KINDRED HEALTHCARE, INC
Form 10-K
February 29, 2016

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, 2015

OR

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

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

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

(502) 596-7300

(Registrant's telephone number, including area code)

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

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes þ No ¨

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No þ

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No ¨

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

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

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

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

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

The aggregate market value of the shares of the registrant held by non-affiliates of the registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2015, was approximately $1,660,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2016, there were 83,803,558 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 2016 definitive proxy statement, which will be filed no later than 120 days after December 31, 2015.

TABLE OF CONTENTS

		Page
PART I		
Item 1.	Business	5
Item 1A.	Risk Factors	48
Item 1B.	Unresolved Staff Comments	67
Item 2.	Properties	67
Item 3.	Legal Proceedings	67
Item 4.	Mine Safety Disclosures	68
PART II		
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	69
Item 6.	Selected Financial Data	71
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	73
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	99
Item 8.	Financial Statements and Supplementary Data	99
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	100
Item 9A.	Controls and Procedures	100
Item 9B.	Other Information	100
PART III		
Item 10.	Directors, Executive Officers and Corporate Governance	101
Item 11.	Executive Compensation	102
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	102
Item 13.	Certain Relationships and Related Transactions, and Director Independence	102
Item 14.	Principal Accounting Fees and Services	102
PART IV		
Item 15.	Exhibits and Financial Statement Schedules	103

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

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS

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

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

In addition to the factors set forth above, other factors that may affect our plans, results, or stock price include, without limitation:

- the impact of healthcare reform, which will initiate significant changes to the United States healthcare system, including potential material changes to the delivery of healthcare services and the reimbursement paid for such services by the government or other third-party payors, including reforms resulting from the Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, the "ACA") or future deficit reduction measures adopted at the federal or state level. Healthcare reform is impacting each of our businesses in some manner. Potential future efforts in the U.S. Congress to repeal, amend, modify, or retract funding for various aspects of the ACA create additional uncertainty about the ultimate impact of the ACA on us and the healthcare industry. Due to the substantial regulatory changes that will need to be implemented by the Centers for Medicare and Medicaid Services ("CMS") and others, and the numerous processes required to implement these reforms, we cannot predict which healthcare initiatives will be implemented at the federal or state level, the timing of any such reforms, or the effect such reforms or any other future legislation or regulation will have on our business, financial position, results of operations, and liquidity,
- our ability to adjust to the new patient criteria for long-term acute care ("LTAC") hospitals under the Pathway for SGR Reform Act of 2013 (the "SGR Reform Act"), which will reduce the population of patients eligible for our hospital services and change the basis upon which we are paid,
- changes in the reimbursement rates or the methods or timing of payment from third-party payors, including commercial payors and the Medicare and Medicaid programs, changes arising from and related to the Medicare prospective payment system for LTAC hospitals, including potential changes in the Medicare payment rules, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and changes in Medicare and Medicaid reimbursement for our transitional care ("TC") hospitals, nursing centers, inpatient rehabilitation hospitals ("IRFs"), and home health and hospice operations, and the expiration of the Medicare Part B therapy cap exception process,

our ability to meet the substantial debt service requirements we incurred to finance the Gentiva Merger (as defined below),

our ability to comply with the terms of the Gentiva CIA (as defined below), which we became subject to as a result of the Gentiva Merger, as well as the RehabCare CIA (as defined below),

risks and uncertainties related to the Gentiva Merger, including, but not limited to, whether the Gentiva Merger will have the accretive effect on our earnings or cash flows that we expect, and the inability to obtain, or delays in obtaining, cost savings and synergies from the Gentiva Merger,

the impact of the final rules issued by CMS in 2012 (the “2012 CMS Rules”), which among other things, reduced Medicare reimbursement to our TC hospitals in 2013 and beyond by imposing a budget neutrality adjustment and modifying the short-stay outlier rules,

the impact of the Budget Control Act of 2011 (as amended by the American Taxpayer Relief Act of 2012 (the "Taxpayer Relief Act")) which instituted an automatic 2% reduction on each claim submitted to Medicare beginning April 1, 2013,

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

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

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

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

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

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

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

our ability to comply with our rental and debt agreements, including payment of amounts owed thereunder and compliance with the covenants contained therein, including under our master lease agreements with Ventas, Inc. ("Ventas"),

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

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

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

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

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

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

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

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

our ability to successfully dispose of unprofitable facilities,

events or circumstances that could result in the impairment of an asset or other charges,

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

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

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

PART I

Item 1. Business

GENERAL

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates TC hospitals, a home health, hospice and community care business, IRFs, a contract rehabilitation services business, nursing centers and assisted living facilities across the United States. We are organized into four operating divisions: the hospital division, the Kindred at Home division (formerly known as the care management division), the Kindred Rehabilitation Services division (formerly known as the rehabilitation division) and the nursing center division. At December 31, 2015, our hospital division operated 95 TC hospitals (certified as LTAC hospitals under the Medicare program) in 22 states. Our Kindred at Home division primarily provided home health, hospice, and community care services from 604 locations in 40 states. Our Kindred Rehabilitation Services division operated 18 IRFs and 100 hospital-based acute rehabilitation units ("ARUs") (certified as IRFs) and provided rehabilitation services primarily in hospitals and long-term care settings in 46 states. Our nursing center division operated 90 nursing centers and seven assisted living facilities in 18 states.

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

Gentiva Merger. On October 9, 2014, we entered into an Agreement and Plan of Merger (the "Gentiva Merger Agreement") with Gentiva Health Services, Inc. ("Gentiva"), providing for our acquisition of Gentiva. On February 2, 2015, we consummated the acquisition with one of our subsidiaries merging with and into Gentiva (the "Gentiva Merger"), with Gentiva continuing as the surviving company and our wholly owned subsidiary. As of December 31, 2014, Gentiva was a leading provider of home health, hospice, and community care services that served patients through approximately 491 locations in 40 states.

