KINDRED HEALTHCARE INC
Form 10-K405/A
August 28, 2001

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K/A

(Mark One)

[X]ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2000

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.
(Formerly Vencor, 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
None	None

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

Common Stock, par value $0.25 per share

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 [X] No [_]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K ((S)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 Form 10-K or any amendment of this Form 10-K. [X]

As of February 28, 2001, there were 70,233,280 shares of the Registrant's common stock, $0.25 par value, outstanding. 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 OTC Bulletin Board on February 28, 2001, was approximately $2,780,000. For purposes of the foregoing calculation only, all directors and executive officers of the Registrant have been deemed affiliates.

DOCUMENTS INCORPORATED BY REFERENCE
None

TABLE OF CONTENTS

		Page
PART I		
Item 1.	Business	3
Item 2.	Properties	43
Item 3.	Legal Proceedings	43
Item 4.	Submission of Matters to a Vote of Security Holders	49
PART II		
Item 5.	Market for Registrant's Common Equity and Related Stockholder Matters	50
Item 6.	Selected Financial Data	51
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	52
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	67
Item 8.	Financial Statements and Supplementary Data	68
Item 9.	Changes in and Disagreements With Accountants on Accounting and Financial Disclosure	68
PART IV		
Item 14.	Exhibits, Financial Statement Schedules, and Reports on Form 8-K	70

INTRODUCTION

On August 14, 2001, the Company announced that it will restate certain of its previously issued consolidated financial statements. The Company recently determined that an oversight related to the allowance for professional liability risks had occurred in its consolidated financial statements beginning in 1998. The oversight resulted in the understatement of the provision for professional liability claims in 1998, 1999 and 2000 because the Company did not record a reserve for claims incurred but not reported at the respective balance sheet dates. See Note 2 of the Notes to Consolidated Financial Statements for a description of the restatement and its effect on the Company's previously issued consolidated financial statements for 1998, 1999 and 2000.

In addition, the Company revised its disclosure of future minimum lease payments under non-cancelable operating leases to exclude contingent rentals. See Note 12 of the Notes to Consolidated Financial Statements.

This Annual Report on Form 10-K/A amends the Company's previously filed Annual Report on Form 10-K for the year ended December 31, 2000. Consolidated financial statement information and related disclosures included in this amended filing reflect, where appropriate, changes resulting from the restatement.

PART I

Item 1. Business

GENERAL

Kindred Healthcare, Inc. ("Kindred" or the "Company") (formerly Vencor, Inc. until April 20, 2001) provides long-term healthcare services primarily through the operation of nursing centers and hospitals. At December 31, 2000, the Company's health services division operated 312 nursing centers (40,189 licensed beds) in 31 states and a rehabilitation therapy business. The Company's hospital division operated 56 hospitals (4,886 licensed beds) in 23 states and an institutional pharmacy business.

The Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") on September 13, 1999. The Company currently is operating its businesses as a debtor-in-possession subject to the jurisdiction of the United States Bankruptcy Court in Delaware (the "Bankruptcy Court"). See "--Proceedings under Chapter 11 of the Bankruptcy Code."

On May 1, 1998, Ventas, Inc. ("Ventas" or the "Company's predecessor") completed the spin-off of its healthcare operations to its stockholders through the distribution of the Company's common stock (the "Spin-off"). Ventas retained ownership of substantially all of its real property and leases such real property to the Company under four master lease agreements. In anticipation of the Spin-off, the Company was incorporated on March 27, 1998 as a Delaware corporation. For accounting purposes, the consolidated historical financial statements of Ventas became the Company's historical financial statements following the Spin-off. Any discussion concerning events prior to May 1, 1998 refers to the Company's business as it was conducted by Ventas prior to the Spin-off.

On September 28, 1995, The Hillhaven Corporation ("Hillhaven") merged into the Company. On March 21, 1997, the Company acquired TheraTx, Incorporated ("TheraTx"), a provider of rehabilitation and respiratory therapy program management services to nursing centers and an operator of 26 nursing centers. On June 24, 1997, the Company acquired a controlling interest in Transitional Hospitals Corporation ("Transitional"), an operator of 19 long-term acute care hospitals located in 13 states. The Company completed the merger of its wholly

owned subsidiary into Transitional on August 26, 1997.

This Annual Report on Form 10-K/A includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). See "--Cautionary Statements."

Proceedings under Chapter 11 of the Bankruptcy Code

On September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Chapter 11 cases have been consolidated for purposes of joint administration under Case Nos. 99-3199 (MFW) through 99-3327 (MFW) (collectively, the "Chapter 11 Cases").

On March 1, 2001, the Bankruptcy Court approved the Company's fourth amended plan of reorganization filed with the Bankruptcy Court on December 14, 2000, as modified at the confirmation hearing (the "Amended Plan"). The order confirming the Amended Plan was entered on March 16, 2001. The Company is proceeding expeditiously to implement the Amended Plan which, under the terms of the Amended Plan, must be effective no later than May 1, 2001.

In connection with the confirmation hearing, the Company entered into a commitment letter for a $120 million senior exit facility with a lending group led by Morgan Guaranty Trust Company of New York (the "Exit Facility"). The Exit Facility will be available to fund the Company's obligations under the Amended Plan and its ongoing operations following emergence from bankruptcy.

The consummation of the Amended Plan is subject to a number of material conditions including, without limitation, the negotiation and execution of definitive agreements for the Exit Facility. There can be no assurance that the Amended Plan will be consummated.

Amended Plan of Reorganization

The Amended Plan represents a consensual arrangement among Ventas, the Company's senior bank lenders (the "Senior Lenders"), holders of the Company's $300 million 9 7/8% Guaranteed Senior Subordinated Notes due 2005 (the "1998 Notes"), the United States Department of Justice (the "DOJ"), acting on behalf of the Department of Health and Human Services' Office of the Inspector General (the "OIG") and the Health Care Financing Administration ("HCFA") (collectively, the "Government") and the advisors to the official committee of unsecured creditors.

The Company distributed its disclosure materials soliciting approval of the Amended Plan on December 29, 2000. Voting on the Amended Plan concluded on February 15, 2001 (other than for Ventas, which voted prior to the confirmation hearing) and the Company received the requisite acceptances from various creditor classes to confirm the Amended Plan.

The following is a summary of certain material provisions of the Amended Plan. The summary does not purport to be complete and is qualified in its entirety by reference to all of the provisions of the Amended Plan, including all exhibits and documents described therein, as filed with the Bankruptcy Court and as may otherwise be amended, modified or supplemented.

The Amended Plan provides for, among other things, the following distributions:

Senior Lender Claims--The Senior Lenders will receive, in the aggregate, new senior subordinated secured notes in the principal amount of $300 million, bearing interest at the rate of LIBOR plus 4 1/2%, with a maturity of seven years (the "New Senior Secured Notes"). The interest on the New Senior Secured Notes will begin to accrue approximately two quarters following the effective date of the Amended Plan and, in lieu of interest payments, the Company will pay a $25.9 million obligation under the Government Settlement (as defined) within the first two full fiscal quarters following the effective date of the Amended Plan as described below. In addition, holders of the Senior Lender claims will receive an aggregate distribution of 65.51% of the

new common stock (the "New Common Stock") of the reorganized Company (subject to dilution from stock issuances occurring after the effective date of the Amended Plan).

Senior Subordinated Noteholder Claims--The holders of the 1998 Notes and the remaining $2.4 million of the Company's 8 5/8% Senior Subordinated Notes due 2007 (collectively, the "Subordinated Noteholder Claims") will receive, in the aggregate, 24.50% of the New Common Stock (subject to dilution from stock issuances occurring after the effective date of the Amended Plan). In addition, the holders of the Subordinated Noteholder Claims will receive, in the aggregate, warrants issued by the Company for the purchase of an aggregate of 7,000,000 shares of New Common Stock, with a five-year term, which will consist of warrants to purchase 2,000,000 shares at a price per share of $30.00, and warrants to purchase 5,000,000 shares at a price per share of $33.33.

Ventas Claim--Ventas will receive the following treatment under the Amended Plan:

The four master leases and the Corydon Lease (as defined) with Ventas will be assumed and simultaneously amended and restated as of the effective date of the Amended Plan (the "Amended Leases"). The principal economic terms of the Amended Leases are as follows:

(1) A decrease of $52 million in the aggregate minimum rent from the annual rent as of May 1, 1999 to a new initial aggregate minimum rent of $174.6 million as of the first month after the effective date of the Amended Plan.

(2) Annual aggregate minimum rent payable in cash will escalate at an annual rate of 3.5% over the prior period annual aggregate minimum rent for the period from May 1, 2001 through April 30, 2004. Thereafter, annual aggregate minimum rent payable in cash will escalate at an annual rate of 2%, plus an additional annual accrued escalator amount of 1.5% of the prior period annual aggregate minimum rent which will accrete from year to year (with an interest accrual at LIBOR plus 4 1/2%). All accrued rent will be payable upon the repayment or refinancing of the New Senior Secured Notes, after which the annual aggregate minimum rent payable in cash will escalate at an annual rate of 3.5% and there will be no further accrual feature.

(3) A one-time option, that can be exercised by Ventas 5 1/4 years after the effective date of the Amended Plan, to reset the annual aggregate minimum rent under one or more of the Amended Leases to the then current fair market rental in exchange for a payment of $5 million (or a pro rata portion thereof if fewer than all of the Amended Leases are reset) to the Company.

(4) Under the Amended Leases, the "Event of Default" provisions also will

be substantially modified and will provide Ventas with more flexibility in exercising remedies for events of default.

In addition to the Amended Leases, Ventas will receive a distribution of 9.99% of the New Common Stock (subject to dilution from stock issuances occurring after the effective date of the Amended Plan).

Ventas also will enter into a tax escrow agreement with the Company as of the effective date that will provide for the escrow of approximately $30 million of federal, state and local refunds until the expiration of the applicable statutes of limitation for the auditing of the refund applications. The escrowed funds will be available for the payment of certain tax deficiencies during the escrow period except that all interest paid by the government in connection with any refund or earned on the escrowed funds will be distributed equally to the parties. At the end of the escrow period, the Company and Ventas will each be entitled to 50% of any proceeds remaining in the escrow account.

All agreements and indemnification obligations between the Company and Ventas, except those modified by the Amended Plan, will be assumed by the Company as of the effective date of the Amended Plan.

United States Claims--The claims of the Government (other than claims of the Internal Revenue Service and criminal claims, if any) will be settled through a government settlement with the Company and Ventas which will be effectuated through the Amended Plan (the "Government Settlement").

Under the Government Settlement, the Company will pay the Government a total of $25.9 million, which will be paid as follows:

(1) $10 million on the effective date of the Amended Plan, and

(2) an aggregate of $15.9 million during the first two full fiscal quarters following the effective date, plus accrued interest at the rate of 6% per annum beginning as of the effective date of the Amended Plan.

