KINDRED HEALTHCARE, INC
Form 10-K
March 02, 2015

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, 2014

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, 2014, was approximately $1,430,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2015, there were 69,968,960 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 2015 definitive proxy statement, which will be filed no later than 120 days after December 31, 2014.

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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

This Annual Report on Form 10-K and the documents we incorporate by reference herein include 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"). These forward-looking statements include, but are not limited to, statements regarding our expected future financial position, results of operations, cash flows, dividends, 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," "would," "should," "will," "intend," "upside," and other similar expressions. Statements in this report concerning the business outlook or future economic performance, anticipated profitability, revenues, expenses, dividends 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 stockholders and other potential investors 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, performance or plans to differ materially from any future results, performance or plans 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 ("SEC").

In addition to the factors set forth above, other 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 the 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,

risks and uncertainties related to the Gentiva Merger (as defined below), including, but not limited to, uncertainties as to whether the Gentiva Merger will have the accretive effect on our earnings or cash flows that we expect, the inability to obtain, or delays in obtaining, cost savings and synergies from the Gentiva Merger, costs and difficulties related to the integration of Gentiva's businesses and operations with our businesses and operations, unexpected costs, liabilities, charges or expenses resulting from the Gentiva Merger, adverse effects on our stock price resulting from the Gentiva Merger, the inability to retain key personnel, and potential adverse reactions, changes to business

relationships or competitive responses resulting from the Gentiva Merger,
our ability to meet the substantial debt service requirements we incurred to finance the Gentiva Merger,
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,
our ability to comply with the terms of Gentiva's Corporate Integrity Agreement, which we became subject to as a result of the Gentiva Merger,
the impact of the final rules issued by CMS in 2012, which among other things, reduced 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 final rules issued by CMS in 2011, 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 (the "Taxpayer Relief Act")) which instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013,
the costs of defending and insuring against alleged professional liability and other claims and investigations (including those related to pending investigations and whistleblower and wage and hour class action lawsuits against us) and our ability to predict the estimated costs and reserves related to such claims and investigations, including the impact of differences in actuarial assumptions and estimates compared to eventual outcomes,
the impact of the Taxpayer Relief Act which, among other things, reduces Medicare payments by an additional 25% for subsequent procedures when multiple therapy services are provided on the same day,
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 hospitals 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 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 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,
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 comply with our rental and debt agreements, including payment of amounts owed thereunder and compliance with the covenants contained therein, including under our master lease agreements with Ventas, Inc. ("Ventas"),
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,
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,
national, regional and industry-specific 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,

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), and

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

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, 2014, our hospital division operated 97 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 90 nursing centers and seven assisted living facilities in 18 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 143 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.

Gentiva Merger. On October 9, 2014, we entered into an Agreement and Plan of Merger (the "Gentiva Merger Agreement") with Gentiva Health Services, Inc. ("Gentiva"), providing for our acquisition of Gentiva. On February 2, 2015, we consummated the acquisition with one of our subsidiaries merging with and into Gentiva (the "Gentiva Merger"), with Gentiva continuing as the surviving company and our wholly owned subsidiary.

At the effective time of the Gentiva Merger, each share of common stock, par value $0.10 per share, of Gentiva ("Gentiva Common Stock") issued and outstanding immediately prior to the effective time of the Gentiva Merger (other than shares held by us, Gentiva and any wholly owned subsidiaries (which were cancelled) and shares owned by stockholders who properly exercised and perfected a demand for appraisal rights under Delaware law), including each deferred share unit, were converted into the right to receive (i) $14.50 in cash (the "Cash Consideration"), without interest, and (ii) 0.257 of a validly issued, fully paid and nonassessable share of our common stock, par value $0.25 per share ("Common Stock") (the "Stock Consideration" and, together with the Cash Consideration, the "Gentiva Merger Consideration").

We used the net proceeds from the Financing Transactions (as defined below), to fund the Cash Consideration for the Gentiva Merger, repay Gentiva's existing debt and pay related transaction fees and expenses.

The Gentiva Merger combined two market leaders in complementary specialties to create a combined company with significantly increased diversity and scale. Further, the Gentiva Merger enhances our leading position in the post-acute and rehabilitation services market in the United States and makes "Kindred at Home" one of the largest and most geographically diversified home health and hospice providers in the United States. By combining two market leaders, we believe that the Gentiva Merger advances the development of our integrated approach to patient care, and creates significant value for our patients, employees and shareholders. The combined company operates across 47 states with approximately 2,870 locations.

