The OIG can pursue a civil claim for violation of the Anti-Kickback Statute under the Civil Monetary Penalty Statute of up to $50,000 per claim and up to three times the amount received from the government for the items or services. We believe that business practices of providers and financial relationships between providers have become subject to increased scrutiny as healthcare reform efforts continue on the federal and state levels. State Medicaid programs are required to enact an anti-kickback statute. Many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients regardless of the source of payment for the care.

The U.S. Department of Justice (the "DOJ") may bring an action under the federal False Claims Act (the "FCA"), alleging that a healthcare provider has defrauded the government by submitting a claim for items or services not rendered as claimed, which may include coding errors, billing for services not provided and submitting false or erroneous cost reports. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. The ACA clarifies that if an item or service is provided in violation of the Anti-Kickback Statute, the claim submitted for those items or services is a false claim that may be prosecuted under the FCA as a false claim. Civil penalties under the FCA are between $5,500 and $11,000 for each claim and up to three times of the amount claimed. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud may bring a claim on behalf of the federal government and receive a percentage of the

federal government's recovery. Due to these whistleblower incentives, lawsuits have become more frequent.

In addition to the penalties described above, violation of any of these laws may subject us to exclusion from participation in any federal or state healthcare program. These fraud and abuse laws and regulations are complex, and we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. While we do not believe we are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing the provisions of these prohibitions will not assert that we are in violation of the provisions of such laws and regulations.

The Balanced Budget Act of 1997 (the "Balanced Budget Act") also includes a number of anti-fraud and abuse provisions. The Balanced Budget Act contains additional civil monetary penalties for violations of the Anti-Kickback Statute discussed above and imposes an affirmative duty on healthcare providers to ensure that they do not employ or contract with persons excluded from the Medicare program. The Balanced Budget Act also provides a minimum ten-year period for exclusion from participation in federal healthcare programs for persons or entities convicted of a prior healthcare offense.

Various states in which we operate hospitals and nursing centers have established minimum staffing requirements or may establish minimum staffing requirements in the future. The implementation of these staffing requirements in some states is not

contingent upon any additional appropriation of state funds in any budget act or other statute. Our ability to satisfy such staffing requirements will depend upon our ability to attract and retain qualified healthcare professionals, including nurses, certified nurse's assistants, therapists and other staff. Failure to comply with such minimum staffing requirements may result in the imposition of fines or other sanctions. If states do not appropriate sufficient additional funds to pay for any additional operating costs resulting from such minimum staffing requirements, our profitability may be materially adversely affected.

The International Classification of Diseases ("ICD") is a classification system for diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, promulgated by the World Health Organization. The Secretary of the U.S. Department of Health and Human Services ("HHS") initially mandated that healthcare payors and providers and their vendors must convert from the current ICD-9 coding system to the materially different ICD-10 coding system by October 1, 2013. HHS subsequently announced its intent to delay the conversion date by one year to October 1, 2014. ICD-10 is the first major change in diagnosis and procedure coding in three decades.

HIPAA. The federal Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," among other requirements, broadened the scope of existing fraud and abuse laws and mandated the adoption of administrative simplification regulations aimed at standardizing transaction formats and billing codes for documenting medical services, dealing with claims submissions and protecting the privacy and security of individually identifiable health information. HIPAA regulations that standardize transactions and code sets require standard formatting for healthcare providers, like us, that submit claims electronically.

The HIPAA privacy regulations apply to "protected health information," which is defined generally as individually identifiable health information transmitted or maintained in any form or medium, excluding certain types of records such as educational records. The privacy regulations seek to limit the use and disclosure of most paper and oral communications, as well as those in electronic form, regarding an individual's past, present or future physical or mental health or condition, or relating to the provision of healthcare to the individual or payment for that healthcare, if the individual can or may be identified by such information. HIPAA provides for the imposition of civil and/or criminal penalties if protected health information is improperly used or disclosed.

HIPAA's security regulations require us to ensure the confidentiality, integrity, and availability of all electronically protected health information that we create, receive, maintain or transmit. We must protect against reasonably anticipated threats or hazards to the security of such information and the unauthorized use or disclosure of such information. The HIPAA unique health identifier standards require us to obtain and use national provider identifiers.

The Health Information Technology for Economic and Clinical Health Act, commonly known as the "HITECH Act," was passed in 2009 and instituted new HIPAA requirements regarding providing individuals with notification of breaches of their unsecured protected health information and reporting to the media of violations involving more than 500 individuals in a single jurisdiction, as well as immediate reporting to HHS of any violation involving 500 individuals or more for publication on the HHS website. The HITECH Act also imposed new requirements on HIPAA business associates and strengthened HIPAA enforcement provisions, including civil monetary penalty amounts. On January 25, 2013, HHS published a final omnibus regulation implementing the changes under the HITECH Act. The compliance date for most of the provisions in the final regulation began September 23, 2013.

We believe we are in substantial compliance with the HIPAA regulations. We cannot assure you that potential non-compliance by us with HIPAA regulations will not have a material adverse effect on our business, financial position, results of operations and liquidity.

Certificates of need and state licensing. Certificate of need, or CON, regulations control the development and expansion of healthcare services and facilities in certain states. Certain states also require regulatory approval prior to certain changes in ownership of a hospital or nursing center. Certain states that do not have CON programs may have other laws or regulations that limit or restrict the development or expansion of healthcare facilities. We operate hospitals in 11 states, nursing centers in 14 states and hospice agencies in one state that require prior approval under CON programs for the development or expansion of our facilities and services. To the extent that CONs or other similar approvals are required for development or expansion of the operations of our hospitals, nursing centers or other services, either through facility development, acquisitions, expansion or provision of new services or other changes, such development or expansion could be affected adversely by the failure or inability to obtain the necessary approvals, changes in the standards applicable to such approvals or possible delays and expenses associated with obtaining such approvals.

We are required to obtain state licenses to operate each of our hospitals and nursing centers and to ensure their participation in government programs. Some states require similar licenses for home health and hospice operations. Once a hospital or nursing center becomes licensed and operational, it must continue to comply with federal, state and local licensing requirements in addition to local building and life-safety codes. All of our hospitals, nursing centers and home health and hospice operations have the necessary licenses. Failure of our hospitals, nursing centers and home health and hospice operations to satisfy applicable licensure and certification requirements could have a material adverse effect on our business, financial position, results of operations and liquidity.

Hospital division

General regulations. The hospital division is subject to various federal and state regulations. In order to receive Medicare reimbursement, each hospital must meet the applicable conditions of participation set forth by HHS relating to the type of hospital, its equipment, personnel and standard of medical care, as well as comply with state and local laws and regulations. We have developed a management system to facilitate our compliance with these various standards and requirements. Among other things, each hospital employs a person who is responsible for leading an ongoing quality assessment and improvement program. Hospitals undergo periodic on-site Medicare certification surveys, which generally are limited in frequency if the hospital is accredited by the Joint Commission or the AOA, national organizations that establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. As of December 31, 2013, 100 TC hospitals operated by the hospital division were certified as a Medicare LTAC provider (with certification pending for one TC hospital) and five hospitals were certified as an IRF provider. In addition, 97 of our hospitals also were certified by their respective state Medicaid programs. Loss of certification could adversely affect a hospital's ability to receive payments from the Medicare and Medicaid programs.

As noted above, the hospital division also is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit, among other things, certain direct and indirect payments for the referral of patients, certain referrals by physicians if they or their immediate family members have a financial relationship with the hospital, or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Such laws include the Anti-Kickback Statute, the Stark Law and the FCA. In addition, some states restrict certain business relationships between physicians and ancillary service providers and some states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in reimbursement programs, as well as civil and criminal penalties. These laws vary considerably from state to state.

Ten of our TC hospitals are owned in part by physician investors. Under amendments to the Stark Law passed in the ACA, the percentage of physician ownership in a hospital to which the physician investors refer Medicare or Medicaid patients may not increase and these hospitals may not expand their bed capacity or number of operating rooms or procedure rooms except for certain hospitals that meet stated requirements and receive permission from CMS.

Accreditation by the Joint Commission or the AOA. Hospitals may receive accreditation from the Joint Commission or the AOA. With respect to accreditation by the Joint Commission, hospitals and certain other healthcare facilities are generally required to have been in operation at least four months in order to be eligible. After conducting on-site surveys, the Joint Commission awards accreditation for up to three years to hospitals found to be in substantial compliance with Joint Commission standards. Accredited hospitals also are periodically resurveyed, at the option of the Joint Commission, upon a major change in facilities or organization and after merger or consolidation. With respect to the AOA, the accreditation process includes an in-depth review of both open and closed patient records, as well as on-site surveys, including direct observation of the care being provided. As of December 31, 2013, all of the TC hospitals and IRFs operated by the hospital division were accredited by either the Joint Commission or the AOA or were in the process of seeking accreditation. The hospital division intends to seek and obtain Joint Commission or AOA accreditation for any additional hospitals it may operate in the future.

Peer review. Federal regulations provide that admission to and utilization of hospitals by Medicare and Medicaid patients must be reviewed by peer review organizations or quality improvement organizations in order to ensure efficient utilization of hospitals and services. A quality improvement organization may conduct such review either prospectively or retrospectively and may, as appropriate, recommend denial of payments for services provided to a

patient. The review is subject to administrative and judicial appeals. Each of the hospitals operated by our hospital division employs a clinical professional to administer the hospital's integrated quality assurance and improvement program. Although intensifying, denials by third party utilization review organizations historically have not had a material adverse effect on the hospital division's operating results.

Overview of hospital division reimbursement

Medicare reimbursement of short-term acute care hospitals – Medicare reimburses general short-term acute care hospitals under IPPS. Under IPPS, Medicare inpatient costs are reimbursed based upon a fixed payment amount per discharge using medical severity diagnostic related groups ("MS-DRGs"). The MS-DRG payment under IPPS is based upon the national average cost of treating a Medicare patient's condition adjusted for regional wage variations. Although the average length of stay varies for each MS-DRG, we believe that the average stay for all Medicare patients subject to IPPS is approximately five days. An additional outlier payment is made for patients with higher treatment costs but these payments are designed only to cover marginal costs. Hospitals that are certified by Medicare as LTAC hospitals and IRFs are excluded from IPPS.

Medicare reimbursement of LTAC hospitals – Since October 2002, the Medicare payment system for LTAC hospitals has been based upon LTAC PPS, a prospective payment system specifically for LTAC hospitals. LTAC PPS maintains long-term acute care hospitals as a distinct provider type, separate from short-term acute care hospitals. Only providers certified as LTAC hospitals

may be paid under this system. As of December 31, 2013, 100 of our TC hospitals are certified as LTAC hospitals (with certification pending for one TC hospital). To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be greater than 25 days. Medicare Advantage patients are included with Medicare fee-for-service patients in order to determine compliance with the 25-day average length of stay requirement. Under the LTAC Legislation, the average Medicare 25-day length of stay rule will remain in effect for patients paid for under the new Medicare LTAC payment system. However, for cost reporting periods beginning on or after October 1, 2015, the 25-day requirement will not apply to patients receiving the site neutral rate or to Medicare Advantage patients treated in LTAC hospitals.

On August 1, 2007, CMS issued final regulations regarding Medicare hospital inpatient payments to short-term acute care hospitals, as well as certain provisions affecting LTAC hospitals. These regulations adopted a new system for LTAC hospitals for classifying patients into diagnostic categories called Medicare Severity Diagnosis Related Groups or more specifically, for LTAC hospitals, “MS-LTC-DRGs.” LTAC PPS is based upon discharged-based MS-LTC-DRGs similar to the system used to pay short-term acute care hospitals.

While the clinical system which groups procedures and diagnoses is identical to the prospective payment system for short-term acute care hospitals, LTAC PPS utilizes different rates and formulas. Three types of payments are used in this system: (1) short-stay outlier payment, which provides for patients whose length of stay is less than 5/6th of the geometric mean length of stay for that MS-LTC-DRG, based upon a lesser of methodology, of which the first three of four calculations are (a) a per diem based upon the average payment for that MS-LTC-DRG, (b) the estimated costs, or (c) the full MS-LTC-DRG payment. If the length of stay is less than an IPPS-comparable threshold for that MS-LTC-DRG, then the fourth payment calculation is an amount comparable to an IPPS per diem for that same DRG, capped at the full IPPS DRG amount. If the length of stay is above the IPPS-comparable threshold but below the 5/6th geometric length of stay for that MS-LTC-DRG, then the fourth payment calculation is a blend of an amount comparable to what would otherwise be paid under IPPS computed as a per diem, capped at the full IPPS MS-DRG comparable payment amount and a per diem based upon the average payment for that MS-LTC-DRG under LTAC PPS; (2) MS-LTC-DRG fixed payment, which provides a single payment for all patients with a given MS-LTC-DRG, regardless of length of stay, cost of care or place of discharge; and (3) high cost outlier payment which provides a partial coverage of costs for patients whose cost of care far exceeds the MS-LTC-DRG reimbursement. For patients in the high cost outlier category, Medicare will reimburse 80% of the costs incurred above a threshold, defined as the MS-LTC-DRG reimbursement plus a fixed loss amount per discharge.

LTAC PPS provides for an adjustment for differences in area wages resulting from salary and benefit variations. There also are additional rules for payment for patients who are transferred from a LTAC hospital to another healthcare setting and are subsequently readmitted to the LTAC hospital. The LTAC PPS payment rates also are subject to annual adjustments.

LTAC Criteria. The LTAC Legislation creates new Medicare criteria and payment rules for LTAC hospitals. Under the new criteria, LTAC hospitals treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and LTAC patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTAC PPS. Other patients will continue to have access to LTAC care, whether they are admitted to LTAC hospitals from acute care hospitals or directly from other settings or the community. LTAC hospitals will be paid at a “site-neutral” rate for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTAC costs.

The effective date of the new patient criteria is October 1, 2015, followed by a two-year phase-in period tied to each LTAC hospital’s cost reporting period. During the phase-in period, payment for patients receiving the site neutral rate will be based 50% on the current LTAC PPS and 50% on the new site neutral rate. Approximately 70% of our LTAC hospitals have a cost reporting period starting on or after July 1 of each year. Accordingly, the phase-in will not begin

for most of our hospitals until after July 1, 2016 and full implementation of the new criteria will not begin until after July 1, 2018.

We continue to analyze Medicare and internal data to estimate the number of our cases that will continue to be paid under the LTAC PPS rate. At this time, we estimate that approximately 40% of our current LTAC patients will be paid at the site neutral rate under the new criteria once it is fully phased-in. The site-neutral payment rates will be based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTAC costs. There can be no assurance that these site neutral payments will not be materially less than the payments currently provided under LTAC PPS.

The additional patient criteria imposed by the LTAC Legislation will reduce the population of patients eligible for LTAC services and change the basis upon which we are paid for other patients. These changes could have a material adverse effect on our business, financial position, results of operations and liquidity.

CMS has, for a number of years, considered the development of facility and patient certification criteria for LTAC hospitals. In addition, CMS published preliminary findings regarding patient and facility-level criteria for LTAC hospitals in 2013. Given the LTAC Legislation, it is unclear whether CMS will continue its analysis of LTAC hospital criteria.

Medicare regulations require that when two or more hospital facilities share the same provider number and are considered to be a single hospital, the "remote" or "satellite" facility must meet certain criteria with respect to the "main" facility. These criteria relate largely to demonstrating a high level of integration between the two facilities. If the criteria are not met, each facility would need to meet all Medicare requirements independently, including, for example, the minimum average length of patient stay for LTAC hospital qualification. It is advantageous for certain satellite facilities that may not independently be able to meet these Medicare requirements to maintain provider-based status so that they will be reimbursed under LTAC PPS. If CMS determines that facilities claiming to be provider-based and being reimbursed accordingly do not meet the integration requirements of the regulations, CMS may recover the amount of any excess reimbursements based upon that claimed status. We have several hospitals in which multiple facilities share a Medicare provider number, and the failure of any one or more of them to meet the provider-based status regulations could materially and adversely affect our business, financial position, results of operations and liquidity.

25 Percent Rule. CMS has regulations governing payments to a LTAC hospital that is a HIH. At December 31, 2013, we operated 22 HIHs with 835 licensed beds. The rules generally limit Medicare payments to the HIH if the Medicare admissions to the HIH from its co-located hospital exceed 25% of the total Medicare discharges for the HIH's cost reporting period, known as the "25 Percent Rule." There are limited exceptions for admissions from rural, urban single and a MSA Dominant hospital. Admissions that exceed this "25 Percent Rule" are paid using IPPS. Patients transferred after they have reached the short-term acute care outlier payment status are not counted toward the admission threshold. Patients admitted prior to meeting the admission threshold, as well as Medicare patients admitted from a non co-located hospital, are eligible for the full payment under LTAC PPS. If the HIH's admissions from the co-located hospital exceed the limit in a cost reporting period, Medicare will pay the lesser of: (1) the amount payable under LTAC PPS; or (2) the amount payable under IPPS, which likely will reduce our revenues for such admissions.

In 2007, CMS issued regulatory changes regarding Medicare reimbursement for LTAC hospitals (the "2007 Final Rule") which expanded the policy known as the "25 Percent Rule" to all LTAC hospitals, regardless of whether they are a HIH. Under the 2007 Final Rule, all LTAC hospitals were to be paid LTAC PPS rates for admissions from a single referral source up to 25% of aggregate Medicare admissions. Patients reaching high cost outlier status in the short-term hospital were not to be counted when computing the 25% limit. Admissions beyond the 25% threshold were to be paid at a lower amount based upon IPPS rates. However, the SCHIP Extension Act initially placed a three-year moratorium on the expansion of the "25 Percent Rule" to freestanding hospitals. That moratorium was extended to five years by the ACA. This moratorium was further extended for one additional year under the 2012 CMS Rules (as defined below). In addition, the SCHIP Extension Act initially provided for a three-year period during which: (1) LTAC hospitals may admit up to 50% of their patients from their co-located hospitals and still be paid according to LTAC PPS; and (2) LTAC hospitals that are co-located with an urban single hospital or a MSA Dominant hospital may admit up to 75% of their patients from such urban single hospital or MSA Dominant hospital and still be paid according to LTAC PPS. Those periods also were extended to five years under the ACA and for one additional year under the 2012 CMS Rules.

The LTAC Legislation extends the moratorium on the expansion of the "25 Percent Rule" to LTAC hospitals certified prior to October 1, 2004 for four years. LTAC hospitals certified after October 1, 2004 continue to be ineligible for relief from the "25 Percent Rule." Freestanding LTAC hospitals will not be subject to the "25 Percent Rule" payment adjustment until cost reporting periods beginning on or after July 1, 2016. In addition, for cost reporting periods beginning before October 1, 2016: (1) LTAC hospitals may admit up to 50% of their patients from a co-located hospital and still be paid according to LTAC PPS; and (2) LTAC hospitals that are co-located with an urban single hospital or a MSA Dominant hospital may admit up to 75% of their patients from such urban single or MSA Dominant hospital and still be paid according to LTAC PPS. The LTAC Legislation further provides that co-located LTAC hospitals certified on or before September 30, 1995 are exempt from the provisions of the "25 Percent Rule." The LTAC Legislation also mandates that the Secretary of the HHS report to Congress by July 1, 2015 on whether the "25

Percent Rule" should continue to be applied.

SCHIP Extension Act; Development Moratoriums. On December 29, 2007, the SCHIP Extension Act became law. This legislation provided for, among other things: (1) a three-year moratorium on the establishment of new LTAC hospitals or satellite facilities or increases in the number of licensed beds at a LTAC hospital or satellite facility; and (2) a three-year moratorium on the application of a one-time budget neutrality adjustment to payment rates to LTAC hospitals under LTAC PPS.

The ACA extended the moratoriums on the establishment of new LTAC hospitals or satellites and bed increases at LTAC hospitals or satellites, the application of a one-time budget neutrality adjustment to rates, and the payment reductions due to the very short-stay outlier provisions from three years to five years. These moratoriums expired on December 29, 2012. As discussed below, the 2012 CMS Rules began a three-year phase-in of a 3.75% budget neutrality adjustment which reduced LTAC hospital rates by 1.3% in 2013.

The LTAC Legislation will impose a new moratorium beginning on January 1, 2015 and continuing through September 30, 2017 on the establishment and classification of new LTAC hospitals, LTAC satellite facilities and LTAC beds in existing LTAC hospitals or satellite hospitals. This moratorium will limit our ability to increase LTAC bed capacity, expand into new areas or increase bed capacity in existing markets that we serve.

Other recent Medicare rate changes

On August 1, 2011, CMS issued final regulations regarding Medicare reimbursement for LTAC hospitals for the fiscal year beginning October 1, 2011. Included in the final regulations is: (1) a market basket increase to the standard federal payment rate of 2.9%; (2) offsets to the standard federal payment rate mandated by the ACA of: (a) 1.0% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.99775 applied to the adjusted standard federal payment rate; (4) adjustments to area wage indexes; and (5) a decrease in the high cost outlier threshold per discharge to $17,931.

On August 1, 2012, CMS issued final rules (the "2012 CMS Rules") which, among other things, reduced Medicare reimbursement to our TC hospitals in 2013 and beyond by imposing a budget neutrality adjustment and modifying the short-stay outlier rules. Included in the 2012 CMS Rules are: (1) a market basket increase to the standard federal payment rate of 2.6%; (2) offsets to the standard federal payment rate mandated by the ACA of: (a) 0.7% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.999265 applied to the adjusted standard federal payment rate; (4) adjustments to area wage indexes; and (5) a decrease in the high cost outlier threshold per discharge to $15,408. Effective December 29, 2012, the 2012 CMS Rules (1) began a three-year phase-in of a 3.75% budget neutrality adjustment which will reduce LTAC hospital rates by approximately 1.3% in each of 2013, 2014 and 2015; and (2) restored a payment reduction that will limit payments for very short-stay outliers that will reduce our TC hospital payments by approximately 0.5%.