Under the Government Settlement, Ventas will pay the Government a total of $103.6 million, which will be paid as follows:

(1) $34 million on the effective date of the Amended Plan, and

(2) the remainder paid over five years, bearing interest at the rate of 6% per annum beginning as of the effective date of the Amended Plan.

In addition, the Company will repay the remaining balance of the obligations under the HCFA Agreement (as defined) (approximately $63.4 million as of December 31, 2000) pursuant to the terms previously agreed to by the Company. See "--Events Leading to Reorganization." As previously announced, the Company has entered into a Corporate Integrity Agreement with the OIG as part of the overall Government Settlement. See "--Corporate Integrity Agreement." The Government Settlement also provides for the dismissal of certain pending claims and lawsuits filed against the Company. See "Legal Proceedings."

General Unsecured Creditors Claims--The general unsecured creditors of the Company will be paid the full amount of their allowed claims existing as of the date of the Company's filing for protection under the Bankruptcy Code. These amounts will be paid in equal quarterly installments over three years beginning at the end of the first full fiscal quarter following the effective date. The Company will pay interest on these claims at the rate of 6% per annum from the

effective date of the Amended Plan, subject to certain exceptions. A convenience class of unsecured creditors, consisting of creditors holding allowed claims in an amount less than or equal to $3,000, will be paid in full within 30 days of the effective date of the Amended Plan.

Preferred Stockholder and Common Stockholder Claims--The holders of preferred stock and common stock of the Company will not receive any distributions under the Amended Plan. The preferred stock and common stock will be canceled on the effective date of the Amended Plan.

Other Significant Provisions--The board of directors of the reorganized Company will consist of: Edward L. Kuntz, the current Chairman of the Board of Directors, Jeff Altman of Franklin Mutual Advisors, L.L.C., James Bolin of Appaloosa Management, L.P., Garry N. Garrison, Isaac Kaufman of Advanced Medical Management, Inc., John H. Klein of BI-Logix, Inc. and David Tepper of Appaloosa Management, L.P.

A restricted share plan was approved under the Amended Plan that provides for the issuance of 600,000 shares of New Common Stock to certain key employees of the Company. The restricted shares will be non-transferable and subject to forfeiture until they have vested generally over a four-year period. In addition, a new stock option plan was approved under the Amended Plan for the issuance of stock options for up to 600,000 shares of New Common Stock to certain key employees of the Company. The Amended Plan also approves the Vencor, Inc. 2000 Long-Term Incentive Plan that provides cash bonus awards to certain key employees on the attainment by the Company of specified performance goals. See "Executive Compensation." The Amended Plan also provides for the continuation of the Company's current management retention plan for its employees and the payment of certain performance bonuses upon the effective date of the Amended Plan.

Debtor-in-Possession Financing Agreement

In connection with the Chapter 11 Cases, the Company entered into a $100 million debtor-in-possession financing agreement (the "DIP Financing"). The Bankruptcy Court granted final approval of the DIP Financing on October 1, 1999. The DIP Financing was initially comprised of a $75 million tranche A revolving loan (the "Tranche A Loan") and a $25 million tranche B revolving loan (the "Tranche B Loan"). Interest is payable at prime plus 2 1/2% on the Tranche A Loan and prime plus 4 1/2% on the Tranche B Loan.

Available aggregate borrowings under the Tranche A Loan were initially limited to $45 million in September 1999 and increased to $65 million in October 1999, $70 million in November 1999 and $75 million thereafter. Pursuant to the most recent amendment to the DIP Financing, the aggregate borrowing limitations under the Tranche A Loan are limited to approximately $48 million until maturity and are reduced for asset sales made by the Company. In addition, Tranche B Loan aggregate borrowings are limited to $23 million as a result of the most recent amendment to the DIP Financing. Borrowings under the Tranche B Loan require the approval of lenders holding at least 75% of the credit exposure under the DIP Financing. The DIP Financing is secured by substantially all of the assets of the Company and its subsidiaries, including certain owned real property. The DIP Financing contains standard representations and warranties and other affirmative and restrictive covenants. At December 31, 2000, there were no outstanding borrowings under the DIP Financing.

Since the consummation of the DIP Financing, the Company and the lenders

under the DIP Financing (the "DIP Lenders") have agreed to several amendments to the DIP Financing. These amendments approved various changes to the DIP Financing including (a) extending the period of time for the Company to file its plan of reorganization, (b) approving certain transactions, (c) revising the Company's cash plan originally submitted with the DIP Financing and (d) revising certain financial covenants.

In the most recent amendment to the DIP Financing, the parties agreed, among other things, to extend the maturity date of the DIP Financing until March 31, 2001 and to revise and update certain financial covenants.
In addition, the most recent amendment extends the period of time for the Company to file the appropriate pleadings to request confirmation and consummation of the Amended Plan through March 31, 2001. At December 31, 2000, the Company was in compliance with the terms of the DIP Financing.

The Company expects to terminate the DIP Financing on or prior to the effective date of the Amended Plan.

Events Leading to Reorganization

The Company reported a net loss from operations in 1998 aggregating $578 million, resulting in certain financial covenant violations under the Company's $1.0 billion bank credit facility (the "Credit Agreement"). Prior to the commencement of the Chapter 11 Cases, the Company received a series of temporary waivers of these covenant violations. The waivers generally included certain borrowing limitations under the $300 million revolving credit portion of the Credit Agreement. The final waiver was scheduled to expire on September 24, 1999.

The Company was informed on April 9, 1999 by HCFA that the Medicare program had made a demand for repayment of approximately $90 million of reimbursement overpayments. On April 21, 1999, the Company reached an agreement with HCFA to extend the repayment of such amounts over 60 monthly installments (the "HCFA Agreement"). Under the HCFA Agreement, non-interest bearing monthly payments of approximately $1.5 million commenced in May 1999. Beginning in December 1999, interest began to accrue on the balance of the overpayments at a statutory rate approximating 13.4%, resulting in a monthly payment of approximately $2.0 million through March 2004. If the Company is delinquent with two consecutive payments, the HCFA Agreement will be defaulted and all subsequent Medicare reimbursement payments to the Company may be withheld. Amounts due under the HCFA Agreement aggregated $63.4 million at December 31, 2000 and have been classified as liabilities subject to compromise in the Company's consolidated balance sheet. The Company

has received Bankruptcy Court approval to continue to make the monthly payments under the HCFA Agreement during the pendency of the Chapter 11 Cases.

On May 3, 1999, the Company elected not to make the interest payment of approximately $14.8 million due on the 1998 Notes. The failure to pay interest resulted in an event of default under the 1998 Notes.

In accordance with generally accepted accounting principles, outstanding borrowings under the Credit Agreement ($511 million) and the principal amount of the 1998 Notes ($300 million) have been presented as liabilities subject to compromise in the Company's consolidated balance sheet at December 31, 2000. If the Chapter 11 Cases had not been filed, the Company would have reported a working capital deficit approximating $942 million at December 31, 2000. The consolidated financial statements do not include any adjustments that might result from the resolution of the Chapter 11 Cases or other matters discussed

herein. During the pendency of the Chapter 11 Cases, the Company is continuing to record the contractual amount of interest expense related to the Credit Agreement. No interest costs have been recorded related to the 1998 Notes since the filing of the Chapter 11 Cases. Contractual interest expense for the 1998 Notes not recorded in the consolidated statement of operations aggregated $30 million in 2000 and $9 million in 1999.

As previously reported, the Company was informed by the DOJ that the Company and Ventas are the subjects of ongoing investigations into various Medicare reimbursement issues, including hospital cost reporting issues, Vencare billing practices and various quality of care issues in the hospitals and nursing centers formerly operated by Ventas and currently operated by the Company. In connection with the Amended Plan, the claims of the DOJ will be settled through the Government Settlement. The Government Settlement also provides for the dismissal of certain pending claims and lawsuits filed against the Company. See "Legal Proceedings."

Agreements with Ventas

On March 18, 1999, the Company served Ventas with a demand for mediation pursuant to the Agreement and Plan of Reorganization governing the Spin-off (the "Spin-off Agreement"). The Company was seeking a reduction in rent and other concessions under its Master Lease Agreements (as defined) with Ventas. Shortly thereafter, the Company and Ventas entered into a series of standstill and tolling agreements which provided that both companies would postpone any claims either may have against the other and extend any applicable statutes of limitation.

As a result of the Company's failure to pay rent, Ventas served the Company with notices of nonpayment under the Master Lease Agreements. Subsequently, the Company and Ventas entered into further amendments to the second standstill and the tolling agreements to extend the time during which no remedies may be pursued by either party and to extend the date by which the Company may cure its failure to pay rent.

In connection with the Chapter 11 Cases, the Company and Ventas entered into a stipulation (the "Stipulation") that provides for the payment by the Company of a reduced aggregate monthly rent of approximately $15.1 million. The Stipulation has been approved by the Bankruptcy Court. The difference between the base rent under the Master Lease Agreements and the reduced aggregate monthly rent is being accrued as an administrative expense subject to compromise in the Chapter 11 Cases.

The Stipulation also continues to toll any statutes of limitations for claims that might be asserted by the Company against Ventas and provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off. The Stipulation automatically renews for one-month periods unless either party provides a 14-day notice of termination. The Stipulation will be terminated upon the effective date of the Amended Plan. See "Legal Proceedings."

On May 31, 2000, the Company announced that the Bankruptcy Court had approved a tax stipulation agreement between the Company and Ventas (the "Tax Stipulation"). The Tax Stipulation provides that certain

8

refunds of federal, state and local taxes received by either party on or after September 13, 1999 will be held by the recipient of such refunds in segregated interest bearing accounts. The Tax Stipulation requires notification before either party can withdraw funds from the segregated accounts and will terminate

upon the effective date of the Amended Plan.

The Company believes that the Amended Plan, if consummated, will resolve all material disputes between the Company and Ventas. The Amended Plan also provides for comprehensive mutual releases between the Company and Ventas, other than for obligations that the Company is assuming under the Amended Plan.

If the Amended Plan does not become effective and the Company and Ventas are unable to otherwise resolve their disputes or maintain an interim resolution, the Company may seek to pursue claims against Ventas arising out of the Spin-off and seek judicial relief barring Ventas from exercising any remedies based on the Company's failure to pay some or all of the rent to Ventas. The Company's failure to pay rent or otherwise comply with the Stipulation, in the absence of judicial relief, would result in an "Event of Default" under the Master Lease Agreements. Upon an Event of Default under the Master Lease Agreements, assuming Ventas were to be granted relief from the automatic stay by the Bankruptcy Court, the remedies available to Ventas include, without limitation, terminating the Master Lease Agreements, repossessing and reletting the leased properties and requiring the Company to (a) remain liable for all obligations under the Master Lease Agreements, including the difference between the rent under the Master Lease Agreements and the rent payable as a result of reletting the leased properties or (b) pay the net present value of the rent due for the balance of the terms of the Master Lease Agreements. Such remedies, however, would be subject to the supervision of the Bankruptcy Court.

