KINDRED HEALTHCARE, INC
Form 10-K
February 28, 2013
Table of Contents

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, 2012

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 ¨ No þ

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. ¨

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, 2012, was approximately $502,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2013, there were 53,276,447 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 2013 definitive proxy statement, which will be filed no later than 120 days after December 31, 2012.

Table of Contents

TABLE OF CONTENTS

Table of Contents

PART I

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 and rehabilitation centers, assisted living facilities, a contract rehabilitation services business and a home health and hospice business across the United States (collectively, the Company or Kindred). At December 31, 2012, the Company s hospital division operated 116 TC hospitals and six IRFs in 26 states. The Company s nursing center division operated 223 nursing and rehabilitation centers and six assisted living facilities in 27 states. The Company s rehabilitation division provided rehabilitation services primarily in hospitals and long-term care settings. The Company s home health and hospice division provided home health, hospice and private duty services from 101 locations in ten states. All references in this Annual Report on Form 10-K to Kindred, Company, we, us, or our mean Kindred Healthcare, In and, unless the context otherwise requires, our consolidated subsidiaries.

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.

Risk Factors. 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 Item 1A Risk Factors.

IntegraCare Acquisition. On August 31, 2012, we acquired IntegraCare Holdings, Inc., a provider of home health, hospice and community services which 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 (as defined below).

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.

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

Table of Contents

$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 executed this option to increase the credit capacity by $200 million in October 2012. See note 11 of the notes to consolidated financial statements. In connection with the Credit Facilities and the Notes, we paid $46 million of lender fees related to debt issuance that were capitalized as deferred financing costs during 2011 and paid $13 million of other financing costs that were charged to interest expense during 2011.

See Part II Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity 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 were leased at the time of the acquisition.

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

In recent years, we have completed several transactions related to the divestiture of unprofitable hospitals and nursing and rehabilitation centers to improve our future operating results.

For accounting purposes, the operating results of these businesses and the losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2012 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 note 4 of the notes to consolidated financial statements.

HEALTHCARE OPERATIONS

We are organized into four operating divisions: the hospital division, the nursing center division, the rehabilitation division and the home health and hospice 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. 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 6 of the notes to consolidated financial statements.

The hospital division operates TC hospitals and IRFs. The nursing center division operates nursing and rehabilitation centers and assisted living facilities. The rehabilitation division provides rehabilitation services primarily in hospitals and long-term care settings. The home health and hospice division provides home health,

Table of Contents

hospice and private duty services to patients in a variety of settings, including homes, skilled nursing facilities and other residential settings. We believe that the independent focus of each division on the unique aspects of its business enhances its ability to attract patients, residents and non-affiliated customers, 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) skilled nursing and rehabilitation 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.

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. Through our organic development and acquisitions, we have created a well-diversified portfolio of service offerings. Kindred operates the largest network of TC hospitals and IRFs and is the largest operator of skilled nursing contract rehabilitation therapy services in the United States. We also are the fourth largest operator of skilled nursing and rehabilitation centers in the United States. The IntegraCare and Professional Acquisitions also significantly increased the scale of our home health and hospice operations. This array of services across our four operating divisions creates multiple earnings streams and avenues for growth and development, and further allows us to coordinate and manage the continuum of care for our patients, reduce lengths of stay, implement physician services strategies and prevent avoidable re-hospitalizations.

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 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 development of TC hospitals and transitional care centers in our skilled nursing and rehabilitation centers. We own the real estate of 24 TC hospitals, one IRF, 25 nursing and rehabilitation centers and two assisted living facilities, a significant increase from the 16 facilities we owned in 2006.

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.

Proven and experienced management team. We have an industry leading management team with strong executive leadership and experience in executing and integrating strategic acquisitions. Paul J. Diaz, Chief Executive Officer, has over 20 years experience in the healthcare industry. We believe our management team has demonstrated the ability to adapt and respond to an unpredictable healthcare environment.

Table of Contents

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. The core of our 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 operating strategy include:

Provide quality, clinical-based care. We are committed to maintaining and improving the quality of our patient care by dedicating appropriate resources at each facility and continuing to refine our clinical initiatives and objectives. We also have implemented technology enhancements and clinical protocols that promote best practices.

Improve operating efficiency. We are continually focused on improving operating efficiency and controlling costs, while maintaining quality patient care, by standardizing key operating procedures and optimizing the skill mix of our staff based upon the clinical needs of each patient or resident. We have implemented specialized programs and technology enhancements to improve our quality and to make our care givers more efficient. We have additionally implemented a Company-wide program to re-engineer processes, improve efficiencies and focus on the provision of shared services across our divisions.

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 21 markets across the country as current or potential Integrated Care Markets. These Integrated Care Markets allow our care givers 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 home health and hospice transactions discussed below, we opened a new TC hospital in Seattle with 50 licensed beds in November 2011 and a 30 bed co-located sub-acute unit in that hospital in February 2012. We opened a replacement TC hospital in Charleston, South Carolina with 59 licensed beds and a 35 bed co-located sub-acute unit in December 2012. We also completed the construction of a new freestanding IRF with 46 licensed beds in Humble, Texas in February 2012, opened a newly constructed, freestanding replacement IRF with 50 licensed beds in Austin, Texas in May 2012, and opened a new transitional care center with 120 licensed beds in Indianapolis, Indiana in May 2011. We currently have new transitional care centers under development in Las Vegas, Nevada with 150 licensed beds and in Indianapolis, Indiana with 100 licensed beds.

Expand 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 ten states through 101 locations. In August 2012, we completed the IntegraCare Acquisition, which significantly expanded the scope of our operations into Texas. In September 2011, we completed the Professional Acquisition, which expanded the scope of our operations in northern California, Arizona, Nevada and Utah. 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.

Reposition assets and management time to higher margin growth businesses. We intend to concentrate our efforts on 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

Table of Contents

in our Integrated Care Markets. We also are accelerating our strategy of exiting unprofitable and non-strategic facilities outside of our Integrated Care Markets through asset sales and the expiration of lease renewals. We previously announced the planned divestiture during 2013 of 54 nursing and rehabilitation centers currently leased from Ventas. In 2013, we expect to explore other divestiture opportunities of additional TC hospitals and nursing and rehabilitation centers in non-strategic markets. Additionally, 86 nursing and rehabilitation centers and 22 TC hospitals leased from Ventas are up for renewal in April 2015. The renewal process for these facilities will begin in October 2013.

Grow through selective acquisitions. We seek growth opportunities through strategic acquisitions in selected target markets, particularly where an acquisition, such as the RehabCare Merger, the IntegraCare Acquisition and the Professional Acquisition, may assist us in scaling our operations more rapidly and efficiently than internal growth. In 2011, our acquisition of RehabCare significantly expanded the scope of our hospital and rehabilitation operations, as well as added IRFs to our post-acute continuum. In 2012 and 2011, we completed the IntegraCare Acquisition and the Professional Acquisition, respectively, both of which significantly expanded our home health and hospice operations.

Participate and invest in new integrated care delivery and payment models. We are actively seeking to participate in accountable care organizations and bundled payment demonstrations with health systems, physician groups and managed care providers to demonstrate our value proposition to these payors and referral sources.

Increase patient and resident volumes, particularly commercial patients. We continue to expand our sales and marketing functions in our hospital and nursing center divisions to grow same-facility admissions and to take advantage of available capacity. Given the relatively higher reimbursement rates from commercial insurers as a group, as compared to Medicare and Medicaid, we continue to focus on expanding our relationships with insurers and enhancing their understanding of our services and promoting our value proposition in order to increase commercial patient volume. Since 2009, we have grown our annual non-government admissions in our hospitals by approximately 55% and increased our non-government patient days in our nursing and rehabilitation centers by approximately 5%. We believe that our expanded service offerings and scope of operations will be attractive to commercial payors.