On August 2, 2013, CMS issued final regulations regarding Medicare reimbursement for LTAC hospitals for the federal fiscal year beginning October 1, 2013. Included in the final regulations are: (1) a market basket increase to the standard federal payment rate of 2.5%; (2) offsets to the standard federal payment rate mandated by the ACA of: (a) 0.5% to account for the effect of a productivity adjustment, and (b) 0.3% as required by statute; (3) a wage level budget neutrality factor of 1.0010531 applied to the adjusted standard federal payment rate; (4) adjustments to area wage indexes; and (5) a decrease in the high cost outlier threshold per discharge to $13,314. In addition, the final regulations also implement the second year of a three-year phase-in of the 3.75% budget neutrality adjustment which will reduce LTAC hospital rates by 1.3% in 2014. CMS has projected the impact of these changes will result in a 1.3% increase to average Medicare payments to LTAC hospitals.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

The ACA requires a quality reporting system for LTAC hospitals beginning in federal fiscal year 2014 under which any market basket update would be reduced by 2% for any LTAC hospital that does not meet the quality reporting standards. CMS has issued final regulations that require LTAC hospitals to report quality measures related to, among other things, catheter-associated urinary tract infections, central line associated blood stream infections, new or worsening pressure ulcers, unplanned re-admissions and falls with major injury.

The Job Creation Act of 2012 (the "Job Creation Act") provides for reductions in reimbursement of Medicare bad debts at our hospitals and nursing centers. For the hospitals, the bad debt reimbursement rate of 70% for all bad debts was lowered to 65% effective for cost reporting periods beginning on or after October 1, 2012.

The LTAC PPS system is subject to significant change. Slight variations in patient acuity or length of stay could significantly change Medicare revenues generated under LTAC PPS. In addition, our TC hospitals may not be able to appropriately adjust their operating costs to changes in patient acuity and length of stay or to changes in reimbursement rates. In addition, we cannot assure you that LTAC PPS will not have a material adverse effect on revenues from commercial third party payors. Various factors, including a reduction in average length of stay, have negatively impacted revenues from commercial third party payors in recent years.

Overview of inpatient rehabilitation hospitals reimbursement

Our IRFs receive fixed payment reimbursement amounts per discharge under the inpatient rehabilitation facility prospective payment system ("IRF-PPS") based upon certain rehabilitation impairment categories established by HHS. Under the IRF-PPS, CMS is required to adjust the payment rates based upon a market basket index, known as the rehabilitation, psychiatric, and long-term care hospital market basket. The market basket update is designed to reflect changes over time in the prices of a mix of goods and services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units.

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for IRF providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to IRFs. In 2004, CMS issued a final rule, known as the "75% Rule," stipulating that to qualify as an IRF under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any IRF that failed to meet its requirements would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. The SCHIP Extension Act reduced the compliance

threshold to 60% instead of 75% and allowed hospitals to continue using a patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitative care under the rule.

On July 29, 2011, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning October 1, 2011. Included in these final regulations are (1) a market basket increase to the standard payment conversion factor of 2.9%; (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) 1.0% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.9988 applied to the standard payment conversion factor; (4) a case mix group budget neutrality factor of 0.9988 applied to the standard payment conversion factor; (5) adjustments to area wage indexes; and (6) a decrease in the high cost outlier threshold per discharge to $10,660.

On July 25, 2012, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning October 1, 2012. Included in these final regulations are: (1) a market basket increase to the standard payment conversion factor of 2.7%; (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) 0.7% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) adjustments to area wage indexes; and (4) a decrease in the high cost outlier threshold per discharge to $10,466.

On July 31, 2013, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning October 1, 2013. Included in these final regulations are: (1) a market basket increase to the standard payment conversion factor of 2.6%; (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) 0.5% to account for the effect of a productivity adjustment, and (b) 0.3% as required by statute; (3) adjustments to area wage indexes; and (4) a decrease in the high cost outlier threshold per discharge to $9,272. CMS has projected the impact of these changes will result in a 2.3% increase to average Medicare payments to IRFs.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

Similar to LTAC hospitals, the ACA requires a quality reporting system for IRFs beginning in fiscal year 2014 in which any market basket update would be reduced by 2% for any IRF that does not meet quality reporting standards. CMS has finalized regulations that required IRFs to report measures related to, among other things, catheter-associated urinary tract infections, pressure ulcers, and unplanned re-admissions.

The Job Creation Act provides for reductions in reimbursement of Medicare bad debts. For the hospitals, the bad debt reimbursement rate of 70% for all bad debts was lowered to 65% effective for cost reporting periods beginning on or after October 1, 2012.

Medicaid reimbursement of LTAC hospitals and IRFs – The Medicaid program is designed to provide medical assistance to individuals unable to afford care. Medicaid payments are made under a number of different systems, which include cost-based reimbursement, prospective payment systems or programs that negotiate payment levels with individual hospitals. Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by state agencies and certain government funding limitations, all of which may increase or decrease the level of payments to our hospitals.

Non-government payments – The hospital division seeks to maximize the number of non-government payment patients admitted to its hospitals, including those covered under commercial insurance and managed care health plans. Non-government payment patients typically have financial resources (including insurance coverage) to pay for their services and do not rely on government programs for support. It is important to our business to establish relationships with commercial insurers, managed care health plans and other private payors and to maintain our reputation with such payors as a provider of quality patient care. We negotiate contracts with purchasers of group healthcare services,

including private employers, commercial insurers and managed care companies. Some payor organizations attempt to obtain discounts from established charges. We focus on demonstrating to these payors how our services can provide them and their customers with the most viable pricing arrangements in circumstances where they may otherwise be faced with funding treatment at higher rates at other healthcare providers. The importance of obtaining contracts with commercial insurers, managed care health plans and other private payors varies among markets, depending on such factors as the number of commercial payors and their relative market strength. Failure to obtain contracts with certain commercial insurers and managed care health plans or reductions in the lengths of stay or payments for our services provided to individuals covered by commercial insurance could have a material adverse effect on our business, financial position, results of operations and liquidity.

Nursing center division

General regulations. The development and operation of nursing centers and the provision of healthcare services are subject to federal, state and local laws relating to the adequacy of medical care, equipment, personnel, operating policies, fire prevention, rate-setting and compliance with building codes and environmental laws. Nursing centers are subject to periodic inspection by

governmental and other authorities to ensure continued compliance with various standards, continued licensing under state law, certification under the Medicare and Medicaid programs and continued participation in the Veterans Administration program.

In addition to general regulations, the nursing center division also is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit, among other things, certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services and prohibit referrals from physicians that have certain financial relationships with the provider. Such laws include the Anti-Kickback Statute, the Stark Law and the FCA. In addition, some states restrict certain business relationships between physicians and ancillary service providers and some states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in reimbursement programs, as well as civil and criminal penalties. These laws vary considerably from state to state.

In certain circumstances, federal law mandates that conviction for certain abusive or fraudulent behavior with respect to one nursing center may subject other facilities under common control or ownership to disqualification from participation in the Medicare and Medicaid programs. In addition, some regulations provide that all nursing centers under common control or ownership within a state are subject to being delicensed if any one or more of such facilities are delicensed.

The failure to obtain, maintain or renew any required regulatory approvals or licenses could adversely affect nursing center division operations including its financial results.

Licensure and requirements for participation. The nursing centers operated and managed by the nursing center division are licensed either on an annual or bi-annual basis and generally are certified annually for participation in Medicare and Medicaid programs through various regulatory agencies that determine compliance with federal, state and local laws. These legal requirements relate to compliance with the laws and regulations governing the operation of nursing centers including the quality of nursing care, the qualifications of the administrative and nursing personnel, and the adequacy of the physical plant and equipment. Federal regulations determine the survey process for nursing centers that is followed by state survey agencies. The state survey agencies recommend to CMS the imposition of federal sanctions and impose state sanctions on facilities for noncompliance with certain requirements. Available sanctions include, but are not limited to, imposition of civil monetary penalties, temporary suspension of payment for new admissions, appointment of a temporary manager, suspension of payment for eligible patients and suspension or decertification from participation in the Medicare and Medicaid programs.

We believe that substantially all of our nursing centers are in substantial compliance with applicable Medicare and Medicaid requirements of participation. In the ordinary course of business, however, our nursing centers periodically receive statements of deficiencies from regulatory agencies. In response, the nursing centers implement plans of correction to address the alleged deficiencies. In most instances, the regulatory agency accepts the nursing center’s plan of correction and places the nursing center back into compliance with regulatory requirements. In some cases, the regulatory agency may take a number of adverse actions against a nursing center, including the imposition of fines, temporary suspension of payment for admission of new residents to the nursing center, decertification from participation in the Medicaid and/or Medicare programs and, in extreme circumstances, revocation of the nursing center’s license.

Overview of nursing center division reimbursement

Medicare – The Medicare Part A program provides reimbursement for extended care services furnished to Medicare beneficiaries who are admitted to nursing centers after at least a three-day stay in an acute care hospital. Covered services include supervised nursing care, room and board, social services, physical, speech and occupational therapies, certain pharmaceuticals and supplies and other necessary services provided by nursing centers. Medicare payments to our nursing centers are based upon certain resource utilization grouping ("RUG") payment rates developed by CMS that provide various levels of reimbursement based upon patient acuity.

The Balanced Budget Act established a Medicare prospective payment system ("PPS") for nursing centers in 1998. The payments received under PPS cover substantially all services for Medicare residents including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals.

Medicare Part B provides reimbursement for certain physician services, limited drug coverage and other outpatient services, such as therapy and other services, outside of a Medicare Part A covered patient stay. Payment for these services is determined according to the MPFS. Annually since 1997, the MPFS has been subject to the SGR, which is intended to keep spending growth in line with allowable spending. Each year since the SGR was enacted, this adjustment produced a scheduled negative update to payment for physicians, therapists and other healthcare providers paid under the MPFS. Annually, since 2002, Congress has stepped in with so-called "doc fix" legislation to suspend payment cuts to physicians. Subsequent legislation annually suspended the payment cut. The SGR Reform Act further suspended the payment cut until March 31, 2014.

Since 2006, federal legislation has provided for an annual Medicare Part B outpatient therapy cap. In succeeding years, CMS increased the amount of the therapy cap. Legislation also was passed that required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. Legislation has annually extended the Medicare Part B outpatient therapy cap exception process. The SGR Reform Act further extended the therapy cap exception process through March 31, 2014. Patients in our facilities whose stay is not reimbursed by Medicare Part A must seek reimbursement for their therapy under Medicare Part B and are subject to the therapy cap.

On January 1, 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Part D") implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit. Under Medicare Part D, dual eligible patients have their outpatient prescription drug costs covered by this new Medicare benefit, subject to certain limitations. Most of our nursing center patients whose drug costs were previously covered by state Medicaid programs are dual eligible patients who qualify for the Medicare drug benefit. Accordingly, Medicaid is no longer a primary payor for the pharmacy services provided to these residents.

Recent Medicare rate changes

In July 2010, CMS increased the number of RUG categories for nursing centers from 53 to 66 (i.e., RUGs IV) and amended the criteria, including the provision of therapy services, used to classify patients into these categories. CMS began paying claims using the RUGs IV system effective October 1, 2010. Under RUGs IV, among other requirements, providers must allocate therapy minutes among the patients being served during concurrent therapy sessions, and a therapist/assistant may treat concurrently only two patients. These changes have required us to employ more therapists to provide additional individual therapy minutes.

The therapy time requirements to qualify for rehabilitation RUG categories are unchanged under RUGs IV, however the regulatory changes altered how minutes were allocated to calculate the RUGs scores using the most recent clinical assessment tool of the minimum data set ("MDS 3.0"). Rather than count all therapy time that a nursing center patient receives, rehabilitation providers must instead allocate therapy minutes between the patients being served during concurrent therapy sessions. In addition, the number of patients that a therapist/assistant may treat concurrently is limited to two patients. Under final rules issued by CMS in 2011, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. Irrespective of the number of patients ultimately treated in a group therapy session, rehabilitation providers must allocate therapy minutes during such sessions as if four patients are being served. Our rehabilitation division hired additional therapists to facilitate the provision of additional individual minutes to address patient needs.

Effective January 1, 2011, reimbursement rates for Medicare Part B therapy services included in the MPFS were reduced by 25% of the practice expense component for subsequent procedures when multiple therapy services are provided on the same day. Effective April 1, 2013, the Taxpayer Relief Act reduced the practice expense component of Medicare payments for subsequent procedures when multiple therapy services are provided on the same day by an additional 25%. We believe that the new rules related to multiple therapy services have reduced our Medicare revenues by $25 million to $30 million on an annual basis.

On July 29, 2011, CMS issued final rules (the "2011 CMS Rules") which, among other things, impose: (1) a negative adjustment to RUGs IV therapy rates, and (2) a net market basket increase of 1.7% consisting of (a) a 2.7% market basket inflation increase, less (b) a 1.0% adjustment to account for the effect of a productivity adjustment, beginning on October 1, 2011. CMS projected the impact of these changes will result in an 11.1% decrease in payments to nursing centers. In addition to these rate changes, the 2011 CMS Rules introduced additional changes to RUG calculations along with adding additional patient assessments. Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. For purposes of assigning patients to

RUGs IV payment categories, the minutes of therapy are divided by four with 25% of the minutes being allocated to each patient. The 2011 CMS Rules also clarify the circumstances for reporting breaks in care of three or more days of therapy and also implement a new change of therapy assessment that is designed to allocate the patient to the RUG level that represents the treatment provided in the last seven days. Both changes produced alterations in the RUG scores billed for the patient and generated additional assessments. The 2011 CMS Rules have reduced our revenues on an annual basis by approximately $100 million in our nursing center business and negatively impacted our rehabilitation therapy business by approximately $50 million.

On July 27, 2012, CMS issued final regulations updating Medicare payment rates for nursing centers effective October 1, 2012. These final regulations implement a net market basket increase of 1.8% consisting of: (1) a 2.5% market basket inflation increase, less (2) a 0.7% adjustment to account for the effect of a productivity adjustment.

On July 31, 2013, CMS issued final regulations updating Medicare payment rates for nursing centers effective October 1, 2013. These final regulations implement a net market basket increase of 1.3% consisting of: (1) a 2.3% market basket inflation increase, less (2) a 0.5% adjustment to account for the effect of a productivity adjustment, and less (3) a 0.5% market basket forecast error adjustment.

In February 2012, the Middle Class Tax Relief Act of 2012 was enacted, which provides that certain Medicare Part B therapy services exceeding a threshold of $3,700 would be subject to a pre-payment manual medical review process effective October 1, 2012. The review process for these services was scheduled to expire on December 31, 2012 but was extended through December 31, 2013 under the Taxpayer Relief Act. The SGR Reform Act extended the therapy cap exception process to March 31, 2014. This review process has had an adverse effect on the provision and billing of services for patients and could negatively impact therapist productivity.

The Job Creation Act provides for reductions in reimbursement of Medicare bad debts for our nursing centers. The Job Creation Act provides for a phase-in of the reduction in the rate of reimbursement for bad debts of patients that are dually eligible for Medicare and Medicaid. The rate of reimbursement for bad debts for these dually eligible patients was reduced from 88% to 76% for cost reporting periods beginning on or after October 1, 2013 and will be reduced to 65% for cost reporting periods beginning on or after October 1, 2014. The rate of reimbursement for bad debts for patients not dually eligible for both Medicare and Medicaid was reduced from 70% to 65%, effective for cost reporting periods beginning on or after October 1, 2012. Approximately 80% of our Medicare bad debt reimbursements are associated with patients that are dually eligible.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

Medicaid – Medicaid is a state-administered program financed by state funds and matching federal funds. The program provides for medical assistance to the indigent and certain other eligible persons. Although administered under broad federal regulations, states are given flexibility to construct programs and payment methods consistent with their individual goals. Accordingly, these programs differ in many respects from state to state.

The nursing center division provides Medicaid-covered services consisting of nursing care, room and board and social services to eligible individuals. In addition, states may at their option cover other services such as physical, occupational and speech therapies and pharmaceuticals. Medicaid programs also are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may materially increase or decrease the level of program payments to nursing centers operated by the nursing center division. We believe that the payments under many of these programs may not be sufficient on an overall basis to cover the costs of serving certain patients participating in these programs. In addition, many states are experiencing budgetary pressures which have resulted in further reductions to Medicaid payments to our nursing centers.

There continue to be legislative and regulatory proposals that would impose further limitations on government and private payments to providers of healthcare services. Many states are considering or have enacted measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. As states face budgetary issues, we anticipate further pressure on Medicaid rates that could negatively impact payments to our nursing centers.

In addition, some states seek to increase the levels of funding contributed by the federal government to their Medicaid programs through a mechanism known as a provider tax. Under these programs, states levy a tax on healthcare providers, which increases the amount of state revenue available to expend on the Medicaid program. This increase in program revenues increases the payment made by the federal government to the state in the form of matching funds. Consequently, the state then has more funds available to support Medicaid rates for providers of Medicaid covered services. However, states may not necessarily use these funds to increase payments to nursing center providers. Provider tax plans are subject to approval by the federal government. Although these plans have been approved in the past, we cannot assure you that such plans will be approved by the federal government in the future.

Non-government payments – The nursing center division seeks to maximize the number of non-government payment residents admitted to our nursing centers, including those covered under private insurance and managed care health plans. Non-government payment residents typically have financial resources (including insurance coverage) to pay for their services and do not rely on government programs for support. It is important to our business to establish relationships with commercial insurers, managed care health plans and other private payors and to maintain our reputation with such payors as a provider of quality patient and resident care. We negotiate contracts with purchasers of group healthcare services, including private employers, commercial insurers and managed care companies. Most payor organizations attempt to obtain discounts from established charges. We focus on demonstrating to these payors how our services can provide them and their customers with the most viable pricing arrangements in circumstances where they may otherwise be faced with funding treatment at higher rates at other healthcare providers. The importance of obtaining contracts with commercial insurers, managed care health plans and other private payors varies among markets, depending on such factors as the number of commercial payors and their relative market strength. Failure to obtain contracts with certain commercial insurers and managed care health plans or reductions in lengths of stay or payments for our services provided to individuals covered by commercial insurance could have a material adverse effect on our business, financial position, results of operations and liquidity.

Rehabilitation division

General regulations. The rehabilitation division is subject to various federal and state regulations. Therapists and other healthcare professionals that we employ are required to be individually licensed or certified pursuant to applicable state and federal laws. We have processes in place in an effort to ensure that our therapists and other healthcare professionals are licensed or certified in accordance with applicable federal and state laws. In addition, we require our therapists and other employees to participate in continuing education programs. The failure of a therapist or other healthcare professional to obtain, maintain or renew required licenses or certifications could adversely affect a customer's and our operations, including negatively impacting our financial results.

As noted above, the rehabilitation division is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit, among other things, certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Such laws include the Anti-Kickback Statute, the Stark Law and the FCA discussed previously. In addition, some states restrict certain business relationships between physicians and ancillary service providers. Some states also prohibit for-profit corporations from providing rehabilitation services through therapists who are directly employed by the corporation or otherwise providing, or holding themselves out as a provider of, clinical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to contract with nursing centers, hospitals and other providers participating in Medicare, Medicaid and other federal healthcare programs, as well as civil and criminal penalties. These laws vary considerably from state to state.

Overview of rehabilitation division revenues

The rehabilitation division receives payment for the rehabilitation and program management services it provides to residents, patients and customers. The basis for payment varies depending upon the type of service provided. Customers in the SRS segment generally pay on the basis of a negotiated patient per diem rate or a negotiated fee schedule based upon the type of service rendered. In the HRS segment, our hospital-based inpatient rehabilitation unit customers generally pay us on the basis of a negotiated fee per discharge. Our LTAC hospital customers pay based upon a negotiated per patient day rate. Our sub-acute rehabilitation customers pay based upon a flat monthly fee or a negotiated fee per patient day. Our outpatient therapy clients typically pay us on the basis of a negotiated fee per unit of service.

As noted above, various federal and state laws and regulations govern reimbursement to nursing centers, hospitals and other healthcare providers participating in Medicare, Medicaid and other federal and state healthcare programs. Though these laws and regulations may not be directly applicable to our rehabilitation division, they are applicable to our customers. If our customers fail to comply with these laws and regulations they could be subject to possible sanctions, including loss of licensure or eligibility to participate in reimbursement programs, as well as civil and criminal penalties, which could materially and adversely affect our business, financial position, results of operations and liquidity. If our arrangements with our customers are found to violate the Anti-Kickback Statute or other fraud and abuse laws, we could be subject to criminal and civil penalties, as well as exclusion from participation in federal and state healthcare programs and potential indemnity claims by our customers. In addition, there continue to be legislative and regulatory proposals to contain healthcare costs by imposing further limitations on government and private payments to providers of healthcare services.

Medicare Part B provides reimbursement for certain physician services, limited drug coverage and other outpatient services, such as therapy and other services, outside of a Medicare Part A covered patient stay. Payment for these services is determined according to the MPFS. Annually since 1997, the MPFS has been subject to the SGR, which is intended to keep spending growth in line with allowable spending. Each year since the SGR was enacted, this

adjustment produced a scheduled negative update to payment for physicians, therapists and other healthcare providers paid under the MPFS. Annually, since 2002, Congress has stepped in with the so-called “doc fix” legislation to suspend payment cuts to physicians. Subsequent legislation annually suspended the payment cut. The Taxpayer Relief Act further suspended the payment cut until December 31, 2013. The SGR Reform Act further suspended the payment cut until March 31, 2014.