Gentiva is a leading provider of home health services, hospice services and community care services serving patients through approximately 491 locations in 40 states as of December 31, 2014. Gentiva provides a single source for skilled nursing; physical, occupational, speech and neuro-rehabilitation services; hospice services; social work; nutrition; disease management education; help with daily living activities; and other therapies and services. Gentiva's

revenues are generated predominantly from federal and state government programs and, to a minor extent, commercial insurance and individual consumers.

Gentiva Merger - Financing Transactions. The following transactions (collectively, the "Financing Transactions"), each as more fully described below, occurred in connection with the Gentiva Merger:

• we issued $1.35 billion aggregate principal amount of senior notes;

• we issued approximately 15 million shares of our Common Stock through two Common Stock offerings and issued approximately 10 million shares of our Common Stock through the Stock Consideration;

• we issued 172,500 tangible equity units (the "Units"); and

• we amended our credit facilities.

Notes Offering. On December 18, 2014, Kindred Escrow Corp. II (the "Escrow Issuer"), one of our subsidiaries, completed a private placement of $750 million aggregate principal amount of 8.00% Senior Notes due 2020 (the "Notes due 2020") and $600 million aggregate principal amount of 8.75% Senior Notes due 2023 (the "Notes due 2023") (the "Notes Offering").

Common Stock Offerings. On November 25, 2014, in an offering registered with the SEC, we completed the sale of 5,000,000 shares of our Common Stock for cash and granted the underwriters a 30-day over-allotment option to purchase up to an additional 750,000 shares of Common Stock. On December 1, 2014, the underwriters exercised their over-allotment option to purchase 395,759 additional shares of Common Stock, which we closed on December 3, 2014. We refer to this offering and sale of our Common Stock herein as the "November Common Stock Offering." The net proceeds of the November Common Stock Offering, after deducting the underwriting discount and offering expenses, were $101.0 million.

On June 25, 2014, in an offering registered with the SEC, we completed the sale of 9,000,000 shares of our Common Stock for cash and granted the underwriters a 30-day option to purchase up to an additional 1,350,000 shares of Common Stock, of which 723,468 shares were purchased on July 14, 2014. We refer to this offering and the sale of our Common Stock herein as the "June Common Stock Offering." The net proceeds of the June Common Stock Offering, after deducting the underwriting discount and offering expenses, were $220.4 million.

Units Offering. On November 25, 2014, in an offering registered with the SEC, we completed the sale of 150,000 Units for cash and granted the underwriters a 13-day over-allotment option to purchase up to an additional 22,500 Units. On December 1, 2014, the underwriters exercised in full their over-allotment option to purchase 22,500 additional Units, which we closed on December 3, 2014. Each Unit is composed of a prepaid stock purchase contract (a "Purchase Contract") and one share of 7.25% Mandatory Redeemable Preferred Stock, Series A (the "Mandatory Redeemable Preferred Stock") having a final preferred stock installment payment date of December 1, 2017 and an initial liquidation preference of $201.58 per share of Mandatory Redeemable Preferred Stock. We refer to this offering and sale of our Units herein as the "Units Offering." The net proceeds from the Units Offering, after deducting the underwriting discount and offering expenses, were $166.3 million.

Credit Facilities Amendments. We amended and restated our Amended ABL Facility (as defined herein) on October 31, 2014 (as amended, the "ABL Facility") to, among other items, modify certain provisions to permit the issuance of notes into an escrow account and, effective upon completion of the Gentiva Merger, modified certain provisions related to the incurrence of debt and the making of acquisitions, investments and restricted payments. We also entered into an incremental joinder agreement to the ABL Facility on December 12, 2014 to provide for additional revolving commitments in an aggregate principal amount of $150 million, effective upon completion of the Gentiva Merger.

We amended and restated our Amended Term Loan Facility (as defined herein) on November 25, 2014 (as amended, the "Term Loan Facility," and, together with the ABL Facility, the "Credit Facilities") to, among other items, modify certain provisions to permit the issuance of notes into an escrow account, increase the applicable interest rate margins on the term loans, temporarily increase the maximum total leverage ratio permitted under the financial maintenance covenants and modify certain provisions related to the incurrence of debt and the making of acquisitions, investments and restricted payments.

See "Part II – Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity" and notes 2, 12, 13 and 15 of the notes to consolidated financial statements for additional information on the Gentiva Merger and the Financing Transactions.