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

Gentiva Financing Transactions. We used the net proceeds from the following transactions (collectively, the "Gentiva Financing Transactions"), to fund the Cash Consideration for the Gentiva Merger, repay Gentiva's existing debt, and pay related transaction fees and expenses:

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

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

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

• we amended our credit facilities.

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

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

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

Units Offering – On November 25, 2014, in an offering registered with the SEC, we completed the sale of 150,000 Units for cash and granted the underwriters a 13-day over-allotment option to purchase up to an additional 22,500 Units. On December 1, 2014,

the underwriters exercised in full their over-allotment option to purchase 22,500 additional Units, which we closed on December 3, 2014. Each Unit is composed of a prepaid stock purchase contract (a "Purchase Contract") and one share of 7.25% Mandatory Redeemable Preferred Stock, Series A (the "Mandatory Redeemable Preferred Stock") having a final preferred stock installment payment date of December 1, 2017 and an initial liquidation preference of $201.58 per share of Mandatory Redeemable Preferred Stock. The net proceeds from this offering, after deducting the underwriting discount and offering expenses, were $166.3 million.

Third Amendment Agreement to the ABL Credit Facility and Incremental ABL Joinder – We amended and restated our Second Amended and Restated ABL Facility (as defined below) on October 31, 2014 (the "Third ABL Amendment Agreement") to, among other items, modify certain provisions to permit the issuance of notes into an escrow account and, effective upon completion of the Gentiva Merger, modify certain provisions related to the incurrence of debt and the making of acquisitions, investments and restricted payments (the "Third Amended and Restated ABL Facility").

We also entered into an incremental joinder agreement to the Third Amended and Restated ABL Facility on December 12, 2014 (the "Incremental ABL Joinder") which, upon the completion of the Gentiva Merger and the satisfaction of certain other conditions, provided for additional revolving commitments in an aggregate principal amount of $150 million. As used herein, the "ABL Facility" refers to the Third Amended and Restated ABL Facility, as amended by the Incremental ABL Joinder and the ABL Amendment No. 2 (as defined below).

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

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

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

At the time of the Centerre Acquisition, Centerre operated 11 IRFs with 614 beds in partnership with some of the nation's leading acute care hospital systems. Centerre had two additional hospitals with a total of 90 beds under construction that were opened in 2015, and a pipeline of additional potential hospitals in various stages of development. Centerre's IRFs were geographically aligned with five of our targeted Integrated Care Markets, which are markets where we have multiple facilities or sites of services. The combination of Centerre's portfolio with our five IRFs and 100 ARUs made our Kindred Rehabilitation Services division one of the largest operators of IRFs in the United States.

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

HCP Acquisition. On November 5, 2013, we signed a definitive agreement with HCP, Inc. and its affiliates ("HCP") to acquire the real estate associated with nine nursing centers that we leased from HCP for approximately $83 million.

The annual lease payments for these nursing centers were approximately $9 million. We completed the acquisition of seven of these nursing centers during 2013 for a total consideration of approximately $61 million. The two remaining facilities were acquired in February 2014 for a total consideration of approximately $22 million.

IntegraCare Acquisition. On August 31, 2012, we acquired IntegraCare Holdings, Inc., a provider of home health, hospice and community services that operated 47 locations across Texas for $71 million in cash (the “IntegraCare Acquisition”). The IntegraCare Acquisition was financed through operating cash flows and proceeds from our Prior ABL Facility.

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

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

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

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

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

Discontinued Operations

We have completed several strategic divestitures to improve our future operating results. Certain of these divestitures are described below. For accounting purposes, the operating results of these businesses and the gains, losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented in accordance with the authoritative guidance in effect through December 31, 2014. Effective January 1, 2015, the authoritative guidance modified the requirements for reporting discontinued operations. A disposal is now required to be reported in discontinued operations only if the disposal represents a strategic shift that has (or will have) a major effect on our operations and financial results.

Assets not sold at December 31, 2015 have been measured at the lower of carrying value or estimated fair value less costs of disposal and have been classified as held for sale in the accompanying consolidated balance sheet. See notes 4 and 5 of the notes to consolidated financial statements.

Ventas Divestitures. On December 27, 2014, we entered into an agreement with Ventas to transition the operations under the leases for nine non-strategic nursing centers (the "2014 Expiring Facilities"). Each lease terminates when the operation of such nursing center is transferred to a new operator. Through December 31, 2015, we transferred the operations of seven of the 2014 Expiring Facilities and recorded a gain on divestiture of $2 million ($1 million net of income taxes). The lease term for eight of these nursing centers was scheduled to expire on April 30, 2018. The lease term for the ninth of these nursing centers was scheduled to expire on April 30, 2020. At December 31, 2015, we continued to operate the two remaining facilities and will continue to do so until the operations are transferred. For accounting purposes, the 2014 Expiring Facilities qualified as assets held for sale, and we reflected the operating results as discontinued operations in the accompanying consolidated statement of operations for all historical periods. Under the terms of the agreement to transition operations of the 2014 Expiring Facilities, we incurred a $40 million

termination fee in exchange for the early termination of the leases, which was paid to Ventas in January 2015. The early termination fee was accrued as rent expense in discontinued operations in 2014.