Since 2006, federal legislation has provided for an annual Medicare Part B outpatient therapy cap. In succeeding years, CMS subsequently increased the amount of the therapy cap. Legislation also was passed that required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. Legislation has annually extended the Medicare Part B outpatient therapy cap exception process. The SGR Reform Act further extended the therapy cap exception process through March 31, 2014. Patients in our facilities whose stay is not reimbursed by Medicare Part A must seek reimbursement for their therapy under Medicare Part B and are subject to the therapy cap.

The therapy time requirements to qualify for rehabilitation RUG categories are unchanged under RUGs IV applicable for nursing centers, however the regulatory changes altered how minutes were allocated to calculate the RUGs scores using MDS 3.0. Rather than count all therapy time that a nursing center patient receives, rehabilitation providers must now allocate therapy minutes between the patients being served during concurrent therapy sessions. In addition, the number of patients that a therapist/assistant may treat concurrently is limited to two patients. Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. Irrespective of the number of patients ultimately treated in a group therapy session, rehabilitation providers must allocate therapy minutes during such sessions as if four patients are being served. Our rehabilitation division hired additional therapists to facilitate the provision of additional individual minutes to address patient needs.

Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. In addition, for purposes of assigning patients to RUGs IV payment categories, the minutes of therapy are divided by four with 25% of the minutes being allocated to each patient. The 2011 CMS Rules also clarify the circumstances for reporting breaks in care of three or more days of therapy and also implement a new change of therapy assessment that is designed to allocate the patient to the RUG level that represents the treatment provided in the last seven days. Both changes produced alterations in the RUG scores billed for the patient and generated additional assessments. The 2011 CMS Rules have reduced our revenues on an annual basis by approximately $100 million in our nursing center business and negatively impacted our rehabilitation therapy business by approximately $50 million.

Effective January 1, 2011, reimbursement rates for Medicare Part B therapy services included in the MPFS were reduced by 25% of the practice expense component for subsequent procedures when multiple therapy services are provided on the same day. Effective April 1, 2013, the Taxpayer Relief Act further reduced the practice expense component of Medicare payments for subsequent procedures when multiple therapy services are provided on the same day by an additional 25%. We believe that the new rules related to multiple therapy services have reduced our Medicare revenues from $25 million to $30 million on an annual basis.

In February 2012, the Middle Class Tax Relief Act of 2012 was enacted, which provides that certain Medicare Part B therapy services exceeding a threshold of $3,700 would be subject to a pre-payment manual medical review process effective October 1, 2012. The review process for these services was scheduled to expire on December 31, 2012 but was extended through December 31, 2013 under the Taxpayer Relief Act. The SGR Reform Act extended the therapy cap exception process to March 31, 2014. This review process has had an adverse effect on the provision and billing of services for patients and could negatively impact therapist productivity.

Reductions in the reimbursement provided to our customers by Medicare or Medicaid could negatively impact the demand and price for our services, impair our ability to collect for our services from customers and could have a material adverse effect on our rehabilitation revenues and growth prospects.

Although reductions or changes in reimbursement from governmental or third party payors and regulatory changes affecting our business represent one of the most significant challenges to our business, our operations are also affected by coverage rules and determinations. Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. Current CMS coverage rules require inpatient rehabilitation services to be ordered by a qualified rehabilitation physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide required rehabilitation nursing, physical therapy, occupational therapy, speech language pathology, social services, psychological services, and prosthetic and orthotic services. CMS has also noted that it is considering specific standards governing the use of group therapies. For individual claims, Medicare contractors make coverage determinations regarding medical

necessity which can represent more restrictive interpretations of the CMS coverage rules. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

Care management division

General regulations. The activities of the care management division primarily consist of the provision of home health and hospice healthcare services. The home health and hospice activities conducted through the care management division are subject to various federal and state regulations. Many states require the entity through which the care management division's home health and hospice services are provided to obtain a license or certification from one or more state agencies. In addition, a substantial majority of our home health and hospice agencies achieved and/or maintain certification through the Medicare deeming authority of one of the three private accreditation bodies: the Joint Commission, the Accreditation Commission for Health Care, and the Community Health Accreditation Program. The physicians, therapists and other healthcare professionals employed by the care management division are required to be individually licensed or certified pursuant to applicable state and federal laws. We have processes in place to ensure that our care management division providers are licensed or certified in accordance with applicable federal and state laws. In addition, we require our physicians, therapists and other employees to participate in continuing education programs. The failure to obtain, maintain or renew required licenses or certifications by our home health and hospice agencies or the physicians, therapists or other healthcare professionals employed through the care management division could have a material adverse effect on our business, financial position, results of operations and liquidity.

As noted above, the care management division also is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit, among other things, certain direct and indirect payments for the referral of patients, certain referrals by physicians if they or their immediate family members have a financial relationship with a home health or hospice agency or other provider, or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Such laws include the Anti-Kickback Statute, the Stark Law, the FCA and various state anti-kickback laws and physician self-referral prohibitions. In addition, some states restrict certain business relationships between physicians and ancillary service providers and some states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in Medicare, Medicaid and other reimbursement programs, as well as civil and criminal penalties. These laws vary considerably from state to state.

Overview of care management division reimbursement

Medicare

Home health. To be eligible to receive Medicare payments for home health services, a patient must be "homebound" (cannot leave home without considerable or taxing effort), require periodic skilled nursing or physical or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician based upon a face-to-face encounter between the patient and the physician.

We receive a standard prospective payment for home health services provided over a base 60-day period, or "episode," of care. There is no limit to the number of episodes a patient may receive as long as he or she remains Medicare eligible. The base episode payment is a flat rate subject to adjustment based upon differences in the expected needs of each patient and upon the geographic location of the services provided. The adjustment is determined by each patient's categorization into one of 153 payment groups, known as home health resource groups, and the cost of care for patients in each group relative to the average patient. Payment is further adjusted for differences in local prices using the hospital wage index. The payment also is subject to retroactive adjustment in certain circumstances, including: (1) an outlier adjustment if the patient's care was unusually costly; (2) a utilization adjustment if the number of visits to the patient was less than five; (3) a partial payment adjustment if the patient transferred to another provider during an

episode; (4) an adjustment based upon the level of required therapy services; and (5) an adjustment based upon the number of episodes of care, with episodes three and higher receiving an increased rate.

On November 4, 2011, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2012. These final regulations implement a net market basket increase of 1.4% consisting of: (1) a 2.4% market basket inflation increase, less (2) a 1.0% adjustment mandated by the ACA. In addition, CMS implemented a 3.79% reduction in case mix.

On November 2, 2012, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2013. These final regulations implement a net market basket increase of 1.3% consisting of: (1) a 2.3% market basket inflation increase, less (2) a 1.0% adjustment mandated by the ACA. In addition, CMS implemented a 1.32% reduction in case mix.

On November 22, 2013, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2014. These final regulations implement a net 1.05% reduction consisting of a 2.3% market basket inflation increase, less (1) a 0.62% ICD-9 grouper refinement, and (2) a 2.73% rebasing adjustment mandated under the ACA. Rebasing the rates includes adjustments to the 60-day episode and per visit payment rates, the non-national medical supply conversion factor and low utilization payment factors. The rebasing is expected to reduce payment rates by 2.8% in each of the next four years, beginning January 1, 2014.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

Hospice. To be eligible to receive hospice care under the Medicare program, a patient must have a terminal illness, as certified by two physicians, with a life expectancy of six months or less. The patient must affirmatively elect hospice treatment to the exclusion of other Medicare benefits related to his or her condition.

We receive payment for our hospice services under Medicare through a prospective payment system that pays an established payment rate for each day that we provide hospice services to a Medicare eligible patient. The rates we receive from Medicare are subject to annual adjustments for inflation and vary based upon the geographic location of the services provided. The rate also varies depending upon which of four established levels of care we provide to the Medicare patient: (1) "routine home care," which is the default level paid for each day a patient is in the hospice program and does not receive one of the higher levels of care; (2) "general inpatient care," which is paid when a patient needs inpatient services for pain or symptom management for a brief period; (3) "continuous home care," which is home care provided during a crisis period when the patient requires intensive monitoring and nursing care; and (4) "respite care," which allows a patient to receive inpatient care for a short period to provide relief for the patient's family and other care givers from the demands of providing care for up to five consecutive days.

The Medicare payments we receive for hospice care are subject to two caps. First, there is the "80-20 Rule" providing that if the number of inpatient care days furnished to Medicare patients exceeds 20% of the total days of hospice care (measured during a 12-month period ending October 31 of each year) provided to Medicare patients, the excess is only eligible for the "routine home care" rate. Second, there is a cap based upon an overall average payment per Medicare beneficiary. Any payments exceeding the cap must be refunded to Medicare.

On July 24, 2012, CMS issued final regulations regarding Medicare payment rates for hospice providers effective October 1, 2012. These final regulations implement a net market basket increase of 1.6% consisting of: (1) a 2.6% market basket inflation increase, less (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) a 0.7% adjustment to account for the effect of a productivity adjustment, and (b) 0.3% as required by statute. CMS has projected the impact of these changes will result in a 0.9% increase in payments to hospice providers.

On August 2, 2013, CMS issued final regulations regarding Medicare payment rates for hospice providers effective October 1, 2013. These final regulations implement a net market basket increase of 1.7% consisting of: (1) a 2.5% market basket inflation increase, less (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) a 0.5% adjustment to account for the effect of a productivity adjustment, and (b) 0.3% as required by statute. In addition, CMS continued the phase-out of the wage index budget neutrality adjustment. CMS has projected the impact of these changes will result in a 1.0% increase in payments to hospice providers.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

Medicaid – Medicaid reimburses home health and hospice providers, physicians, and certain other health care providers for care provided to certain low income patients. Reimbursement varies from state to state and is based upon a number of different systems including cost-based, prospective payment and negotiated rate systems. Rates are subject to multiple adjustments in different circumstances and are subject to statutory and regulatory changes and interpretations and rulings by individual state agencies.

Non-government payments – The care management division seeks to maximize the number of its non-government payment patients, including those covered under private insurance and managed care health plans. Non-government payment patients typically have financial resources (including insurance coverage) to pay for their services and do not

rely upon government programs for support. We negotiate contracts with purchasers of group healthcare services, including private employers, commercial insurers and managed care companies. Most payor organizations attempt to obtain discounts from established charges. We focus on demonstrating to these payors how our services can provide them and their customers with the most viable pricing arrangements in circumstances where they may otherwise be faced with funding treatments at higher rates at other healthcare providers. The importance of obtaining contracts with commercial insurers, managed care health plans and other private payors varies among markets, depending on such factors as the number of commercial payors and their relative market strength.

MASTER LEASE AGREEMENTS

At December 31, 2013, we leased from Ventas and its affiliates 38 TC hospitals and 105 nursing centers under five master lease agreements (as amended, the “Master Lease Agreements”). Included in the 105 nursing centers leased at December 31, 2013 are the 2013 Expiring Facilities, all of which have lease terms expiring on September 30, 2014. For accounting purposes, the 2013 Expiring

Facilities qualify as assets held for sale and we reflected the operating results as discontinued operations in the accompanying consolidated statement of operations for all historical periods.

Term and Renewals

Each Master Lease Agreement includes land, buildings, structures and other improvements on the land, easements and similar appurtenances to the land and improvements, and permanently affixed equipment, machinery and other fixtures relating to the operation of the leased properties. There are several bundles of leased properties under each Master Lease Agreement, with each bundle containing approximately seven to 19 leased nursing centers and/or TC hospitals.

2012 lease renewals and expirations

Under the Master Lease Agreements, we had 73 nursing centers and 16 TC hospitals eligible for renewal prior to an April 30, 2013 lease expiration date. In April 2012, we renewed the leases for 19 nursing centers and six TC hospitals for an additional five years. In May 2012, we entered into a fifth Master Lease Agreement with Ventas to extend the lease term for ten years for ten TC hospitals that were otherwise scheduled to expire on April 30, 2013 (“Master Lease No. 5”). These 19 nursing centers and 16 TC hospitals contain 2,178 licensed nursing center beds and 1,682 licensed hospital beds.

In addition, we did not renew 54 nursing centers that comprised the 2012 Expiring Facilities. The 2012 Expiring Facilities contained 6,140 licensed nursing center beds and generated revenues of approximately $475 million for the year ended December 31, 2012. The annual rent for these facilities approximated $57 million. We transferred the operations of all of the 2012 Expiring Facilities to new operators during 2013 and have accordingly reclassified the results of operations and losses associated with the 2012 Expiring Facilities to discontinued operations, net of income taxes, for all periods presented.

2013 lease renewals and expirations

Under the Master Lease Agreements, we had 86 nursing centers and 22 TC hospitals eligible for renewal prior to an April 30, 2015 lease expiration date. On September 30, 2013, we entered into an agreement with Ventas to renew the leases for 26 nursing centers and 22 TC hospitals (previously defined as the 2013 Renewal Facilities) as follows:

- the leases for 15 nursing centers and three TC hospitals were renewed for an additional five year term effective May 1, 2015, with annual rents increasing by $4 million on October 1, 2014 and otherwise subject to rent escalators found in the original Master Lease Agreements; and
- the leases for 11 nursing centers and 19 TC hospitals will be moved to an amended and restated Master Lease No. 5 (“Amended Master Lease No. 5”) and renewed for a ten year, seven month term effective October 1, 2014, with annual rents under Amended Master Lease No. 5 increasing by $11 million on October 1, 2014 and otherwise subject to annual increases (up to a 4% cap) based on changes in the Consumer Price Index.

For accounting purposes, we began recording the additional rents over the new lease term on a straight-line basis beginning on October 1, 2013, the effective date of the agreements.

The 2013 Renewal Facilities contain 3,134 licensed nursing center beds and 1,753 licensed hospital beds and generated revenues of approximately $811 million for the year ended December 31, 2013. The current aggregate annual rent, before the rent increases noted above, for the 2013 Renewal Facilities approximates $79 million.

On September 30, 2013, we also entered into an agreement with Ventas that provided for (1) the non-renewal of 60 nursing centers that comprise the 2013 Expiring Facilities, with lease terms ending on September 30, 2014 rather than

their original April 30, 2015 termination date, (2) more flexibility to Ventas to accelerate the transfer of the 2013 Expiring Facilities, (3) a $20 million payment by us to Ventas as part of this transaction that is recorded as an early lease termination charge (rent expense) in discontinued operations in 2013, and (4) the settlement of other matters between the parties.

The 2013 Expiring Facilities contain 7,070 licensed beds and generated revenues of approximately $514 million for the year ended December 31, 2013. The current aggregate annual rent for the 2013 Expiring Facilities approximates $60 million. We have reclassified the results of operations and losses associated with the 2013 Expiring Facilities to discontinued operations, net of income taxes, for all periods presented.

Except as noted below, the terms of Amended Master Lease No. 5 are substantially similar to the terms of the other Master Lease Agreements.

Renewals

Following the exit of the 2013 Expiring Facilities, we will lease 45 nursing centers and 38 TC hospitals from Ventas within eight separate renewal bundles. Each bundle may be renewed for at least one five-year renewal term, provided notice of renewal is provided between 12 and 18 months prior to the expiration of the lease term. The following chart sets forth the current lease renewals under the Master Lease Agreements:

| Renewal group | Master leases | Expiration date | Renewal date | Facility renewals Nursing centers | Facility renewals TC hospitals | Renewal bundles |
|---|---|---|---|---|---|---|
| Group 1 | 1, 2, 4 | April 30, 2018 | October 31, 2016 – April 29, 2017 | 19 | 6 | 3 |
| Group 2 | 1, 2 | April 30, 2020 | October 31, 2018 – April 29, 2019 | 15 | 3 | 2 |
| Group 3 | 5 | April 30, 2023 | October 31, 2021 – April 29, 2022 | – | 10 | 1 |
| Group 4 | 5 | April 30, 2025 | October 31, 2023 – April 29, 2024 | 11 | 19 | 2 |

Conditions to effectiveness of renewals

We may not extend the Master Lease Agreements beyond any previously exercised renewal term if, at the time we seek such extension and at the time such extension takes effect: (1) an event of default has occurred and is continuing or (2) a Medicare/Medicaid event of default (as described below) and/or a licensed bed event of default (as described below) has occurred and is continuing with respect to one, two or three leased properties, depending on the number of leased properties under a particular Master Lease Agreement. The renewal term of each Master Lease Agreement is subject to termination upon default by us and certain other conditions described in the Master Lease Agreements.

Rent appraisal process and our right to revoke such renewals

Under the Master Lease Agreements, if we provide Ventas with notice that we intend to renew one or more renewal bundles, Ventas may then initiate an appraisal process to establish a new fair market rental (as defined in the Master Lease Agreements) (“FMR”) for any or all of these bundles.

Under the appraisal process, an independent appraiser determines the FMR for each renewal bundle and each property within such renewal bundle. Once FMR is determined, the appraiser sends to both parties simultaneously the aggregate FMR for such renewal bundle and the FMR for each property within the bundle. Ventas, in its sole discretion, then determines whether: (1) to accept the appraised FMR for the renewal bundle in the aggregate or (2) make no changes to the current base rent and contingent annual rent escalator for the renewal bundle. If Ventas selects the new FMR for a renewal bundle, then the new FMR would become effective at the start of the renewal term unless we elect to revoke our renewal by the applicable deadline set forth in the Master Lease Agreements.

The determination of FMR requires certain levels of subjectivity and judgment related to the many variables that may be considered under the circumstances. As a result, it is important for investors to consider the possibility of a wide range of outcomes with respect to the appraisal process.

Rental Amounts and Escalators

Each Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. Accordingly, in addition to rent, we are required to pay the following: (1) all insurance required in connection with the leased properties and the business conducted on the leased properties, (2) certain taxes levied on or with respect to the leased

properties (other than taxes on the income of Ventas) and (3) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

We paid rents to Ventas (including amounts classified within discontinued operations) approximating $248 million for the year ended December 31, 2013, $260 million for the year ended December 31, 2012 and $253 million for the year ended December 31, 2011.

Each Master Lease Agreement provides for rent escalations each May 1 if the patient revenues for the leased properties meet certain criteria as measured using the preceding calendar year revenues as compared to the base period. All annual rent escalators are payable in cash. The contingent annual rent escalator is 2.7% for Master Lease Agreements Nos. 1, 3 and 4. The contingent annual rent escalator for Master Lease Agreement No. 2 is based upon the Consumer Price Index with a floor of 2.25% and a ceiling of 4%.

In 2013, the contingent annual rent escalator for Master Lease Agreement No. 2 was 2.25%. Beginning the second full year of the lease term, the contingent annual rent escalator for Amended Master Lease No. 5 is based on the percentage increase, if any, in the Consumer Price Index, subject to a ceiling of 4%.

Restrictive Covenants under Amended Master Lease No. 5

Pursuant to the provisions of Amended Master Lease No. 5, we may not (1) develop any additional TC hospitals within a ten-mile radius of each of the TC hospitals subject to Amended Master Lease No. 5, (2) develop any additional nursing centers within a five-mile radius of each of the nursing centers subject to Amended Master Lease No. 5, or (3) increase the number of licensed beds at TC hospitals or nursing centers that are within the restricted areas and not leased to us by Ventas under Amended Master Lease No. 5. We are not restricted, however, from acquiring operating TC hospitals or nursing centers within (or outside of) the restricted areas.

Events of Default

Under each Master Lease Agreement, an "Event of Default" will be deemed to occur if, among other things:

- we fail to pay rent or other amounts within five days after notice,
- we fail to comply with covenants, which failure continues for 30 days or, so long as diligent efforts to cure such failure are being made, such longer period (not over 180 days) as is necessary to cure such failure,
- certain bankruptcy or insolvency events occur, including filing a petition of bankruptcy or a petition for reorganization under the bankruptcy code,
- an event of default arises from our failure to pay principal or interest on any indebtedness exceeding $50 million,
- the maturity of any indebtedness exceeding $50 million is accelerated,
- we cease to operate any leased property as a provider of healthcare services for a period of 30 days,
- a default occurs under any guaranty of any lease or the indemnity agreements with Ventas,
- we or our subtenant lose any required healthcare license, permit or approval or fail to comply with any legal requirements as determined by a final unappealable determination,
- we fail to maintain insurance,
- we create or allow to remain certain liens,
- we breach any material representation or warranty,
- a reduction occurs in the number of licensed beds in a facility, generally in excess of 10% (or less than 10% if we have voluntarily "banked" licensed beds) of the number of licensed beds in the applicable facility on the commencement date (a "licensed bed event of default"),
- Medicare or Medicaid certification with respect to a participating facility is revoked and re-certification does not occur for 120 days (plus an additional 60 days in certain circumstances) (a "Medicare/Medicaid event of default"),
- we become subject to regulatory sanctions as determined by a final unappealable determination and fail to cure such regulatory sanctions within the specified cure period for any facility,
- we fail to cure a breach of any permitted encumbrance within the applicable cure period and, as a result, a real property interest or other beneficial property right of Ventas is at material risk of being terminated, or
- we fail to cure the breach of any of the obligations of Ventas as lessee under any existing ground lease within the applicable cure period and, if such breach is a non-monetary, non-material breach, such existing ground lease is at material risk of being terminated.

Under Amended Master Lease No. 5, an "Event of Default" shall also be deemed to occur upon our failure to cure any violation of the restrictive covenants applicable to Amended Master Lease No. 5, as set forth above. In addition to any remedies set forth below, Ventas may seek injunctive relief or specific or equitable performance upon our breach of these restrictive covenants.

Remedies for an Event of Default

Upon an Event of Default under one of the Master Lease Agreements, Ventas may, at its option, exercise the following remedies:

(1) after not less than ten days notice to us, terminate the Master Lease Agreement to which such Event of Default relates, repossess any leased property, relet any leased property to a third party and require that we pay Ventas, as liquidated damages, the net present value of the rent for the balance of the term, discounted at the prime rate,

(2) without terminating the Master Lease Agreement to which such Event of Default relates, repossess the leased property and relet the leased property with us remaining liable under such Master Lease Agreement for all obligations to be performed by us thereunder, including the difference, if any, between the rent under such Master Lease Agreement and the rent payable as a result of the reletting of the leased property, and

(3) seek any and all other rights and remedies available under law or in equity.