Centerre Acquisition. On November 11, 2014, we entered into an agreement to acquire Centerre Healthcare Corporation ("Centerre"), a national company dedicated to operating IRFs (the "Centerre Acquisition"). On January 1, 2015, we completed the Centerre Acquisition for a purchase price of approximately $195 million in cash, which was recorded as an acquisition deposit at December 31, 2014.

Centerre operates 11 IRFs with 614 beds in partnership with some of the nation's leading acute care hospital systems. Centerre has two additional hospitals with a total of 90 beds under construction and scheduled to open in 2015, and a

pipeline of additional potential hospitals in various stages of development. Centerre's IRFs are geographically aligned with five of our targeted Integrated Care Markets, markets where we have multiple facilities or sites of services. The combination of Centerre's portfolio with our IRFs, and the existing 100 hospital-based acute rehabilitation units ("ARUs") (certified as IRFs) managed by us, makes our rehabilitation division one of the largest operators of IRFs in the nation.

Because the Gentiva Merger and the Centerre Acquisition were both completed during 2015, our results of operations and operating statistics in this Form 10-K do not reflect the Gentiva Merger or the Centerre Acquisition.

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 Prior ABL Facility (as defined herein).

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 (the "IntegraCare Acquisition"). The IntegraCare Acquisition was financed through operating cash flows and proceeds from our Prior 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 Prior 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 "RehabCare 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 ARUs. The RehabCare Merger expanded our service offerings, positioned us for future growth and provided opportunities for significant operating synergies.

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 Prior ABL 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 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.

Additional Financing Transactions. In connection with the RehabCare Merger, we entered into a $650 million senior secured asset-based revolving credit facility (the "Prior ABL Facility") and a $700 million senior secured term loan facility (the "Prior Term Loan Facility") (collectively, the "Prior Credit Facilities"), and completed the private placement of $550 million of senior notes due 2019 (the "Notes due 2019"). We used proceeds from the Prior Credit Facilities and the Notes due 2019 to pay the RehabCare Merger Consideration, repay all amounts outstanding under our and RehabCare's previous credit facilities and to pay transaction costs. On April 9, 2014, we completed a private

placement of $500 million aggregate principal amount of 6.375% senior notes due 2022 (the "Notes due 2022"). On May 9, 2014, the Notes due 2019 were redeemed at a redemption price equal to 100% of the principal amount plus accrued and unpaid interest, thereby satisfying and discharging the indenture governing the Notes due 2019.

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, 2014 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 4 and 5 of the notes to consolidated financial statements.

Ventas Divestitures. On December 27, 2014, we entered into an agreement with Ventas to transition the operations under the leases for nine non-strategic nursing centers (the "2014 Expiring Facilities"). Each lease will terminate when the operation of such nursing center is transferred to a new operator, which is expected to occur during 2015. The current lease term for eight of these nursing centers is scheduled to expire on April 30, 2018. The current lease term for the ninth of these nursing centers is scheduled to

expire on April 30, 2020. We will continue to operate these facilities until operations are transferred. For accounting purposes, the 2014 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 agreement, we incurred a $40 million termination fee in exchange for the early termination of the leases, which was paid to Ventas in January 2015. The early termination fee was accrued as rent expense in discontinued operations in 2014 and is included in other accrued liabilities on the balance sheet at December 31, 2014.

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 exit 59 nursing centers and close another facility (collectively, the "2013 Expiring Facilities"). The lease term for the 2013 Renewal Facilities and 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 expired on September 30, 2014, unless we and Ventas were able to transfer the operations earlier; provided however, that we were obligated to continue to operate any 2013 Expiring Facilities not transferred by December 31, 2014 for a limited amount of time and under certain reduced rent obligations provided for in the agreements. We transferred the operations of all of the 2013 Expiring Facilities to new operators during the year ended December 31, 2014 and we reclassified the results of operations and losses associated with the 2013 Expiring Facilities to discontinued operations, net of income taxes, for all periods presented. Under the terms of the agreement, we paid $20 million to Ventas in 2013 in exchange for the early termination of the leases. The early terminations fee was recorded as rent expense in discontinued operations in 2013.

In April 2012, we announced that we would not renew 54 nursing centers (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.

See "– Master Lease Agreements" and note 4 of the notes to consolidated financial statements for additional information on the 2014 Expiring Facilities, the 2013 Renewal Facilities, the 2013 Expiring Facilities and the 2012 Expiring Facilities.

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 Prior 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 Prior ABL Facility.