Continue growing our rehabilitation division through business development and external contract sales. Our rehabilitation division focuses on the enhancement of rehabilitation programs for our customers and the expansion of our business in strategic markets. We strive to increase our market share by demonstrating our value proposition to customers in areas of clinical excellence and programming, staff recruiting and retention, regulatory and reimbursement support, census development and committed customer service.

Continue effective recruiting and retention of qualified therapists. Our rehabilitation division continuously strives to recruit and retain qualified therapists in an industry-wide employment environment characterized by a shortage of qualified personnel. We offer competitive incentive and recognition programs for our therapists and have increased our recruiting infrastructure to reduce open positions, decrease contract labor and improve productivity. We also promote continuing education opportunities to enhance the personal knowledge and growth of our therapists and encourage our therapists participation in nurturing a culture of quality and customer service.

Table of Contents

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 116 TC hospitals with 8,382 licensed beds and six IRFs with 259 licensed beds in 26 states as of December 31, 2012. We operate the largest network of TC hospitals and IRFs in the United States based upon number of facilities. Our TC hospitals are certified as long-term acute care (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.

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 2012, 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.

Table of Contents

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,		
	2012	2011	2010
Revenues	$ 2,927,495	$ 2,531,448	$ 1,959,738
Operating income	$ 600,649	$ 488,201	$ 360,369
Hospitals in operation at end of period	122	123	88
Licensed beds at end of period	8,641	8,614	6,777
Admissions	69,016	59,869	45,225
Patient days	1,883,742	1,670,551	1,372,363
Average length of stay	27.3	27.9	30.3
Revenues per admission	$ 42,418	$ 42,283	$ 43,333
Revenues per patient day	$ 1,554	$ 1,515	$ 1,428
Medicare case mix index (discharged patients only)	1.16	1.18	1.20
Average daily census	5,147	4,577	3,760
Occupancy %	65.0	65.0	65.1
Annualized employee turnover %	20.1	20.3	22.0
Assets at end of period	$ 2,140,185	$ 2,056,103	$ 1,100,138
Capital expenditures:			
Routine	$ 38,272	$ 46,393	$ 36,967
Development	42,265	67,321	41,140

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 6 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.

Table of Contents

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 Patient			Medicaid Patient			Medicare Advantage Patient			Commercial insurance and other Patient		
	Admissions	days	Revenues	Admissions	days	Revenues	Admissions	days	Revenues	Admissions	days	Revenues
2012	67%	61%	62%	6%	10%	6%	11%	11%	10%	16%	18%	22%
2011	66	60	60	8	11	8	9	10	10	17	19	22
2010	64	56	56	9	13	9	9	10	10	18	21	25

For the year ended December 31, 2012, revenues of the hospital division totaled approximately $2.9 billion or 45% 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, 2012:

State	Licensed beds	Number of facilities			
		Owned by us	Leased from Ventas (2)	Leased from other parties	Total
Arizona	167		2	1	3
California	1,097	5	5	5	15
Colorado	105		1	1	2
Florida (1)	745	2	6	2	10
Georgia (1)	117			2	2
Illinois (1)	625	1	4	2	7
Indiana	221	1	1	2	4
Kentucky (1)	414		1	1	2
Louisiana	218		1	1	2
Massachusetts (1)	566	3	2	1	6
Michigan (1)	77			1	1
Missouri (1)	335	1	2	2	5
Nevada	222	1	1	1	3
New Jersey (1)	117			3	3
New Mexico	61		1		1
North Carolina (1)	124		1		1
North Dakota	72			2	2
Ohio	309	2		3	5
Oklahoma	153		1	2	3
Pennsylvania	443	2	2	4	8
South Carolina (1)	94	1			1
Tennessee (1)	109		1	1	2
Texas	1,988	3	6	21	30
Virginia (1)	60	1			1
Washington (1)	140	2			2
Wisconsin	62			1	1

Totals	8,641	25	38	59	122

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

Table of Contents

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 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

Table of Contents

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 223 nursing and rehabilitation centers (27,142 licensed beds) and six assisted living facilities (341 licensed beds) located in 27 states as of December 31, 2012. We are the fourth largest operator of nursing and rehabilitation centers in the United States based upon number of facilities. Through our nursing and rehabilitation 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 and rehabilitation 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 2012 was 32 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 and rehabilitation 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 have also established initiatives to reduce potentially avoidable 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 and rehabilitation centers are certified to provide services under the Medicare and Medicaid programs. Our nursing and rehabilitation 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 95 of our nursing and rehabilitation centers. These units within our nursing and rehabilitation 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

Table of Contents

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.

Several of our nursing and rehabilitation 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 and rehabilitation centers capable of providing these higher intensity clinical services as transitional care centers. We currently classify 37 of our nursing and rehabilitation 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 and rehabilitation 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,		
	2012	**2011**	**2010**
Revenues	$ 2,148,140	$ 2,254,099	$ 2,187,885
Operating income	$ 273,142	$ 338,265	$ 303,418
Facilities in operation at end of period:			
Nursing and rehabilitation centers:			
Owned or leased	219	220	222
Managed	4	4	4
Assisted living facilities	6	6	7
Licensed beds at end of period:			
Nursing and rehabilitation centers:			
Owned or leased	26,657	26,663	26,957
Managed	485	485	485
Assisted living facilities	341	413	463
Patient days (a)	8,237,116	8,496,611	8,675,214
Revenues per patient day (a)	$ 261	$ 265	$ 252
Average daily census (a)	22,506	23,278	23,768
Admissions (a)	78,932	80,794	76,451
Occupancy % (a)	83.2	85.9	87.4
Medicare average length of stay (a,b)	32.0	32.8	34.0
Annualized employee turnover %	39.6	39.2	39.6
Assets at end of period	$ 616,382	$ 638,078	$ 647,355
Capital expenditures:			
Routine	$ 20,764	$ 34,304	$ 37,024
Development	8,057	19,167	26,701

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

Table of Contents

Sources of Nursing and Rehabilitation Center Revenues

Nursing and rehabilitation 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 and rehabilitation 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 and rehabilitation 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
2012	16%	33%	59%	41%	5%	7%	20%	19%
2011	17	36	58	38	5	7	20	19
2010	16	35	60	40	4	7	20	18

For the year ended December 31, 2012, revenues of the nursing center division totaled approximately $2.2 billion or 33% of our total revenues (before eliminations). For more information regarding the reimbursement for our nursing and rehabilitation center services, see Governmental Regulation Nursing Center Division Overview of Nursing Center Division Reimbursement.

Table of Contents

Nursing and Rehabilitation Center Facilities

The following table lists by state the number of nursing and rehabilitation centers and assisted living facilities and related licensed beds we operated as of December 31, 2012:

		Number of facilities				
State	Licensed beds	Owned by us	Leased from Ventas (2)	Leased from other parties	Managed	Total
Alabama (1)	464		2	1		3
Arizona	562		3	1		4
California	2,381	4	6	10		20
Colorado	460		4			4
Connecticut (1)	522		5			5
Georgia (1)	520		4			4
Idaho	695	1	7			8
Indiana	3,662	10	13	2		25
Kentucky (1)	1,556	2	10	1		13
Maine (1)	756		8	2		10
Massachusetts (1)	4,765	2	26	12	3	43
Montana (1)	276		2			2
Nevada	174		2			2
New Hampshire (1)	502		3			3
North Carolina (1)	1,939		16	2		18
Ohio (1)	2,029	5	9	2		16
Oregon (1)	205		2			2
Pennsylvania	103		1			1
Rhode Island (1)	187		2			2
Tennessee (1)	1,065		3	5		8
Texas	405	3				3
Utah	411		4			4
Vermont (1)	294		1		1	2
Virginia (1)	601		4			4
Washington (1)	656		7			7
Wisconsin (1)	1,922		11	1		12
Wyoming	371		4			4
Totals	27,483	27	159	39	4	229

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

Nursing Center Division Management and Operations

Each of our nursing and rehabilitation centers is managed by a state-licensed executive director who is supported by other professional personnel, including 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 registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing and rehabilitation center, the types of services provided and the acuity level of the patients and residents. The nursing and rehabilitation centers contract with physicians who provide medical director services and serve on performance improvement committees. We provide our nursing and rehabilitation centers with centralized administrative services in the

15

Table of Contents

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. 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 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 and rehabilitation 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 and rehabilitation centers. These surveys are reviewed by performance improvement committees at each nursing and rehabilitation center to promote and improve resident care.