In addition to the remedies noted above, under the Master Lease Agreements, in the case of a facility-specific event of default, Ventas may terminate a Master Lease Agreement as to the leased property to which the Event of Default relates, and may, but need not, terminate the entire Master Lease Agreement. Each of the Master Lease Agreements includes special rules relative to Medicare/Medicaid events of default and a licensed bed event of default. In the event a Medicare/Medicaid event of default and/or a licensed bed event of default occurs and is continuing: (1) with respect to not more than two properties at the same time under a Master Lease Agreement that covers 41 or more properties and (2) with respect to not more than one property at the same time under a Master Lease Agreement that covers 21 to and including 40 properties, Ventas may not exercise termination or dispossession remedies against any property other than the property or properties to which the event of default relates. Thus, in the event Medicare/Medicaid events of default and licensed bed events of default would occur and be continuing: (1) with respect to one property under a Master Lease Agreement that covers less than 20 properties, (2) with respect to two or more properties at the same time under a Master Lease Agreement that covers 21 to and including 40 properties, or (3) with respect to three or more properties at the same time under a Master Lease Agreement that covers 41 or more properties, then Ventas would be entitled to exercise all rights and remedies available to it under the Master Lease Agreements.

Assignment and Subletting

Except as noted below, the Master Lease Agreements provide that we may not assign, sublease or otherwise transfer any leased property or any portion of a leased property as a whole (or in substantial part), including by virtue of a change of control, without the consent of Ventas, which may not be unreasonably withheld if the proposed assignee: (1) is a creditworthy entity with sufficient financial stability to satisfy its obligations under the related Master Lease Agreement, (2) has not less than four years experience in operating healthcare facilities for the purpose of the applicable facility’s primary intended use, (3) has a favorable business and operational reputation and character, and (4) has all licenses, permits, approvals and authorizations to operate the facility and agrees to comply with the use restrictions in the related Master Lease Agreement. Amended Master Lease No. 5 excludes certain change of control transactions from the transfer restrictions that are otherwise applicable to us. Such exclusions apply only to Amended Master Lease No. 5 and the transfer restrictions applicable under the other Master Lease Agreements remain in effect.

The obligation of Ventas to consent to a subletting or assignment is subject to the reasonable approval rights of any mortgagee and/or the lenders under its credit agreement. We may sublease up to 20% of each leased property for restaurants, gift shops and other stores or services customarily found in hospitals or nursing centers without the consent of Ventas, subject, however, to there being no material alteration in the character of the leased property or in the nature of the business conducted on such leased property.

In addition, each Master Lease Agreement allows us to assign or sublease (1) without the consent of Ventas, 10% of the nursing center facilities in each Master Lease Agreement and (2) with Ventas’ consent (which consent will not be unreasonably withheld, delayed or conditioned), two hospitals in each Master Lease Agreement, if either: (a) the applicable regulatory authorities have threatened to revoke our Medicaid or Medicare certification or an authorization necessary to operate such leased property or (b) we cannot profitably operate such leased property. Any such proposed assignee/sublessee must satisfy the requirements listed above and it must have all licenses, permits, approvals and other authorizations required to operate the leased properties in accordance with the applicable permitted use. With respect to any assignment or sublease made under this provision, Ventas agrees to execute a nondisturbance and

attornment agreement with such proposed assignee or subtenant. Upon any assignment or subletting, we will not be released from our obligations under the applicable Master Lease Agreement.

Subject to certain exclusions, we must pay to Ventas 80% of any consideration received by us on account of an assignment and 80% (50% in the case of existing subleases) of sublease rent payments (approximately equal to revenue net of specified allowed expenses attributable to a sublease, and specifically defined in the Master Lease Agreements), provided that Ventas's right to such payments will be subordinate to that of our lenders.

ADDITIONAL INFORMATION

Employees

As of December 31, 2013, we had approximately 40,000 full-time and 23,300 part-time and per diem employees. We had approximately 2,000 unionized employees at 24 of our facilities as of December 31, 2013.

The market for qualified nurses, therapists and other healthcare professionals is highly competitive. We, like other healthcare providers, have experienced difficulties in attracting and retaining qualified personnel such as nurses, certified nurse's assistants, nurse's aides, therapists and other providers of healthcare services. Our hospitals and nursing centers are particularly dependent on nurses for patient care. Our rehabilitation division continues to seek qualified therapists to fill open positions. The difficulty we have experienced in hiring and retaining qualified personnel has increased our average wage rates and may force us to increase our use of contract personnel. We expect to continue to experience increases in our labor costs primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel. Salaries, wages and benefits were approximately 61% of our consolidated revenues for the year ended December 31, 2013. Our ability to manage labor costs will significantly affect our future operating results.

Professional and General Liability Insurance

Our healthcare operations are insured for professional and general liability risks by our wholly owned limited purpose insurance subsidiary, Cornerstone Insurance Company ("Cornerstone"). Cornerstone covers losses up to specified limits per occurrence. On a per claim basis, coverage for losses in excess of those covered by Cornerstone are maintained through unaffiliated commercial reinsurance carriers. Cornerstone insures all claims in all states up to a per occurrence limit without the benefit of any aggregate stop loss limit.

We believe that our insurance is adequate in amount and coverage. There can be no assurance that in the future such insurance will be available at a reasonable price or that we will be able to maintain adequate levels of professional and general liability insurance coverage.

Where You Can Find More Information

We file annual, quarterly and current reports, proxy statements and other information with the Securities and Exchange Commission (the "SEC") under the Exchange Act.

Our filings with the SEC are available to the public free of charge on the SEC website at http://www.sec.gov, which contains reports, proxy and information statements and other information. You also may read or obtain copies of this information in person or by mail from the SEC's Public Reference Room, 100 F Street, NE, Room 1580, Washington, D.C. 20549. Please call the SEC at 1-800-SEC-0330 for further information on the operation of the Public Reference Room.

Our filings with the SEC, including our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments thereto, are available free of charge on our website, through a link to the SEC's website, as soon as reasonably practicable after they are electronically filed with or furnished to the SEC. Our website is www.kindredhealthcare.com. Information made available on our website is not a part of this document.

Item 1A. Risk Factors

You should consider carefully all the risks described below, together with all of the information included in this Annual Report on Form 10-K, in evaluating our Company and our common stock. To facilitate your consideration of all of the risks described below, these risks are organized under headings and subheadings for your convenience. If any of the risks described in this Annual Report on Form 10-K were to occur, it could have a material adverse effect on our business, financial position, results of operations, liquidity and stock price.

Risk Factors Relating to Reimbursement and Regulation of Our Business

Healthcare reform has initiated significant changes to the United States healthcare system.

Various healthcare reform provisions became law upon enactment of the ACA. The reforms contained in the ACA have impacted each of our businesses in some manner. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. The reforms include the possible modifications to the conditions of qualification for payment, bundling payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. The ACA also provides for: (1) reductions to the annual market basket payment updates for LTAC hospitals, IRFs, home health agencies and hospice providers, which could result in lower reimbursement than in the preceding year; (2) additional annual "productivity adjustment" reductions to the annual market basket payment update as determined by CMS for LTAC hospitals, IRFs, and nursing centers (beginning in federal fiscal year 2012), home health agencies (beginning in federal fiscal year 2015) and hospice providers (beginning in federal fiscal year 2013); (3) new transparency, reporting and certification requirements for nursing centers, including disclosures regarding organizational structure, officers, directors, trustees, managing employees and financial, clinical and other related data; (4) a quality reporting system for hospitals (including LTAC hospitals and IRFs) beginning in federal fiscal year 2014; and (5) reductions in Medicare payments to hospitals (including LTAC hospitals and IRFs) beginning in federal fiscal year 2014 for failure to meet certain quality reporting standards or to comply with standards in new value based purchasing demonstration project programs.

In addition, a primary goal of healthcare reform is to reduce costs, which includes reductions in the reimbursement paid to us and other healthcare providers. Moreover, healthcare reform could negatively impact insurance companies, other third party payors, our customers, as well as other healthcare providers, which may in turn negatively impact our business. As such, healthcare reforms and changes resulting from the ACA, as well as other similar healthcare reforms, could have a material adverse effect on our business, financial position, results of operations and liquidity.

Changes in the reimbursement rates or methods or timing of payment from third party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a substantial reduction in our revenues and operating margins.

We depend on reimbursement from third party payors, including the Medicare and Medicaid programs, for a substantial portion of our revenues. For the year ended December 31, 2013, we derived approximately 52% of our total revenues (before eliminations) from the Medicare and Medicaid programs and the balance from other third party payors, such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. The Medicare and Medicaid programs are highly regulated and subject to frequent and substantial changes. See "Part I – Item 1 – Business – Governmental Regulation."

Congress continues to discuss deficit reduction measures, leading to a high degree of uncertainty regarding potential reforms to governmental healthcare programs, including Medicare and Medicaid. These discussions, along with other

continuing efforts to reform governmental healthcare programs, both as part of the ACA and otherwise, could result in major changes in the healthcare delivery and reimbursement system on a national and state level. Potential reforms include changes directly impacting the government and private reimbursement systems for each of our businesses. Reforms or other changes to the payment systems, including modifications to the conditions of qualification for payment, the imposition of enrollment limitations on new providers, or bundling payments to cover acute and post-acute care or services provided to dually eligible Medicare and Medicaid patients may be proposed or could be adopted by Congress or CMS in the future.

The Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013.

The Taxpayer Relief Act also reduces Medicare payments by an additional 25% for subsequent procedures when multiple therapy services are provided on the same day. We believe that the new rules related to multiple therapy services have reduced our Medicare revenues by $25 million to $30 million on an annual basis.

On August 1, 2012, CMS issued the 2012 CMS Rules which, among other things, reduced Medicare reimbursement to our TC hospitals in 2013 and beyond by imposing a budget neutrality adjustment and modifying the short-stay outlier rules. Effective

December 29, 2012, the 2012 CMS Rules: (1) began a three-year phase-in of a 3.75% budget neutrality adjustment, which will reduce LTAC hospital rates by approximately 1.3% in each of 2013, 2014 and 2015; and (2) restored a payment reduction that will limit payments for very short-stay outliers that will reduce our TC hospital payments by approximately 0.5%.

On July 29, 2011, CMS issued the 2011 CMS Rules which, among other things, significantly reduced Medicare payments to nursing centers and changed the reimbursement for the provision of group rehabilitation therapy services to Medicare beneficiaries beginning October 1, 2011. CMS projected the impact of these changes would result in an 11.1% decrease in payments to nursing centers. In addition to these rate changes, the 2011 CMS Rules introduced additional changes to RUG calculations along with adding additional patient assessments. Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. In addition, for purposes of assigning patients to RUGs IV payment categories, the minutes of group therapy are divided by four with 25% of the minutes being allocated to each patient. The 2011 CMS Rules also clarify the circumstances for reporting breaks in care of three or more days of therapy and also implement a new change of therapy assessment that is designed to allocate the patient to the RUG level that represents the treatment provided in the last seven days. Both changes produced alterations in the RUG scores billed for the patient and generated additional assessments. The 2011 CMS Rules reduced our revenues on an annual basis by approximately $100 million in our nursing center business and negatively impacted our rehabilitation therapy business by approximately $50 million.

On November 22, 2013, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2014. These final regulations implement a net 1.05% reduction consisting of a 2.3% market basket inflation increase, less (1) a 0.62% ICD-9 grouper refinement, and (2) a 2.73% rebasing adjustment mandated under the ACA. Rebasing the rates includes adjustments to the 60-day episode and per visit payment rates, the non-national medical supply conversion factor and low utilization payment factors. The rebasing is expected to reduce payment rates by 2.8% in each of the next four years, beginning January 1, 2014.

In February 2012, Congress passed the Job Creation Act which provides for reductions in reimbursement of Medicare bad debts at our hospitals and nursing centers. For the hospitals, the bad debt reimbursement rate for all bad debts was lowered to 65% effective for cost reporting periods beginning on or after October 1, 2012. For the nursing centers, the Job Creation Act provides for a phase-in of the reduction in the rate of reimbursement for bad debts of patients that are dually eligible for Medicare and Medicaid. The rate of reimbursement for bad debts for these dually eligible patients was reduced from 88% to 76% in October 2013 and will be reduced to 65% for cost reporting periods beginning on or after October 1, 2014. The rate of reimbursement for bad debts for patients not dually eligible for both Medicare and Medicaid was reduced from 70% to 65%, effective with cost reporting periods beginning on or after October 1, 2012. Approximately 90% of our Medicare bad debt reimbursements incurred at our nursing centers are associated with patients that are dually eligible.

Weak economic conditions also could adversely affect the budgets of individual states and of the federal government. This could result in attempts to reduce or eliminate payments for federal and state healthcare programs, including Medicare and Medicaid, and could result in an increase in taxes and assessments on our activities. In addition, private third party payors are continuing their efforts to control healthcare costs through direct contracts with healthcare providers, increased utilization review and greater enrollment in managed care programs and preferred provider organizations. These private payors increasingly are demanding discounted fee structures and are requesting that healthcare providers assume more financial risk.

Though we cannot predict what reform proposals will be adopted or finally implemented, healthcare reform and regulations may have a material adverse effect on our business, financial position, results of operations and liquidity through, among other things, decreasing funds available for our services or increasing operating costs. We could be affected adversely by the continuing efforts of governmental and private third party payors to contain healthcare costs.

We cannot assure you that reimbursement payments under governmental and private third party payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Future changes in third party payor reimbursement rates or methods, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a material reduction in our revenues. Our operating margins continue to be under pressure because of reduced Medicare reimbursement, deterioration in pricing flexibility, changes in payor mix, changes in length of stay and growth in operating expenses in excess of increases in payments by third party payors. In addition, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients or commercial payors remains limited. These results could have a material adverse effect on our business, financial position, results of operations and liquidity.

The implementation of new patient criteria for LTAC hospitals under the LTAC Legislation will reduce the population of patients eligible for LTAC PPS and change the basis upon which we are paid which could adversely affect our revenues and profitability.

The LTAC Legislation creates new Medicare criteria and payment rules for LTAC hospitals. Under the new criteria, LTAC hospitals treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTAC PPS. Other patients will

continue to have access to LTAC care, whether they are admitted to LTAC hospitals from acute care hospitals or directly from other settings or the community. LTAC hospitals will be paid at a "site-neutral" rate for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTAC costs.

The effective date of the new patient criteria is October 1, 2015, followed by a two-year phase-in period tied to each LTAC hospital's cost reporting period. During the phase-in period, payment for patients receiving the site neutral rate will be based 50% on the current LTAC PPS and 50% on the new site neutral rate. Approximately 70% of our LTAC hospitals have a cost reporting period starting on or after July 1 of each year. Accordingly, the phase-in will not begin for most of our hospitals until after July 1, 2016 and full implementation of the new criteria will not begin until after July 1, 2018.

We continue to analyze Medicare and internal data to estimate the number of our cases that will continue to be paid under the LTAC PPS rate. At this time, we estimate that approximately 40% of our current LTAC patients will be paid at the site neutral rate under the new criteria once it is fully phased-in. The site-neutral payment rates will be based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTAC costs. There can be no assurance that these site neutral payments will not be materially less than the payments currently provided under LTAC PPS.

The additional patient criteria imposed by LTAC Legislation will reduce the population of patients eligible for LTAC PPS and change the basis upon which we are paid for other patients. In addition, the LTAC Legislation will be subject to additional governmental regulations and the interpretation and enforcement of those regulations. These changes could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

In the ordinary course of our business, we are subject regularly to inquiries and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. We also are subject to government investigations. We believe that the regulatory environment surrounding most segments of the healthcare industry will remain intense.

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, qualifications and licensure of staff, environmental and occupational health and safety, and the confidentiality and security of health-related information. In particular, various laws, including the anti-kickback, anti-fraud and abuse amendments codified under the Social Security Act, prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by Medicare or other governmental programs. Sanctions for violating the anti-kickback, anti-fraud and abuse amendments under the Social Security Act include criminal penalties, civil sanctions, fines and possible exclusion from government programs such as Medicare and Medicaid. See "Part I – Item 1 – Business – Governmental Regulation."

Federal and state governments continue to pursue intensive enforcement policies resulting in a significant number of inspections, audits, citations of regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bans on Medicare and Medicaid payments for new admissions and civil monetary penalties or criminal penalties. RAC audits and other audits evaluating the medical necessity of services provided are expected to further intensify the regulatory environment surrounding the healthcare industry as third party firms engaged by CMS commence extensive reviews of claims data and medical and other

records to identify improper payments to healthcare providers under the Medicare program. If we fail to comply with the extensive laws, regulations and prohibitions applicable to our businesses, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to investigations, audits or other enforcement actions related to these laws, regulations or prohibitions. Furthermore, should we lose the licenses for one or more of our facilities as a result of regulatory action or otherwise, we could be in default under our Master Lease Agreements, our Credit Facilities and indenture governing the Notes. Failure of our staff to satisfy applicable licensure requirements, or of our hospitals, IRFs, nursing centers, our rehabilitation operations, and home health and hospice operations, to satisfy applicable licensure and certification requirements could have a material adverse effect on our business, financial position, results of operations and liquidity.

We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations, or the intensity of federal and state enforcement actions. Changes in the regulatory framework, including those associated with healthcare reform, and sanctions from various enforcement actions could have a material adverse effect on our business, financial position, results of operations and liquidity.

We face and are currently subject to reviews, audits and investigations under our contracts with federal and state government agencies and other payors, and these reviews, audits and investigations could have adverse findings that may negatively impact our business.

As a result of our participation in the Medicare and Medicaid programs, we face and are currently subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. An increasing level of governmental and private resources is being devoted to the investigation of allegations of fraud and abuse in the Medicare and Medicaid programs, and federal and state regulatory authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act, the Medicare and Medicaid programs and other applicable laws. We are routinely subject to audits under various government programs, including the RAC program, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program. In addition, we, like other hospital and nursing center operators and rehabilitation therapy service providers, are subject to ongoing investigations by the OIG, the DOJ and state attorneys general into the billing of rehabilitation and other services provided to Medicare and Medicaid patients, including whether rehabilitation therapy services were property documented and billed, whether services provided were medically necessary and general compliance with conditions of participation with Medicare and Medicaid. Private pay sources such as third party insurance and managed care entities also often reserve the right to conduct audits. Our costs to respond to and defend reviews, audits and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require us to refund or retroactively adjust amounts that have been paid under the relevant government program or from other payors. Moreover, an adverse review, audit or investigation also could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include:

- state or federal agencies imposing fines, penalties and other sanctions on us;
- loss of our right to participate in the Medicare or Medicaid programs or one or more third party payor networks;
- indemnity claims asserted by customers and others for which we provide services; and
- damage to our reputation in various markets, which could adversely affect our ability to attract patients, residents and employees.

If they were to occur, these consequences could have a material adverse effect on our business, financial position, results of operations and liquidity.

We are subject to extensive and complex federal and state government laws and regulations which govern and restrict our relationships with physicians and other referral sources.

The Anti-Kickback Statute, the Stark Law, the FCA and similar state laws materially restrict our relationships with physicians and other referral sources. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our healthcare facilities, and these laws govern those relationships. The OIG has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti-Kickback Statute. While we endeavor to comply with the safe harbors, most of our current arrangements, including with physicians and other referral sources, may not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-Kickback Statute, but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-Kickback Statute. Allegations of violations of the Anti-Kickback Statute may be brought under federal civil monetary penalty laws, which require a lower burden of proof than other fraud and abuse laws, including the Anti-Kickback Statute.

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the

regulations implementing the exceptions are detailed and complex, and we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-Kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

Additionally, if we violate the Anti-Kickback Statute or the Stark Law, or if we improperly bill for our services, we may be found to violate the FCA, either under a suit brought by the government or by a private person under a qui tam, or "whistleblower," lawsuit.

If we fail to comply with the Anti-Kickback Statute, the Stark Law, the FCA or other applicable laws and regulations, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities or healthcare activities), exclusion of one or more facilities or healthcare activities from participation in the Medicare, Medicaid and other federal and state healthcare programs and, for violations of certain laws, regulations and criminal penalties.

We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial position, results of operations and liquidity, and our business reputation could suffer significantly. In addition, other legislation or regulations at the federal or state level may be adopted that adversely affect our business.

Future cost containment initiatives undertaken by third party payors may limit our revenues and profitability.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs or to respond to healthcare reform could affect the profitability of our services. These payors attempt to control healthcare costs by contracting with providers of healthcare to obtain services on a discounted basis. We believe that this trend will continue and intensify and may further limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments reduce the amounts they pay for services or limit access to our services, our profit margins may decline, or we may lose patients if we choose not to renew our contracts with these insurers at lower rates. These results could have a material adverse effect on our business, financial position, results of operations and liquidity.

Further consolidation of managed care organizations and other third party payors may adversely affect our profits.

Managed care organizations and other third party payors have continued to consolidate in order to enhance their ability to influence the delivery and cost structure of healthcare services. Consequently, the healthcare needs of a large percentage of the United States population are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers for needed services. In addition, third party payors, including managed care payors, increasingly are demanding discounted fee structures. To the extent that these organizations terminate us as a preferred provider, engage our competitors as a preferred or exclusive provider or demand discounted fee structures, our business, financial position, results of operations and liquidity could be materially and adversely affected.

If our TC hospitals fail to maintain their certification as LTAC hospitals, our revenues and profitability could decline.