General

On September 14, 1999, the Company received approval from the Bankruptcy Court to pay pre-petition and post-petition employee wages, salaries, benefits and other employee obligations. The Bankruptcy Court also approved orders granting authority, among other things, to pay pre-petition claims of certain critical vendors, utilities and patient obligations. All other pre-petition liabilities are classified in the consolidated balance sheet as liabilities subject to compromise. The Company currently is paying the post-petition claims of all vendors and providers in the ordinary course of business.

Under the Bankruptcy Code, actions to collect pre-petition indebtedness against the Company are subject to an automatic stay and other contractual obligations against the Company may not be enforced. The automatic stay does not necessarily apply to certain actions against Ventas for which the Company has agreed to indemnify Ventas in connection with the Spin-off. In addition, the Company may assume or reject executory contracts, including lease obligations, under the Bankruptcy Code. Parties affected by these rejections may file claims with the Bankruptcy Court in accordance with the reorganization process.

Liabilities Subject to Compromise

A substantial portion of pre-petition liabilities are subject to settlement under the Amended Plan. "Liabilities subject to compromise" refers to liabilities incurred prior to the commencement of the Chapter 11 Cases. These liabilities, consisting primarily of long-term debt, amounts due to third-party payors and certain accounts payable and accrued liabilities, represent the Company's estimate of known or potential claims to be resolved in connection with the Chapter 11 Cases. Such claims remain subject to future adjustments based on assertions of additional claims, negotiations, actions of the Bankruptcy Court, further developments with respect to disputed claims, future rejection of executory contracts or unexpired leases, determination as to the value of any collateral securing claims and other events. Proposed payment terms for these amounts are set forth in the Amended Plan.

All pre-petition liabilities, other than those for which the Company has

received Bankruptcy Court approval to pay, are classified in the consolidated balance sheet as liabilities subject to compromise. A

summary of the principal categories of claims classified as liabilities subject to compromise under the Chapter 11 Cases follows (in thousands):

	December 31, 2000	December 31, 1999
Long-term debt:		
Credit Agreement	$ 510,908	$ 506,114
1998 Notes	300,000	300,000
Amounts due under the HCFA Agreement	63,405	80,296
8 5/8% Senior Subordinated Notes	2,391	2,391
Unamortized deferred financing costs	(10,306)	(12,626)
Other	2,873	4,592
	869,271	880,767
Due to third-party payors	116,062	112,694
Accounts payable	36,053	33,693
Income taxes	13,478	-
Accrued liabilities:		
Interest	90,655	45,521
Ventas rent	81,902	33,884
Other	52,952	52,858
	225,509	132,263
	$1,260,373	$1,159,417

Substantially all of the liabilities subject to compromise would have been classified as current liabilities if the Chapter 11 Cases had not been filed.

HEALTHCARE OPERATIONS

The Company is organized into two operating divisions: the health services division, which provides long-term care services by operating nursing centers and a rehabilitation therapy business and the hospital division, which provides long-term acute care to medically complex patients by operating hospitals and an institutional pharmacy business.

The Company believes that the independent focus of each division on the unique aspects and quality concerns of their respective businesses enhances their ability to attract patients, improve operations and achieve cost containment objectives.

The Company believes that the demand for long-term care is increasing. Improved medical care and advances in medical technology continue to increase the survival rates for victims of disease and trauma. Many of these patients never fully recover and require long-term care. The incidence of chronic medical complications increases with age, particularly in connection with certain degenerative conditions. As the average age of the United States

population increases, the Company believes that there will be an increase in the demand for long-term care at all levels of the continuum of care.

At the same time, the long-term care industry is continuing to experience significant changes. Some of the significant factors affecting the long-term care industry include the Medicare prospective payment system ("PPS") for nursing centers and other cost containment measures resulting from the Balanced Budget Act of 1997 (the "Budget Act"), heightened regulatory scrutiny by federal and state regulators, the dramatic increase in the costs of defending and insuring against alleged patient care liability claims, the expansion of managed care, and an increased public awareness of healthcare spending by governmental agencies at the federal and state levels.

As a result of reimbursement reductions imposed under the Budget Act, most providers have been required to deliver quality patient care more efficiently. Medicare revenues recorded under PPS in the Company's health services division have been substantially less than the cost-based reimbursement it received before the enactment of the Budget Act. PPS has dramatically affected the operations of substantially all companies in the long-term care industry. The Budget Act also reduced payments made to the Company's hospitals by reducing incentive payments, allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. Increased regulatory scrutiny and costs associated with patient care liability claims, particularly on large for-profit, multi-facility providers, also have had a significant negative impact on the long-term care industry.

As a result of significant declines in the demand for ancillary services caused by the Budget Act, the Company completed a realignment of its former Vencare division in the fourth quarter of 1999. Vencare's physical rehabilitation, speech and occupational therapies were integrated into the Company's health services division. Vencare's institutional pharmacy business was assigned to the hospital division. Vencare's respiratory therapy and other ancillary businesses were discontinued.

HEALTH SERVICES DIVISION

At December 31, 2000, the health services division provided long-term healthcare and rehabilitation services in 312 nursing centers containing 40,189 licensed beds located in 31 states. At December 31, 2000, the Company owned six nursing centers, leased 272 nursing centers from third parties and managed 34 nursing centers.

The Company's nursing centers provide residents with routine long-term care services, including daily dietary, social and recreational services and a full range of pharmacy and medical services. The nursing centers also provide rehabilitation services, including physical, occupational and speech therapies. In addition, management believes that the Company is a leading provider of care for patients with Alzheimer's disease. The Company offers specialized programs at more than 80 nursing centers for patients suffering from Alzheimer's disease. Most of these patients reside in separate units within the nursing centers and are cared for by teams of professionals specializing in the unique problems experienced by Alzheimer's patients.

Since the Vencare realignment in 1999, the health services division has provided physical, occupational and speech therapies primarily to nursing center patients. The health services division has 267 contracts to provide rehabilitation services to patients at facilities not operated by the health services division.

Health Services Division Strategy

The strategy of the health services division is to improve its patient census by providing quality, clinical-based services. The health services division is focused on qualitative and quantitative performance indicators with the goal of providing quality care under the cost containment objectives imposed by government and private payors. The health services division is refining its method of delivering services to create the optimal strategy of providing quality care, based on clinical outcomes, within the constraints of PPS. The health services division's ability to control costs, including its labor costs, will significantly impact its future operating results.

The factors which affect consumers' selection of a nursing center vary by community and include a nursing center's competitive position and its relationships with local referral sources. Nursing centers in a given market are judged by various referral sources, which include physicians, hospital discharge planners, community organizations and families. Nursing center marketing efforts are conducted at the local market level by the nursing center administrators and admissions coordinators. Nursing center personnel are assisted in carrying out their marketing strategies by regional marketing staffs. The marketing efforts of the health services division focuses on the quality of care provided at its facilities with the goal of increasing patient census levels.

In addition, the Company believes there will be an increase in the need for nursing center services as the average age of the United States population increases.

The health services division continues to refine the delivery of ancillary services to external customers to maintain profitability under the cost constraints of PPS. Since the Vencare realignment, the Company's nursing centers generally provide ancillary services to patients through the use of internal staff. The health services division has terminated many unprofitable external ancillary services contracts in response to the economic conditions facing the long-term care industry.

Selected Health Services Division Operating Data

The following table sets forth certain operating data for the health services division after reflecting the realignment of the former Vencare businesses for all periods presented (dollars in thousands, except statistics):

	Year Ended December 31,		
	2000	1999	1998
Nursing centers:			
Revenues	$ 1,675,627	$ 1,594,244	$ 1,667,343
Operating income (restated)	$ 278,738	$ 169,128	$ 213,036
Facilities in operation at end of period:			
Owned or leased	278	282	278
Managed	34	13	13
Licensed beds at end of period:			
Owned or leased	36,466	36,912	36,701
Managed	3,723	1,661	1,661

Patient days (a)	11,580,295	11,656,439	11,939,266
Revenues per patient day (a)	$ 145	$ 137	$ 140
Average daily census (a)	31,640	31,935	32,710
Occupancy % (a)	86.1	86.8	87.3
Rehabilitation services:			
Revenues	$ 135,036	$ 195,731	$ 264,574
Operating income (restated)	$ 8,047	$ 2,891	$ 18,398
Other ancillary services:			
Revenues	$ -	$ 43,527	$ 168,165
Operating income	$ 4,737	$ 4,166	$ 30,183

(a) Excludes managed facilities.

As used in the above table, the term "operating income" is defined as earnings before interest, income taxes, depreciation, amortization, rent, corporate overhead and unusual transactions. The term "licensed beds" refers to the maximum number of beds permitted in the 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 daily census" is computed by dividing each facility's patient days by the number of calendar days the respective facility is in operation. "Occupancy %" is computed by dividing average daily census by the number of licensed beds, adjusted for the length of time each facility was in operation during each respective period.

Total assets of the health services division were $495 million and $489 million at the end of 2000 and 1999, respectively.

12

Sources of Nursing Center Revenues

Nursing center revenues are derived principally from Medicare and Medicaid programs and from private payment patients. Consistent with the nursing center industry, changes in the mix of the health services division's patient population among these three categories significantly affect the profitability of its operations. Although Medicare and higher acuity patients generally produce the most revenue per patient day, profitability with respect to higher acuity patients is reduced by the costs associated with the higher level of nursing care and other services generally required by such patients. The Company believes that private payment patients generally constitute the most profitable category and Medicaid patients generally constitute the least profitable category.

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

	Medicare		Medicaid		Private and Other	
Year	Patient Days	Revenues	Patient Days	Revenues	Patient Days	Revenues
2000	13%	28%	67%	49%	20%	23%
1999	12	26	66	49	22	25
1998	13	29	65	45	22	26

For the year ended December 31, 2000, revenues of the health services division totaled approximately $1.7 billion or 59% of the Company's total revenues (before eliminations).

Both governmental and private third-party payors employ cost containment measures designed to limit payments made to healthcare providers. Those measures include the adoption of initial and continuing recipient eligibility criteria which may limit payment for services, the adoption of coverage criteria which limit the services that will be reimbursed and the establishment of payment ceilings which set the maximum reimbursement that a provider may receive for services. Furthermore, government reimbursement programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative rulings and government funding restrictions, all of which may materially increase or decrease the rate of program payments to the health services division for its services.