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 regulatory compliance.

Substantially all of our nursing and rehabilitation centers are certified to provide services under the Medicare and Medicaid programs. A nursing center s qualification to participate in such programs depends upon many factors, such as accommodations, equipment, clinical services, safety, personnel, physical environment and adequacy of policies and procedures.

Nursing Center Division Competition

Our nursing and rehabilitation 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 and rehabilitation 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 based generally on fixed rates), there is substantial price competition for private payment residents.

Table of Contents

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 and hospital rehabilitation services. Our SRS operations provide contract therapy services primarily to freestanding skilled nursing centers. As of December 31, 2012, our SRS segment provided rehabilitative services to 1,726 nursing centers in 44 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, 2012, our HRS segment operated 105 hospital-based inpatient rehabilitation units and provided rehabilitation services in 123 LTAC hospitals, 21 sub-acute (or skilled nursing) units, and 119 outpatient clinics.

SRS Operations

Our SRS operations involve therapy management services provided primarily to freestanding skilled 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, 2012, SRS managed 1,726 contract therapy programs. We are the largest contract therapy company in the United States based upon fiscal 2012 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 clinical practices that 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, 2012, we managed or operated 105 hospital-based inpatient rehabilitation units. The hospital-based inpatient rehabilitation units we operate provide high acuity rehabilitation for patients recovering from strokes, orthopedic conditions and head injuries. We establish hospital-based inpatient rehabilitation units in acute care hospitals that have vacant space and 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.

Table of Contents

A hospital-based acute rehabilitation unit within a hospital affords the hospital the ability 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, a speech/language pathologist, a social worker, a case manager and other appropriate support personnel.

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, 2012, we operated therapy programs in 123 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, 2012, we managed therapy programs in 21 sub-acute (or skilled nursing) units. These hospital-based units provide lower intensity rehabilitation for medically complex patients. Patients diagnoses typically require long-term care and 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 being sent to a freestanding skilled nursing facility. 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, 2012, we managed or operated 119 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.

Table of Contents

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,		
	2012	2011	2010
SRS:			
Revenues	$ 1,010,101	$ 775,158	$ 403,755
Operating income	$ 80,663	$ 65,916	$ 33,703
Revenue mix %:			
Company-operated	22	30	56
Non-affiliated	78	70	44
Sites of service (at end of period)	1,726	1,774	635
Revenue per site	$ 584,468	$ 592,848	$ 686,480
Therapist productivity %	80.4	80.4	82.0
Assets at end of period	$ 335,197	$ 425,499	$ 55,781
Routine capital expenditures	$ 2,274	$ 1,700	$ 2,356

	Year ended December 31,		
	2012	2011	2010
HRS:			
Revenues	$ 293,532	$ 200,824	$ 83,678
Operating income	$ 69,745	$ 43,731	$ 18,969
Revenue mix %:			
Company-operated	38	42	94
Non-affiliated	62	58	6
Sites of service (at end of period):			
Inpatient rehabilitation units	105	102	1
LTAC hospitals	123	115	91
Sub-acute units	21	25	7
Outpatient units	119	115	12
Other	5	8	4
	373	365	115
Revenue per site	$ 799,454	$ 783,412	$ 777,690
Assets at end of period	$ 340,668	$ 347,491	$ 798
Routine capital expenditures	$ 348	$ 238	$ 293
Annualized employee turnover % (SRS and HRS combined)	16.9	16.5	14.4

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

Table of Contents

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, 2012, revenues of the SRS segment totaled approximately $1.0 billion or 15% of our total revenues (before eliminations). For the year ended December 31, 2012, revenues of the HRS segment totaled approximately $294 million or 5% of our total revenues (before eliminations). Approximately 26% of our rehabilitation division revenues (before eliminations) in 2012 were generated from services provided to hospitals and nursing and rehabilitation centers operated by us.

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, 2012:

State	Company-operated	Non-affiliated	Total
Alabama	3	6	9
Arizona	4	5	9
Arkansas		5	5
California	21	40	61
Colorado	4	35	39
Connecticut	5	8	13
Delaware		1	1
Florida		44	44
Georgia	4	18	22
Idaho	8	2	10
Illinois		216	216
Indiana	25	28	53
Iowa		28	28
Kansas		59	59
Kentucky	13	32	45
Maine	8	24	32
Maryland		40	40
Massachusetts	42	33	75
Michigan		29	29
Minnesota		58	58
Missouri		243	243
Montana	2	4	6
Nebraska		3	3
Nevada	2	2	4
New Hampshire	3	2	5
New Jersey		4	4
New Mexico		14	14
New York		22	22
North Carolina	18	54	72
North Dakota		4	4
Ohio	14	49	63

Table of Contents

State	Company-operated	Non-affiliated	Total
Oklahoma		25	25
Oregon	2	3	5
Pennsylvania	1	66	67
Rhode Island	2	2	4
South Carolina		5	5
Tennessee	8	32	40
Texas	3	155	158
Utah	4		4
Vermont	2	3	5
Virginia	4	39	43
Washington	7	12	19
Wisconsin	12	47	59
Wyoming	4		4
Totals	225	1,501	1,726

The following table lists by state the number of HRS contracts we serviced as of December 31, 2012:

State	Hospital-based inpatient rehab units	LTAC hospitals	Sub-acute units	Outpatient units	Other	Total
Arizona		3	1			4
Arkansas	7		1	6		14
California	10	16	1	1		28
Colorado		2				2
Delaware	1					1
Florida		10		5		15
Georgia	3	1	2			6
Illinois	7	6		4	1	18
Indiana	11	6	1	4		22
Iowa	4			2		6
Kansas	4			3		7
Kentucky		2	1			3
Louisiana	5	3		3		11
Massachusetts	1	6	1	3	2	13
Michigan	7	2		8		17
Minnesota	3					3
Mississippi	3					3
Missouri	6	4		5		15
Nevada		3		1		4
New Jersey		2	1	8		11
New Mexico		1				1
New York				10		10
North Carolina		1	1			2
North Dakota	1	2				3
Ohio	6	8	1	13		28
Oklahoma	5	3	2	1		11
Pennsylvania	7	8	3	4		22
Puerto Rico	1					1

Table of Contents

State	Hospital-based inpatient rehab units	LTAC hospitals	Sub-acute units	Outpatient units	Other	Total
Rhode Island	1			2		3
South Carolina	1	1	1			3
Tennessee	2	1				3
Texas	5	28	1	14	2	50
Virginia	1	1		21		23
Washington	1	2	2	1		6
Wisconsin	1	1				2
Wyoming	1		1			2
Totals	105	123	21	119	5	373

Sales and Marketing

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

Rehabilitation Division Management and Operations

A division president and a chief financial officer manage our rehabilitation division. Our operations are divided between the SRS and HRS lines of business. The SRS segment is divided into two geographic areas lead by senior vice presidents who report to the division senior vice president. These senior vice presidents have five to six regional vice presidents reporting to them. The HRS segment is lead by a senior vice president who reports to the division president. The HRS segment is divided into two geographic areas lead by division vice presidents. These areas are further divided into six geographic regions lead by regional vice presidents. In both the SRS and HRS segments, area directors of operations report to the regional vice presidents. Each area director of operations is responsible for the overall management of 15 to 20 on-site program directors. Each of our rehabilitation customers has an on-site program director responsible for managing the therapy operations at such facility. A senior vice president of clinical operations manages the clinical education of our therapists and our quality care initiatives.