If our TC hospitals, satellite TC facilities or HIHs fail to meet or maintain the standards for certification as LTAC hospitals, such as average minimum length of patient stay, they will receive payments under the prospective payment system applicable to general acute care hospitals (IPPS) rather than payment under the system applicable to LTAC hospitals. Payments at rates applicable to general acute care hospitals would result in our TC hospitals receiving less Medicare reimbursement than they currently receive for patient services and our profitability would decline. To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be greater than 25 days. Medicare Advantage patients are included with Medicare fee-for-service patients in order to determine compliance with the 25 day average length of stay requirements. Under the LTAC Legislation, the average Medicare 25-day length of stay rule will remain in effect for patients paid for under the new Medicare LTAC payment system. However, for cost reporting periods beginning on or after October 1, 2015, the 25-day requirement will not apply to patients receiving the site neutral rate or to Medicare Advantage patients treated in LTAC hospitals.

Beginning in 2020, the LTAC Legislation requires that at least 50% of our patients must be paid under the new LTAC payment system to maintain Medicare certification as a LTAC hospital. Under the new criteria, LTAC hospitals treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTAC

PPS.

The failure of one or more of our LTAC hospitals to maintain its Medicare certification as a LTAC hospital could have a material adverse effect on our business, financial position, results of operations and liquidity.

Expiration of the moratorium imposed on certain federal regulations otherwise applicable to LTAC hospitals, including HIHs and satellite hospitals, could have an adverse effect on our future revenues and profitability.

CMS has regulations governing payments to LTAC hospitals that are co-located with another hospital, such as a HIH. The rules generally limit Medicare payments to the HIH if the Medicare admissions to the HIH from its co-located hospital exceed 25% of the total Medicare discharges for the HIH's cost reporting period. There are limited exceptions for admissions from rural, urban single and MSA Dominant hospitals. Patients transferred after they have reached the short-term acute care outlier payment status are not counted toward the admission threshold. Patients admitted prior to meeting the admission threshold, as well as Medicare patients admitted from a non co-located hospital, are eligible for the full payment under LTAC PPS. If the HIH's admissions from the co-located hospital exceed the limit in a cost reporting period, Medicare will pay the lesser of: (1) the amount payable under LTAC PPS or (2) the amount payable under IPPS, which likely will reduce our revenues for such admissions.

In 2007, CMS issued regulations which expanded the “25 Percent Rule” to all LTAC hospitals, regardless of whether they are co-located with another hospital. Under these regulations, all LTAC hospitals were to be paid LTAC PPS rates for admissions from a single referral source up to 25% of aggregate Medicare admissions. Patients reaching high cost outlier status in the short-term hospital were not to be counted when computing the 25% limit. Admissions beyond the 25% threshold are to be paid at a lower amount based upon IPPS rates.

Since 2007, various legislative enactments have created moratoriums on the expansion of the “25 Percent Rule” to freestanding LTAC hospitals. The LTAC Legislation extends the moratorium on the expansion of the “25 Percent Rule” to LTAC hospitals certified prior to October 1, 2004 for four years. LTAC hospitals certified after October 1, 2004 continue to be ineligible for relief from the “25 Percent Rule.” Freestanding LTAC hospitals will not be subject to the “25 Percent Rule” payment adjustment until cost reporting periods beginning on or after July 1, 2016. In addition, for cost reporting periods beginning before October 1, 2016: (1) LTAC hospitals may admit up to 50% of their patients from a co-located hospital and still be paid according to LTAC PPS; and (2) LTAC hospitals that are co-located with an urban single hospital or a MSA Dominant hospital may admit up to 75% of their patients from such urban single or MSA Dominant hospital and still be paid according to LTAC PPS. The LTAC Legislation further provides that co-located LTAC hospitals certified on or before September 30, 1995 are exempt from the provisions of the “25 Percent Rule.” The LTAC Legislation also mandates that the Secretary of the HHS report to Congress by July 1, 2015 on whether the “25 Percent Rule” should continue to be applied.

Since these rules are complex and are based upon the volume of Medicare admissions and the source of those admissions, we cannot predict with any certainty the impact on our future revenues or operations from these regulations. If the “25 Percent Rule” is ultimately fully implemented, it could have a material adverse effect on our business, financial position, results of operations and liquidity.

The upcoming moratorium on the Medicare certification of new LTAC hospitals and beds in existing LTAC hospitals will limit our ability to increase LTAC hospital bed capacity, expand into new areas or increase services in existing areas we serve.

The LTAC Legislation will impose a moratorium beginning on January 1, 2015 and continuing through October 1, 2017 on the establishment and classification of new LTAC hospitals, LTAC satellite facilities and LTAC beds in existing LTAC hospitals or satellite hospitals. This moratorium will limit our ability to increase LTAC bed capacity, expand into new areas or increase bed capacity in existing markets that we serve.

Healthcare reform and other regulations could adversely affect the liquidity of our customers, which could have an adverse effect on their ability to make timely payments to us for our products and services.

The ACA and other laws and regulations that limit or restrict Medicare and Medicaid payments to our customers could adversely impact the liquidity of our customers, resulting in their inability to pay us, or to timely pay us, for our products and services. In addition, if our customers fail to comply with applicable laws and regulations they could be subject to possible sanctions, including loss of licensure or eligibility to participate in reimbursement programs, as well as civil and criminal penalties. These developments could have a material adverse effect on our business, financial position, results of operations and liquidity.

If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.

IRFs are subject to a requirement that 60% or more of the patients admitted to the facilities have one or more of 13 specific conditions in order to qualify for IRF-PPS. If that compliance threshold is not maintained, the IRF will be reimbursed at the lower prospective payment system applicable to acute care hospitals. That may lead to reduced

revenue in the IRFs that we operate or manage and also may lead customers of IRFs to attempt to renegotiate the terms of their contracts or terminate their contracts, in either case adversely affecting the projected revenues and profitability we expect.

If we are found to have violated laws protecting the confidentiality of patient health information, we could be subject to civil or criminal penalties, which could increase our liabilities and harm our reputation or our business.

There are a number of federal and state laws protecting the confidentiality of certain patient health information, including patient records, and restricting the use and disclosure of that protected information. In particular, the privacy rules under HIPAA protect medical records and other personal health information by limiting their use and disclosure, giving individuals the right to access, amend and seek accounting of their own health information and limiting most uses and disclosures of health information to the minimum amount reasonably necessary to accomplish the intended purpose. If we are found to be in violation of the privacy or security rules under HIPAA or other federal or state laws protecting the confidentiality of patient health information, we could be subject to sanctions and civil or criminal penalties, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operations and liquidity.

Risk Factors Relating to Our Indebtedness

Our indebtedness could adversely affect our cash flow and prevent us from fulfilling our obligations.

We have a substantial amount of indebtedness. As of December 31, 2013, we had total indebtedness of approximately $1.6 billion in addition to availability of approximately $396 million under the ABL Facility (subject to a borrowing base and after giving effect to approximately $8 million of letters of credit outstanding on December 31, 2013). Our substantial amount of indebtedness could have important consequences. For example it could:

make it more difficult for us to satisfy our obligations with respect to our indebtedness;
increase our vulnerability to general adverse economic and industry conditions;
expose us to fluctuations in the interest rate environment because the interest rates under the Credit Facilities are variable;
require us to dedicate a substantial portion of our cash flow from operations to make payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions, dividends and other general corporate purposes;
limit our ability to borrow additional funds for working capital, capital expenditures, acquisitions and other general purposes;
limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate, which may place us at a competitive disadvantage compared to our competitors that have less debt; and
restrict us from pursuing business opportunities.

Our indebtedness may restrict our current and future operations, which could adversely affect our ability to respond to changes in our business and manage our operations.

The terms of the Credit Facilities and the indenture governing the Notes include a number of restrictive covenants that impose significant operating and financial restrictions on us and our restricted subsidiaries, including restrictions on our and our restricted subsidiaries' ability to, among other things:

incur additional indebtedness;
create liens;
consolidate or merge;
sell assets, including capital stock of our subsidiaries;
engage in transactions with our affiliates;
pay dividends on our capital stock or redeem, repurchase or retire our capital stock or indebtedness; and
make investments, loans, advances and acquisitions.

The terms of the Credit Facilities also include certain additional restrictive covenants that impose significant operating and financial restrictions on us and our restricted subsidiaries, including restrictions on our and our restricted subsidiaries' ability to, among other things:

engage in business other than relating to owning, operating or managing healthcare facilities;
enter into sale and lease-back transactions;
modify certain agreements;
make or incur capital expenditures; and
hold cash and temporary cash investments outside of collateral accounts.

In addition, the Credit Facilities require us to comply with financial covenants, including a maximum leverage ratio and a minimum fixed charge coverage ratio.

Our ability to comply with these agreements may be affected by events beyond our control, including prevailing economic, financial and industry conditions. These covenants could have an adverse effect on our business by limiting

our ability to take advantage of financing, merger and acquisition or other opportunities. The breach of any of these covenants or restrictions could result in a default under the Credit Facilities or the indenture governing the Notes.

Our failure to comply with the agreements relating to our outstanding indebtedness, including as a result of events beyond our control, could result in an event of default that could materially and adversely affect our business, financial condition, results of operations and liquidity.

If there were an event of default under any of the agreements relating to our outstanding indebtedness, including the Credit Facilities and the indenture governing the Notes, we may not be able to incur additional indebtedness under the Credit Facilities and the holders of the defaulted debt could cause all amounts outstanding with respect to that debt to be due and payable immediately. We cannot assure you that our assets or cash flow would be sufficient to fully repay borrowings under our outstanding debt instruments if accelerated upon an event of default, which could have a material adverse effect on our ability to continue to operate as a going concern. Further, if we are unable to repay, refinance or restructure our secured debt, the holders of such debt could proceed against the collateral securing that indebtedness. In addition, any event of default or declaration of acceleration under one debt instrument also could result in an event of default under one or more of our other debt instruments or under the Master Lease Agreements. Moreover, counterparties to some of our contracts material to our business may have the right to amend or terminate those contracts if we have an event of default or a declaration of acceleration under certain of our indebtedness, which could adversely affect our business, financial condition, results of operations and liquidity.

We, including our subsidiaries, have the ability to incur substantially more indebtedness, including senior secured indebtedness, which could further increase the risks associated with our leverage.

Subject to the restrictions in the Credit Facilities and the indenture governing the Notes, we, including our subsidiaries, have the ability to incur significant additional indebtedness. As of December 31, 2013:

- we had $1.0 billion of senior secured indebtedness under the Credit Facilities;
- we had $550 million of senior unsecured indebtedness under the Notes;
- we had approximately $396 million available for borrowing under the ABL Facility (subject to a borrowing base and after giving effect to approximately $8 million of letters of credit outstanding on December 31, 2013) which, if borrowed, would be senior secured indebtedness; and
- subject to our compliance with certain covenants and other conditions, we have the option to incur certain additional secured indebtedness and/or additional unsecured indebtedness which would rank pari passu with the Notes.

Although the terms of the Credit Facilities and the indenture governing the Notes include restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of important exceptions, and indebtedness incurred in compliance with these restrictions could be substantial. If we incur significant additional indebtedness, the related risks that we face could increase.

We may not be able to generate sufficient cash to pay rents related to our leased properties and service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

A substantial portion of our cash flows from operations is dedicated to the payment of rents related to our leased properties, as well as principal and interest obligations on our outstanding indebtedness. Our ability to generate cash depends on many factors beyond our control, and any failure to meet our debt service obligations could harm our business, financial condition and results of operations. Our ability to make payments on and to refinance our indebtedness and to fund working capital needs and planned capital expenditures will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, business, legislative, regulatory and other factors that are beyond our control.

If our business does not generate sufficient cash flow from operations or if future borrowings are not available to us in an amount sufficient to enable us to pay our indebtedness or to fund our other liquidity needs, we may need to

refinance all or a portion of our indebtedness on or before the maturity thereof, sell assets, reduce or delay capital investments or seek to raise additional capital, any of which could have a material adverse effect on our operations. In addition, we may not be able to effect any of these actions, if necessary, on commercially reasonable terms or at all. The terms of existing or future debt instruments may limit or prevent us from taking any of these actions. Our ability to restructure or refinance our indebtedness will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, any failure to make scheduled payments of interest and principal on our outstanding indebtedness would likely result in a reduction of our credit rating, which could harm our ability to incur additional indebtedness on commercially reasonable terms or at all. Our inability to generate sufficient cash flow to satisfy our debt service obligations, or to refinance or restructure our obligations on commercially reasonable terms or at all, would have an adverse effect, which could be material, on our business, financial condition, results of operations and liquidity.

In addition, our Master Lease Agreements and/or our outstanding indebtedness:

require us to dedicate a substantial portion of our cash flow to payments on our rent and interest obligations, thereby reducing the availability of cash flow to fund working capital, capital expenditures and other general corporate activities, including cash dividends;
require us to pledge as collateral substantially all of our assets;
require us to maintain a certain defined fixed coverage ratio above a specified level and a certain defined total indebtedness ratio below a specified level, thereby reducing our financial flexibility;
require us to limit the amount of capital expenditures we can incur in any fiscal year; and
restrict our ability to discontinue the operation of any leased property despite its level of profitability and otherwise restrict our operational flexibility.

These provisions:

could have a material adverse effect on our ability to withstand competitive pressures or adverse economic conditions (including adverse regulatory changes);
could adversely affect our ability to make material acquisitions, obtain future financing or take advantage of business opportunities that may arise;
could increase our vulnerability to a downturn in general economic conditions or in our business; and
could adversely affect our ability to continue to make cash dividends.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

Borrowings under the Credit Facilities bear interest at variable rates. Interest rate changes could affect the amount of our interest payments, and accordingly, our future earnings and cash flows, assuming other factors are held constant. Pursuant to the terms of the Credit Facilities, we have entered into an interest rate swap that fixes a portion of our interest rate interest payments in order to reduce interest rate volatility; however, any interest rate swaps we enter into do not fully mitigate our interest rate risk. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. For example, a change of one-eighth percent in the interest rates for the Credit Facilities would increase or decrease annual interest expense by approximately $1 million.

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.

As of December 31, 2013, we lease 38 of our TC hospitals and 105 of our nursing centers from Ventas under our Master Lease Agreements. Sixty of these nursing centers comprise the 2013 Expiring Facilities, all of which qualify as assets held for sale and the operating results of which have been reflected as discontinued operations in the accompanying consolidated statement of operations for all historical periods. Our failure to pay the rent or otherwise comply with the provisions of any of our Master Lease Agreements would result in an “Event of Default” under such Master Lease Agreement and also could result in a default under the Credit Facilities and, if repayment of the borrowings under the Credit Facilities were accelerated, also under the indenture governing the Notes. Upon an Event of Default, remedies available to Ventas include, without limitation, terminating such Master Lease Agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such Master Lease Agreement, including the difference between the rent under such Master 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 Master Lease Agreement. The exercise of such remedies would have a material adverse effect on our business, financial position, results of operations and liquidity.

For additional information on the Master Lease Agreements, see “Part I – Item 1 – Business – Master Lease Agreements.”

We may not be able to continue paying a regular dividend and the failure to do so could adversely affect our stock price.

Our ability to continue paying regular dividends is based on many factors, including the success of our operations, the level of demand for our services, the level of payments for our services, changes in healthcare regulations and our liquidity needs that may vary substantially from our estimates. Many of these factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. In addition, our Credit Facilities and the indenture governing the Notes limit our ability to pay dividends to stockholders and may prevent further dividends if we are in default under any of those agreements. The failure to continue paying regular dividends could adversely affect our stock price.

Repayment of our indebtedness is dependent on cash flow generated by our subsidiaries.

Our subsidiaries own a significant portion of our assets and conduct a significant portion of our operations. Accordingly, repayment of our indebtedness is dependent, to a significant extent, on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Certain of our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our outstanding indebtedness.

Risks Factors Relating to Our Capital and Liquidity

The condition of the financial markets, including volatility and weakness in the equity, capital and credit markets, could limit the availability and terms of debt and equity financing sources to fund the capital and liquidity requirements of our businesses.

Financial markets experienced significant disruptions over the past several years. These disruptions impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reduced the availability of certain types of debt financing. Despite the instability over the past several years within the financial markets nationally and globally, we have not experienced any individual lender limitations to extend credit under our Credit Facilities. However, the obligations of each of the lending institutions in the ABL Facility are separate and the availability of future borrowings under the ABL Facility could be impacted by volatility and disruptions in the financial credit markets or other events. We cannot assure you that a prolonged downturn in the credit markets or other circumstances will not impact our ability to access or to refinance the Credit Facilities. Our inability to access or refinance the Credit Facilities would have a material adverse effect on our business, financial position, results of operations and liquidity.

The Credit Facilities are collateralized by substantially all of our assets including certain owned real property and is guaranteed by substantially all of our subsidiaries. The terms of the Credit Facilities and the indenture governing the Notes include financial covenants and certain other provisions that limit acquisitions and annual capital expenditures. We were in compliance with the terms of the Credit Facilities and the indenture governing the Notes at December 31, 2013. However, a downturn in operating earnings or events beyond our control could impair our ability to comply with the covenants contained within the Credit Facilities and the indenture governing the Notes. If we anticipated a potential financial or other covenant violation, however, we would seek relief from our lenders for the Credit Facilities and the holders of the Notes, which likely would include costs to us, and such relief may not be on terms as favorable as those in the Credit Facilities or the Notes, as applicable. Under these circumstances, there is also the potential that our lenders under the Credit Facilities or the holders of the Notes would not grant relief to us. A default due to the violation of a financial or other covenant contained within the Credit Facilities, the indenture governing the Notes or the occurrence of an “Event of Default” under the Master Lease Agreements could require us to immediately repay all amounts then outstanding under the Credit Facilities and the Notes.

If we have future capital needs that cannot be funded from operating cash flows, any future issuances of equity securities may dilute the value of our common stock and any additional issuances of debt may increase our leverage.

Though we anticipate that the cash amounts generated internally, together with amounts available under the Credit Facilities, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available, or available on terms favorable to

us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions. If available, we may obtain additional capital through the public or private sale of debt or equity securities. However, our ability to access the public debt or equity capital markets, on terms favorable to us or at all, may be limited by further disruptions in these markets or other events. If we sell equity securities, the transaction could be dilutive to our existing shareholders. Furthermore, these securities could have rights, preferences and privileges more favorable than those of our common stock. If we incur additional debt, our leverage may increase and could have a material adverse effect on our business, financial position, results of operations and liquidity.

Our stock price is volatile and fluctuations in our operating results, quarterly earnings and other factors may result in declines in the price of our common stock.

Equity markets are prone to, and in the last few years have experienced, significant price and volume fluctuations. Volatility over the past few years has had a significant impact on the market price of securities issued by many companies, including us and other companies in the healthcare industry. If we are unable to operate our businesses as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and other factors beyond our control could have an adverse effect on the price of our common stock, including:

regulatory and reimbursement changes;

quarterly variations in operating results;
adverse outcomes from litigation and government or regulatory investigations;
changes in financial estimates and recommendations by securities analysts;
general economic conditions;
operating and stock price performance of other companies that investors may deem comparable;
press releases or negative publicity relating to our competitors or us or relating to trends in healthcare;
sales of stock by insiders;
changes in our credit ratings;
natural disasters, terrorist attacks and pandemics; and
limitations on our ability to repurchase our common stock.

Market volatility and declines in the price of our common stock could have a material adverse effect on our ability to obtain capital or complete acquisitions through the public or private sale or issuance of our equity securities.

In addition, security holders often institute class action litigation following periods of volatility in the price of a company's securities. If the market value of our common stock experiences adverse fluctuations and we become a party to this type of litigation, regardless of the outcome, we could incur substantial legal costs and our management's attention could be diverted from the operation of our business, causing our business to decline.

Disruptions in the financial markets could negatively impact our investment portfolio.

We hold a substantial investment portfolio in our limited purpose insurance subsidiary. Investments held in our limited purpose insurance subsidiary consist principally of cash and cash equivalents, debt securities, equities and certificates of deposit that are held to satisfy the payment of claims and expenses related to professional liability and workers compensation risks. Our investment policy governing insurance subsidiary investments precludes the investment portfolio managers from selling any security at a loss without prior authorization from us. The investment managers also limit the exposure to any one issue, issuer or type of investment. We intend, and have the ability, to hold insurance subsidiary investments for a long duration without the necessity of selling securities to fund the underwriting needs of our insurance subsidiary. This ability to hold securities allows sufficient time for recovery of temporary declines in the market value of equity securities and the par value of debt securities as of their stated maturity date. We cannot assure you, however, that we will recover declines in the market value of our investments. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in the future. Furthermore, we cannot assure you that declines in the market value of our investments will not require us to further capitalize our limited purpose insurance subsidiary or otherwise have a material adverse effect on our business, financial position, results of operations and liquidity.

Risk Factors Relating to Our Operations

Acquisitions, investments and strategic alliances that we have made or may make in the future may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

We intend to continue to selectively pursue strategic acquisitions of, investments in, and strategic alliances with, hospitals, IRFs, nursing centers, rehabilitation operations, and home health and hospice operations, particularly where an acquisition may assist us in scaling our operations more rapidly and efficiently than internal growth. Acquisitions may involve significant cash expenditures, debt incurrence, additional operating losses, amortization of certain intangible assets of acquired companies, dilutive issuances of equity securities and expenses that could have a material adverse effect on our business, financial position, results of operations and liquidity.