On September 30, 2013, we entered into agreements with Ventas to exit 59 nursing centers and close another facility (collectively, the “2013 Expiring Facilities”). Under the terms of the agreements, the lease term for the 2013 Expiring Facilities expired on September 30, 2014, unless we and Ventas were able to transfer the operations earlier; provided however, that we were obligated to continue to operate any 2013 Expiring Facilities not transferred by December 31, 2014 for a limited amount of time and under certain reduced rent obligations provided for in the agreements. We transferred the operations of all of the 2013 Expiring Facilities to new operators during the year ended December 31, 2014. Another facility was closed and its operating license and equipment were sold during the year ended December 31, 2014. Proceeds from the sale of equipment and inventory for the 2013 Expiring Facilities totaled $15 million for the year ended December 31, 2014. For accounting purposes, the 2013 Expiring Facilities qualified as assets held for sale and we reflected the operating results as discontinued operations in the accompanying consolidated

statement of operations for all historical periods. Under the terms of the agreements, we paid $20 million to Ventas in exchange for the early termination of these leases. The early termination payment was recorded as rent expense in discontinued operations in 2013.

In April 2012, we announced that we would not renew 54 nursing centers (the "2012 Expiring Facilities") under operating leases with Ventas that expired on April 30, 2013. We transferred the operations of all of the 2012 Expiring Facilities to new operators during 2013 and we reclassified the results of operations and losses associated with the 2012 Expiring Facilities to discontinued operations, net of income taxes, for all periods presented.

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

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

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

HEALTHCARE OPERATIONS

We are organized into four operating divisions: the hospital division, the Kindred at Home division, the Kindred Rehabilitation Services division and the nursing center division.

The hospital division operates TC hospitals. The Kindred at Home division primarily provides home health, hospice, and community care services to patients in a variety of settings, including homes, nursing centers, and other residential settings. The Kindred Rehabilitation Services division operates IRFs and ARUs and provides rehabilitation services primarily in hospitals and long-term care settings. The nursing center division operates nursing centers and assisted living facilities.

Based upon the authoritative guidance for business segments, our operating divisions represent six reportable operating segments, including (1) hospitals, (2) home health services, (3) hospice services, (4) Kindred Hospital Rehabilitation Services (formerly known as hospital rehabilitation services), (5) RehabCare (formerly known as skilled nursing rehabilitation services), and (6) nursing centers. The Kindred Hospital Rehabilitation Services and RehabCare operating segments are both contained within the Kindred Rehabilitation Services division, while home health and hospice services are contained within the Kindred at Home division.

COMPETITIVE STRENGTHS

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

Diversified service offerings across the post-acute continuum enable integrated care and population health. We have a large and diversified portfolio of service offerings including TC hospitals, home health and hospice operations, IRFs, contract rehabilitation services, and nursing centers. The Gentiva Merger and the Centerre Acquisition in early 2015 further enhanced our ability to offer a diverse array of services. We are the largest post-acute healthcare provider with the full continuum of care in place to successfully manage an entire episode of care. We have designated 23 markets across the United States as Integrated Care Markets. In these Integrated Care Markets, we are developing our diverse services, allowing us to coordinate and manage the care for our patients, improve care transitions, reduce lengths of stay, implement physician services strategies, prevent avoidable rehospitalizations, and reduce costs.

Well positioned for emerging payment models. 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 operating in emerging payment models, including episodic payments. Our diversified service offerings across our four operating divisions enable us to do this effectively and to participate with other healthcare providers in determining the most appropriate setting for patients as they continue their care throughout a post-acute episode. The Gentiva Merger and the Centerre Acquisition significantly expanded our home health, hospice, and IRF operations. As a leading provider in six critical segments of the post-acute continuum, we are well positioned to deliver the right care at the right site of service. We also are positioned to become a valuable partner to health systems and managed care organizations, which are seeking to increase care coordination, improve care transitions, reduce rehospitalizations, reduce lengths of stay, more effectively manage healthcare costs, and develop new care delivery and payment models.

Strong cash flow generation. We have demonstrated the ability to generate strong operating cash flows in a highly regulated environment. The Gentiva Merger and the Centerre Acquisition reflect our continuing efforts to strengthen our operating cash flows

by investing in higher growth and less capital intensive businesses. Our operating cash flows offer opportunities to fund our acquisition and development strategies, as well as reduce our leverage over time.

Delivering quality, innovation, and value in our healthcare operations. Our TC hospitals, IRFs, nursing centers, and home health and hospice operations continue to improve on quality indicators and beat industry benchmarks. We are committed to "succeeding in our core" operations by maintaining and improving the quality of our patient care by dedicating appropriate resources at each site of service and refining our clinical initiatives and objectives. We are focused on sending more patients home, more quickly and reducing rehospitalizations, both of which create cost savings and improve patient satisfaction.

OUR STRATEGY

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

The key elements of our business strategy include:

Strengthening our care management capabilities. Since 2013, we have focused on improving our care transitions and patient outcomes by further developing capabilities to deliver integrated care across various care settings. Our acquisition of Gentiva and Centerre in early 2015 have significantly strengthened our ability to provide integrated care. Led by our Kindred at Home division, we are developing programs that will enable us and our partners to better manage episodes of care, create seamless transitions between care settings, and improve patient satisfaction, thereby reducing lengths of stay and rehospitalizations at a lower cost to Medicare, Medicaid and other payors. While we continue to grow our home health and hospice business, we are testing new delivery and payment models, and developing capabilities to support our Integrated Care Markets and our Continue the Care® strategies. These capabilities include (1) physician coverage across sites of service through our Kindred House Calls® business, (2) care managers to improve care transitions, (3) information sharing and technology connectivity, (4) patient placement tools, such as our 24-hour telephone contact center that provides consumers with post-acute care resources, and (5) condition-specific clinical programs and outcome measures.