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

Rehabilitation Division Competition

In the geographic markets that we serve, there are national, regional and local rehabilitation services providers that offer rehabilitation services comparable to ours. A number of our competitors may have greater financial and other resources than we do, may be more established in the markets in which we compete and may be willing to provide services at lower prices. In addition, a number of long-term care facilities and hospitals may

Table of Contents

elect not to outsource rehabilitation services thereby reducing our potential customer base. While there are several large rehabilitation providers, the market generally is highly fragmented and is primarily comprised of smaller independent providers.

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

HOME HEALTH AND HOSPICE DIVISION

Our home health and hospice division provides home health, hospice and private duty services to patients in a variety of settings, including homes, skilled nursing facilities and other residential settings. As of December 31, 2012, our home health and hospice division operated 101 locations in ten states, employing approximately 4,300 care givers to serve the needs of over 8,700 patients on a daily basis. The home health and hospice division generated revenues of approximately $143 million in 2012 or 2% of our total revenues (before eliminations).

Our home health operations offer medical care and other services to patients in their homes or other residential settings. Experienced nurses, therapists and home health aides work with the patient and his or her family members to maximize the patient s ability to handle a wide variety of daily activities and to educate the patient regarding medications and medical conditions. Our services include nursing, physical, occupational and speech therapies, and medical social work.

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

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

Selected Home Health and Hospice Division Operating Data

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

	Year ended December 31,		
	2012	2011	2010
Revenues	$ 143,340	$ 60,736	$ 17,522
Operating income (loss)	$ 13,708	$ 3,103	$ (66)
Locations (at end of period)	101	51	15
Annualized employee %	29.5	32.4	36.4
Assets at end of period	$ 202,156	$ 104,374	$ 31,274
Capital expenditures:			
Routine	$ 1,616	$ 164	$ 66
Development		1,167	

Sources of Home Health and Hospice Division Revenues

Home health and hospice division revenues are derived principally from the Medicare and Medicaid programs, private insurers and private pay patients. Medicare reimburses both home health and hospice services under prospective payment systems, which are subject to numerous qualifications, standards and adjustments.

Table of Contents

Medicaid reimburses home health and hospice service providers using a number of state specific systems. We often negotiate contract rates of reimbursement with private insurers. Reimbursement under Medicare and Medicaid is subject to frequent change as lawmakers and government regulators seek to balance the need for healthcare services against the constraints of governmental budgets.

The following table sets forth the approximate percentages of home health and hospice division revenues derived from the payor sources indicated:

Year ended December 31,	Medicare	Medicaid	Private insurance	Private pay
2012	67%	9%	3%	21%
2011	69	9	6	16
2010	88	7	2	3

For more information regarding the reimbursement of our home health and hospice division, see Governmental Regulation Home Health and Hospice Division Overview of Home Health and Hospice Division Reimbursement.

Home Health and Hospice Division Management and Operations

The home health and hospice division is headed by a senior vice president, overseeing a vice president for each of the three regions of the home health and hospice division. In addition, the home health and hospice division has division level compliance, clinical services, finance, operations and human resources executives. The sales and marketing efforts for the home health and hospice division are led by three divisional vice presidents, who in turn report to our senior vice president of enterprise sales.

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

Home Health and Hospice Division Competition

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

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

GOVERNMENTAL REGULATION

Medicare and Medicaid

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over and certain disabled persons. Medicaid is a medical assistance program administered by each state funded with federal and state funds pursuant to which healthcare benefits are available to certain indigent or

Table of Contents

disabled patients. Within the Medicare and Medicaid statutory framework, there are substantial areas subject to administrative rulings, interpretations and discretion that may affect payments made under Medicare and Medicaid. A substantial portion of our revenues are derived from patients covered by the Medicare and Medicaid programs.

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

Recent Regulatory Changes

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

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act (enacted on March 23, 2010) and the Healthcare Education and Reconciliation Act (enacted on March 30, 2010) (collectively, the ACA). The reforms contained in the ACA have affected each of our businesses in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. These reforms include the possible modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers.

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

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

Table of Contents

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

The Budget Control Act of 2011, enacted on August 2, 2011, increased the United States debt ceiling in connection with deficit reductions over the next ten years. Under the Budget Control Act of 2011, $1.2 trillion in domestic and defense spending reductions were automatically set to begin February 1, 2013, split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. As discussed below, the American Taxpayer Relief Act of 2012 (the Taxpayer Relief Act) subsequently delayed by two months the automatic budget sequestration cuts established by the Budget Control Act of 2011. At this time, we believe that the automatic 2% reduction on each claim submitted to Medicare will begin on April 1, 2013. Reductions to Medicare and Medicaid reimbursement resulting from the Budget Control Act of 2011 could have a material adverse effect on the Company s business, financial position, results of operations and liquidity.

The Taxpayer Relief Act was enacted on January 2, 2013. As noted above, this Act delayed by two months the automatic budget sequestration cuts established by the Budget Control Act of 2011. The Taxpayer Relief Act also: (1) reduces Medicare payments by 50% for subsequent procedures when multiple therapy services are provided on the same day; (2) extends the Medicare Part B outpatient therapy cap exception process to December 31, 2013; (3) suspends until December 31, 2013 the sustainable growth rate adjustment (SGR) reduction applicable to the Medicare Physician Fee Schedule (MPFS) for certain services provided under Medicare Part B; (4) increases the statute of limitations to recover Medicare overpayments from three years to five years; and (5) creates a new federal Commission on Long-Term Care that has six months in which to provide recommendations on the establishment, implementation and financing of a comprehensive, coordinated and high-quality system that ensures the availability of long-term care services. We believe that the new rules related to multiple therapy services will reduce the Company s Medicare revenues by $25 million to $30 million on an annual basis.

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

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

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

Federal, state and local regulations

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, and the privacy and security of health-related information. In addition, various anti-fraud and abuse laws, including physician self-referral laws, anti-kickback laws and laws regarding filing of false claims, codified under the Social Security Act and other statutes, prohibit certain business practices and relationships in connection with healthcare services for patients

Table of Contents

whose care will be paid by Medicare, Medicaid or other governmental programs. Sanctions for violating these anti-fraud and abuse laws include criminal penalties, civil penalties and possible exclusion from government programs such as Medicare and Medicaid.

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

We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory penalties, including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. These enforcement policies, along with the costs incurred to respond to and defend reviews, audits and investigations, could have a material adverse effect on our business, financial position, results of operations and liquidity. We vigorously contest such penalties where appropriate; however, these cases can involve significant legal and other expenses and consume our resources.

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

The Anti-Kickback Statute, Section 1128B of the Social Security Act (the Anti-Kickback Statute) prohibits the knowing and willful offer, payment, solicitation or receipt of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of an individual, in return for recommending, or to arrange for, the referral of an individual for any item or service payable under any federal healthcare program, including Medicare or Medicaid. The OIG has issued regulations that create safe harbors for certain conduct and business relationships that are deemed protected under the Anti-Kickback Statute. In order to receive safe harbor protection, all of the requirements of a safe harbor must be met. The fact that a given business arrangement does not fall within one of these safe harbors, however, does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria, if investigated, will be evaluated based upon all facts and circumstances and risk increased scrutiny and possible sanctions by enforcement authorities. The Anti-Kickback Statute is a criminal statute, with penalties of up to $25,000, up to five years in prison, or both. The OIG can pursue a civil claim for violation of the

Table of Contents

Anti-Kickback Statute under the Civil Monetary Penalty Statute of up to $50,000 per claim and up to three times the amount received from the government for the items or services. We believe that business practices of providers and financial relationships between providers have become subject to increased scrutiny as healthcare reform efforts continue on the federal and state levels. State Medicaid programs are required to enact an anti-kickback statute. Many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients regardless of the source of payment for the care.