Acquisitions, investments and strategic alliances involve numerous risks. These risks include:

limitations on our ability to identify acquisitions that meet our target criteria and limitations on our ability to complete such acquisitions on reasonable terms and valuations;

limitations on our ability to access equity or capital to fund acquisitions, including difficulty in obtaining financing for acquisitions at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility or ability to access additional capital when needed;

entry into markets or businesses in which we may have limited or no experience;

difficulties integrating acquired operations, personnel and information systems, and in realizing projected efficiencies and cost savings, particularly in the case of significant acquisitions;

diversion of management's time from existing operations;
potential loss of key employees or customers of acquired companies;
inaccurate assessment of assets and liabilities and exposure to undisclosed or unforeseen liabilities of acquired companies, including liabilities for the failure to comply with healthcare laws;
inability to operate acquired facilities profitably or succeed in achieving improvements in their financial performance; and
impairment of acquired goodwill and intangible assets.

We continue to seek acquisitions and other strategic opportunities for each of our businesses that may negatively impact our business, financial position, results of operations and liquidity.

We continue to seek acquisitions and other strategic opportunities for each of our businesses, particularly where an acquisition or strategic opportunity may assist us in scaling our operations more rapidly and efficiently than internal growth. Accordingly, we are often engaged in evaluating potential transactions and other strategic alternatives, some of which may be significant in size, and we engage in preliminary discussions that may result in one or more transactions. Although there is uncertainty that any of our discussions will result in definitive agreements or the timing of announcement or completion of any transaction, our business, short-term and long-term financial position, results of operations and liquidity may be impacted if we announce or complete any such transaction or if we incur substantial costs or other losses in connection with such transaction, whether or not it is completed. Moreover, although we intend to enter into transactions that enhance long-term shareholder value, our ability to achieve this objective would be subject to integration risks, the ability to retain and attract key personnel, the ability to realize synergies and other risks, all of which would be more material with transactions of significant size.

In addition to acquisitions, we also may pursue strategic opportunities involving the construction of new hospitals or nursing centers. The construction of new facilities involves numerous risks, including construction delays, cost over-runs, and the satisfaction of zoning and other regulatory requirements. We may be unable to operate newly constructed facilities profitably and such facilities may involve significant cash expenditures, debt incurrence, additional operating losses, and expenses that could have a material adverse effect on our business, financial position, results of operations and liquidity.

We operate 14 of our facilities and one home health agency through joint ventures with unrelated parties. We are the majority owner of each of those joint ventures. We may enter into additional joint ventures with unrelated parties in the future to acquire, own or operate hospitals, IRFs, nursing centers and/or home health and hospice services. We will typically seek to be the majority owner of any such new joint ventures. While, as the majority owner, we typically control the day-to-day activities of these joint ventures, the joint venture agreements with our partners often include provisions reserving certain major actions for super-majority approval. Such actions may include entering into a new business activity or ceasing an existing activity, taking on substantial debt, admitting new partners, and terminating the venture. In addition, the joint venture agreements may restrict our ability to derive cash from the joint venture and affect our ability to transfer our interest in the joint venture. We may be required to provide additional capital to a joint venture if our partner defaults on its capital obligations.

Significant legal actions could subject us to increased operating costs and substantial uninsured liabilities, which could materially and adversely affect our business, financial position, results of operations and liquidity.

We incur significant costs to investigate and defend against a variety of claims, including professional liability, wage and hour, and minimum staffing claims, among others, particularly in our hospital and nursing center operations. In addition to large compensatory claims, plaintiffs' attorneys are increasingly seeking, and have sometimes been successful in obtaining, significant fines, punitive damages and attorneys' fees. Furthermore, there are continuing efforts to limit the ability of healthcare providers to utilize arbitration as a process to resolve these claims. As a result of these factors, our defense costs and potential liability exposure are significant, unpredictable, and likely to increase.

We also are subject to lawsuits under the FCA and comparable state laws for submitting fraudulent bills for services to the Medicare and Medicaid programs. These lawsuits, which may be initiated by "whistleblowers," can involve significant monetary damages, fines, attorneys' fees and the award of bounties to private qui tam plaintiffs who successfully bring these suits and to the government programs. We also are subject to payment obligations under contracts we enter into with our rehabilitation division customers to indemnify them against claim denials associated with our services.

While we are able to insure against certain of these costs and liabilities, such as our professional liability risks described below, we are not able to do so in many other cases. In the absence of insurance proceeds, we must fund these costs and liabilities from operating cash flows, which can reduce our operating margins and our funds available for investment in our business, and otherwise limit our operating and financial flexibility.

We insure a substantial portion of our professional liability risks primarily through our limited purpose insurance subsidiary. Provisions for loss for our professional liability risks are based upon management's best available information including actuarially determined estimates. The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of, or less than, the amounts recorded. Changes in the number of professional liability claims and the cost to settle these claims significantly impact the allowance for professional liability risks. A relatively small variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the allowance for professional liability risks. Differences between the ultimate claims costs and our historical provisions for loss and actuarial assumptions and estimates could have a material adverse effect on our business, financial position, results of operations and liquidity.

If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected.

We insure a substantial portion of our professional liability risks primarily through our limited purpose insurance subsidiary. Our limited purpose insurance subsidiary covers losses up to specified limits per occurrence. On a per claim basis, coverage for losses in excess of those insured by the limited purpose insurance subsidiary are maintained through unaffiliated commercial reinsurance carriers. Our limited purpose insurance subsidiary insures all claims in all states up to a per occurrence limit without the benefit of any aggregate stop loss limit. We maintain professional and general liability insurance in amounts and coverage that management believes are sufficient for our operations. However, our insurance may not cover all claims against us or the full extent of our liability nor continue to be available at a reasonable cost. Moreover, the cost of reinsurance coverage maintained with unaffiliated commercial insurance carriers is costly and may continue to increase. There can be no assurances that in the future reinsurance will be available at a reasonable price or that we will be able to maintain adequate levels of professional and general liability insurance coverage. If we are unable to maintain adequate insurance coverage or are required to pay punitive damages that are uninsured, we may be exposed to substantial liabilities, which could have a material adverse effect on our business, financial position, results of operations and liquidity.

Federal and state employment-related laws and regulations could increase our cost of doing business and subject us to significant back pay awards, fines and lawsuits.

Our operations are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act which governs such matters as minimum wages, overtime pay, compensable time, recordkeeping and other working conditions, the Americans with Disabilities Act and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission, regulations of the Office of Civil Rights, regulations of state attorneys general, federal and state wage and hour laws, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment-related matters. Because labor represents such a large portion of our operating costs, compliance with these evolving federal and state laws and regulations could substantially increase our cost of doing business while failure to do so could subject us to significant back pay awards, fines and lawsuits. We are currently subject to employee-related claims, lawsuits (including class action lawsuits) and administrative proceedings in connection with our operations, including, but not limited to, those related to wrongful discharge, discrimination or violations of equal employment or federal and state wage and hour laws. These claims, lawsuits and proceedings are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. Our failure to comply with federal and state

employment-related laws and regulations could have a material adverse effect on our business, financial position, results of operations and liquidity.

Certain events or circumstances could result in the impairment of our assets or other charges, including, without limitation, impairments of goodwill and identifiable intangible 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, such as when the market value of our common stock is below book equity value. On an ongoing basis, we also evaluate, based upon the fair value of our reporting units, whether the carrying value of our goodwill is impaired. 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.

During 2013, we determined that pretax impairment charges aggregating $77 million were necessary, which included $76 million of goodwill and $1 million of property and equipment. The goodwill impairment charge was directly related to a Medicare rebasing adjustment for payments to home health providers which will reduce the payment rate by 2.8% in each of the next four years beginning on January 1, 2014. The property and equipment impairment charge was related to the 2011 CMS Rules, which significantly reduced Medicare payments to our skilled nursing rehabilitation services operating segment and our nursing centers.

During 2012, we determined that pretax impairment charges aggregating $109 million were necessary, which included $108 million of goodwill and $1 million of property and equipment. These charges were directly related to the Taxpayer Relief Act and the 2011 CMS Rules, which significantly reduced Medicare payments to our skilled nursing rehabilitation services operating segment and our nursing centers.

In the fourth quarter 2011, we incurred a pretax impairment charge of $54 million, of which $38 million was reclassified to discontinued operations, on the value of the certificates of need intangible assets of certain hospitals and co-located nursing centers in Massachusetts. See note 1 of the notes to consolidated financial statements.

During 2011, we also determined that pretax impairment charges aggregating $57 million were necessary, which included $52 million of goodwill and $5 million of property and equipment. These charges were directly related to the 2011 CMS Rules.

Future adverse changes in the operating environment and related key assumptions used to determine the fair value of our reporting units and indefinite-lived intangible assets or a decline in the value of our common stock may result in future impairment charges for a portion or all of these assets. Moreover, the value of our goodwill and indefinite-lived intangible assets could be negatively impacted by potential healthcare reforms. Any such impairment charges could have a material adverse effect on our business, financial position and results of operations.

We could experience significant increases to our operating costs due to shortages of qualified nurses, therapists and other healthcare professionals or union activity.

The market for qualified nurses, therapists and other healthcare professionals is highly competitive. We, like other healthcare providers, have experienced difficulties in attracting and retaining qualified personnel such as nurses, certified nurse’s assistants, nurse’s aides, therapists and other providers of healthcare services. Our hospitals, nursing centers and home health and hospice operations are particularly dependent on nurses for patient care. Our rehabilitation division continues to seek qualified therapists to fill open positions. The difficulty we have experienced in hiring and retaining qualified personnel has increased our average wage rates and may force us to increase our use of contract personnel.

In addition, healthcare providers are experiencing a high level of union activity across the country. At December 31, 2013, approximately 2,000 of the employees at 24 of our facilities were unionized. Though we cannot predict the degree to which we will be affected by future union activity, there are continuing legislative proposals that could result in increased union activity. We could experience an increase in labor and other costs from such union activity. Furthermore, we could experience a disruption of our operations if our employees were to engage in a strike or other work stoppage.

We expect to continue to experience increases in our labor costs primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel. Salaries, wages and benefits were approximately 61% of our consolidated revenues for the year ended December 31, 2013. Our ability to manage labor costs will significantly affect our future operating results.

We could experience significant legal actions, fines and increases in our operating costs if we fail to comply with state minimum staffing requirements.

Various states in which we operate hospitals and nursing centers have established minimum staffing requirements or may establish minimum staffing requirements in the future. Staffing requirements in some states are not contingent upon any additional appropriation of state funds in any budget act or other statute. Our ability to satisfy such staffing requirements will, among other things, depend upon our ability to attract and retain qualified healthcare professionals.

While we seek to comply with all applicable staffing requirements, the regulations in this area are complex and we may experience compliance issues from time to time. Failure to comply with such minimum staffing requirements may result in one or more facilities failing to meet the conditions of participation under relevant federal and state healthcare programs and the imposition of fines or other sanctions. Private litigation involving these matters also has become more common, and certain of our facilities are the subject of litigation involving claims brought in 2010 that we did not meet relevant staffing requirements from time to time since 2006.

Moreover, a portion of the staffing costs we incur is funded by states through Medicaid program appropriations or otherwise. If states do not appropriate sufficient additional funds to pay for any additional operating costs resulting from such minimum staffing requirements, our profitability may be materially adversely affected.

If we lose our key management personnel, we may not be able to successfully manage our business and achieve our objectives.

Our future success depends in large part upon the leadership and performance of our executive management team and key employees and our ability to retain and motivate these individuals. Competition for these individuals is intense and there can be no assurance that we will retain our key officers and employees or that we can attract or retain other highly qualified individuals in the

future. If we lose the services of one or more of our key officers or employees, or if one or more of them decides to join a competitor or otherwise compete directly or indirectly with us, we may not be able to successfully manage our business, achieve our business objectives or replace them with similarly qualified personnel. If we lose key personnel, we may be unable to replace them with personnel of comparable experience, reputation in the industry or skills. The loss of any of our key officers or employees could have a material adverse effect on our business, financial position, results of operations and liquidity.

If we fail to attract patients and compete effectively with other healthcare providers or if our referral sources fail to view us as an attractive post-acute healthcare provider, our revenues and profitability may decline.

The post-acute healthcare services industry is highly competitive. Our hospitals face competition from healthcare providers that provide services comparable to those offered by our hospitals. Many competing hospitals are larger and more established than our hospitals. We may experience increased competition from existing hospitals, as well as hospitals converted, in whole or in part, to specialized care facilities. Our nursing centers compete on a local and regional basis with other nursing centers and post-acute healthcare providers. Some of our competitors operate newer facilities and may offer services not provided by us or are operated by entities having greater financial and other resources than us. Our rehabilitation and care management divisions compete with national, regional and local service providers within our markets. Several of these competitors may have greater financial and other resources than us, may be more established in the markets in which we compete and may be willing to provide services at lower prices. We cannot assure you that increased competition in the future will not adversely affect our business, financial position, results of operations and liquidity.

In addition, we rely significantly on appropriate referrals from physicians, hospitals and other healthcare providers in the communities in which we deliver our services to attract appropriate patients and residents. Our referral sources are not obligated to refer business to us and may refer business to other healthcare providers. We believe many of our referral sources refer patients and residents to us as a result of the quality of our patient services and our efforts to establish and build a relationship with them. If any of our facilities fail to achieve or maintain a reputation for providing high quality care, or are perceived to provide a lower quality of care than comparable facilities within the same geographic area, or customers of our rehabilitation therapy, home health and hospice services perceive that they could receive higher quality services from other providers, our ability to attract and retain patients and customers could be adversely affected. We believe that the perception of our quality of care by potential residents or patients or their families seeking our services is influenced by a variety of factors, including physician and other healthcare professional referrals, community information and referral services, newspapers and other print and electronic media, results of patient surveys, recommendations from family and friends, and published quality care statistics compiled by CMS or other industry data. If we lose, or fail to maintain, existing relationships with our referral resources, fail to develop new relationships or if we are perceived by our referral sources for any reason as not providing high quality patient care, our patient volumes and the quality of our patient mix could suffer and our revenue and profitability could decline.

Failure to maintain the security and functionality of our information systems, or to defend a cyber security attack, could adversely affect our business, financial position, results of operation and liquidity.

We are dependent on the proper function and availability of our information systems and related software programs. Though we have taken steps to protect the safety and security of our information systems and the patient health information and other data maintained within those systems, there can be no assurance that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations.

As a result of our acquisition activities, we have acquired additional information systems. We have been taking steps to reduce the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating to fewer information systems. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in technology, evolving industry and regulatory standards, and changing customer preferences.

In addition, certain software supporting our business and information systems are licensed to us by independent software developers. Our inability, or the inability of these developers, to continue to maintain and upgrade our information systems and software could disrupt or reduce the efficiency of our operations. In addition, costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our operations.

A cyber security attack that bypasses our information systems security could cause a security breach which may lead to a material disruption to our information systems infrastructure or business and may involve a loss of business or patient health information. If a cyber security attack were to be successful, it could result in the theft, destructions, loss, misappropriation or release of confidential information or intellectual property, and could cause operational or business delays that may impact materially our ability to provide various healthcare services. Any successful cyber security attack also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties.

Failure to maintain the security and functionality of our information systems and related software, or to defend a cyber security attack, could expose us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, breach of patient health information, loss of customers, disputes with payors and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations and liquidity.

We have limited operational and strategic flexibility since we lease a substantial number of our facilities.

We lease a substantial number of our facilities from Ventas and other third parties. Under our leases, we generally are required to operate continuously our leased properties as a provider of healthcare services. In addition, these leases generally limit or restrict our ability to assign the lease to another party. Our failure to comply with these lease provisions would result in an event of default under the leases and subject us to material damages, including potential defaults under the Credit Facilities and the indenture governing the Notes. Given these restrictions, we may be forced to continue operating unprofitable facilities to avoid defaults under our leases. See “Part I – Item 1 – Business – Master Lease Agreements.”

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 among payors and patient acuity. 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.

We may be unable to reduce costs to offset completely any decreases in our revenues.

Reduced levels of occupancy in our facilities and reductions in reimbursements from Medicare, Medicaid or other payors would adversely impact our revenues and liquidity. We may be unable to put in place corresponding reductions in costs in response to declines in census or other revenue shortfalls. The inability to timely adjust our operations to address a decrease in our revenues could have a material adverse effect on our business, financial position, results of operations and liquidity.

We are exposed to the credit risk of our payors and customers which in the future may cause us to make larger allowances for doubtful accounts or incur bad debt write-offs.

Due to weak economic conditions, recent Medicare and Medicaid reimbursement reductions and other factors, commercial payors and customers may default on their payments to us and individual patients may default on co-payments and deductibles for which they are responsible under the terms of either commercial insurance programs or Medicare. Although we review the credit risk of our commercial payors and customers regularly, such risks may arise from events or circumstances that are difficult to anticipate or control, such as a general economic downturn or changes in Medicare or Medicaid reimbursement. If our payors or customers default on their payments to us in the future, we may have to record higher provisions for allowances for doubtful accounts or incur bad debt write-offs, both of which could have a material adverse effect on our business, financial position, results of operations and liquidity.

Delays in collection of our accounts receivable could adversely affect our business, financial position, results of operations and liquidity.

Prompt billing and collection are important factors in our liquidity. Billing and collection of our accounts receivable are subject to the complex regulations that govern Medicare and Medicaid reimbursement and rules imposed by non-government payors. Our inability, or the inability of our customers, to bill and collect on a timely basis pursuant to these regulations and rules could subject us to payment delays that could negatively impact our business, financial position, results of operations and liquidity. In addition, we may experience delays in reimbursement as a result of the failure to receive prompt approvals related to change of ownership applications for acquired or other facilities or from delays caused by our or other third parties' information system failures. Significant delays in billing and/or collections may adversely affect the borrowing base under the ABL Facility, potentially limiting the availability of funds under the ABL Facility.

Terrorist attacks, pandemics or natural disasters could negatively impact our business, financial position, results of operations and liquidity.

Terrorist attacks, pandemics, or acts of nature, such as floods, fires, hurricanes, tornadoes or earthquakes, may cause damage or disruption to us, our employees and our facilities, which could have an adverse impact on our residents and patients. In order to provide care for our residents and patients, we are dependent upon consistent and reliable delivery of food, pharmaceuticals, power and other products to our facilities and the availability of employees to provide services at our facilities. If the delivery of goods or the ability of employees to reach our facilities were interrupted due to a natural disaster, pandemic or a terrorist attack, it could have a

significant negative impact on 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 facilities, which would be costly and would involve substantial risks to our operations and potentially to our residents and patients. The impact of natural disasters, pandemics and terrorist attacks is inherently uncertain. Such events could severely damage or destroy one or more of our facilities, harm our business, reputation and financial performance or otherwise have a material adverse effect on our business, financial position, results of operations and liquidity.

Climate change poses both regulatory and physical risks that could adversely impact our business, financial position, results of operations and liquidity.

Climate change could have a potential economic impact on us and climate change mitigation programs and regulations could increase our costs. Energy costs could be higher as a result of climate change regulations. Our costs could increase if utility companies pass on their costs, such as those associated with carbon taxes, emission cap and trade programs, or renewable portfolio standards. In addition, climate change may increase the frequency or intensity of natural disasters. As such, we cannot assure you that climate change will not adversely impact our business, financial position, results of operations and liquidity.

The inability or failure of management in the future to conclude that we maintain effective internal control over financial reporting, or the inability of our independent registered public accounting firm to issue a report of our internal control over financial reporting, could have a material adverse effect on our business, financial position, results of operations and liquidity.

We report annually on the effectiveness of our internal control over financial reporting, and our independent registered public accounting firm also must audit the effectiveness of our internal control over financial reporting on an annual basis. If we fail to have, or management or our independent registered public accounting firm is unable to conclude that we maintain, effective internal controls and procedures for financial reporting, we could be unable to provide timely and reliable financial information which could have a material adverse effect on our business, financial position, results of operations and liquidity. Different interpretations of accounting principles or changes in generally accepted accounting principles could have a material adverse effect on our business, financial position, results of operations and liquidity.

Generally accepted accounting principles are complex, continually evolving and changing and may be subject to varied interpretation by third parties, including the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles or changes in generally accepted accounting principles could have a material adverse effect on our business, financial position, results of operations and liquidity.

## Item 1B. Unresolved Staff Comments

None.

## Item 2. Properties

For information concerning the hospitals and nursing centers operated by us, see “Part I – Item 1 – Business – Hospital Division – Hospital Facilities,” “Part I – Item 1 – Business – Nursing Center Division – Nursing Center Facilities,” and “Part I – Item 1 – Business – Master Lease Agreements.” We believe that our facilities are adequate for our future needs in such locations. All borrowings under the Credit Facilities are secured by a first priority lien and second priority lien on all

eligible real property, which is held in fee.

Our corporate headquarters is located in a 287,000 square foot building in Louisville, Kentucky.

We are subject to various federal, state and local laws and regulations governing the use, discharge and disposal of hazardous materials, including medical waste products. Compliance with these laws and regulations is not expected to have a material adverse effect on us. It is possible, however, that environmental issues may arise in the future which we cannot predict.

Item 3. Legal Proceedings

We are a party to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from our obligation to self-report suspected violations of law by the Company). We cannot predict the ultimate outcome of pending litigation and regulatory and other governmental and internal audits and investigations. These matters could potentially subject us to sanctions, damages, recoupments, fines and other penalties, some of which may not be covered by insurance. The DOJ, CMS or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future which may, either individually or in the aggregate, have a material adverse effect on our business, financial position, results of operations and liquidity. Certain material pending proceedings are described below. See note 20 of the notes to consolidated financial statements for a description of other pending legal proceedings.

Whistleblower lawsuits

Our subsidiary, RehabCare, and two other unrelated therapy services providers, were defendants in a whistleblower lawsuit styled United States ex rel. Health Dimensions Rehabilitation, Inc. v. RehabCare Group, Inc., et al. in federal district court for the Eastern District of Missouri, which settled in January 2014. This action was filed under seal in federal district court for the District of Minnesota on July 11, 2007 and transferred to federal district court for the Eastern District of Missouri in May 2012.