Aggressively growing Kindred at Home. We continue to expand our presence in the home health and hospice business within our Kindred at Home division. With the Gentiva Merger, we provide services in 604 locations in 40 states as of December 31, 2015, making us one of the largest home health and hospice companies in the United States based on revenues. We intend to continue expanding our home health and hospice operations through additional acquisitions, partnerships, and de novo site development, particularly in our Integrated Care Markets.

Aggressively growing IRFs. With the Centerre acquisition, we have one of the largest inpatient rehabilitation platforms in the United States based on revenues with 18 IRFs (including 15 joint ventures) and 100 ARUs as of December 31, 2015. During 2015, we opened two new IRFs (40 beds in Arlington, Texas and 50 beds in Madison, Wisconsin) and expect to open two additional IRFs in 2016 (50 beds in Avon, Ohio and 50 beds in Chandler, Arizona). We also have an active pipeline of potential IRF transactions with joint venture partners. We intend to expand our IRF operations through additional de novo site developments with various healthcare partners.

Advancing our Integrated Care Market strategy. Our operating divisions remain focused on enabling our patients to Continue the Care® during an episode of care at one of our facilities or sites of service in markets where we operate multiple facilities or sites of service. Our Integrated Care Markets allow our caregivers to coordinate and manage the continuum of care for our patients, as well as implement physician services strategies. The Integrated Care Markets provide opportunities to improve quality and patient satisfaction, improve care transitions, lower hospital

readmissions, increase volumes, and lower costs.

During the last few years, we have focused our development activities on expanding our Integrated Care Markets. In addition to the significant expansion of our home health, hospice, and IRF operations discussed above, we continue to increase the number of our nursing facilities providing higher-level recovery and rehabilitation services (which we refer to as transitional care centers). In January 2016, we opened de novo transitional care centers in Las Vegas, Nevada with 160 beds and in Phoenix, Arizona with 120 beds. In addition, we expect construction to begin during 2016 for three additional transitional care centers in Louisville, Kentucky, Dallas, Texas and Austin, Texas, which together will have approximately 310 beds. During 2014, we opened a new 100-bed transitional care center in Indianapolis, Indiana.

Initiating multi-faceted strategy to mitigate LTAC patient criteria. We have developed a multi-faceted mitigation strategy to address new patient criteria in our TC hospitals. Our strategy includes actively pursuing post-intensive care patients that are LTAC eligible but have not historically used our services, focusing our TC hospital operations on attracting site-neutral patients by

modifying our available clinical pathways and demonstrating the value of these services to payors and short-term acute care hospitals. We also are taking actions to reposition our existing TC hospital portfolio to adjust to new patient criteria.

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex and post-intensive care patients through the operation of a national network of 95 TC hospitals with 7,094 licensed beds in 22 states as of December 31, 2015. We operate the largest network of TC hospitals in the United States based upon revenues. Our TC hospitals are certified as LTAC hospitals under the Medicare program.

As a result of our commitment to the hospital business, we have developed a comprehensive program of care for medically complex and post-intensive care 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, outpatient wound care, rehabilitation therapy, CT scanning, one-day surgery, and laboratory tests.

In our TC hospitals, we treat medically complex and post-intensive care 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 and post-intensive care patients are characteristically dependent on technology for continued life support, including mechanical ventilation, total parenteral nutrition, respiratory or cardiac monitors, and kidney dialysis machines.

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 and post-intensive care 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 and post-intensive care 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.

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,		
	2015	2014	2013
Revenues	$2,440,779	$2,450,068	$2,400,076
Operating income	$477,515	$522,955	$508,572
Hospitals in operation at end of period	95	97	97
Licensed beds at end of period	7,094	7,147	7,105
Admissions	50,629	52,260	51,312
Patient days	1,478,204	1,474,739	1,450,634
Average length of stay	29.2	28.2	28.3
Revenues per admission	$48,209	$46,882	$46,774
Revenues per patient day	$1,651	$1,661	$1,654
Medicare case mix index (discharged patients only)	1.162	1.163	1.170
Average daily census	4,050	4,040	3,974
Occupancy %	64.9	64.6	63.6
Assets at end of period	$1,633,801	$1,751,695	$1,746,085
Capital expenditures:			
Routine	$28,935	$29,881	$28,390
Development	$–	$2,087	$11,812

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

Sources of Hospital Revenues

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

	Year ended December 31,		
	2015	2014	2013
Revenue mix %:			
Medicare	57	58	60
Medicaid	5	7	6
Medicare Advantage	11	11	11
Medicaid Managed	6	3	2
Commercial insurance and other	21	21	21
Admissions mix %:			
Medicare	66	66	68
Medicaid	4	6	6
Medicare Advantage	11	10	11
Medicaid Managed	5	4	2
Commercial insurance and other	14	14	13
Patient days mix %:			
Medicare	59	60	62
Medicaid	7	9	8
Medicare Advantage	12	11	12
Medicaid Managed	6	4	2
Commercial insurance and other	16	16	16

For the year ended December 31, 2015, revenues of the hospital division totaled approximately $2.5 billion or 33% 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 licensed beds we operated as of December 31, 2015:

State	Licensed beds	Number of facilities Owned by us	Leased from Ventas (2)	Leased from other parties	Total
Arizona	167	–	2	1	3
California	1,028	4	5	4	13
Colorado	105	–	1	1	2
Florida (1)	747	3	6	1	10
Georgia (1)	117	–	–	2	2
Illinois (1)	575	–	4	2	6
Indiana	221	1	1	2	4
Kentucky (1)	414	–	1	1	2
Louisiana	168	–	1	–	1
Massachusetts (1)	197	1	2	–	3
Michigan (1)	77	–	–	1	1
Missouri (1)	354	–	2	3	5
Nevada	254	1	1	1	3
New Jersey (1)	117	–	–	3	3
New Mexico	61	–	1	–	1
North Carolina (1)	124	–	1	–	1
Ohio	309	2	–	3	5
Oklahoma	93	–	1	1	2
Pennsylvania	265	1	2	2	5
Tennessee (1)	109	–	1	1	2
Texas	1,452	2	6	11	19
Washington (1)	140	2	–	–	2
Totals	7,094	17	38	40	95

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

Quality Assessment and Improvement

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

The hospital division has implemented a program whereby its TC hospitals 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 medically complex and post-intensive care patients. 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 and post-intensive care 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, clinical operations, regulatory compliance, 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 providing quality patient care.