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

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

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

Various states in which we operate hospitals and nursing and rehabilitation centers have established minimum staffing requirements or may establish minimum staffing requirements in the future. The implementation of these staffing requirements in some states is not contingent upon any additional appropriation of state funds in any budget act or other statute. Our ability to satisfy such staffing requirements will depend upon our ability to attract and retain qualified healthcare professionals, including nurses, certified nurse s assistants, therapists and other staff. Failure to comply with such minimum staffing requirements may result in the imposition of fines or other sanctions. If states do not appropriate sufficient additional funds to pay for any additional operating costs resulting from such minimum staffing requirements, our profitability may be materially adversely affected.

The International Classification of Diseases (ICD) is a classification system for diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, promulgated by the World Health Organization. The Secretary of the U.S. Department of Health and Human Services (HHS) initially mandated that healthcare payors and providers and their vendors must convert from the current ICD-9 coding system to the materially different ICD-10 coding system by October 1, 2013. HHS subsequently announced its intent to delay the conversion date, but has not yet determined the new date by which conversion to ICD-10 must be completed. ICD-10 is the first major change in diagnosis and procedure coding in three decades.

Table of Contents

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

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

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

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

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

Certificates of need and state licensing. Certificate of need, or CON, regulations control the development and expansion of healthcare services and facilities in certain states. Certain states also require regulatory approval prior to certain changes in ownership of a hospital or nursing center. Certain states that do not have CON programs may have other laws or regulations that limit or restrict the development or expansion of healthcare facilities. We operate hospitals in 13 states and nursing and rehabilitation centers in 17 states that require state approval for the expansion of our facilities and services under CON programs. To the extent that CONs or other similar approvals are required for expansion of the operations of our hospitals or nursing and rehabilitation centers, either through facility acquisitions, expansion or provision of new services or other changes, such expansion could be affected adversely by the failure or inability to obtain the necessary approvals, changes in the standards applicable to such approvals or possible delays and expenses associated with obtaining such approvals.

We are required to obtain state licenses to operate each of our hospitals and nursing and rehabilitation centers and to ensure their participation in government programs. Some states require similar licenses for home health and hospice operations. Once a hospital or nursing and rehabilitation center becomes licensed and operational, it must continue to comply with federal, state and local licensing requirements in addition to local building and life-safety codes. All of our hospitals, nursing and rehabilitation centers and home health and

Table of Contents

hospice operations have the necessary licenses. Failure of our hospitals, nursing and rehabilitation centers and home health and hospice operations to satisfy applicable licensure and certification requirements could have a material adverse effect on our business, financial position, results of operations and liquidity.

Hospital division

General regulations. The hospital division is subject to various federal and state regulations. In order to receive Medicare reimbursement, each hospital must meet the applicable conditions of participation set forth by HHS relating to the type of hospital, its equipment, personnel and standard of medical care, as well as comply with state and local laws and regulations. We have developed a management system to facilitate our compliance with these various standards and requirements. Among other things, each hospital employs a person who is responsible for leading an ongoing quality assessment and improvement program. Hospitals undergo periodic on-site Medicare certification surveys, which generally are limited in frequency if the hospital is accredited by the Joint Commission or the AOA, national organizations that establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. As of December 31, 2012, 116 hospitals operated by the hospital division were certified as Medicare LTAC providers and six hospitals were certified as an IRF provider. In addition, 107 of our hospitals also were certified by their respective state Medicaid programs. Loss of certification could adversely affect a hospital s ability to receive payments from the Medicare and Medicaid programs.

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

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

Accreditation by the Joint Commission or the AOA. Hospitals may receive accreditation from the Joint Commission or the AOA. With respect to accreditation by the Joint Commission, hospitals and certain other healthcare facilities are generally required to have been in operation at least four months in order to be eligible. After conducting on-site surveys, the Joint Commission awards accreditation for up to three years to hospitals found to be in substantial compliance with Joint Commission standards. Accredited hospitals also are periodically resurveyed, at the option of the Joint Commission, upon a major change in facilities or organization and after merger or consolidation. With respect to the AOA, the accreditation process includes an in-depth review of both open and closed patient records, as well as on-site surveys, including direct observation of the care being provided. As of December 31, 2012, all of the TC hospitals and IRFs operated by the hospital division were accredited by either the Joint Commission or the AOA or were in the process of seeking accreditation. The hospital division intends to seek and obtain Joint Commission or AOA accreditation for any additional hospitals it may operate in the future.

Peer review. Federal regulations provide that admission to and utilization of hospitals by Medicare and Medicaid patients must be reviewed by peer review organizations or quality improvement organizations in order to ensure efficient utilization of hospitals and services. A quality improvement organization may conduct such

Table of Contents

review either prospectively or retrospectively and may, as appropriate, recommend denial of payments for services provided to a patient. The review is subject to administrative and judicial appeals. Each of the hospitals operated by our hospital division employs a clinical professional to administer the hospital s integrated quality assurance and improvement program. Denials by third party utilization review organizations historically have not had a material adverse effect on the hospital division s operating results.

Overview of hospital division reimbursement

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

Medicare reimbursement of LTAC hospitals Since October 2002, the Medicare payment system for LTAC hospitals has been based upon the Long-Term Acute Care Prospective Payment System (LTAC PPS), a prospective payment system specifically for LTAC hospitals. LTAC PPS maintains long-term acute care hospitals as a distinct provider type, separate from short-term acute care hospitals. Only providers certified as LTAC hospitals may be paid under this system. All of our TC hospitals are certified as LTAC hospitals. To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be greater than 25 days. Medicare Advantage patients are included with Medicare fee-for-service patients in order to determine compliance with the 25 day average length of stay requirement.

CMS has, for a number of years, considered the development of facility and patient certification criteria for LTAC hospitals, potentially as an alternative to the current certification system pursuant to which LTAC hospitals must maintain an average Medicare length of stay of 25 days. In 2004, MedPAC recommended to Congress the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for LTAC hospitals in order to ensure that only appropriate patients are admitted to these facilities. Since the MedPAC recommendation, CMS has initiated studies to examine such recommendations and those studies are ongoing. Implementation of additional criteria that may limit the population of patients eligible for our hospital services or change the basis on which we are paid could have a material adverse effect on our business, financial position, results of operations and liquidity.

The Long-Term Care Hospital Improvement Act of 2011 was introduced into the United States Senate (the LTAC Legislation) during a prior Congressional session. The LTAC Legislation would have implemented new patient and facility criteria for LTAC hospitals. The LTAC Legislation provided for patient criteria to ensure that LTAC hospital patients are physician screened for appropriateness prior to admission and throughout their stay. In addition, facility criteria would have established common requirements for the programmatic, personnel and clinical operations of a LTAC hospital. The LTAC Legislation further provided that at least 70% of patients must be medically complex in order for a hospital to maintain its Medicare certification as a LTAC hospital. While the LTAC Legislation was not enacted during a prior Congressional session, nor has it been reintroduced during the current session of Congress, we believe that similar legislation establishing patient and facility criteria for LTAC hospitals could be introduced in the future. However, there can be no assurances that the LTAC Legislation or any other legislation establishing patient and facility criteria for LTAC hospitals will be enacted in the future.

On August 1, 2007, CMS issued final regulations regarding Medicare hospital inpatient payments to short-term acute care hospitals, as well as certain provisions affecting LTAC hospitals. These regulations adopted a new system for LTAC hospitals for classifying patients into diagnostic categories called Medicare Severity

Table of Contents

Diagnosis Related Groups or more specifically, for LTAC hospitals, MS-LTC-DRGs. LTAC PPS is based upon discharged-based MS-LTC-DRGs similar to the system used to pay short-term acute care hospitals.