The lawsuit pertained to a subcontractor arrangement entered in 2006 by RehabCare and another unrelated therapy service provider, and fees paid under and in connection with the transaction. The complaint alleged civil violations of the federal False Claims Act based upon an underlying claim that the transaction violated the federal Anti-Kickback Statute. The United States sought single damages in the amount of approximately $226 million, treble damages, per claim penalties of $5,500 to $11,000 for each claim submitted, other unspecified damages, attorneys' fees and costs. Based upon the results of certain pre-trial motions, new facts associated with the case and settlement discussions occurring in September 2013, we recorded an additional $23 million loss provision in the third quarter of 2013 (for a total loss reserve of $25 million) related to this matter. In January 2014, the lawsuit was settled with our payment of $25 million to the United States and $150,000 to the whistleblower's attorneys and was dismissed by the court with prejudice.

Class action lawsuit

On January 6, 2014, a purported class action complaint was filed in the United States federal district court for the Southern District of Florida, Miami Division, against us and one of our subsidiaries. The lawsuit, styled Pines Nursing Home, et al., v. Polaris and RehabCare Group, Inc., et al., alleges that one of our subsidiaries sent "junk" faxes in violation of the Telephone Consumer Protection Act of 1991 and the Junk Fax Prevention Act of 2005. The complaint seeks damages, statutory fines and penalties, attorneys' fees and an injunction prohibiting such conduct in the future. We dispute the allegations in the complaint and will defend this lawsuit vigorously.

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 PRICE FOR COMMON STOCK

AND DIVIDEND HISTORY

Our common stock is quoted on the New York Stock Exchange (the "NYSE") under the ticker symbol "KND." The prices in the table below, for the calendar quarters indicated, represent the high and low sale prices for our common stock as reported on the NYSE.

| | Sales price of common stock | |
|---|---|---|
| 2013 | High | Low |
| First quarter | $11.74 | $10.21 |
| Second quarter | $14.49 | $9.75 |
| Third quarter | $16.63 | $12.50 |
| Fourth quarter | $20.51 | $13.13 |

| 2012 | High | Low |
|---|---|---|
| First quarter | $13.62 | $8.63 |
| Second quarter | $10.87 | $7.60 |
| Third quarter | $12.76 | $8.80 |
| Fourth quarter | $12.13 | $9.68 |

Our Credit Facilities and the indenture governing the Notes contain covenants that limit, among other things, our ability to pay dividends. Any determination to pay dividends in the future will be dependent upon our results of operations, financial position, our liquidity needs, compliance with our Credit Facilities and the indenture governing the Notes, restrictions imposed by applicable laws and other factors deemed relevant by our Board of Directors.

On August 5, 2013, we announced that our Board of Directors had approved the initiation of a quarterly cash dividend to our shareholders. An initial quarterly cash dividend of $0.12 per common share was paid on September 9, 2013 to shareholders of record as of the close of business on August 19, 2013. A subsequent quarterly cash dividend of $0.12 per common share was paid on December 9, 2013 to shareholders of record as of the close of business on November 18, 2013.

As of January 31, 2014, there were 1,810 holders of record of our common stock.

See “Part III – Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters,” for disclosures regarding our equity compensation plans.

PERFORMANCE GRAPH

The following graph summarizes the cumulative total return to shareholders of our common stock from December 31, 2008 to December 31, 2013, compared to the cumulative total return on the Standard & Poor's 500 Stock Index (the "S&P Composite Index") and the Standard & Poor's 1500 Health Care Index (the "S&P 1500 Health Care Index"). The graph assumes an investment of $100 in each of our common stock, the S&P Composite Index, and the S&P 1500 Health Care Index on December 31, 2008, and also assumes the reinvestment of all cash dividends.

COMPARISON OF CUMULATIVE TOTAL RETURN

| | 12/31/08 | 12/31/09 | 12/31/10 | 12/30/11 | 12/31/12 | 12/31/13 |
|---|---|---|---|---|---|---|
| Kindred Healthcare, Inc. | $100.00 | $141.78 | $141.09 | $90.40 | $83.10 | $154.07 |
| S&P Composite Index | 100.00 | 126.46 | 145.51 | 148.59 | 172.37 | 228.19 |
| S&P 1500 Health Care Index | 100.00 | 120.76 | 127.04 | 142.13 | 168.22 | 239.19 |

ISSUER PURCHASES OF EQUITY SECURITIES

| Period | Total number of shares (or units) purchased (1) | Average price paid per share (or unit) (2) | Total number of shares (or units) purchased as part of publicly announced plans or programs | Maximum number (or approximate dollar value) of shares (or units) that may yet be purchased under the plans or programs (1) |
|---|---|---|---|---|
| Month #1 (October 1 – October 31) | 1,023 | $ 14.40 | – | $ – |
| Month #2 (November 1 – November 30) | – | – | – | – |
| Month #3 (December 1 – December 31) | 35,747 | 18.83 | – | – |
| Total | 36,770 | $ 18.71 | – | $ – |

(1) These amounts represent shares of our common stock, par value $0.25 per share, (i) withheld to offset tax withholding obligations that occurred upon the vesting and release of service-based restricted share awards previously granted under our stock-based compensation plans for our employees (the "Withheld Shares"), and (ii) tendered to pay the exercise price and tax withholding obligations on stock options previously granted under our equity plans for our employees and directors (the "Tendered Shares"). The total tax withholding obligation is calculated by dividing the closing price of our common stock on the NYSE on the applicable vesting date to determine the total number of Withheld Shares required to satisfy such withholding obligation. The option exercise payment was divided by the closing price of our common stock on the NYSE on the day prior to the date the option was exercised to determine the total number of Tendered Shares required to satisfy such option exercise payment.

(2) The average price per share for each period was calculated by dividing the sum of the aggregate value of the Withheld Shares and Tendered Shares by the total number of Withheld Shares and Tendered Shares.

Item 6. Selected Financial Data

On June 1, 2011, we completed the RehabCare Merger, and the operating results of RehabCare have been included as part of our selected financial data since June 1, 2011. For more information about the RehabCare Merger, see "Part I – Item 1 – Business – General – RehabCare Merger" and note 4 of the notes to consolidated financial statements.

In 2013 and in recent years, we have completed several strategic divestitures to improve our future operating results. For accounting purposes, the operating results of these businesses and the losses associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented. See notes 2 and 3 of the notes to consolidated financial statements.

The results of operations for the historical periods included in the following table are not necessarily indicative of the results to be expected for future periods. In addition, see “Part I – Item 1A – Risk Factors” for a discussion of risk factors that could impact our future results of operations, including the RehabCare Merger.

| | Year ended December 31, | | | | |
|---|---|---|---|---|---|
| (In thousands, except per share amounts) | 2013 | 2012 | 2011 | 2010 | 2009 |
| Statement of Operations Data: | | | | | |
| Revenues | $4,900,510 | $4,928,509 | $4,212,526 | $3,130,655 | $3,051,638 |
| Salaries, wages and benefits | 2,988,487 | 3,012,321 | 2,576,673 | 1,859,013 | 1,822,486 |
| Supplies | 328,999 | 343,102 | 314,102 | 261,284 | 254,153 |
| Rent | 318,077 | 310,178 | 281,330 | 242,979 | 234,681 |
| Other operating expenses | 985,883 | 914,272 | 852,537 | 655,955 | 616,073 |
| Other income | (1,440) | (12,660) | (13,180) | (12,210) | (13,100) |
| Impairment charges | 77,193 | 108,953 | 73,554 | – | – |
| Depreciation and amortization | 157,329 | 162,685 | 128,875 | 91,305 | 94,089 |
| Interest expense | 108,049 | 107,875 | 80,900 | 7,054 | 7,851 |
| Investment income | (4,051) | (997) | (988) | (1,212) | (4,380) |
| | 4,958,526 | 4,945,729 | 4,293,803 | 3,104,168 | 3,011,853 |
| Income (loss) from continuing operations before income taxes | (58,016) | (17,220) | (81,277) | 26,487 | 39,785 |
| Provision (benefit) for income taxes | (13,204) | 29,707 | (14,041) | 9,311 | 15,267 |
| Income (loss) from continuing operations | (44,812) | (46,927) | (67,236) | 17,176 | 24,518 |
| Discontinued operations, net of income taxes: | | | | | |
| Income (loss) from operations | (36,136) | 12,348 | 13,517 | 39,768 | 39,025 |
| Loss on divestiture of operations | (83,887) | (4,745) | – | (453) | (23,432) |
| Income (loss) from discontinued operations | (120,023) | 7,603 | 13,517 | 39,315 | 15,593 |
| Net income (loss) | (164,835) | (39,324) | (53,719) | 56,491 | 40,111 |
| (Earnings) loss attributable to noncontrolling interests | (3,657) | (1,043) | 238 | – | – |
| Income (loss) attributable to Kindred | $(168,492) | $(40,367) | $(53,481) | $56,491 | $40,111 |
| Amounts attributable to Kindred stockholders: | | | | | |
| Income (loss) from continuing operations | $(48,469) | $(47,970) | $(66,998) | $17,176 | $24,518 |
| Income (loss) from discontinued operations | (120,023) | 7,603 | 13,517 | 39,315 | 15,593 |
| Net income (loss) | $(168,492) | $(40,367) | $(53,481) | $56,491 | $40,111 |
| Earnings (loss) per common share: | | | | | |
| Basic: | | | | | |
| Income (loss) from continuing operations | $(0.93) | $(0.93) | $(1.45) | $0.43 | $0.63 |
| Discontinued operations: | | | | | |
| Income (loss) from operations | (0.69) | 0.24 | 0.29 | 1.01 | 1.00 |
| Loss on divestiture of operations | (1.61) | (0.09) | – | (0.01) | (0.60) |
| Income (loss) from discontinued operations | (2.30) | 0.15 | 0.29 | 1.00 | 0.40 |
| Net income (loss) | $(3.23) | $(0.78) | $(1.16) | $1.43 | $1.03 |
| Diluted: | | | | | |
| Income (loss) from continuing operations | $(0.93) | $(0.93) | $(1.45) | $0.44 | $0.62 |
| Discontinued operations: | | | | | |
| Income (loss) from operations | (0.69) | 0.24 | 0.29 | 1.00 | 1.00 |

| | | | | | |
|---|---|---|---|---|---|
| Loss on divestiture of operations | (1.61) | (0.09) | – | (0.01) | (0.60) |
| Income (loss) from discontinued operations | (2.30) | 0.15 | 0.29 | 0.99 | 0.40 |
| Net income (loss) | $(3.23) | $(0.78) | $(1.16) | $1.43 | $1.02 |
| Shares used in computing earnings (loss) per common share: | | | | | |
| Basic | 52,249 | 51,659 | 46,280 | 38,738 | 38,339 |
| Diluted | 52,249 | 51,659 | 46,280 | 38,954 | 38,502 |
| Cash dividends declared and paid per common share | $0.24 | $– | $– | $– | $– |
| Financial Position: | | | | | |
| Working capital | $404,307 | $438,435 | $384,359 | $214,654 | $241,032 |
| Total assets | 3,945,869 | 4,237,946 | 4,138,493 | 2,337,415 | 2,022,224 |
| Long-term debt | 1,579,391 | 1,648,706 | 1,531,882 | 365,556 | 147,647 |
| Equity | 1,121,216 | 1,292,844 | 1,320,541 | 1,031,759 | 966,594 |

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

You should read the following discussion together with the selected financial data in Item 6 and our consolidated financial statements and the notes thereto included in this Annual Report on Form 10-K. All financial and operating data presented in Items 6 and 7 reflect the continuing operations of our business for all periods presented unless otherwise indicated.

Overview

We are a healthcare services company that through our subsidiaries operates TC hospitals, IRFs, nursing centers, assisted living facilities, a contract rehabilitation services business and a home health and hospice business across the United States. At December 31, 2013, our hospital division operated 101 TC hospitals (7,315 licensed beds) and five IRFs (215 licensed beds) in 22 states. Our nursing center division operated 100 nursing centers (12,638 licensed beds) and six assisted living facilities (341 licensed beds) in 23 states. Our rehabilitation division provided rehabilitation services primarily in hospitals and long-term care settings. Our care management division primarily provided home health, hospice and private duty services from 159 locations in 13 states.

We have completed several strategic divestitures to improve our future operating results. For accounting purposes, the operating results of these businesses and the losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2013 have been measured at the lower of carrying value or estimated fair value less costs of disposal and have been classified as held for sale in the accompanying consolidated balance sheet. See notes 2 and 3 of the notes to consolidated financial statements.

The operating results of acquired businesses have been included in our accompanying consolidated financial statements from the respective acquisition dates.

RehabCare Merger

On June 1, 2011, we completed the RehabCare Merger. Upon consummation of the RehabCare Merger, each issued and outstanding share of RehabCare common stock was converted into the right to receive the Merger Consideration. We issued approximately 12 million shares of our common stock in connection with the RehabCare Merger. The purchase price totaled $963 million and was comprised of $662 million in cash and $301 million of our common stock at fair value. We also assumed $356 million of long-term debt in the RehabCare Merger, of which $345 million was refinanced on June 1, 2011. The operating results of RehabCare have been included in our accompanying consolidated financial statements since June 1, 2011.

At the RehabCare Merger date, we acquired 32 TC hospitals, five IRFs, approximately 1,200 rehabilitation therapy sites of service and 102 hospital-based inpatient rehabilitation units. The RehabCare Merger expanded our service offerings, positioned us for future growth and provided opportunities for significant operating synergies.

In connection with the RehabCare Merger, we entered into the Credit Facilities and issued the Notes. In 2011, we used proceeds from the Credit Facilities and the Notes to pay the Merger Consideration, repay all amounts outstanding under our and RehabCare's previous credit facilities and to pay transaction costs. The amounts outstanding under our and RehabCare's former credit facilities that were repaid at the RehabCare Merger closing were $390 million and $345 million, respectively. The Credit Facilities also included an option to increase the credit capacity in an aggregate amount between the two facilities by $200 million. We exercised this option to increase the aggregate credit capacity by $200 million in October 2012. See note 12 of the notes to consolidated financial statements. In connection with the Credit Facilities and the Notes, we paid $46 million of lender fees related to debt issuance that were capitalized as deferred financing costs during 2011 and paid $13 million of other financing costs that were charged to interest

expense during 2011. See "– Liquidity" for additional information on the Credit Facilities and the Notes.

Senior Home Care Acquisition

In December 2013, we completed the Senior Home Care Acquisition for $95 million, which was financed through operating cash flows and proceeds from our ABL Facility. The Senior Home Care Acquisition included 47 home health locations in Florida and Louisiana.

HCP Acquisition

In November 2013, we signed a definitive agreement with HCP to acquire the real estate associated with nine nursing centers that we leased from HCP for approximately $83 million. The annual lease payments for these nursing centers were approximately $9 million. We completed the acquisition of seven of these nursing centers during 2013 for a total consideration of approximately $61 million. The two remaining facilities were acquired in February 2014.

IntegraCare Acquisition

In August 2012, we completed the IntegraCare Acquisition for $71 million in cash plus a potential $4 million cash earn out based on 2013 earnings growth, which was financed through operating cash flows and proceeds from our ABL Facility. The IntegraCare Acquisition included 47 home health and hospice locations across Texas.

Professional Acquisition

In September 2011, we completed the Professional Acquisition for $51 million, which was financed through operating cash flows and proceeds from our ABL Facility. The Professional Acquisition included 27 home health and hospice locations in northern California, Arizona, Nevada and Utah.

Divestitures

Vibra Sale In September 2013, we completed the sale of the Vibra Facilities for approximately $187 million to an affiliate of Vibra. The net proceeds of approximately $180 million from this transaction were used to reduce borrowings under our ABL Facility.

The Vibra Facilities consist of 14 TC hospitals containing 1,002 licensed beds, one IRF containing 44 licensed beds and one nursing center containing 135 licensed beds. Six of the TC hospitals and the one nursing center were owned facilities. The remaining Vibra Facilities were leased. The Vibra Facilities generated revenues of approximately $272 million and segment operating income of approximately $40 million (excluding the allocation of approximately $8 million of overhead costs) for the year ended December 31, 2012. The Vibra Facilities had aggregate rent expense of approximately $12 million for the year ended December 31, 2012.

We recorded a loss on divestiture of $94 million ($74 million net of income taxes) for the year ended December 31, 2013 related to the Vibra Facilities. The loss on divestiture included a $69 million write-off of goodwill, which was allocated based upon the relative fair value of the Vibra Facilities, and a $21 million write-off of intangible assets.

Signature Sale In July 2013, we completed the sale of the Signature Facilities for approximately $47 million to affiliates of Signature. The proceeds from this transaction were used to reduce the borrowings under our ABL Facility.

The Signature Facilities contain 900 licensed beds. Five of the Signature Facilities were owned facilities and the remaining Signature Facilities were leased. The Signature Facilities generated revenues of approximately $63 million and segment operating income of approximately $11 million (excluding the allocation of approximately $2 million of overhead costs) for the year ended December 31, 2012. The Signature Facilities had aggregate rent expense of approximately $2 million for the year ended December 31, 2012.

We recorded a loss on divestiture of $2 million ($1 million net of income taxes) for the year ended December 31, 2013 related to the Signature Facilities.

The results of operations and losses on divestiture of operations, net of income taxes, for the Signature Facilities and the Vibra Facilities were reclassified to discontinued operations during 2013.

Ventas Divestitures On September 30, 2013, we entered into agreements to exit the 2013 Expiring Facilities. The current lease term for the 2013 Expiring Facilities was scheduled to expire in April 2015. Under the terms of the agreements, the lease term for the 2013 Expiring Facilities will now expire on September 30, 2014. For accounting purposes, the 2013 Expiring Facilities qualified as assets held for sale and we reflected the operating results as discontinued operations in the accompanying consolidated statement of operations for all historical periods. Under the

terms of the agreements, we paid $20 million to Ventas in exchange for the early termination of certain leases. The early termination payment was recorded as rent expense in discontinued operations in 2013. The disposal group was measured at its fair value less cost to sell and we recorded an asset impairment charge of $8 million related to leasehold improvements in the 2013 Expiring Facilities. These charges were recorded in discontinued operations in the third quarter of 2013 in the accompanying consolidated statement of operations.

In April 2012, we announced that we would not renew the 2012 Expiring Facilities under operating leases with Ventas that expired on April 30, 2013. We transferred the operations of all of the 2012 Expiring Facilities to new operators during 2013 and we reclassified the results of operations and losses associated with the 2012 Expiring Facilities to discontinued operations, net of income taxes, for all periods presented. We received cash proceeds of $13 million for the year ended December 31, 2013 for the sale of property and equipment and inventory related to the 2012 Expiring Facilities.

Other Divestitures  During the fourth quarter of 2013, we also entered into an agreement for the planned disposition of a TC hospital. In connection with the planned disposition, we recorded a loss on divestiture of $9 million ($6 million net of income taxes) consisting of a real estate write-down of $8 million and a write-off of $1 million of goodwill, both based upon the relative fair value of

the hospital. For accounting purposes, we reflected the operating results of this facility as discontinued operations in the accompanying consolidated statement of operations for all historical periods.

During 2012, we sold one TC hospital and closed two additional TC hospitals, each reported as discontinued operations, resulting in a loss on divestiture aggregating $8 million ($5 million net of income taxes).

During 2013, in connection with the closing of a TC hospital reported as continuing operations, we recorded costs of $6 million ($4 million net of income taxes) primarily consisting of a write-off of an indefinite-lived asset of $3 million, a write-off of $1 million of goodwill based upon the relative fair value of the hospital and a $2 million fair value adjustment of real estate.

During 2013, we also recorded a write-off of an indefinite-lived intangible asset of $1 million associated with closing a home health location reported as continuing operations.

Critical Accounting Policies

Our discussion and analysis of financial condition and results of operations are based upon our consolidated financial statements which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires the use of estimates and judgments that affect the reported amounts and related disclosures of commitments and contingencies. We rely on historical experience and on various other assumptions that we believe to be reasonable under the circumstances to make judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ materially from these estimates.

We believe the following critical accounting policies, among others, affect the more significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenue recognition

We have agreements with third party payors that provide for payments to each of our operating divisions. These payment arrangements may be based upon prospective rates, reimbursable costs, established charges, discounted charges or per diem payments. Net patient service revenue is recorded at the estimated net realizable amounts from Medicare, Medicaid, Medicare Advantage, other third party payors and individual patients for services rendered. Retroactive adjustments that are likely to result from future examinations by third party payors are accrued on an estimated basis in the period the related services are rendered and adjusted as necessary in future periods based upon new information or final settlements.

A summary of revenues by payor type follows (in thousands):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| Medicare | $2,057,761 | $2,098,383 | $1,844,116 |
| Medicaid | 579,322 | 564,426 | 563,486 |
| Medicare Advantage | 374,996 | 359,595 | 311,283 |
| Other | 2,102,660 | 2,114,859 | 1,677,885 |
| | 5,114,739 | 5,137,263 | 4,396,770 |
| Eliminations | (214,229 ) | (208,754 ) | (184,244 ) |

| | | |
|---|---|---|
| $4,900,510 | $4,928,509 | $4,212,526 |

Collectibility of accounts receivable

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies, skilled nursing and hospital customers, and individual patients and other customers. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

In evaluating the collectibility of accounts receivable, we consider a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third party payors and general industry conditions. Actual collections of accounts receivable in subsequent periods may require changes in the estimated provision for loss. Changes in these estimates are charged or credited to the results of operations in the period of the change. Based upon improved cash collections in our rehabilitation division, we recognized a change in estimate that reduced the provision for doubtful accounts by $8 million in 2012.

The provision for doubtful accounts totaled $27 million for 2013, $11 million for 2012 and $20 million for 2011.