A division president, chief operating officer, and a chief financial officer manage the hospital division. The operations of the hospital division are divided into five operational units consisting of two regions and three districts, each headed by an officer of the division who reports directly to the chief operating officer. 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 hospital division vice president of 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 healthcare facilities that provide services comparable to those offered by our hospitals. Certain competing hospitals and healthcare facilities 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 nongovernment reimbursement sources is intense. The primary competitive factors in the LTAC hospital 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 business with licensed hospitals that compete with our hospitals. The competitive position of any LTAC hospital 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.

In addition, certain third-parties, known as conveners, offer patient placement and care transition services to managed care companies, Medicare Advantage plans, bundled payment participants, accountable care organizations, and other healthcare providers as part of an effort to manage post acute-care provider ("PAC") utilization and associated costs. Thus, conveners influence patient decision on which PAC setting to choose, as well as how long to remain in a particular PAC facility. Given their focus on perceived financial savings, conveners customarily suggest that patients avoid higher cost PAC settings altogether or move as soon as practicable to lower cost PAC settings. However, conveners are not healthcare providers and may suggest a PAC setting or duration of care that may not be appropriate from a clinical perspective. Conveners may suggest that patients select alternate care settings to our TC hospitals, IRFs, nursing centers or home health and hospice locations or otherwise suggest shorter lengths of stay in such settings. Because LTAC hospitals are the highest cost PAC setting due to the intensity of services provided to patients in these facilities, we believe that our TC hospitals are the most likely to be adversely affected by the activities of these third-party conveners.

KINDRED AT HOME DIVISION

Our Kindred at Home division primarily provides home health, hospice, and community care services for patients in a variety of settings, including their homes, nursing centers, and other residential settings. The Gentiva Merger significantly increased the diversity and scale of our operations. As a result, Kindred at Home provides services in 604 locations in 40 states, making us one of the largest and geographically diversified home health and hospice companies in the United States as of December 31, 2015. See "—General—Gentiva Merger" and note 2 of the notes to consolidated financial statements for additional information on the Gentiva Merger.

Our home health operations offer medical care and other services for 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 management of their 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, hospitals, and inpatient hospice units. Working in conjunction with a patient's attending physician and/or the hospice medical director, our team of hospice 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 community care services include personal care (bathing and grooming), meal preparation, companionship, light housekeeping, shopping, respite care, and transportation.

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

Selected Kindred at Home Division Operating Data

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

	Year ended December 31,		
	2015	2014	2013
Kindred at Home:			
Home Health:			
Revenues (1)	$1,578,500	$298,907	$173,242
Operating income (1)	$250,641	$20,149	$4,440
Sites of service (at end of period)	373	133	153
Episodic revenues	$1,194,536	$232,127	n/a
Total episodic admissions	249,805	42,047	n/a
Medicare episodic admissions	218,850	38,716	n/a
Total episodes	406,313	85,618	n/a
Episodes per admission	1.63	2.04	n/a
Revenue per episode	$2,940	$2,711	n/a
Assets at end of period (1)	$1,435,176	$203,154	$197,252
Routine capital expenditures (1)	$4,201	$783	$1,369
Hospice:			
Revenues	$656,527	$50,095	$51,685
Operating income	$105,092	$5,390	$5,523
Sites of service (at end of period)	175	29	35
Admissions	45,657	3,448	n/a
Average length of stay	97	95	n/a
Patient days	4,373,044	325,054	n/a
Revenue per patient day	$150	$154	n/a
Average daily census	11,981	891	n/a
Assets at end of period	$922,710	$32,733	$46,871
Routine capital expenditures	$1,215	$64	$154

(1) Includes community care and home-based physician services.
n/a – not available.

Sources of Kindred at Home Division Revenues

Kindred at Home division revenues are derived principally from the Medicare and Medicaid programs, private insurers, and private pay patients. Medicare reimburses both home health and hospice services under prospective

payment systems, which are subject to numerous qualifications, standards, and adjustments. Medicaid reimburses home health and hospice service providers using a number of state-specific systems. We often negotiate contract rates of reimbursement with private insurers.

The following table sets forth the approximate percentages of home health (including community care and home-based physician services) revenues derived from the payor sources indicated:

Year ended December 31,	Medicare	Medicaid	Private insurance	Private pay
2015	68 %	15 %	8 %	9 %
2014	74	5	5	16
2013	63	11	6	20

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

Year ended December 31,	Medicare	Medicaid	Private pay
2015	94%	4%	2%
2014	94	4	2
2013	95	3	2

For the year ended December 31, 2015, revenues of the Kindred at Home division totaled approximately $2.2 billion or 31% of our total revenues (before eliminations). For more information regarding the reimbursement of our Kindred at Home division, see "—Governmental Regulation—Kindred at Home Division—Overview of Kindred at Home Division Reimbursement."