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

Prior to the implementation of PPS, Medicare nursing center reimbursement was based upon reasonable direct and indirect costs of services provided to patients. The Budget Act established PPS for nursing centers for cost reporting periods beginning on or after July 1, 1998. All of the Company's nursing centers adopted PPS on July 1, 1998. During the first three years, the per diem rates for nursing centers are based on a blend of facility-specific costs and federal costs. Thereafter, the per diem rates will be based solely on federal costs. The payments received under PPS cover all services for Medicare patients including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals. Since November 1999, various legislative and regulatory actions have provided a measure of relief from some of the impact of the Budget Act. Despite the effects of these recent actions, the Medicare revenues recorded under PPS in the Company's nursing centers have been substantially less than the cost-based reimbursement received before the enactment of the Budget Act. See "--Governmental Regulation--Regulatory Changes" and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Medicaid. Medicaid is a state-administered program financed by state funds and matching federal funds. The program provides for medical assistance to the indigent and certain other eligible persons. Although administered under broad federal regulations, states are given flexibility to construct programs and payment

methods consistent with their individual goals. Accordingly, these programs differ from state to state in many respects.

Prior to the Budget Act, federal law, generally referred to as the "Boren Amendment," required Medicaid programs to pay rates that were reasonable and adequate to meet the costs incurred by an efficiently and economically operated nursing center providing quality care and services in conformity with all applicable laws and regulations. Despite the federal requirements, disagreements frequently arose between nursing centers and states regarding the

adequacy of Medicaid payments. By repealing the Boren Amendment, the Budget Act eases the restrictions on the states' ability to reduce their Medicaid reimbursement levels for such services. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may materially increase or decrease the level of program payments to nursing centers operated by the health services division. Management believes that the payments under many of these programs may not be sufficient on an overall basis to cover the costs of serving certain patients participating in these programs. Furthermore, the Omnibus Budget Reconciliation Act of 1987, as amended, mandates an increased emphasis on ensuring quality patient care, which has resulted in additional expenditures by nursing centers. The health services division provides to eligible individuals Medicaid-covered services consisting of nursing care, room and board and social services. In addition, states may at their option cover other services such as physical, occupational and speech therapies and pharmaceuticals.

Private Payment. The health services division seeks to maximize the number of private payment patients admitted to its nursing centers, including those covered under private insurance and managed care health plans. Private payment patients typically have financial resources (including insurance coverage) to pay for their monthly services and do not rely on government programs for support.

There can be no assurance that payments under governmental and private third-party payor programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. In addition, there can be no assurance that facilities operated by the health services division, or the provision of services and supplies by the health services division, will meet the requirements for participation in such programs. The Company could be affected adversely by the continuing efforts of governmental and private third-party payors to contain the amount of reimbursement for healthcare services.

14

Nursing Center Facilities

The following table lists by state the number of nursing centers and related licensed beds owned by the Company or leased from Ventas and other third parties as of December 31, 2000:

		Number of Facilities				
State	Licensed Beds	Owned by the Company	Leased from Ventas(2)	Leased from Other Parties	Managed	Total
Alabama(1).............	781	-	3	1	2	6
Arizona................	1,393	-	6	-	6	12
California.............	2,205	1	11	4	2	18
Colorado...............	695	-	4	1	-	5
Connecticut(1).........	983	-	8	-	-	8
Florida(1).............	2,713	2	15	1	2	20
Georgia(1).............	1,211	-	5	4	-	9
Idaho..................	867	1	8	-	-	9
Indiana................	5,075	-	14	15	6	35
Kentucky(1)............	2,080	1	12	4	-	17
Louisiana(1)...........	485	-	-	1	2	3

Maine(1)................	775	-	10	-	-	10
Massachusetts(1)........	4,039	-	31	3	2	36
Mississippi(1)..........	125	-	-	1	-	1
Montana(1)..............	446	-	2	1	-	3
Nebraska(1).............	163	-	1	-	-	1
Nevada(1)...............	180	-	2	-	-	2
New Hampshire(1)........	622	-	3	-	1	4
North Carolina(1).......	2,764	-	19	4	-	23
Ohio(1).................	2,155	-	11	4	1	16
Oregon(1)...............	254	-	2	-	-	2
Pennsylvania............	200	-	1	1	-	2
Rhode Island(1).........	201	-	2	-	-	2
Tennessee(1)............	2,541	-	4	11	-	15
Texas...................	1,521	-	1	2	8	11
Utah....................	848	-	5	1	1	7
Vermont(1)..............	310	-	1	-	1	2
Virginia(1).............	749	-	4	1	-	5
Washington(1)...........	1,012	1	9	-	-	10
Wisconsin(1)............	2,345	-	12	2	-	14
Wyoming.................	451	-	4	-	-	4
Totals................	40,189	6	210	62	34	312

----

(1) These states have Certificate of Need ("CON") regulations. See "--Governmental Regulation--Health Services Division."

(2) See "--Master Lease Agreements."

Health Services Division Management and Operations

A divisional president and a chief financial officer manage the health services division. The nursing center operations of the division are divided into four geographic regions with each region headed by an operational vice president, each of whom reports to the divisional president. Ancillary services operations also are managed by a vice president who reports to the divisional president. The health services division is supported by district and/or regional staff in the areas of nursing, dietary and rehabilitation services, state and federal reimbursement, human resources management, maintenance, sales and financial services. In addition, the Company's corporate headquarters provides other services in the areas of information systems, human resources management, state

15

and federal reimbursement, state licensing and certification, legal, finance and accounting support, purchasing and facilities management. Financial control is maintained principally through fiscal and accounting policies.

Each nursing center is managed by a state-licensed administrator who is supported by other professional personnel, including a director of nursing, staff development professional (responsible for employee training), activities director, social services director, licensed dietitian, business office manager and, in general, physical, occupational and speech therapists. The directors of nursing are state-licensed nurses who supervise nursing staff which include registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing center and on the level of care provided by the nursing center. The nursing centers contract with physicians who serve as medical directors and serve on quality assurance committees.

Quality Assessment and Improvement

Quality of care is monitored and enhanced by quality assurance or performance improvement committees and family satisfaction surveys. These committees oversee patient healthcare needs and patient and staff safety. Additionally, physicians serve on these committees as medical directors and advise on healthcare policies and practices. Regional and district nursing professionals visit each nursing center periodically to review practices and recommend improvements where necessary in the level of care provided and to assure compliance with requirements under applicable Medicare and Medicaid regulations. Surveys of patients' families are conducted from time to time in which the families are asked to rate various aspects of service and the physical condition of the nursing centers. These surveys are reviewed by performance improvement committees at each facility to promote quality patient care.

The health services division provides training programs for nursing center administrators, managers, nurses and nursing assistants. These programs are designed to maintain high levels of quality patient care.

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

Health Services Division Competition

The nursing centers operated by the health services division compete on a local and regional basis with other nursing centers and other long-term healthcare providers. The competitive position varies within each community served. The Company believes that the quality of care, reputation, location and physical appearance of its nursing centers and, in the case of private patients, the charges for services, are significant competitive factors. Some competitors are located in buildings that are newer than those operated by the health services division and may provide services not offered by the health services division. Although there is limited, if any, price competition with respect to Medicare and Medicaid patients (since revenues received for services provided to such patients are based generally on fixed rates), there is significant competition for private payment patients.

Although the ancillary services markets are fragmented, significant competition exists for these services. The primary competitive factors for the ancillary services markets are quality of services, charges for services and responsiveness to the needs of patients, families and the facilities in which the services are provided. In addition, many nursing centers are developing internal staff to provide these services, particularly in response to the implementation of PPS.

The long-term care industry is divided into a variety of competitive areas which market similar services. These competitors include nursing centers, hospitals, extended care centers, assisted living facilities, home health agencies and similar institutions. The industry includes government-owned, church-owned, secular not-for-profit and for-profit institutions. Many of these competitors have greater financial and other resources than the Company.

16

HOSPITAL DIVISION

The Company's hospitals primarily provide long-term acute care to medically

complex patients. These hospitals treat patients who suffer from multiple systemic failures or conditions such as neurological disorders, head injuries, brain stem and spinal cord trauma, cerebral vascular accidents, chemical brain injuries, central nervous system disorders, developmental anomalies and cardiopulmonary disorders. Medically complex patients often are dependent on technology for continued life support, such as mechanical ventilators, total parental nutrition, respiration or cardiac monitors and dialysis machines. Approximately 50% of the hospital division's medically complex patients are ventilator-dependent for some period of time during their hospitalization.

The hospital division's patients suffer from conditions which require a high level of monitoring and specialized care, yet may not need the services of an intensive care unit. Due to their severe medical conditions, the hospital division's patients generally are not clinically appropriate for admission to a nursing center. Their medical condition is periodically or chronically unstable. By combining general acute care services with the ability to care for medically complex patients, the Company believes that its long-term care hospitals provide their patients with high quality, cost-effective care.

During 2000, the average length of stay for patients in its long-term care hospitals was approximately 36 days. Although the hospital division's patients range in age from pediatric to geriatric, approximately 70% of the hospital division's patients are over 65 years of age. Hospital operations are regulated by a number of government and private agencies. See "--Governmental Regulation--Hospital Division."

Services Provided by the Hospital Division

Medically Complex. The Company's long-term acute care hospitals use a comprehensive program of care for its medically complex patients that draws upon the talents of interdisciplinary teams, including licensed pulmonary specialists. The teams evaluate medically complex patients upon admission to determine treatment programs. The hospital division has developed specialized treatment programs focused on the needs of medically complex patients. Where appropriate, the treatment programs may involve the services of several disciplines, such as pulmonary and physical therapy. Individual attention to patients who have the cognitive and physical abilities to respond to therapy is emphasized.

General Acute Care. The hospital division operates two general acute care hospitals and one surgical hospital. Certain of the hospital division's long-term care hospitals also provide outpatient services in support of their long-term care services. General acute care and outpatient services may include inpatient services, diagnostic services, CT scanning, one-day surgery, laboratory, X-ray, respiratory therapy, cardiology and physical therapy.

Pharmacies. Since the Vencare realignment in 1999, the hospital division has provided institutional pharmacy services. The institutional pharmacy business focuses on providing a full array of institutional pharmacy services to nursing centers and specialized care centers, including nursing centers operated by the Company. Institutional pharmacy sales encompass a wide variety of products including prescription medication, prosthetics and respiratory services.

Hospital Division Strategy

The hospital division differentiates its hospitals as a result of its ability to care for medically complex patients in a high quality, cost-effective setting. The hospital division is committed to maintaining its quality of care by dedicating appropriate resources to each of its hospitals. In addition, the hospital division is focusing its efforts on containing and reducing costs to operate competitively under the reduced Medicare reimbursement established by the Budget Act while maintaining quality care. The hospital division seeks to

improve operating efficiencies and reduce costs by standardizing operations and optimizing staffing based on the hospital's occupancy and the clinical needs of its patients. The hospital division has developed a patient classification

system called Customcare(TM) that is designed to ensure that patients receive the necessary level of care. This model allows the hospital division to monitor employee skill mix and manage labor costs. The hospital division's ability to control costs, including its labor costs, will significantly impact its future operating results.