Allowances for insurance risks

We insure a substantial portion of our professional liability risks and workers compensation risks through our limited purpose insurance subsidiary. Provisions for loss for these risks are based upon management's best available information including actuarially determined estimates.

The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of, or less than, the amounts recorded. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited.

Provisions for loss for professional liability risks retained by our limited purpose insurance subsidiary have been discounted based upon actuarial estimates of claim payment patterns using a discount rate of 1% to 5% depending upon the policy year. The discount rate was 1% for the 2011 through 2013 policy years and 1% to 5% for all prior policy years. The discount rates are based upon the risk free interest rate for the respective year. Amounts equal to the discounted loss provision are funded annually. We do not fund the portion of professional liability risks related to estimated claims that have been incurred but not reported. Accordingly, these liabilities are not discounted. The allowance for professional liability risks aggregated $307 million at December 31, 2013 and $291 million at December 31, 2012. If we did not discount any of the allowances for professional liability risks, these balances would have approximated $310 million at December 31, 2013 and $293 million at December 31, 2012.

As a result of deterioration in professional liability and workers compensation underwriting results of our limited purpose insurance subsidiary in 2012 and 2011, we made capital contributions of $14 million and $9 million in 2013 and 2012, respectively, to our limited purpose insurance subsidiary. Conversely, as a result of improved professional liability underwriting results of our limited purpose insurance subsidiary in 2010, we received a distribution of $3 million in 2011 from our limited purpose insurance subsidiary. These transactions were completed in accordance with applicable regulations. Neither the capital contributions nor the distribution had any impact on earnings.

Changes in the number of professional liability claims and the cost to settle these claims significantly impact the allowance for professional liability risks. A relatively small variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the allowance for professional liability risks. For example, a 1% variance in the allowance for professional liability risks at December 31, 2013 would impact our operating income by approximately $3 million.

The provision for professional liability risks (continuing operations), including the cost of coverage maintained with unaffiliated commercial reinsurance carriers, aggregated $57 million for 2013, $53 million for 2012 and $43 million for 2011. The increase in 2013 and 2012 was primarily attributable to an increase in frequency and severity of claims. Changes in estimates for prior year professional liability costs reduced professional liability costs by approximately $7 million, $6 million and $13 million in 2013, 2012 and 2011, respectively.

With respect to our discontinued operations, we recorded an unfavorable pretax adjustment of $9 million in 2013 and favorable pretax adjustments of $2 million in 2012 and $3 million in 2011 resulting from changes in estimates for professional liability reserves related to prior years.

Provisions for loss for workers compensation risks retained by our limited purpose insurance subsidiary are not discounted and amounts equal to the loss provision are funded annually. The allowance for workers compensation risks aggregated $188 million at December 31, 2013 and $193 million at December 31, 2012. The provision for workers compensation risks (continuing operations), including the cost of coverage maintained with unaffiliated

commercial insurance carriers, aggregated $39 million for 2013, $42 million for 2012 and $40 million for 2011. The decrease in workers compensation costs in 2013 was primarily attributable to prior year commercial insurance adjustments while the increase in 2012 was primarily attributable to an increase in claims resulting from the growth in the number of employees, primarily from the RehabCare Merger.

See notes 3 and 9 of the notes to consolidated financial statements.

Accounting for income taxes

The provision (benefit) for income taxes is based upon our annual reported income or loss for each respective accounting period. We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets are recovered or liabilities are settled. We also recognize as deferred

tax assets the future tax benefits from net operating losses ("NOLs") and capital loss carryforwards. A valuation allowance is provided for these deferred tax assets if it is more likely than not that some portion or all of the net deferred tax assets will not be realized.

Our effective income tax rate was 22.8% in 2013, 172.5% in 2012 and 17.3% in 2011. The effective income tax rate for 2013 and 2012 was negatively impacted by $32 million and $92 million, respectively, representing the portion of pretax asset impairment charges recorded in each period that are not deductible for income tax purposes. The effective income tax rate in 2011 was negatively impacted by certain impairment charges and transaction costs that were non-deductible for income tax purposes. We recorded favorable income tax adjustments related to the resolution of state income tax contingencies from prior years that reduced the provision for income taxes by approximately $0.6 million in 2013, $0.2 million in 2012 and $3 million in 2011.

There are significant uncertainties with respect to capital loss carryforwards that could affect materially the realization of certain deferred tax assets. Accordingly, we have recognized deferred tax assets to the extent it is more likely than not they will be realized and a valuation allowance is provided for deferred tax assets to the extent that it is uncertain that the deferred tax asset will be realized. We recognized net deferred tax assets totaling $55 million at December 31, 2013 and $3 million at December 31, 2012.

We identified deferred income tax assets for state income tax NOLs of $57 million and $53 million at December 31, 2013 and 2012, respectively, and a corresponding deferred income tax valuation allowance of $50 million and $48 million at December 31, 2013 and 2012, respectively, for that portion of the net deferred income tax assets that we will likely not realize in the future. We had deferred tax assets for federal income tax NOLs of $26 million and $8 million at December 31, 2013 and 2012, respectively, with a corresponding deferred income tax valuation allowance of $0.2 million at December 31, 2013 and no deferred income tax valuation allowance at December 31, 2012. The federal income tax NOLs expire in various amounts through 2034.

We are subject to various federal and state income tax audits in the ordinary course of business. Such audits could result in increased tax payments, interest and penalties. While we believe our tax positions are appropriate, we cannot assure you that the various authorities engaged in the examination of our income tax returns will not challenge our positions.

We record accrued interest and penalties associated with uncertain tax positions as income tax expense in the consolidated statement of operations. Accrued interest related to uncertain tax provisions totaled $0.1 million as of December 31, 2013 and December 31, 2012.

To the extent the unrecognized income tax benefits become realized or the related accrued interest is no longer necessary, our provision for income taxes would be favorably impacted by $0.3 million.

The federal statute of limitations remains open for tax years 2010 through 2012. During 2013, we resolved federal income tax audits for the 2010 through 2011 tax years. We are currently under examination by the Internal Revenue Service (the "IRS") for the 2012 and 2013 tax years. We have been accepted into the IRS's Compliance Assurance Process ("CAP") for the 2012 through 2014 tax years. CAP is an enhanced, real-time review of a company's tax positions and compliance. We expect participation in CAP to improve the timeliness of our federal tax examinations.

State jurisdictions generally have statutes of limitations for tax returns ranging from three to five years. The state impact of federal income tax changes remains subject to examination by various states for a period of up to one year after formal notification to the states. We currently have various state income tax returns under examination.

In connection with the RehabCare Merger, an accounting method change for the 2011 tax year resulted in a non-recurring reduction in income tax payments of approximately $8 million during 2012. Our earnings were not impacted by this transaction.

Valuation of long-lived assets, goodwill and intangible assets

We review the carrying value of certain long-lived assets and finite lived intangible assets with respect to any events or circumstances that indicate an impairment or an adjustment to the amortization period is necessary. If circumstances suggest that the recorded amounts cannot be recovered based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

In assessing the carrying values of long-lived assets, we estimate future cash flows at the lowest level for which there are independent, identifiable cash flows. For this purpose, these cash flows are aggregated based upon the contractual agreements underlying the operation of the facility or group of facilities. Generally, an individual facility is considered the lowest level for which there are independent, identifiable cash flows. However, to the extent that groups of facilities are leased under a master lease agreement in which the operations of a facility and compliance with the lease terms are interdependent upon other facilities in the agreement (including our ability to renew the lease or divest a particular property), we define the group of facilities under a master lease agreement as the lowest level for which there are independent, identifiable cash flows. Accordingly, the estimated cash flows of all facilities within a master lease agreement are aggregated for purposes of evaluating the carrying values of long-lived assets.

Our intangible assets with finite lives are amortized in accordance with the authoritative guidance for goodwill and other intangible assets using the straight-line method over their estimated useful lives ranging from one to 20 years. As a result of the RehabCare Merger, we acquired finite lived intangible assets consisting of customer relationships ($189 million), a trade name ($17 million) and non-compete agreements ($3 million) with estimated useful lives ranging from two to 15 years.

In connection with the preparation of our operating results for the fourth quarter of 2013, we determined that the impact of regulatory changes announced on November 22, 2013 related to our home health reporting unit was an impairment triggering event. The regulatory changes resulted from action by CMS to, among other changes, rebase home health payment rates by reducing the national standardized 60 day episode payment rate by 2.8% in each of the next four years beginning January 1, 2014. We tested the recoverability of the home health reporting unit goodwill, other intangible assets and long-lived assets. We recorded a pretax impairment charge aggregating $76 million ($58 million net of income taxes) in the fourth quarter of 2013 to reflect the amount by which the carrying value of our home health reporting unit goodwill exceeded the estimated fair value. We determined that other intangible assets and long-lived assets in the home health reporting unit were not impaired.

In connection with the preparation of our operating results for the fourth quarter of 2012, we determined that the impact of regulatory changes related to our skilled nursing rehabilitation services reporting unit was a triggering event in the fourth quarter of 2012, simultaneously with our annual impairment test. The regulatory changes included a new pre-payment manual medical review process for certain Medicare Part B services exceeding $3,700 which became effective October 1, 2012 and new rules which became effective April 1, 2013 under the Taxpayer Relief Act that reduced Medicare Part B payments by an additional 25% for subsequent procedures when multiple therapy services are provided on the same day. We tested the recoverability of our skilled nursing rehabilitation services reporting unit goodwill, other intangible assets and long-lived assets. We recorded a pretax impairment charge aggregating $108 million ($102 million net of income taxes) (which represented the entire skilled nursing rehabilitation services reporting unit goodwill) in the fourth quarter of 2012 to reflect the amount by which the carrying value of goodwill exceeded the estimated fair value. We determined that other intangible assets and long-lived assets in the skilled nursing rehabilitation services reporting unit were not impaired.

On July 29, 2011, CMS issued the 2011 CMS Rules. In connection with the 2011 CMS Rules, we determined that the impact of the 2011 CMS Rules was a triggering event in the third quarter of 2011 and accordingly tested the recoverability of our nursing centers reporting unit goodwill, intangible assets and property and equipment asset groups impacted by the reduced Medicare payments. We recorded pretax impairment charges aggregating $11 million ($7 million net of income taxes) in 2011. The charges included $6 million of goodwill (which represented the entire nursing centers reporting unit goodwill) and $5 million of property and equipment. In addition, we recorded pretax impairment charges aggregating $1 million ($1 million net of income taxes) for both of the years ended December 31, 2013 and 2012 of property and equipment expenditures in the same nursing center asset groups.

During 2011, the estimated negative impact from changes in the reimbursement of group rehabilitation therapy services to Medicare beneficiaries implemented by the 2011 CMS Rules on October 1, 2011 was greater than expected, and as a result, we lowered our cash flow expectations for our skilled nursing rehabilitation services reporting unit, causing the carrying value of goodwill of this reporting unit to exceed its estimated fair value in testing the recoverability of goodwill. As a result, we recorded a pretax impairment charge of $46 million ($43 million net of income taxes) in 2011. We also reviewed the other intangible assets and long-lived assets related to the skilled nursing rehabilitation services reporting unit and determined there were no impairments of these assets.

All of the previously discussed charges reflect the amount by which the carrying value of certain assets exceeded their estimated fair value.

None of the previously discussed impairment charges impacted our cash flows or liquidity.

In accordance with the authoritative guidance for goodwill and other intangible assets, we are required to perform an impairment test for goodwill and indefinite-lived intangible assets at least annually or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. We perform our annual goodwill impairment test at the end of each fiscal year for each of our reporting units. A reporting unit is either an operating segment or one level below the operating segment, referred to as a component. When the components within our operating segments have similar economic characteristics, we aggregate the components of our operating segments into one reporting unit. Accordingly, we have determined that our reporting units are hospitals, nursing centers, skilled nursing rehabilitation services, hospital rehabilitation services, home health and hospice. The home health and hospice reporting units are included in the care management division. The carrying value of goodwill for each of our reporting units at December 31, 2013 and December 31, 2012 follows (in thousands):

| | December 31, 2013 | December 31, 2012 |
|---|---|---|
| Hospitals | $ 679,480 | $ 747,065 |
| Nursing centers | – | – |
| Rehabilitation division: | | |
| Skilled nursing rehabilitation services | – | – |
| Hospital rehabilitation services | 173,334 | 168,019 |
| Home health | 112,378 | 99,317 |
| Hospice | 26,910 | 26,865 |
| | $ 992,102 | $ 1,041,266 |

As a result of the RehabCare Merger, goodwill was assigned to our hospital reporting unit ($534 million), skilled nursing rehabilitation services reporting unit ($151 million) and hospital rehabilitation services reporting unit ($168 million).

The goodwill impairment test involves a two-step process. The first step is a comparison of each reporting unit's fair value to its carrying value. If the carrying value of the reporting unit is greater than its fair value, there is an indication that impairment may exist and the second step must be performed to measure the amount of impairment loss, if any. Based upon the results of the step one impairment test for goodwill for hospitals, hospital rehabilitation services and hospice reporting units for the year ended December 31, 2013, no goodwill impairment charges were recorded in connection with our annual impairment test. Based upon the results of the step one impairment test for goodwill for our hospitals, hospital rehabilitation services, home health and hospice reporting units for the years ended December 31, 2012 and December 31, 2011, no impairment charges were recorded.

Since quoted market prices for our reporting units are not available, we apply judgment in determining the fair value of these reporting units for purposes of performing the goodwill impairment test. We rely on widely accepted valuation techniques, including discounted cash flow and market multiple analyses approaches, which capture both the future income potential of the reporting unit and the market behaviors and actions of market participants in the industry that includes the reporting unit. These types of analyses require us to make assumptions and estimates regarding future cash flows, industry-specific economic factors and the profitability of future business strategies. The discounted cash flow approach uses a projection of estimated operating results and cash flows that are discounted using a weighted average cost of capital. Under the discounted cash flow approach, the projection uses management's best estimates of economic and market conditions over the projected period for each reporting unit including growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense and capital expenditures. Other significant estimates and assumptions include terminal value growth rates, changes in working capital requirements and weighted average cost of capital. The market multiple analysis estimates fair value by applying cash flow multiples to the reporting unit's operating results. The multiples are derived from comparable

publicly traded companies with similar operating and investment characteristics to the reporting units.

Other than the impairment of goodwill for our home health reporting unit, we have determined that there was no other goodwill or other intangible asset impairments as of December 31, 2013. However, adverse changes in the operating environment and related key assumptions used to determine the fair value of our reporting units and indefinite-lived intangible assets or declines in the value of our common stock may result in future impairment charges for a portion or all of these assets. Specifically, if the rate of growth of government and commercial revenues earned by our reporting units were to be less than projected or if healthcare reforms were to negatively impact our business, an impairment charge of a portion or all of these assets may be required. An impairment charge could have a material adverse effect on our business, financial position and results of operations, but would not be expected to have an impact on our cash flows or liquidity.

Indefinite-lived intangible assets

Our indefinite-lived intangible assets consist of trade names, Medicare certifications and certificates of need. The fair values of our indefinite-lived intangible assets are derived from current market data and projections at a facility level which include management's best estimates of economic and market conditions over the projected period including growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense and capital expenditures. Other significant estimates and assumptions include terminal value growth rates, changes in working capital requirements and weighted average cost of capital. Certificates of need intangible assets are estimated primarily using both a replacement cost methodology and an excess earnings method, a form of discounted cash flows, which is based upon the concept that net after-tax cash flows provide a return supporting all of the assets of a business enterprise.

At December 31, 2011, the carrying value of our certificates of need intangible assets exceeded its fair value as a result of declining earnings and cash flows related to five hospitals and two co-located nursing centers in Massachusetts, all of which were acquired in 2006. The declining earnings and cash flows were attributable to a difficult LTAC hospital operating environment in Massachusetts in which we were unable to achieve consistent operating results, as well as automatic future Medicare reimbursement reductions triggered in December 2011 by the Budget Control Act of 2011. In addition, we decided in the fourth quarter of 2011 to close one of the five hospitals. The pretax impairment charge related to the certificates of need totaled $54 million ($33 million net of income taxes), of which $38 million ($23 million net of income taxes) was reclassified to discontinued operations. We reviewed the other long-lived assets related to these five hospitals and two co-located nursing centers and determined there was no impairment. Based upon the results of the annual impairment test for indefinite-lived intangible assets other than certificates of need intangible assets discussed above for the years ended December 31, 2013, 2012 and 2011, no impairment charges were recorded.

As a result of the RehabCare Merger, we acquired indefinite-lived intangible assets consisting of trade names ($115 million), Medicare certifications ($76 million) and certificates of need ($8 million).

The annual impairment tests for certain of our indefinite-lived intangible assets are performed as of May 1, July 1, September 1 and October 1 while all others are performed as of December 31. No impairment charges were recorded in connection with the annual impairment tests as of October 1, 2013, September 1, 2013, July 1, 2013 or May 1, 2013.

Recently Issued Accounting Requirements

In July 2013, the Financial Accounting Standards Board (the "FASB") issued authoritative guidance related to financial statement presentation of an unrecognized tax benefit. The main provisions of the guidance state that an entity must present an unrecognized tax benefit, or a portion of an unrecognized tax benefit, in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. The guidance is effective for all interim and annual reporting periods beginning after December 15, 2013. Early adoption is permitted for all entities. The adoption of the guidance is not expected to have a material impact on our business, financial position, results of operations or liquidity.

In February 2013, the FASB amended its authoritative guidance issued in December 2011 related to the deferral of the requirement to present reclassification adjustments out of accumulated other comprehensive income in both the statement in which net income is presented and the statement in which other comprehensive income is presented. The amended provisions require an entity to provide information about the amounts reclassified out of accumulated other comprehensive income by component. In addition, an entity is required to present, either on the face of the statement where net income is presented or in the notes, significant amounts reclassified out of accumulated other

comprehensive income by the respective line items of net income but only if the amount reclassified is required under United States generally accepted accounting principles to be reclassified to net income in its entirety in the same reporting period. For all other amounts, an entity is required to cross-reference to other disclosures that provide additional details about these amounts. All other requirements of the original June 2011 update were not impacted by the amendment which became effective for all interim and annual reporting periods beginning after December 15, 2012. The adoption of the guidance did not have a material impact on our business, financial position, results of operations or liquidity.

Impact of Medicare and Medicaid Reimbursement

We depend on reimbursement from third party payors, including the Medicare and Medicaid programs, for a substantial portion of our revenues. For the year ended December 31, 2013, we derived approximately 52% of our total revenues (before eliminations) from the Medicare and Medicaid programs and the balance from other third party payors, such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers.

The Medicare and Medicaid programs are highly regulated and subject to frequent and substantial changes. See “Part I – Item 1 – Business – Governmental Regulation” for an overview of the reimbursement systems impacting our businesses and “Part I – Item 1A – Risk Factors.”

Results of Operations – Continuing Operations

For the years ended December 31, 2013, 2012 and 2011

A summary of our operating data follows (dollars in thousands):

| | Year ended December 31, | | |
|---|---|---|---|
| | 2013 | 2012 | 2011 |
| Revenues: | | | |
| Hospital division | $2,521,649 | $2,604,925 | $2,265,106 |
| Nursing center division | 1,089,760 | 1,092,416 | 1,107,976 |
| Rehabilitation division: | | | |
| Skilled nursing rehabilitation services | 991,790 | 1,003,002 | 762,128 |
| Hospital rehabilitation services | 286,613 | 293,580 | 200,824 |
| | 1,278,403 | 1,296,582 | 962,952 |
| Care management division | 224,927 | 143,340 | 60,736 |
| | 5,114,739 | 5,137,263 | 4,396,770 |
| Eliminations: | | | |
| Skilled nursing rehabilitation services | (115,986) | (108,599) | (107,718) |
| Hospital rehabilitation services | (93,993) | (96,777) | (74,860) |
| Nursing centers | (4,250) | (3,378) | (1,666) |
| | (214,229) | (208,754) | (184,244) |
| | $4,900,510 | $4,928,509 | $4,212,526 |
| Loss from continuing operations: | | | |
| Operating income (loss): | | | |
| Hospital division | $523,156 | $562,224 | $457,867 |
| Nursing center division | 135,362 | 141,258 | 155,672 |
| Rehabilitation division: | | | |
| Skilled nursing rehabilitation services | 36,696 | 67,960 | 49,833 |
| Hospital rehabilitation services | 73,925 | 69,745 | 43,731 |
| | 110,621 | 137,705 | 93,564 |
| Care management division | 9,963 | 13,708 | 3,103 |
| Corporate: | | | |
| Overhead | (176,495) | (179,063) | (174,800) |
| Insurance subsidiary | (1,914) | (2,127) | (2,306) |
| | (178,409) | (181,190) | (177,106) |
| Impairment charges | (77,193) | (108,953) | (73,554) |
| Transaction costs | (2,112) | (2,231) | (50,706) |
| Operating income | 521,388 | 562,521 | 408,840 |
| Rent | (318,077) | (310,178) | (281,330) |
| Depreciation and amortization | (157,329) | (162,685) | (128,875) |
| Interest, net | (103,998) | (106,878) | (79,912) |
| Loss before income taxes | (58,016) | (17,220) | (81,277) |
| Provision (benefit) for income taxes | (13,204) | 29,707 | (14,041) |
| | $(44,812) | $(46,927) | $(67,236) |

A summary of our consolidating statement of operations follows (in thousands):

| | Year ended December 31, 2013 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Rehabilitation division | | | | | | | |
| | Hospital division (a,b) | Nursing center division (a) | Skilled nursing services (a,c,d) | Hospital services (a,c) | Total | Care management division (a,c,e) | Corporate (a,c,f) | Transaction-related costs | Eliminations | Consolidated |
| Revenues | $2,521,649 | $1,089,760 | $991,790 | | | | | | | |