Kindred at Home Division Management and Operations

At December 31, 2015, the Kindred at Home division was headed by a president, overseeing a chief operating, and clinical, financial, and administrative officers, and a senior vice president of sales. A president for each of the five geographic regions and a sixth president over the community care operations, report to the chief operating officer of the division. In addition, the Kindred at Home division has division-level sales, clinical services, finance, and operations executives.

We provide our Kindred at Home division with centralized administrative support in the areas of information systems, regulatory compliance, reimbursement guidance, licensing support as well as legal, finance, accounting, purchasing, marketing, 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.

Kindred at Home Division Competition

Our Kindred at Home division operates in a highly competitive and significantly fragmented industry. Our competitors include relatively large providers of home health and hospice services, both for profit and nonprofit and smaller independent local operators. There often are no significant barriers to entry in many of the markets in which our Kindred at Home 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 Kindred at Home division competes based upon its reputation for providing quality services, charging competitive prices, and being consistently responsive to the needs of our patients and their families and physicians.

KINDRED REHABILITATION SERVICES DIVISION

Our Kindred Rehabilitation Services division operates IRFs and ARUs and provides rehabilitation services, including physical and occupational therapies and speech pathology services, to residents and patients of nursing centers, hospitals, outpatient clinics, home health agencies, and assisted living facilities. Within our Kindred Rehabilitation Services division, we are organized into two reportable operating segments: Kindred Hospital Rehabilitation Services and RehabCare. We are one of the largest providers of rehabilitation services in the United States based upon fiscal 2015 revenues of approximately $1.5 billion.

Kindred Hospital Rehabilitation Services Operations

Our Kindred Hospital Rehabilitation Services segment operates IRFs and ARUs and provides program management and therapy services on an inpatient basis in 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, 2015, our Kindred Hospital Rehabilitation Services segment operated 18 IRFs and 100 ARUs and provided rehabilitation services in 119 LTAC hospitals, seven sub-acute (or skilled nursing) units and 130 outpatient clinics.

Inpatient rehabilitation hospitals. Our IRFs provide services to patients who require intensive inpatient rehabilitative care. Our IRF patients have typically experienced significant physical disability due to various medical and physical conditions, such as brain injuries, spinal cord injuries, stroke, hip fractures, certain orthopedic problems, and neuromuscular disease, which require medical and rehabilitative healthcare services in an inpatient setting. Our nurses and physical, occupational, and speech therapists work with physicians in a multi-disciplinary environment 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.

Hospital-based inpatient rehabilitation units. We are a leading provider of ARU management services on a contract basis. As of December 31, 2015, we operated 100 ARUs. The ARUs we operate provide high acuity rehabilitation for patients recovering from strokes, medically complex and orthopedic conditions, traumatic brain injuries, and other neurological disease processes. We establish ARUs in acute care hospitals that have vacant space and/or unmet rehabilitation needs in their markets. We also work with acute care hospitals that currently operate ARUs 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 ARUs, 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 ARUs 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.

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

LTAC hospitals. We 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, 2015, we operated therapy programs in 119 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 effective and efficient quality rehabilitation services in addition to enhancing overall prevention programs in accordance with applicable standards of care.

Sub-acute units. As of December 31, 2015, we managed therapy programs in seven sub-acute (or skilled nursing) units. These hospital-based units provide lower intensity rehabilitation for medically complex patients. Patients' diagnoses cover a wide range of medical conditions, including stroke, post-surgical conditions, pulmonary disease, cancer, congestive heart failure, burns, and wounds. These sub-acute units enable patients to remain in a hospital setting where emergency medical needs can be met quickly as opposed to having to be transported from a nursing center. These types of units are typically located within the acute care hospital and are either 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 manage outpatient therapy programs that provide therapy services to patients with a variety of medical, orthopedic, and neurological conditions that may be related to work or sports injuries. As of December 31, 2015, we managed 130 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.

RehabCare Operations

Our RehabCare segment provides therapy management services primarily to nursing centers, assisted living facilities, independent living communities, home health agencies, and hospice providers, allowing our customers to fulfill their continuing need for therapists on a full-time or part-time basis without the need to hire, train, and retain their own full-time staff. As of December 31, 2015, our RehabCare segment provided rehabilitative services in 1,798 sites of service in 43 states.

RehabCare 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 fractures, neurologic, orthopedic, cardiac, and pulmonary conditions. We also provide clinical education and programming that is developed and supported by our clinical experts. These programs are implemented in an effort to ensure that clinical practices support the provision of quality rehabilitation services in accordance with applicable standards of care.

RehabCare recruits and retains qualified professionals with the clinical expertise to provide quality patient care and measurable rehabilitation outcomes. RehabCare also provides quality-assurance training for all clinicians to maintain compliance with regulatory requirements.

Selected Kindred Rehabilitation Services Division Operating Data

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

	Year ended December 31,		
	2015	2014	2013
Kindred Hospital Rehabilitation Services:			
Revenues	$609,122	$374,201	$352,097
Operating income	$176,127	$98,196	$89,183
Assets at end of period	$802,686	$366,153	$379,782
Capital expenditures:			
Routine	$948	$194	$454
Development	$4,701	$–	$5
Freestanding IRFs:			
End of period data:			
Number of IRFs	18	5	5
Number of licensed beds	919	215	215
Discharges (1)	15,991	4,224	3,866
Occupancy % (1)	70.2	70.3	63.0
Average length of stay (1)	13.2	13.1	12.8
Revenue per discharge (1)	$19,104	$17,757	$16,938
Contract services:			
Sites of service (at end of period):			
Inpatient rehabilitation units (ARUs)	100	100	104
LTAC hospitals	119	117	121
Sub-acute units	7	10	10
Outpatient units	130	138	144
	356	365	379
Revenue per site	$837,606	$805,590	$831,914
Revenue mix %:			
Company-operated	30	30	32
Non-affiliated	70	70	68

(1) Excludes non-consolidating IRF.