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

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

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

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

CMS has regulations governing payments to a LTAC hospital that is co-located within a host hospital (HIH). At December 31, 2012, we operated 25 HIHs with 943 licensed beds. The rules generally limit Medicare payments to the HIH if the Medicare admissions to the HIH from its co-located hospital exceed 25% of the total Medicare discharges for the HIH s cost reporting period, known as the 25 Percent Rule. There are limited exceptions for admissions from rural, urban single and MSA Dominant (as defined below) hospitals. Admissions that exceed this 25 Percent Rule are paid using IPPS. Patients transferred after they have reached

Table of Contents

the short-term acute care outlier payment status are not counted toward the admission threshold. Patients admitted prior to meeting the admission threshold, as well as Medicare patients admitted from a non co-located hospital, are eligible for the full payment under LTAC PPS. If the HIH s admissions from the co-located hospital exceed the limit in a cost reporting period, Medicare will pay the lesser of: (1) the amount payable under LTAC PPS; or (2) the amount payable under IPPS.

On May 1, 2007, CMS issued regulatory changes regarding Medicare reimbursement for LTAC hospitals (the 2007 Final Rule) which expanded the policy known as the 25 Percent Rule to all LTAC hospitals, regardless of whether they are co-located with another hospital. Under the 2007 Final Rule, all LTAC hospitals were to be paid LTAC PPS rates for admissions from a single referral source up to 25% of aggregate Medicare admissions. Patients reaching high cost outlier status in the short-term hospital were not to be counted when computing the 25% limit. Admissions beyond the 25% threshold were to be paid at a lower amount based upon IPPS rates. However, as set forth below, the SCHIP Extension Act initially placed a three-year moratorium on the expansion of the 25 Percent Rule to freestanding hospitals that was further extended by ACA and later by the 2012 CMS Rule (as defined below).

On December 29, 2007, the SCHIP Extension Act became law. This legislation provided for, among other things: (1) a mandated study by the Secretary of HHS on the establishment of LTAC hospital certification criteria; (2) enhanced medical necessity review of LTAC hospital cases; (3) a three-year moratorium on the establishment of a LTAC hospital or satellite facility, subject to exceptions for facilities under development; (4) a three-year moratorium on an increase in the number of licensed beds at a LTAC hospital or satellite facility, subject to exceptions for states where there is only one other LTAC hospital and upon request following the closure or decrease in the number of licensed beds at a LTAC hospital within the state; (5) a three-year moratorium on the application of a one-time budget neutrality adjustment to payment rates to LTAC hospitals under LTAC PPS; (6) a three-year moratorium on very short-stay outlier payment reductions to LTAC hospitals initially implemented on May 1, 2007; (7) a three-year moratorium on the application of the so-called 25 Percent Rule to freestanding LTAC hospitals; (8) a three-year period during which LTAC hospitals that are co-located with another hospital may admit up to 50% of their patients from their co-located hospital and still be paid according to LTAC PPS; (9) a three-year period during which LTAC hospitals that are co-located with an urban single hospital or a hospital that generates more than 25% of the Medicare discharges in a metropolitan statistical area (MSA Dominant hospital) may admit up to 75% of their patients from such urban single hospital or MSA Dominant hospital and still be paid according to LTAC PPS; and (10) the elimination of the July 1, 2007 market basket increase in the standard federal payment rate of 0.71%, effective for discharges occurring on or after April 1, 2008.

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

The ACA also extended the moratorium on the expansion of the 25 Percent Rule to freestanding LTAC hospitals from three years to five years. Following the ACA, the moratorium on the expansion of the 25 Percent Rule to freestanding LTAC hospitals was set to expire for cost reporting periods beginning on or after July 1, 2012. However, the 2012 CMS Rule further extended the moratorium to all freestanding LTAC hospitals with cost report periods beginning on or after October 1, 2012 and before October 1, 2013. This created a potential gap period but it will not affect any of our freestanding TC hospitals.

With respect to HIHs, the ACA extended to five years the period during which: (1) HIHs may admit up to 50% of their patients from their co-located hospitals and still be paid according to LTAC PPS; and (2) HIHs that are co-located with an urban single hospital or a MSA Dominant hospital may admit up to 75% of their patients

Table of Contents

from such urban single or MSA Dominant hospital and still be paid according to LTAC PPS. The 2012 CMS Rule further extended these periods to HIHs with cost report periods beginning on or after October 1, 2012 and before October 1, 2013.

Other recent Medicare rate changes

On July 30, 2010, CMS issued final regulations regarding Medicare reimbursement for LTAC hospitals for the fiscal year beginning October 1, 2010. Included in those final regulations is: (1) a market basket increase to the standard federal payment rate of 2.5%; (2) an offset of 2.5% applied to the standard federal payment rate to account for the effect of documentation and coding changes; (3) an offset of 0.5% applied to the standard federal payment rate as mandated by the ACA; (4) adjustments to area wage indexes; and (5) an increase in the high cost outlier threshold per discharge to $18,785. CMS indicated that all of these changes will result in a 0.5% increase to average Medicare payments to LTAC hospitals.

On August 1, 2011, CMS issued final regulations regarding Medicare reimbursement for LTAC hospitals for the fiscal year beginning October 1, 2011. Included in the final regulations is: (1) a market basket increase to the standard federal payment rate of 2.9%; (2) offsets to the standard federal payment rate mandated by the ACA of: (a) 1.0% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.99775 applied to the adjusted standard federal payment rate; (4) adjustments to area wage indexes; and (5) a decrease in the high cost outlier threshold per discharge to $17,931. CMS has projected the impact of these proposed changes will result in a 2.5% increase to average Medicare payments to LTAC hospitals. We believe that the impact of these proposed changes to LTAC PPS resulted in an approximate 0.7% increase in payments to our TC hospitals.

On August 1, 2012, CMS issued final rules (the 2012 CMS Rule) which, among other things, will reduce Medicare reimbursement to our TC hospitals in 2013 and beyond by imposing a budget neutrality adjustment and modifying the short-stay outlier rules. Included in the 2012 CMS Rule is: (1) a market basket increase to the standard federal payment rate of 2.6%; (2) offsets to the standard federal payment rate mandated by the ACA of: (a) 0.7% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.999265 applied to the adjusted standard federal payment rate; (4) adjustments to area wage indexes; and (5) a decrease in the high cost outlier threshold per discharge to $15,408. Effective December 29, 2012, the 2012 CMS Rule (1) began a three-year phase-in of a 3.75% budget neutrality adjustment which will reduce LTAC hospital rates by 1.3% in 2013; and (2) restored a payment reduction that will limit payments for very short-stay outliers that will reduce our TC hospital payments by approximately 0.5%. The 2012 CMS Rule also (1) provides for a one-year extension of the existing moratorium on the 25 Percent Rule pending the results of an ongoing research initiative to re-define the role of LTAC hospitals in the Medicare program, and (2) allows for the expiration of the current moratorium on the development or expansion of LTAC hospitals on December 29, 2012.

In aggregate, based upon its review of the 2012 CMS Rule, we expect that LTAC Medicare payment rates will decline slightly in 2013 compared to current rates. The 2012 CMS Rule does not include the impact of a 2% sequestration payment reduction mandated by Congress that is now expected to apply to each claim submitted to Medicare beginning April 1, 2013.

Beginning April 1, 2013, the Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) will automatically reduce federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. At this time, we believe that the automatic 2% reduction on each claim submitted to Medicare will begin on April 1, 2013. Reductions to Medicare and Medicaid reimbursement resulting from the Budget Control Act of 2011 could have a material adverse effect on our business, financial position, results of operations and liquidity.