The hospital division intends to market aggressively its quality of care standards and broaden its expertise beyond pulmonary services in specific markets.

The Company believes that the demand for long-term care is increasing as the average age of the United States population increases. The incidence of respiratory problems increases with age, particularly in connection with certain degenerative conditions.

In addition, medically displaced patients that require a high level of monitoring and specialized care, yet may not require the continued services of an intensive care unit, provide a patient base for the Company's hospitals. Due to their extended recovery period, these patients generally would not receive specialized multi-disciplinary treatment focused on the unique aspects of a long-term recovery program in a general acute care hospital, and yet are not appropriate for admission to a nursing center or rehabilitation hospital.

The hospital division also benefits from historical reimbursement policies and practices that make it difficult to place medically complex patients in an appropriate healthcare setting. Under the Medicare program, general acute care hospitals are reimbursed under a prospective payment system or a fixed payment system which provides an economic incentive to general acute care hospitals to minimize the length of a patient's stay. As a result, these hospitals generally receive less than full cost for providing care to patients with extended lengths of stay. Furthermore, the prospective payment system does not provide for reimbursement more frequently than once every 60 days, placing an additional economic burden on a general acute care hospital providing long-term care. The long-term acute care hospitals operated by the hospital division, however, are excluded from the prospective payment system and generally receive reimbursement on a more favorable basis for providing long-term hospital care to Medicare patients. Commercial reimbursement sources, such as insurance companies, managed care companies and health maintenance organizations ("HMOs"), some of which pay based on established hospital charges, typically seek the most economical source of care available.

The hospital division seeks to increase its admissions by expanding and improving its relationship with physicians, general acute care hospitals and other discharge planners by emphasizing its quality of care and its cost-effective setting.

Selected Hospital Division Operating Data

The following table sets forth certain operating data for the hospital division after reflecting the realignment of the former Vencare businesses for all periods presented (dollars in thousands, except statistics):

Year Ended December 31,

	2000	1999	1998
Hospitals:			
Revenues....................................	$1,007,947	$850,548	$919,847
Operating income (restated).................	$ 205,858	$132,050	$247,272
Facilities in operation at end of period.....	56	56	57
Licensed beds at end of period..............	4,886	4,931	4,979
Patient days................................	1,044,663	982,301	947,488
Revenues per patient day....................	$ 965	$ 866	$ 971
Average daily census........................	2,854	2,691	2,596
Occupancy %.................................	60.8	56.9	54.0
Pharmacy:			
Revenues....................................	$ 204,252	$171,493	$149,991
Operating income (restated).................	$ 7,421	$ 342	$ 15,301

Total assets of the hospital division were $354 million and $337 million at the end of 2000 and 1999, respectively.

Sources of Hospital Revenues

The hospital division receives payment for hospital services from third-party payors, including government reimbursement programs such as Medicare and Medicaid and non-government sources such as commercial insurance companies, HMOs, preferred provider organizations ("PPOs") and contracted providers. Patients covered by non-government payors generally will be more profitable to the hospital division than those covered by Medicare and Medicaid programs. The following table sets forth the approximate percentages of the hospital patient days and revenues derived from the payor sources indicated:

	Medicare		Medicaid		Private and Other	
Year	Patient Days	Revenues	Patient Days	Revenues	Patient Days	Revenues
2000.....................	67%	55%	13%	10%	20%	35%
1999.....................	68	58	12	11	20	31
1998.....................	68	59	13	10	19	31

For the year ended December 31, 2000, revenues of the hospital division totaled approximately $1.2 billion or 41% of the Company's total revenues (before eliminations). Changes caused by the Budget Act have reduced Medicare payments made to the hospital division related to incentive payments under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. See "--Governmental Regulation--Regulatory Changes" and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Hospital Facilities

The following table lists by state the number of hospitals and related licensed beds owned by the Company or leased from Ventas and other third parties as of December 31, 2000:

State	Licensed Beds	Number of Facilities: Owned by the Company	Leased from Ventas(2)	Leased from Other Parties	Total
Arizona	109	-	2	-	2
California	543	2	6	-	8
Colorado	68	-	1	-	1
Florida(1)	536	-	6	1	7
Georgia(1)	72	-	-	1	1
Illinois(1)	564	-	4	1	5
Indiana	167	-	2	1	3
Kentucky(1)	374	-	1	-	1
Louisiana	168	-	1	-	1
Massachusetts(1)	86	-	2	-	2
Michigan(1)	400	-	2	-	2
Minnesota	92	-	1	-	1
Missouri(1)	227	-	2	-	2
Nevada(1)	52	-	1	-	1
New Mexico	61	-	1	-	1
North Carolina(1)	124	-	1	-	1
Oklahoma	59	-	1	-	1
Pennsylvania	115	-	2	-	2
Tennessee(1)	49	-	1	-	1
Texas	714	2	6	2	10
Virginia(1)	164	-	1	-	1
Washington(1)	80	1	-	-	1
Wisconsin	62	1	-	-	1
Totals	4,886	6	44	6	56

----

(1) These states have CON regulations. See "--Governmental Regulation--Hospital Division."

(2) See "--Master Lease Agreements."

Hospital Patient Admissions

Substantially all of the acute and medically complex patients admitted to the hospitals are transferred from other healthcare providers. Patients are referred from general acute care hospitals, rehabilitation hospitals, nursing centers and home care settings. Referral sources include physicians, discharge planners, case managers of managed care plans, social workers, third-party administrators, HMOs and insurance companies.

The hospital division employs case managers who are responsible for, among other things, educating healthcare professionals from other referral sources as to the unique nature of the services provided by its long-term care hospitals. Specifically, case managers train the staffs of discharging institutions about long-term care hospital services and the types of patients who could benefit from such services. The case managers are responsible for assisting discharging institutions in establishing long-term care hospital policies and practices.

These professionals also review referrals and coordinate admissions subsequent to the referring provider determining that the patient is appropriate for a long-term care hospital and that the Company's hospital is the appropriate long-term care hospital. Each hospital maintains a pre-admission assessment system to evaluate clinical needs and other information in determining the appropriateness of each patient referral.

20

Professional Staff

Each hospital is staffed with a multi-disciplinary team of healthcare professionals. A professional nursing staff trained to care for long-term acute patients is on duty 24 hours each day in the hospitals. Other professional staff includes respiratory therapists, physical therapists, occupational therapists, speech therapists, pharmacists, registered dietitians and social workers.

The physicians at the hospitals are not employees of the Company and may be members of the medical staff of other hospitals. Each of the hospitals has a fully credentialed, multi-specialty medical staff to meet the needs of the medically complex, long-term acute patient. Typically, each patient is visited at least once a day by a physician. A broad range of physician services is available including, but not limited to, pulmonology, internal medicine, infectious diseases, neurology, nephrology, cardiology, radiology and pathology. Generally, the hospital division does not enter into exclusive contracts with physicians to provide services to its patients.

The hospital division believes that its future success will depend in part upon its continued ability to hire and retain qualified healthcare personnel. Accordingly, the hospital division seeks the highest quality of professional staff within each market.

Hospital Division Management and Operations

A divisional president and a chief financial officer manage the hospital division. The operations of the hospitals are divided into three geographic regions with each region headed by an operational vice president, each of whom reports to the divisional president. The clinical issues and quality concerns of the hospital division are managed by the division's chief medical officer and vice president of clinical operations. Institutional pharmacy operations also are managed by a vice president who reports to the divisional president. The Company's corporate headquarters also provides services in the areas of information systems design and development, training, human resources management, reimbursement expertise, legal advice, technical accounting support, purchasing and facilities management. Financial control is maintained principally through fiscal and accounting policies.

A hospital administrator supervises and is responsible for the day-to-day operations at each hospital. Each hospital also employs a controller who monitors the financial matters of each hospital, including the measurement of actual operating results compared to budgets. In addition, each hospital employs an assistant administrator to oversee the clinical operations of the hospital and a quality assurance manager to direct an integrated quality assurance program.

Quality Assessment and Improvement

The hospital division maintains a strategic outcome program which includes a centralized pre-admission evaluation program and concurrent review of all of

its patient population against utilization and quality screenings, as well as quality of life outcomes data collection and patient and family satisfaction surveys. In addition, each hospital has an integrated quality assessment and improvement program administered by a quality review manager which encompasses utilization review, quality improvement, infection control and risk management. The objective of these programs is to ensure that patients are admitted appropriately to its hospitals and that quality healthcare is provided in a cost-effective manner.

The hospital division has implemented a program whereby its hospitals are reviewed by internal quality auditors for compliance with standards of the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"). The purposes of this internal review process are to (a) ensure ongoing compliance with industry recognized standards for hospitals, (b) assist management in analyzing each hospital's operations and (c) provide consulting and educational programs for each hospital to identify opportunities to improve patient care.

Hospital Division Competition

As of December 31, 2000, the hospitals operated by the hospital division were located in 42 geographic markets in 23 states. In each geographic market, there are general acute care hospitals which provide services comparable to those offered by the Company's hospitals. In addition, the hospital division believes that as of December 31, 2000 there were approximately 300 hospitals in the United States certified by Medicare as general long-term hospitals, some of which provide similar services to those provided by the hospital division. Many of these general acute care hospitals and long-term hospitals are larger and more established than the hospitals operated by the hospital division. Certain competing hospitals are operated by not-for-profit, nontaxpaying or governmental agencies, which can finance capital expenditures on a tax-exempt basis, and which receive funds and charitable contributions unavailable to the hospital division.

Cost containment efforts by federal and state governments and other third-party payors designed to encourage more efficient utilization of hospital services generally have resulted in lower hospital industry occupancy rates in recent years. As a result of these efforts, a number of acute care hospitals have converted to specialized care facilities. Some hospitals have developed step-down units which attempt to serve the needs of patients who require care at a level between that provided by an intensive care unit and a general medical/surgical floor. This trend may continue due to the current oversupply of acute care hospital beds and the increasing consolidation and affiliation of free-standing hospitals into larger systems. As a result, the hospital division may experience increased competition from existing hospitals and converted facilities.

Competition for patients covered by non-government reimbursement sources is intense. The primary competitive factors in the long-term acute care business include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies have entered the long-term acute care market with licensed hospitals that compete with the Company's hospitals.

Some nursing centers, while not licensed as hospitals, have developed units which provide a greater intensity of care than typically provided by a nursing center. The condition of patients in these nursing centers is less acute than the condition of patients in the hospitals operated by the hospital division.

The competitive position of any hospital also is affected by the ability of its management to negotiate contracts with purchasers of group healthcare services, including private employers, managed care companies, PPOs and HMOs. Such organizations attempt to obtain discounts from established hospital charges. The importance of obtaining contracts with PPOs, HMOs and other organizations which finance healthcare, and its effect on a hospital's competitive position, vary from market to market, depending on the number and market strength of such organizations.