	Year ended December 31,		
	2015	2014	2013
RehabCare:			
Revenues	$915,486	$1,007,036	$995,907
Operating income	$43,815	$70,974	$63,963
Revenue mix %:			
Company-operated	15	12	11
Non-affiliated	85	88	89

Sites of service (at end of period)	1,798	1,935	1,806
Revenue per site	$505,909	$534,077	$568,231
Assets at end of period	$347,738	$360,860	$339,103
Routine capital expenditures	$1,449	$2,247	$2,608

Sources of Kindred Rehabilitation Services Division Revenues

In the Kindred Hospital Rehabilitation Services segment, our IRFs derive a significant portion of their revenues from Medicare, Medicaid, and other payors that received discounts from their established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts are calculated are complex and are subject to interpretation and adjustment. IRFs estimate the allowance for contractual discounts on a patient-specific basis given their interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the IRFs' estimates.

Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Regarding the rehabilitation and program management services we provide to residents, patients, and customers, the basis for payment varies depending upon the type of service provided. In the Kindred Hospital Rehabilitation Services segment, our (1) ARU customers generally pay us on the basis of a negotiated fee per discharge, (2) LTAC hospital customers generally pay based upon a negotiated per patient day rate, (3) sub-acute rehabilitation customers generally pay based upon a flat monthly fee or a negotiated fee per patient day, and (4) outpatient therapy clients typically pay us on the basis of a negotiated fee per unit of service. In the RehabCare segment, our customers generally pay us on the basis of a negotiated patient per diem rate or a negotiated fee schedule based upon the type of service rendered.

For the year ended December 31, 2015, revenues of the Kindred Rehabilitation Services division totaled approximately $1.5 billion or 21% of our total revenues (before eliminations). Approximately 15% of our Kindred Rehabilitation Services division revenues (before eliminations) in 2015 were generated from services provided to hospitals, nursing centers, and care management functions that we operated.

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

Geographic Coverage

The following table lists by state the number of sites of service of our Kindred Hospital Rehabilitation Services operating segment as of December 31, 2015:

			Contract services			
State	IRFs	ARUs	LTAC hospitals	Sub-acute units	Outpatient units	Total
Alabama	–	1	–	–	–	1
Arizona	–	1	3	–	–	4
Arkansas	–	5	–	1	9	15
California	–	10	16	–	1	27
Colorado	–	–	2	–	3	5
Delaware	–	1	–	–	–	1
District of Columbia	–	–	2	–	–	2
Florida	–	–	11	–	5	16
Georgia	–	4	2	2	–	8
Illinois	–	6	6	–	10	22
Indiana	1	7	6	–	13	26
Iowa	–	3	–	–	2	5
Kansas	–	5	–	–	2	7
Kentucky	–	1	2	–	–	3
Louisiana	–	6	2	1	19	28
Massachusetts	–	1	5	–	3	9
Michigan	–	8	3	–	3	14
Minnesota	–	1	–	–	–	1
Mississippi	–	4	–	1	2	7
Missouri (1)	3	7	4	–	9	20
Nevada	–	–	3	–	–	3
New Jersey	–	–	2	–	8	10
New Mexico	–	–	1	–	–	1
North Carolina	–	–	1	–	4	5
North Dakota	–	1	2	–	–	3
Ohio	1	5	7	1	18	31
Oklahoma	1	3	3	–	–	6
Pennsylvania	2	4	5	–	–	9
Puerto Rico	–	1	–	–	–	1
Rhode Island	–	2	–	–	4	6
South Carolina	–	1	1	–	2	4
Tennessee (1)	1	2	1	–	–	3
Texas	7	8	25	–	10	43
Virginia	–	–	1	–	–	1
Washington	–	1	2	–	1	4
West Virginia	–	–	–	–	2	2
Wisconsin	2	–	1	–	–	1
Wyoming	–	1	–	1	–	2
Totals	18	100	119	7	130	356

(1) These states have CON regulations for our IRFs. See "—Governmental Regulation—Federal, State and Local Regulations."

The following table lists by state the number of sites of service of our RehabCare operating segment as of December 31, 2015:

State	Company-operated	Non-affiliated	Total
Alabama	1	9	10
Arizona	1	10	11
Arkansas	1	5	6
California	27	76	103
Colorado	10	36	46
Connecticut	–	6	6
Delaware	–	1	1
District of Columbia	–	3	3
Florida	32	62	94
Georgia	1	10	11
Idaho	7	4	11
Illinois	–	284	284
Indiana	17	28	45
Iowa	–	25	25
Kansas	2	54	56
Kentucky	3	32	35
Louisiana	–	10	10
Maine	–	25	25
Maryland	3	39	42
Massachusetts	19	31	50
Michigan	–	30	30
Minnesota	–	66	66
Missouri	1	169	170
Montana	2	6	8
Nebraska	–	6	6
Nevada	–	2	2
New Hampshire	1	2	3
New Jersey	–	4	4
New Mexico	–	2	2
New York	–	19	19
North Carolina	4	58	62
North Dakota	–	6	6
Ohio	9	64	73
Oklahoma	–	29	29
Oregon	–	1	1
Pennsylvania	–	53	53
Rhode Island	–	2	2
South Carolina	–	4	4
Tennessee	12	46	58
Texas	24	193	217
Vermont	2	2	4
Virginia	3	15	18
Washington	3	10	13
Wisconsin	–	74	74

Totals	185	1,613	1,798

Sales and Marketing

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

RehabCare's new business efforts are led by a divisional vice president of business development and eight directors of business development in geographically defined regions.