The ACA requires a quality reporting system for LTAC hospitals beginning in federal fiscal year 2014 under which any market basket update would be reduced by 2% for any LTAC hospital that does not meet the quality reporting standards. The final regulations issued on August 1, 2011 include three quality reporting

Table of Contents

measures: (1) catheter-associated urinary tract infections; (2) central line associated blood stream infections; and (3) new or worsening pressure ulcers. CMS also listed 27 additional quality measures that it was considering for future adoption. CMS has indicated that data collection associated with these events began in October 2012.

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

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

Overview of inpatient rehabilitation hospitals reimbursement

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

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for IRF providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to IRFs. In 2004, CMS issued a final rule, known as the 75% Rule, stipulating that to qualify as an IRF under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any IRF that failed to meet its requirements would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. The SCHIP Extension Act reduced the compliance threshold to 60% instead of 75% and allowed hospitals to continue using a patient s secondary medical conditions, or comorbidities, to determine whether a patient qualifies for inpatient rehabilitative care under the rule.

On July 22, 2010, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning on October 1, 2010. The pricing changes in this rule include a 2.5% market basket update that has been reduced to 2.25% under the requirements of the ACA.

On July 29, 2011, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning October 1, 2011. Included in these final regulations are (1) a market basket increase to the standard payment conversion factor of 2.9%; (2) offsets to the standard payment conversion factor mandated by the ACA of: (a) 1.0% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) a wage level budget neutrality factor of 0.9988 applied to the standard payment conversion factor; (4) a case mix group budget neutrality factor of 0.9988 applied to the standard payment conversion factor; (5) adjustments to area wage indexes; and (6) a decrease in the high cost outlier threshold per discharge to $10,660. CMS has projected the impact of these proposed changes will result in a 2.2% increase to average Medicare payments to IRFs.

On July 25, 2012, CMS issued final regulations regarding Medicare reimbursement for IRFs for the fiscal year beginning October 1, 2012. Included in these final regulations are: (1) a market basket increase to the standard payment conversion factor of 2.7%; (2) offsets to the standard payment conversion factor mandated by

Table of Contents

the ACA of: (a) 0.7% to account for the effect of a productivity adjustment, and (b) 0.1% as required by statute; (3) adjustments to area wage indexes; and (4) a decrease in the high cost outlier threshold per discharge to $10,466. CMS has projected the impact of these changes will result in a 2.1% increase to average Medicare payments to IRFs.

Beginning April 1, 2013, the Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) will automatically reduce federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. At this time, we believe that the automatic 2% reduction on each claim submitted to Medicare will begin on April 1, 2013. Reductions to Medicare and Medicaid reimbursement resulting from the Budget Control Act of 2011 could have a material adverse effect on our business, financial position, results of operations and liquidity.

Similar to LTAC hospitals, the ACA requires a quality reporting system for IRFs beginning in fiscal year 2014 in which any market basket update would be reduced by 2% for any IRF that does not meet quality reporting standards. The final regulations issued on July 29, 2011 include two quality reporting measures, catheter-associated urinary tract infections and pressure ulcers, and CMS indicated that it is still developing a 30-day comprehensive all risk standardized readmission measure that is expected to be standardized in the near future. CMS also listed 26 additional quality measures that it was considering for future adoption. CMS has indicated that data collection associated with these events began in October 2012.

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

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

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

Nursing center division

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

Table of Contents

and environmental laws. Nursing and rehabilitation centers are subject to periodic inspection by governmental and other authorities to ensure continued compliance with various standards, continued licensing under state law, certification under the Medicare and Medicaid programs and continued participation in the Veterans Administration program. The failure to obtain, maintain or renew any required regulatory approvals or licenses could adversely affect nursing center division operations including its financial results.

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

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

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

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

Overview of nursing center division reimbursement

Medicare The Medicare Part A program provides reimbursement for extended care services furnished to Medicare beneficiaries who are admitted to nursing and rehabilitation centers after at least a three-day stay in an acute care hospital. Covered services include supervised nursing care, room and board, social services, physical,

Table of Contents

speech and occupational therapies, certain pharmaceuticals and supplies and other necessary services provided by nursing and rehabilitation centers. Medicare payments to our nursing and rehabilitation centers are based upon certain resource utilization grouping (RUG) payment rates developed by CMS that provide various levels of reimbursement based upon patient acuity.

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

Medicare Part B provides reimbursement for certain physician services, limited drug coverage and other outpatient services, such as therapy and other services, outside of a Medicare Part A covered patient stay. Payment for these services is determined according to the MPFS. Annually since 1997, the MPFS has been subject to the SGR, which is intended to keep spending growth in line with allowable spending. Each year since the SGR was enacted, this adjustment produced a scheduled negative update to payment for physicians, therapists and other healthcare providers paid under the MPFS. Annually, since 2002, Congress has stepped in with so-called doc fix legislation to suspend payment cuts to physicians. Various legislation has annually suspended the payment cut. The Taxpayer Relief Act further suspended the payment cut until December 31, 2013.

Since 2006, federal legislation has provided for an annual Medicare Part B outpatient therapy cap. In succeeding years, CMS increased the amount of the therapy cap. Legislation also was passed that required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. Legislation has annually extended the Medicare Part B outpatient therapy cap exception process. The Job Creation Act extended the therapy cap exception process through December 31, 2012. The Taxpayer Relief Act further extended the therapy cap exception process through December 31, 2013. Patients in our facilities whose stay is not reimbursed by Medicare Part A must seek reimbursement for their therapy under Medicare Part B and are subject to the therapy cap.

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

Recent Medicare rate changes

On July 16, 2010, CMS issued a notice that updates the payment rates for nursing centers for the fiscal year beginning October 1, 2010. That notice provided for an increase in rates of 1.7%, which is comprised of a market basket increase of 2.3% less a forecast error adjustment of 0.6%. In addition, for the fiscal year beginning October 1, 2010, CMS increased the number of RUG categories for nursing centers from 53 to 66 (i.e., RUGs IV) and amended the criteria, including the provision of therapy services, used to classify patients into these categories. CMS indicated that these changes would be enacted in a budget neutral manner. CMS began paying claims using the RUGs IV system effective October 1, 2010. Based upon our experience, these final regulations resulted in increased payments to us for the federal fiscal year ending September 30, 2011. Under RUGs IV, among other requirements, providers must allocate therapy minutes among the patients being served during concurrent therapy sessions, and a therapist/assistant may treat concurrently only two patients. These changes have required us to employ more therapists to provide additional individual therapy minutes.

The therapy time requirements to qualify for rehabilitation RUG categories are unchanged under RUGs IV, however the regulatory changes altered how minutes were allocated to calculate the RUGs scores using the most recent clinical assessment tool of the minimum data set (MDS 3.0). Rather than count all therapy time that a

Table of Contents

nursing center patient receives, rehabilitation providers must instead allocate therapy minutes between the patients being served during concurrent therapy sessions. In addition, the number of patients that a therapist/assistant may treat concurrently is limited to two patients. Under final rules issued by CMS in 2011, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. Irrespective of the number of patients ultimately treated in a group therapy session, rehabilitation providers must allocate therapy minutes during such sessions as if four patients are being served. Our rehabilitation division hired additional therapists to facilitate the provision of additional individual minutes to address patient needs.

Effective January 1, 2011, reimbursement rates for Medicare Part B therapy services included in the MPFS were reduced by 25% for subsequent procedures when multiple therapy services are provided on the same day. CMS projected that the rule would result in an approximate 7% rate reduction for Medicare Part B therapy services in calendar year 2011. We estimate that this rule reduced our revenues related to Medicare Part B therapy services by approximately $7 million for 2011. The Taxpayer Relief Act will further reduce Medicare payments for subsequent procedures when multiple therapy services are provided on the same day. We believe that the new rules related to multiple therapy services will reduce our Medicare revenues by $25 million to $30 million on an annual basis.