The hospital division also competes with other companies in providing institutional pharmacy services. Many of these companies have greater financial and other resources than the Company.

MASTER LEASE AGREEMENTS

As part of the Spin-off, the Company and Ventas entered into four master lease agreements that set forth the material terms governing the lease of over 250 parcels of real property, buildings and other improvements (primarily nursing centers and long-term acute care hospitals) operated by the Company. The leased properties are divided into groups of properties and a master lease agreement was entered into with respect to each such group of properties. In August 1998, the Company and Ventas entered into a fifth lease agreement with respect to a nursing center in Corydon, Indiana (the "Corydon Lease"). The provisions of the Corydon Lease, except for the provisions relating to rental amounts and the termination date, are substantially similar to the terms of the other master lease agreements with Ventas. The four master lease agreements, as amended, and the Corydon Lease shall be referred to herein collectively as the "Master Lease Agreements" and each, a "Master Lease Agreement."

The following description of the Master Lease Agreements does not purport to be complete but contains a summary of the material provisions of the Master Lease Agreements. As part of the Amended Plan, the Company and Ventas will enter into the Amended Leases which have substantially different terms than the current Master Lease Agreements. See "--Proceedings under Chapter 11 of the Bankruptcy Code--Amended Plan of Reorganization."

Each Master Lease Agreement includes land, buildings, structures and other improvements on the land, easements and similar appurtenances to the land and improvements, permanently affixed equipment, and machinery and other fixtures relating to the operation of the leased properties. There are multiple bundles of leased properties under each Master Lease Agreement (other than the Corydon Lease) with each bundle containing approximately seven to twelve leased properties. All leased properties within a bundle have the same primary terms ranging from 10 to 15 years (the "Base Term"). At the option of the Company, all, but not less than all, of the leased properties in a bundle may be extended for one five-year renewal term beyond the Base Term (the "First Renewal Term") at the then existing rental rate plus 2% per annum. At the option of the Company, all, but not less than all, of the leased properties in a bundle may be extended for two additional five-year renewal terms beyond the First Renewal Term (together with the First Renewal Term, the "Renewal Term") at the then fair market value rental rate. The Base Term and Renewal Term of each leased property are subject to termination upon default by either party and certain other conditions described in the Master Lease Agreements.

Rental Amounts

Each Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. The aggregate annual rent for the twelve-month period

commencing immediately following the Spin-off for the leased properties was approximately $222 million, with a 2% per annum escalator over the previous twelve-month period if certain lessee revenue parameters were obtained. During 2000, the aggregate annual rent was approximately $230 million. In connection with the Chapter 11 Cases, the Company and Ventas entered into the Stipulation which provides for the payment by the Company of a reduced aggregate monthly rent of approximately $15.1 million beginning in September 1999. The difference between the $19.3 million aggregate monthly rent under the Master Lease Agreements and the reduced monthly rent under the Stipulation is being accrued as an administrative expense subject to compromise in the Chapter 11 Cases. During the pendency of the Chapter 11 Cases, the Company is recording the entire contractual amount of the aggregate monthly rent.

In addition, the Company is required to pay:

- all insurance required in connection with the leased properties and the business conducted on the leased properties;
- all taxes levied on or with respect to the leased properties (other than taxes on the net income of Ventas); and
- all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

Use of the Leased Property

The Master Lease Agreements require that the Company utilize each leased property solely as a hospital or a nursing center and related uses, or as Ventas may otherwise consent (which consent may not be unreasonably withheld). The Company is responsible for maintaining or causing to be maintained all licenses, certificates and permits necessary for it to comply with various healthcare regulations. The Company is obligated to operate continuously each leased property as a provider of healthcare services.

Events of Default

An "Event of Default" will be deemed to have occurred under any Master Lease Agreement if, among other things:

- the Company fails to pay rent or other amounts within five days after notice;
- the Company fails to comply with covenants continuing for 30 days or, so long as diligent efforts to cure such failure are being made, such longer period (not to exceed 180 days) as is necessary to cure such failure;
- certain bankruptcy or insolvency events occur, including filing a petition of bankruptcy or a petition for reorganization under the Bankruptcy Code;
- the Company ceases to operate any leased property as a provider of healthcare services for a period of 30 days;
- the Company loses any required healthcare license, permit or approval;
- the Company fails to maintain insurance;
- the Company creates or allows to remain certain liens;

- a reduction occurs in the number of licensed beds in excess of 10% of the number of licensed beds in the applicable facility on the date the applicable facility was leased;

- certification for reimbursement under Medicare with respect to a participating facility is revoked;

- there is any breach of any material representation or warranty of the Company;

- the Company becomes subject to regulatory sanctions and has failed to cure or satisfy such regulatory sanctions within its specified cure period in any material respect with respect to any facility; or

- there is any default under any guaranty of the lease or under certain indemnity agreements between the Company and Ventas.

Except as noted below, upon an Event of Default under a particular Master Lease Agreement, Ventas may, at its option, exercise the following remedies:

- after not less than ten days' notice to the Company, terminate the Master Lease Agreement, repossess the leased property and relet the leased property to a third party and require the Company pay to Ventas, as liquidated damages, the net present value of the rent for the balance of the term, discounted at prime rate;

- without terminating the Master Lease Agreement, repossess the leased property and relet the leased property with the Company remaining liable under the Master Lease Agreement for all obligations to be performed by the Company thereunder, including the difference, if any, between the rent under the Master Lease Agreement and the rent payable as a result of the reletting of the leased property; and

- seek any and all other rights and remedies available under law or in equity.

Certain Events of Default are considered facility-specific events of default. A facility-specific event of default is caused by:

- the loss of any required healthcare license, permit or approval;

- a reduction in the number of licensed beds in excess of 10% of the number of licensed beds in the applicable facility or a revocation of certification for reimbursement under Medicare with respect to any facility that participates in such programs; or

- the Company becoming subject to regulatory sanctions and failing to cure or satisfy such regulatory sanctions within its specified cure period.

Upon the occurrence of a facility-specific event of default, Ventas may, if it so desires, terminate the related Master Lease Agreement with respect to only the applicable facility that is the subject of the facility-specific event of default and collect liquidated damages attributable to such facility multiplied by the number of

years remaining on the applicable lease; provided, however, that upon the occurrence of the fifth facility-specific event of default, determined on a cumulative basis, Ventas would be permitted to exercise all of the rights and remedies set forth in the Master Lease Agreement with respect to all facilities

covered under the Master Lease Agreement, without regard to the facility from which such fifth facility-specific event of default emanated.

Any remedies provided under the Master Lease Agreements currently are subject to the supervision of the Bankruptcy Court. See "--Proceedings under Chapter 11 of the Bankruptcy Code--Agreements with Ventas."

Maintenance, Modification and Capital Additions

The Company is required to maintain the leased properties in good repair and condition, making all repairs, modifications and additions required by law, including any capital addition. The Company is required to pay for all capital expenditures and other expenses for the maintenance, repair, restoration or refurbishment of a leased property. The Company also is required to maintain all personal property at each of the leased properties in good order, condition and repair, as is necessary to operate the leased property in compliance with all applicable licensure, certification, legal and insurance requirements and otherwise in accordance with customary practice in the industry. The Company may undertake any capital addition that materially adds to or improves a leased property without the consent of Ventas, subject to the Company delivering to Ventas the plans and specifications and the Company's compliance with customary construction requirements.

Insurance

The Company is required to maintain liability, all risk property and workers' compensation insurance for the leased properties at a level at least comparable to those in place with respect to the leased properties prior to the Spin-off.

Environmental Matters

The Master Lease Agreements provide that the Company will indemnify Ventas (and its officers, directors and stockholders) against any environmental claims (including penalties and clean-up costs) resulting from any condition arising on or under, or relating to, the leased properties at any time on or after the commencement date of the Master Lease Agreements. The Company also will indemnify Ventas (and its officers, directors and stockholders) against any environmental claim (including penalties and clean-up costs) resulting from any condition permitted to deteriorate on or after the commencement date of the Master Lease Agreements. Ventas has agreed to indemnify the Company (and its officers, directors and stockholders) against any environmental claims (including penalties and clean-up costs) resulting from any condition arising on or under, or relating to, the leased properties at any time before the commencement date of the Master Lease Agreements.

Assignment and Subletting

The Master Lease Agreements provide that the Company may not assign, sublease or otherwise transfer any leased property or any portion of a leased property as a whole (or in substantial part), including upon a change of control (as defined in the Master Lease Agreements), without the consent of Ventas, which may not be unreasonably withheld if the proposed assignee is a creditworthy entity with sufficient financial stability to satisfy its obligations under the related Master Lease Agreement, has not less than four years experience in operating healthcare facilities, has a favorable business and operational reputation and character and agrees to comply with the use restrictions in the related Master Lease Agreement. The obligation of Ventas to consent to a subletting or assignment is subject to the reasonable approval rights of any mortgagee and/or the lenders under its credit agreement. The Company may sublease up to 20% of each leased property for restaurants, gift shops and other stores or services customarily found in hospitals or nursing centers without the consent of Ventas, subject, however, to there being no material

alteration in the character of the leased property or in the nature of the business conducted on such leased property.

Right of First Refusal to Purchase

The Master Lease Agreement provides that if Ventas receives a bona fide offer from a third party to purchase any leased property during the first three years of the term and Ventas wishes to accept the offer, prior to entering into a contract of sale with the third party, Ventas must first offer the Company the right to purchase the leased property on substantially the same terms and conditions as are contained in the third-party offer.

GOVERNMENTAL REGULATION

Medicare and Medicaid

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over and certain disabled persons. Medicaid is a medical assistance program administered by each state pursuant to which healthcare benefits are available to certain indigent patients. Within the Medicare and Medicaid statutory framework, there are substantial areas subject to administrative rulings, interpretations and discretion that may affect payments made under Medicare and Medicaid. A substantial portion of the Company's revenues are derived from patients covered by the Medicare and Medicaid programs. See "--Health Services Division--Sources of Nursing Center Revenues" and "--Hospital Division--Sources of Hospital Revenues."

Extensive Regulation

In the ordinary course of its business, the Company is subject regularly to inquiries, investigations and audits by federal and state agencies that oversee the Healthcare Regulations (as defined).

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services (collectively, the "Healthcare Regulations"). In addition, various laws including antikickback, antifraud and abuse amendments codified under the Social Security Act (the "Antikickback Amendments") prohibit certain business practices and relationships that might affect the provisions and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by Medicare or other governmental programs. Sanctions for violating the Antikickback Amendments include criminal penalties and civil sanctions, including fines and possible exclusion from government programs such as the Medicare and Medicaid programs.

The Department of Health and Human Services ("HHS") has issued regulations that describe some of the conduct and business relationships permissible under the Antikickback Amendments ("Safe Harbors"). The fact that a given business arrangement does not fall within a Safe Harbor does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable Safe Harbors criteria, however, risk increased scrutiny and possible sanctions by enforcement authorities.