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:

Diversified service offerings allow us to Continue the Care® across the post-acute continuum. We have a diversified portfolio of service offerings including TC hospitals, IRFs, nursing centers, contract rehabilitation services, home health and hospice operations. We are the only post-acute healthcare provider with the full continuum of care in place to successfully manage an entire episode of care. We have designated 23 markets across the United States as current or potential Integrated Care Markets. We focus on developing our diverse services in these 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. This array of services across our four operating divisions creates multiple earnings streams and avenues for growth and development. The Gentiva Merger and the Centerre Acquisition further enhance our ability to offer a diverse array of services.

Well 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. The Gentiva Merger significantly expands our home health and hospice operations and the Centerre Acquisition expands our IRF operations. As a leading provider in four critical segments of the post-acute continuum, we are well 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 cash flow generation. We have demonstrated the ability to generate strong operating cash flows in a highly regulated environment. We believe the Gentiva Merger and the Centerre Acquisition will further strengthen our operating cash flows. 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 quarterly cash dividend to our shareholders in 2013, which reflects confidence in our ability to generate meaningful and sustainable free cash flows.

OUR STRATEGY

We are one of the largest diversified post-acute healthcare providers in the United States, and accordingly, we believe that we 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 “succeeding in the core” by 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.

Aggressively growing Kindred at Home and RehabCare. We continue to expand our presence in the home health and hospice business, known as "Kindred at Home," and provide services in 143 locations in 13 states as of December 31, 2014. In February 2015, we completed the Gentiva Merger. Following the Gentiva Merger, Kindred at Home has approximately 635 locations in 41 states and is one of the largest home health and hospice companies in the United States based on revenues. In addition, we have committed significant resources to develop a senior management team for these growing operations, which will enable and support future growth. We intend to continue expanding our home health and hospice and rehabilitation operations through additional acquisitions, partnerships 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 is expected to 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 currently includes the operations of Gentiva. In addition to expanding the home health and hospice business, the care management division is responsible for 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. We believe that 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® strategies. These capabilities are expected to include (1) physician coverage across sites of service, (2) care managers to improve care transitions, (3) information sharing and technology connectivity, (4) patient placement tools and (5) condition-specific clinical programs and outcome measures.

Advancing Integrated Care Market strategy. 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. Our 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 readmissions, 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 2014, we opened a new 100-bed transitional care center in Indianapolis, Indiana. During 2013, we began construction of a new 120-bed transitional care center in Phoenix, Arizona and a 160-bed transitional care center in Las Vegas, Nevada, each of which should open in the second half of 2015. 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. In addition, the Centerre Acquisition added seven of its 13 operational or in development IRFs to our Integrated Care Markets.

Improving capital structure and enhance shareholder returns. We seek to improve our capital structure by owning more of our operating facilities, which lowers our lease obligations and allows us to dispose of non-strategic or underperforming assets. During 2014, we completed the previously announced acquisition of two leased nursing centers for $22 million. Seven additional nursing centers, associated with this acquisition, were acquired in the fourth quarter of 2013 for $61 million. In addition, since initiating a quarterly dividend of $0.12 per common share in the third quarter of 2013, we have declared six regular quarterly cash dividends to shareholders, which reflects and reaffirms confidence in our ability to generate meaningful and sustainable free cash flows. We believe that the Gentiva Merger and the Centerre Acquisition will be accretive to earnings and cash flows, exclusive of transaction and integration costs, and enhance shareholder value.

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 97 TC hospitals with 7,147 licensed beds and five IRFs with 215 licensed beds in 22 states as of December 31, 2014. Effective January 1, 2015, the Centerre Acquisition added 11 IRFs with 614 beds to our portfolio, with two additional IRFs with 90 beds to open during 2015. We operate the largest network of TC hospitals and IRFs in the United States based upon revenues. 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 2014, 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,		
	2014	2013	2012
Revenues	$2,525,074	$2,465,560	$2,543,829
Operating income	$538,840	$516,130	$555,333
Hospitals in operation at end of period	102	102	102
Licensed beds at end of period	7,362	7,320	7,248
Admissions	56,508	55,171	57,901
Patient days	1,529,906	1,500,105	1,555,964
Average length of stay	27.1	27.2	26.9
Revenues per admission	$44,685	$44,689	$43,934
Revenues per patient day	$1,650	$1,644	$1,635
Medicare case mix index (discharged patients only)	1.16	1.17	1.17
Average daily census	4,192	4,110	4,251
Occupancy %	64.8	63.5	66.3
Annualized employee turnover %	21.6	21.3	19.7
Assets at end of period	$1,783,603	$1,776,899	$2,129,303
Capital expenditures:			
Routine	$29,881	$28,571	$38,272
Development	2,087	11,817	42,265

