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	–	–	