Kindred Rehabilitation Services Division Management and Operations

A president, chief financial officer, and a chief medical officer manage our Kindred Rehabilitation Services division. Our operations are further divided between the Kindred Hospital Rehabilitation Services and RehabCare operating segments.

The Kindred Hospital Rehabilitation Services segment is led by a chief operating officer who reports to the division president. With respect to our IRFs, our operations are led by a vice president who oversees the administrators that are responsible for the day-to-day operations at each of our IRFs. Each IRF (or network of IRFs) also employs a controller to monitor financial matters, a chief clinical officer to oversee clinical operations, and a director of quality management to oversee quality assurance programs. With respect to the provision of therapy services and program management, our operations are led by a division vice president who manages five regional vice presidents.

The RehabCare segment is led by a chief operating officer, who reports to the division president. The chief operating officer has six division vice presidents reporting to him with six regional vice presidents reporting to the divisional vice presidents.

In both the Kindred Hospital Rehabilitation Services and RehabCare segments, area directors of operations report to the regional vice presidents. Each area director of operations is responsible for the overall management of 15 to 30 on-site program directors. Many of our rehabilitation customers have on-site program directors responsible for managing the therapy operations at such facility. There are two division vice presidents of clinical operations that manage clinical education for our therapists and implement quality care initiatives.

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

Kindred Rehabilitation Services Division Competition

The IRF industry is highly fragmented, and there are generally several competitors in each geographic market that we serve that provide similar services to those provided by our IRFs. In addition, several of the markets in which our IRFs operate have other IRFs that provide comparable services. Other providers of acute-care services may attempt to become competitors in the future. Also, other acute-care hospital operators may choose to expand their IRF services in our markets. Certain competing IRFs are operated by nonprofit, non-taxpaying, or governmental agencies, which can finance capital expenditures on a tax-exempt basis and receive funds and charitable contributions unavailable to us. Similarly, nursing facilities may market themselves as offering certain rehabilitation services even though they may not be required to offer the same level of care.

Competition for IRF patients covered by nongovernment reimbursement sources is intense. The primary competitive factors in the IRF business include quality of care and services, treatment outcomes achieved, charges for services, and responsiveness to the needs of patients, families, payors, and physicians. Other companies have entered the IRF business with licensed IRFs that compete with our IRFs. The competitive position of any IRF is also 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. 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.

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

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

NURSING CENTER DIVISION

Our nursing center division provides quality, cost-effective care through the operation of a national network of 90 nursing centers (11,535 licensed beds) and seven assisted living facilities (375 beds) located in 18 states as of December 31, 2015. Through our nursing centers, we provide short-stay patients and long-stay residents with a full range of medical, nursing, rehabilitative, pharmacy, and routine services, including daily nutrition, social, and recreational services.

Consistent with industry trends, patients and residents admitted to our nursing centers arrive with greater medical complexity and require a more extensive and costly level of care. This is particularly true with our Medicare population for whom the average length of stay in 2015 was 29 days. To appropriately care for a higher acuity short-stay patient population and a more frail and unstable long-stay resident population, we have improved the delivery of the clinical and hospitality services offered to our patients and residents by adjusting the level of clinical and hospitality staffing, enhancing nursing skills via ongoing education and skills validation, and improving clinical case management through the employment of clinical case managers.

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

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

Several of our nursing centers provide higher-level clinical services focused primarily upon patients arriving for recovery, recuperation, and rehabilitation. We refer to these patients as transitional care patients and the nursing centers capable of providing these higher-intensity clinical services as transitional care centers. We currently classify 56 facilities as transitional care centers. Transitional care patients are typically associated with Medicare, Medicare Advantage, and commercial insurance payors.

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

Our nursing center division also manages 12 hospital-based sub-acute units (471 licensed beds) in seven states. Seven of these units (244 licensed beds) are co-located within hospitals owned and operated by our hospital division. These units typically consist of 20 to 50 beds offering skilled nursing services, providing a range of rehabilitation services including physical, occupational, speech, and ventilator or other respiratory therapy to patients recovering from a variety of surgical procedures as well as medical conditions such as stroke and cardiac ailments. Five of these units (227 licensed beds) are managed for unaffiliated companies, are certified as either hospital-based or nursing center sub-acute units, and specialize in providing respiratory and ventilator therapy.

23

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,		
	2015	2014	2013
Revenues	$1,092,075	$1,062,549	$1,005,383
Operating income	$149,364	$146,728	$124,856
Facilities in operation at end of period:			
Nursing centers:			
Owned or leased	86	86	85
Managed	4	4	4
Assisted living facilities	7	7	6
Licensed beds at end of period:			
Nursing centers:			
Owned or leased	11,050	11,050	11,018
Managed	485	485	485
Assisted living facilities	375	375	341
Patient days (1)	3,411,225	3,457,503	3,477,933
Revenues per patient day (1)	$320	$307	$289
Average daily census (1)	9,346	9,473	9,529
Admissions (1)	39,002	38,772	38,406
Occupancy % (1)	79.4	80.7	81.6
Medicare average length of stay (1,2)	28.7	29.6	31.1
Assets at end of period	$494,066	$513,603	$552,336
Capital expenditures:			
Routine	$18,781	$20,976	$23,023
Development	$11,746	$3,170	$7

(1) Excludes managed facilities.
(2) Computed by dividing total Medicare discharge patient days by total Medicare discharges.

Sources of Nursing Center Division Revenues

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

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

	Year ended December 31, 2015