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

	Year ended December 31,		
	2014	2013	2012
Revenue mix %:			
Medicare	59	60	62
Medicaid	6	6	6
Medicare Advantage	11	11	10
Medicaid Managed	3	2	2
Commercial insurance and other	21	21	20
Admissions mix %:			
Medicare	67	69	68
Medicaid	6	5	6
Medicare Advantage	10	11	10
Medicaid Managed	3	2	2
Commercial insurance and other	14	13	14
Patient days mix %:			
Medicare	60	63	63
Medicaid	9	8	8
Medicare Advantage	11	11	11
Medicaid Managed	4	2	2
Commercial insurance and other	16	16	16

For the year ended December 31, 2014, revenues of the hospital division totaled approximately $2.5 billion or 48% 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, 2014:

		Number of facilities Owned			
State	Licensed beds	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)	747	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	265	1	2	2	5
Tennessee (1)	109	–	1	1	2
Texas	1,632	2	6	15	23
Washington (1)	140	2	–	–	2
Totals	7,362	18	38	46	102

(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 90 nursing centers (11,535 licensed beds) and seven assisted living facilities (375 beds) located in 18 states as of December 31, 2014. 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 nutrition, 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 2014 was 30 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, enhancing nursing skills via ongoing education and skills validation 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 prevent 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.

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 56 facilities as transitional care centers. 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.

Our nursing center division also manages twelve hospital-based sub-acute units (481 licensed beds) in six states. Seven of these units (244 licensed beds) are co-located within hospitals owned and operated by our hospital division. These units typically consist of 20 to 50 beds offering skilled nursing services, providing 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. Five of these units (237 licensed beds) are managed for unaffiliated companies, are certified as either hospital-based or nursing center sub-acute units, and specialize in providing respiratory and ventilator therapy.

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,		
	2014	2013	2012
Revenues	$1,062,549	$1,005,383	$1,003,511
Operating income	$146,728	$124,856	$126,271
Facilities in operation at end of period:			
Nursing centers:			
Owned or leased	86	85	85
Managed	4	4	4
Assisted living facilities	7	6	6
Licensed beds at end of period:			
Nursing centers:			
Owned or leased	11,050	11,018	11,018
Managed	485	485	485
Assisted living facilities	375	341	341
Patient days (a)	3,457,503	3,477,933	3,574,351
Revenues per patient day (a)	$307	$289	$281
Average daily census (a)	9,473	9,529	9,766
Admissions (a)	38,772	38,406	38,723
Occupancy % (a)	80.7	81.6	83.5

Medicare average length of stay (a,b)	29.6	31.1	31.1
Annualized employee turnover %	42.4	42.5	38.2
Assets at end of period	$513,603	$552,336	$626,016
Capital expenditures:			
Routine	$20,976	$23,023	$20,764
Development	3,170	7	8,057

(a) Excludes managed facilities.
(b) Computed by dividing total Medicare discharge patient days by total Medicare discharges.
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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 revenues and patient days derived from the payor sources indicated:

	Year ended December 31,		
	2014	2013	2012
Revenue mix %:			
Medicare	32	34	36
Medicaid	40	37	36
Medicare Advantage	8	8	8
Medicaid Managed	4	4	3
Private and other	16	17	17
Patient day mix % (a):			
Medicare	16	17	18
Medicaid	55	54	54
Medicare Advantage	6	6	5
Medicaid Managed	7	6	6
Private and other	16	17	17

(a) Excludes managed facilities.

For the year ended December 31, 2014, revenues of the nursing center division totaled approximately $1.1 billion or 20% 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, 2014:

		Number of facilities				
		Owned				
State	Licensed beds	by us	Leased from Ventas (2)	Leased from other parties	Managed	Total
Arizona	100	–	–	1	–	1
California	2,093	5	4	9	–	18
Colorado	108	–	1	–	–	1
Georgia (1)	162	–	1	–	–	1
Idaho	584	1	6	–	–	7
Indiana	2,421	7	8	2	–	17
Kentucky (1)	319	2	1	–	–	3
Maine	102	–	–	2	–	2
Massachusetts (1)	2,112	1	2	11	3	17
Montana (1)	276	–	2	–	–	2
New Hampshire (1)	290	–	1	–	–	1
North Carolina (1)	297	–	3	–	–	3
Ohio (1)	979	7	–	–	–	7
Tennessee (1)	668	4	–	1	–	5
Texas	405	3	–	–	–	3
Vermont (1)	294	–	1			