In addition, Section 1877 of the Social Security Act, which restricts referrals by physicians of Medicare and other government-program patients to

providers of a broad range of designated health services with which they have ownership or certain other financial arrangements, was amended effective January 1, 1995, to broaden significantly the scope of prohibited physician referrals under the Medicare and Medicaid programs to providers with which they have ownership or certain other financial arrangements (the "Self-Referral Prohibitions"). Many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. These laws and regulations are extremely complex and little judicial or regulatory interpretation exists. The Company does not believe its arrangements are in violation of the Self-Referral Prohibitions. There can be no assurance, however, that governmental officials charged with responsibility for enforcing the provisions of the Self-Referral Prohibitions will not assert that one or more of the Company's arrangements are in violation of such provisions.

26

The Budget Act also provides a number of antifraud and abuse provisions. The Budget Act contains additional civil monetary penalties for violations of the Antikickback Amendments and imposes an affirmative duty on providers to ensure that they do not employ or contract with persons excluded from the Medicare program. The Budget Act also provides a minimum ten year period for exclusion from participation in federal healthcare programs for persons or entities convicted of a prior healthcare offense.

The Health Insurance Portability and Accountability Act of 1997 ("HIPAA"), which became effective January 1, 1997, amends, among other things, Title XI (42 U.S.C. (S)1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not they are reimbursed under federal programs. In addition to broadening the scope of the fraud and abuse laws, HIPAA also mandates the adoption of regulations aimed at: (a) standardizing transaction formats and billing codes for documenting medical services and dealing with claims submissions; and (b) protecting the privacy and security of individually identifiable health information.

HIPAA regulations that standardize transactions and code sets became final in the fourth quarter of 2000. Those regulations do not require healthcare providers to submit claims electronically, but require standard formatting for those that do. The Company currently submits its claims electronically and will continue to do so. Therefore, the Company will be required to comply with HIPAA transaction and code set standards by October 2002.

Final HIPAA privacy regulations were published in December 2000. Those regulations apply to "protected health information," which is defined generally as individually identifiable health information transmitted or maintained in any form or medium, excluding certain education records and student medical records. The privacy regulations seek to limit the use and disclosure of most paper and oral communications, as well as those in electronic form, regarding an individual's past, present or future physical or mental health or condition, or relating to the provision of healthcare to the individual or payment for that healthcare, if the individual can or may be identified by such information. HIPAA provides for the imposition of civil or criminal penalties if protected health information is improperly disclosed. The Company must comply with the privacy regulations by April 2003.

HIPAA's security regulations have not yet been finalized. The proposed security regulations specify administrative procedures, physical safeguards, and technical services and mechanisms designed to ensure the privacy of protected health information. The Company will be required to comply with the

security regulations 26 months after the regulations become final.

The Company is currently evaluating the impact of compliance with HIPAA regulations, but it has not completed its analysis or finalized the estimated costs to comply. There can be no assurances that the Company's compliance with HIPAA regulations will not have an adverse affect on the Company's financial position, results of operations or cash flows.

Some states require state approval for development and expansion of healthcare facilities and services, including findings of need for additional or expanded healthcare facilities or services. CONs, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for expansion of existing facilities, construction of new facilities, addition of beds, acquisition of major items of equipment or introduction of new services. The Company operates nursing centers in 22 states and hospitals in 12 states that require state approval for the expansion of its facilities and services under CON programs. There can be no assurance that the Company will be able to obtain a CON for any or all future projects. If the Company is unable to obtain the requisite CON, its growth and business could be affected adversely.

The Company believes that the regulatory environment surrounding the long-term care industry has intensified, particularly on large for-profit, multi-facility providers. The federal government has imposed intensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies, and other regulatory sanctions including terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. Such

sanctions can have a material adverse effect on the Company's results of operations, liquidity and financial position. The Company vigorously contests such sanctions, and in several cases has obtained injunctions against such sanctions. While the Company generally has been successful to date in contesting such sanctions, these cases involve significant legal expense and the time of management and there can be no assurance that the Company will be successful in the future.

In connection with the Government Settlement, the Company entered into the Corporate Integrity Agreement. Under the Corporate Integrity Agreement, the Company will implement a comprehensive internal quality improvement program and a system of internal financial controls in its nursing centers and long-term hospitals and its regional and corporate offices. The Corporate Integrity Agreement is intended to promote compliance with the various healthcare regulations applicable to the Company. The Corporate Integrity Agreement also provides for third-party monitoring and reporting by the Company to the federal government.

Health Services Division

The health services division is subject to various federal and state regulations. In particular, the development and operation of nursing centers and the provision of healthcare services are subject to federal, state and local laws relating to the adequacy of medical care, equipment, personnel, operating policies, fire prevention, rate-setting and compliance with building codes and environmental laws. Nursing centers are subject to periodic inspection by governmental and other authorities to assure continued compliance with various standards, their continued licensing under state law, certification under the Medicare and Medicaid programs and continued participation in the Veterans Administration program. The failure to obtain,

retain or renew any required regulatory approvals or licenses could adversely affect nursing center operations.

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

The Company believes that substantially all of its nursing centers currently are in material compliance with applicable Medicare and Medicare requirements of participation. In the ordinary course of business, however, the nursing centers receive statements of deficiencies from regulatory agencies. In response, the health services division will implement plans of correction to address the alleged deficiencies. In most instances, the regulatory agency will accept the facility's plan of correction and place the nursing center back into compliance with regulatory requirements. In some cases or upon repeat violations, the regulatory agency may take a number of adverse actions against the nursing center. These adverse actions may include the imposition of fines, temporary suspension of admission of new patients to the nursing center, decertification from participation in the Medicaid and/or Medicare programs and, in extreme circumstances, revocation of the nursing center's license.

The health services division also is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws often prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Such laws include the Antikickback Amendments. These provisions prohibit, among other things, the offer, payment, solicitation or receipt of any form of remuneration in return for the referral of Medicare and Medicaid patients. In addition, some states restrict certain business relationships between physicians and pharmacies, and many

states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in reimbursement programs as well as civil and criminal penalties. These laws vary from state to state.

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

Certificate of Need and State Licensing. CON regulations control the

development and expansion of healthcare services and facilities in certain states. CON laws generally provide that approval must be obtained from the designated state health planning agency prior to the expansion of existing facilities, construction of new facilities, addition of beds, acquisition of major items of equipment or introduction of new services. Certain states also require regulatory approval prior to certain changes in ownership of a nursing center. Certain states have eliminated their CON programs and other states are considering alternatives to their CON programs. Of the 31 states in which the Company's nursing centers are located as of December 31, 2000, Alabama, Connecticut, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Vermont, Virginia, Washington and Wisconsin have CON programs. To the extent that CONs or other similar approvals are required for expansion of the operations of the health services division, either through facility acquisitions, expansion or provision of new services or other changes, such expansion could be affected adversely by the failure or inability to obtain the necessary approvals, changes in the standards applicable to such approvals or possible delays and expenses associated with obtaining such approvals.

State licensing is a prerequisite to the operation of each nursing center and to participation in government programs. Once a nursing center becomes licensed and operational, it must continue to comply with federal, state and local licensing requirements in addition to local building and life-safety codes. All of the nursing centers operated by the health services division have obtained the necessary licenses to conduct business.

Hospital Division

The hospital division is subject to various federal and state regulations. In order to receive Medicare reimbursement, each hospital must meet the applicable conditions of participation set forth by HHS relating to the type of hospital, its equipment, personnel and standard of medical care, as well as comply with state and local laws and regulations. The Company has developed a management system to comply with the various standards and requirements. Each hospital employs a person who is responsible for an ongoing quality assessment and improvement program. Hospitals undergo periodic on-site Medicare certification surveys, which generally are limited if the hospital is accredited by JCAHO. As of December 31, 2000, all of the hospitals operated by the hospital division were certified as Medicare providers and 54 of such hospitals also were certified by their respective state Medicaid programs. A loss of certification could affect adversely a hospital's ability to receive payments from the Medicare and Medicaid programs.

Since 1983, Medicare has reimbursed general acute care hospitals under a prospective payment system ("Hospital PPS"). Under Hospital PPS, Medicare inpatient costs are reimbursed based upon a fixed payment amount per discharge using diagnosis related groups ("DRG"). The DRG payment under Hospital PPS is based upon the national average cost of treating a Medicare patient's condition. Although the average length of stay varies for each DRG, the average stay for all Medicare patients subject to Hospital PPS is approximately six days. An additional outlier payment is made for patients with higher treatment costs. Outlier payments are only designed to cover marginal costs. Additionally, it takes 60 days or more for Hospital PPS payments to be made. Accordingly, Hospital PPS creates an economic incentive for general short-term acute care hospitals to discharge medically complex Medicare patients as soon as clinically possible. Hospitals that are certified by Medicare as general long-term hospitals are excluded from Hospital PPS. The Company believes that the

incentive for short-term acute care hospitals to discharge medically complex patients as soon as clinically possible creates a substantial referral source for its long-term hospitals.

The Social Security Amendments of 1983 excluded certain hospitals including general long-term hospitals from Hospital PPS. A general long-term hospital is defined as a hospital that has an average length of stay greater than 25 days. Inpatient operating costs for general long-term hospitals are reimbursed under the cost-based reimbursement system, subject to a computed target rate (the "Target") per discharge for inpatient operating costs established by TEFRA. As discussed below, the Budget Act made significant changes to the TEFRA provisions.

Prior to the Budget Act, Medicare operating costs per discharge in excess of the Target were reimbursed at the rate of 50% of the excess up to 10% of the Target. Hospitals whose operating costs were lower than the Target were reimbursed their actual costs plus an incentive. This incentive was equal to 50% of the difference between their actual costs and the Target but may not exceed 5% of the Target. For cost report periods beginning on or after October 1, 1997, the Budget Act reduced the incentive payments to an amount equal to 15% of the difference between the actual costs and the Target, but not to exceed 2% of the Target. Costs in excess of the Target are still being reimbursed at the rate of 50% of the excess up to 10% of the Target but the threshold to qualify for such payments was raised from 100% to 110% of the Target. The Budget Act also capped the Targets based on the 75th percentile for each category of hospitals using 1996 data.

Prior to October 1, 1997, new hospitals could apply for an exemption from the TEFRA Target provisions. For hospitals certified prior to October 1, 1992, the exemption was optional and, if granted, lasted for three years. For certifications since October 1, 1992, the exemption is automatic and is effective for two years. Under the Budget Act, a new provider will no longer receive unlimited cost-based reimbursement for its first few years in operation. Instead, for the first two years, it will be paid the lower of its costs or 110% of the median TEFRA Target for 1996 adjusted for inflation. During this two-year period, providers remain subject to the TEFRA penalty and incentive payments discussed in the previous paragraph.