On July 29, 2011, CMS issued final rules (the 2011 CMS Rules) which, among other things, impose: (1) a negative adjustment to RUGs IV therapy rates, and (2) a net market basket increase of 1.7% consisting of (a) a 2.7% market basket inflation increase, less (b) a 1.0% adjustment to account for the effect of a productivity adjustment, beginning on October 1, 2011. CMS projected the impact of these changes will result in an 11.1% decrease in payments to skilled nursing and rehabilitation centers. In addition to these rate changes, the 2011 CMS Rules introduced additional changes to RUG calculations along with adding additional patient assessments. Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. In addition, for purposes of assigning patients to RUGs IV payment categories, the minutes of group therapy are divided by four with 25% of the minutes being allocated to each patient. The 2011 CMS Rules also clarify the circumstances for reporting breaks in care of three or more days of therapy and also implement a new change of therapy assessment that is designed to allocate the patient to the RUG level that represents the treatment provided in the last seven days. Both changes are likely to produce alterations in the RUG scores billed for the patient along with generating additional patient assessments. We believe that the 2011 CMS Rules on an annual basis have reduced our revenues by approximately $100 million to $110 million in our nursing center business and have negatively impacted our rehabilitation therapy business by approximately $40 million to $50 million.

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

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

In February 2012, Congress passed the Job Creation Act which provides for reductions in reimbursement of Medicare bad debts at our nursing and rehabilitation centers. The Job Creation Act provides for a phase-in of the reduction in the rate of reimbursement for bad debts of patients that are dually eligible for Medicare and Medicaid. The rate of reimbursement for bad debts for these dually eligible patients will be reduced from 100% to 88%, then 76% and then 65% for cost reporting periods beginning on or after October 1, 2012, October 1, 2013, and October 1, 2014, respectively. The rate of reimbursement for bad debts for patients not dually eligible

Table of Contents

for both Medicare and Medicaid was reduced from 70% to 65%, effective with cost reporting periods beginning on or after October 1, 2012. Approximately 90% of our Medicare bad debt reimbursements are associated with patients that are dually eligible.

Beginning April 1, 2013, the Budget Control Act of 2011 (as amended by the Taxpayer Relief Act) will automatically reduce federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. At this time, we believe that the automatic 2% reduction on each claim submitted to Medicare will begin on April 1, 2013. Reductions to Medicare and Medicaid reimbursement resulting from the Budget Control Act of 2011 could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

The nursing center division provides Medicaid-covered services consisting of nursing care, room and board and social services to eligible individuals. In addition, states may at their option cover other services such as physical, occupational and speech therapies and pharmaceuticals. Medicaid programs also are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may materially increase or decrease the level of program payments to nursing and rehabilitation centers operated by the nursing center division. We believe that the payments under many of these programs may not be sufficient on an overall basis to cover the costs of serving certain patients participating in these programs. In addition, the downturn in the United States economy over the past few years has accentuated budgetary pressures impacting state fiscal budgets, thereby further reducing Medicaid payments to our nursing and rehabilitation centers from current levels.

Under the American Recovery & Reinvestment Act of 2009, state Medicaid programs were granted a temporary increase in federal medical assistance percentage (FMAP) funding. As a result of the economic downturn experienced by most states, the practical effect of the increase in FMAP funding meant the payments for services in nursing and rehabilitation centers in most states were either frozen or increased nominally relative to annual adjustments normally associated with the Medicaid budget process. After various legislative extensions, the enhanced FMAP rate expired June 30, 2011. As a result, state Medicaid programs have less federal funds to support the payments for our services.

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

In addition, some states seek to increase the levels of funding contributed by the federal government to their Medicaid programs through a mechanism known as a provider tax. Under these programs, states levy a tax on healthcare providers, which increases the amount of state revenue available to expend on the Medicaid program. This increase in program revenues increases the payment made by the federal government to the state in the form of matching funds. Consequently, the state then has more funds available to support Medicaid rates for providers of Medicaid covered services. However, states may not necessarily use these funds to increase payments to nursing center providers. Provider tax plans are subject to approval by the federal government and were included as a provision in the Tax Relief and Health Care Act of 2006, codifying the maximum Medicaid provider tax rate at 5.5% through fiscal year 2011. Effective October 1, 2011, the maximum Medicaid provider tax rate was restored to 6.0%. Although these plans have been approved in the past, we cannot assure you that such plans will be approved by the federal government in the future.

Table of Contents

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

Rehabilitation division

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

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

Overview of rehabilitation division revenues

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

Table of Contents

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

Medicare Part B provides reimbursement for certain physician services, limited drug coverage and other outpatient services, such as therapy and other services, outside of a Medicare Part A covered patient stay. Payment for these services is determined according to the MPFS. Annually since 1997, the MPFS has been subject to the SGR, which is intended to keep spending growth in line with allowable spending. Each year since the SGR was enacted, this adjustment produced a scheduled negative update to payment for physicians, therapists and other healthcare providers paid under the MPFS. Annually, since 2002, Congress has stepped in with so-called doc fix legislation to suspend payment cuts to physicians. Various legislation has annually suspended the payment cut. The Taxpayer Relief Act further suspended the payment cut until December 31, 2013.

Since 2006, federal legislation has provided for an annual Medicare Part B outpatient therapy cap. In succeeding years, CMS subsequently increased the amount of the therapy cap. Legislation also was passed that required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. Legislation has annually extended the Medicare Part B outpatient therapy cap exception process. The Job Creation Act extended the therapy cap exception process through December 31, 2012. The Taxpayer Relief Act further extended the therapy cap exception process through December 31, 2013. Patients in our facilities whose stay is not reimbursed by Medicare Part A must seek reimbursement for their therapy under Medicare Part B and are subject to the therapy cap.

For the fiscal year beginning October 1, 2010, CMS finalized provisions that increase the number of RUG categories for nursing centers from 53 to 66 (i.e., RUGs IV) and amend the criteria, including the provision of therapy services, used to classify patients into these categories. Effective October 1, 2010, CMS began paying claims using the RUGS IV system.

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

Effective January 1, 2011, reimbursement rates for Medicare Part B therapy services included in the MPFS were reduced by 25% for subsequent procedures when multiple therapy services are provided on the same day. CMS projected that the rule would result in an approximate 7% rate reduction for Medicare Part B therapy services in calendar year 2011. We estimate that this rule reduced our revenues related to Medicare Part B

Table of Contents

therapy services by approximately $7 million for 2011. The Taxpayer Relief Act will further reduce Medicare payments for subsequent procedures when multiple therapy services are provided on the same day. We believe that the new rules related to multiple therapy services will reduce our Medicare revenues from $25 million to $30 million on an annual basis.

On July 29, 2011, CMS issued the 2011 CMS Rules which, among other things, impose: (1) a negative adjustment to RUGs IV therapy rates, and (2) a net market basket increase of 1.7% consisting of (a) a 2.7% market basket inflation increase, less (b) a 1.0% adjustment to account for the effect of a productivity adjustment, beginning on October 1, 2011. CMS projected the impact of these changes will result in an 11.1% decrease in payments to skilled nursing and rehabilitation centers. In addition to these rate changes, the 2011 CMS Rules introduced additional changes to RUG calculations along with adding additional patient assessments. Under the 2011 CMS Rules, group therapy is defined as therapy sessions with four patients who are performing similar therapy activities. In addition, for purposes of assigning patients to RUGs IV payment categories, the minutes of group therapy are divided by four with 25% of the minutes being allocated to each patient. The 2011 CMS Rules also clarify the circumstances for reporting breaks in care of three or more days of therapy and also implement a new change of therapy assessment that is designed to allocate the patient to the RUG level that represents the treatment provided in the last seven days. Both changes are likely to produce alterations in the RUG scores billed for the patient along with generating additional patient assessments. We believe that the 2011 CMS Rules on an annual basis have reduced our revenues by approximately $100 million to $110 million in our nursing center business and have negatively impacted our rehabilitation therapy business by approximately $40 million to $50 million.

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