As of December 31, 2000, 54 of the hospitals operated by the Company were subject to TEFRA Target provisions. The reduction in TEFRA incentive payments has had a material adverse effect on the hospital division's operating results. These reductions, which began between May 1, 1998 and September 1, 1998 with respect to the Company's hospitals, are expected to have a material adverse impact on hospital revenues in the future and may impact adversely the Company's ability to develop additional long-term care hospitals.

The Company also operates two general acute care hospitals that are subject to Hospital PPS and are not subject to the TEFRA Target provisions.

Medicare and Medicaid reimbursements generally are determined from annual cost reports filed by the Company, which are subject to audit by the respective agency administering the programs. Management believes that adequate provisions for loss have been recorded to reflect any adjustments that could result from audits of these cost reports.

Federal regulations provide that admission to and utilization of hospitals by Medicare and Medicaid patients must be reviewed by peer review organizations ("PROs") in order to ensure efficient utilization of hospitals and services. A PRO may conduct such review either prospectively or retroactively and may, as appropriate, recommend denial of payments for services provided to a patient. Such review is subject to administrative and judicial appeal. Each of the

hospitals operated by the hospital division employs a clinical professional to administer the hospital's integrated quality assurance and improvement program, including its utilization review program. PRO denials have not had a material adverse effect on the hospital division's operating results.

The Antikickback Amendments prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under federal healthcare programs. Sanctions for violating the Antikickback Amendments include criminal and civil penalties and exclusion from federal

healthcare programs. Pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, HHS and the OIG specified certain Safe Harbors that describe conduct and business relationships permissible under the Antikickback Amendments. These Safe Harbor regulations have resulted in more aggressive enforcement of the Antikickback Amendments by HHS and the OIG.

Section 1877 of the Social Security Act (commonly known as "Stark I") states that a physician who has a financial relationship with a clinical laboratory generally is prohibited from referring patients to that laboratory. The Omnibus Budget Reconciliation Act of 1993 contains provisions ("Stark II") amending Section 1877 to expand greatly the scope of Stark I. Effective January 1995, Stark II broadened the referral limitations of Stark I to include, among other designated health services, inpatient and outpatient hospital services. Under Stark I and Stark II (collectively referred to as the "Stark Provisions"), a "financial relationship" is defined as an ownership interest or a compensation arrangement. If such a financial relationship exists, the entity generally is prohibited from claiming payment for such services under the Medicare or Medicaid programs. Compensation arrangements generally are exempted from the Stark Provisions if, among other things, the compensation to be paid is set in advance, does not exceed fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. These laws and regulations, however, are extremely complex and the industry has the benefit of little judicial or regulatory interpretation. The Company believes that business practices of providers and financial relationships between providers have become subject to increased scrutiny as healthcare reform efforts continue on the federal and state levels.

The pharmacy operations within the hospital division are subject to regulation by the various states in which business is conducted as well as by the federal government. The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the United States Food and Drug Administration. Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, which is administered by the United States Drug Enforcement Administration (the "DEA"), dispensers of controlled substances must register with the DEA, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties.

JCAHO Accreditation. Hospitals receive accreditation from JCAHO, a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. Generally, hospitals and certain other healthcare facilities are required to have been in operation at least six months in order to be eligible for accreditation by JCAHO. After conducting on-site surveys, JCAHO awards accreditation for up to three years to hospitals found to be in substantial compliance with JCAHO standards. Accredited hospitals are periodically resurveyed, at the option of JCAHO, upon a major change in facilities or

organization and after merger or consolidation. As of December 31, 2000, all of the hospitals operated by the hospital division were accredited by JCAHO. The hospital division intends to seek and obtain JCAHO accreditation for any additional facilities it may purchase or lease and convert into long-term hospitals. The hospital division does not believe that the failure to obtain JCAHO accreditation at any hospital would have a material adverse effect on the hospital division's results of operations.

State Regulatory Environment. The hospital division operates seven hospitals in Florida, a state that regulates hospital rates. These operations contribute a significant portion of the hospital division's revenues and operating income. Accordingly, the hospital division's revenues and operating income could be materially adversely affected by Florida rate setting laws or other cost containment efforts. The hospital division also operates ten hospitals in Texas, eight hospitals in California, and five hospitals in Illinois that contribute a significant portion of its revenues and operating income. Although Texas, California and Illinois do not currently regulate hospital rates, the adoption of such legislation or other cost containment measures in these or other states could have a material adverse effect on the hospital division's revenues and operating income. The Company is unable to predict whether and in what form such legislation may be adopted. Certain other states in which the hospital division operates hospitals require disclosure of specified financial information. The hospital division considers the regulatory environment, including but not limited to, any mandated rate setting, in evaluating its hospital operations.

Certificates of Need and State Licensing. Some states have amended their CON regulations to require CON approval prior to the conversion of a hospital from a general short-term facility to a general long-term facility. Of the 23 states in which its hospitals were located as of December 31, 2000, Florida, Georgia, Illinois, Kentucky, Massachusetts, Michigan, Missouri, Nevada, North Carolina, Tennessee, Virginia and Washington have CON programs. With one exception, the hospital division was not required to obtain a CON in connection with previous acquisitions due to the relatively low renovation costs and the absence of the need for additional licensed beds or changes in services. CONs may be required in connection with the future hospital or services expansion of the hospital division. There can be no assurance that the hospital division will be able to obtain the CONs necessary for any or all future projects. If the hospital division is unable to obtain the requisite CONs, its businesses could be affected adversely.

State licensing of hospitals is a prerequisite to the operation of each hospital and to participation in government programs. Once a hospital becomes licensed and operational, it must continue to comply with federal, state and local licensing requirements in addition to local building and life-safety codes. All of the hospitals operated by the hospital division have obtained the necessary licenses to conduct business.

Regulatory Changes

The Budget Act contained extensive changes to the Medicare and Medicaid programs intended to reduce the projected amount of increase in payments under those programs over a five year period. Virtually all spending reductions come from reimbursements to providers and changes in program components. The Budget Act has affected adversely the revenues in each of the Company's operating divisions.

The Budget Act established PPS for nursing centers for cost reporting periods

beginning on or after July 1, 1998. While most nursing centers in the United States became subject to PPS during the first quarter of 1999, all of the Company's nursing centers adopted PPS on July 1, 1998. During the first three years, the per diem rates for nursing centers are based on a blend of facility-specific costs and federal costs. Thereafter, the per diem rates are based solely on federal costs. The payments received under PPS cover all services for Medicare patients including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals.

The Budget Act also reduced payments made to the hospitals operated by the Company's hospital division by reducing TEFRA incentive payments, allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. The reductions in allowable costs for capital expenditures became effective October 1, 1997. The reductions in the TEFRA incentive payments and allowable costs for bad debts became effective between May 1, 1998 and September 1, 1998. The reductions in payments for services to patients transferred from a general acute care hospital became effective October 1, 1998. These reductions have had a material adverse impact on hospital revenues. In addition, these reductions also may affect adversely the hospital division's ability to develop additional long-term care hospitals in the future.

Under PPS, the volume of ancillary services provided per patient day to nursing center patients also has declined dramatically. As previously discussed, Medicare reimbursements to nursing centers under PPS include substantially all services provided to patients, including ancillary services. Prior to the implementation of PPS, the costs of such services were reimbursed under cost-based reimbursement rules. The decline in the demand for ancillary services is mostly attributable to efforts by nursing centers to reduce operating costs. As a result, many nursing centers are electing to provide ancillary services to their patients through internal staff or are seeking lower acuity patients who require less ancillary services. In response to PPS and a significant decline in the demand for ancillary services, the Company realigned its Vencare division in the fourth quarter of 1999 by integrating the physical rehabilitation, speech and occupational therapy businesses into the health services division and assigning the institutional pharmacy business to the hospital division. Vencare's respiratory therapy and other ancillary businesses were discontinued.

Since November 1999, various legislative and regulatory actions have provided a measure of relief from some of the impact of the Budget Act. In November 1999, the Balanced Budget Refinement Act (the "BBRA") was enacted. Effective April 1, 2000, the BBRA made a temporary 20% upward adjustment in the payment rates for the care of higher acuity patients and allowed nursing centers to transition more rapidly to the federal payment rates. The BBRA also imposed a two-year moratorium on certain therapy limitations for skilled nursing center patients covered under Medicare Part B. Effective October 1, 2000, the BBRA increased all PPS payment categories by 4% for two years.

In April 2000, HCFA published a proposed rule which set forth updates to the Resource Utilization Grouping ("RUG") payment rates used under PPS for nursing centers. On July 31, 2000, HCFA issued a final rule that indefinitely postponed any refinements to the RUG categories used under PPS. It also provided for the continuance of Medicare payment relief set forth in the BBRA, including the 20% upward adjustment for certain higher acuity RUG categories through September 30, 2001 and the scheduled 4% increase (effective October 2000) for all RUG categories through September 30, 2002.

In December 2000, the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 ("BIPA") was enacted to provide up to $35 billion in additional funding to the Medicare and Medicaid programs over the next five years. Under BIPA, the nursing component for each RUG category will increase by 16.66% over the current rates for skilled nursing care for the period April 1, 2001 through September 30, 2002. BIPA also will provide some relief from scheduled reductions to the annual inflation adjustments to the RUG payment rates through September 2001.

In addition, BIPA slightly increased payments for inpatient services and TEFRA incentive payments for long-term acute care hospitals. Allowable costs for bad debts also will be increased by 10%. Both of these provisions will become effective for cost reporting periods beginning September 1, 2001.

Despite the recent legislation and regulatory actions discussed above, Medicare revenues recorded under PPS in the Company's health services division have been substantially less than the cost-based reimbursement it received before the enactment of the Budget Act. In addition, the recent legislation did not impact materially the reductions in Medicare revenues received by the Company's hospitals as a result of the Budget Act.

There also continues to be state legislative proposals that would impose more limitations on government and private payments to providers of healthcare services such as the Company. By repealing the Boren Amendment, the Budget Act eased existing impediments on the states' ability to reduce their Medicaid reimbursement levels. Many states have enacted or are considering enacting measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. Some states also are considering regulatory changes that include a moratorium on the designation of additional long-term care hospitals. Regulatory changes in the Medicare and Medicaid reimbursement systems applicable to the hospital division also are being considered. There also are legislative proposals including cost caps and the establishment of Medicaid prospective payment systems for nursing centers.

The Company could be affected adversely by the continuing efforts of governmental and private third-party payors to contain the amount of reimbursement for healthcare services. There can be no assurance that payments under governmental and private third-party payor programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. In addition, there can be no assurance that facilities operated by the Company, or the provision of services and supplies by the Company, will meet the requirements for participation in such programs.

There can be no assurance that future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs will not have a material adverse effect on the Company's results of operations, liquidity and financial position.

CORPORATE INTEGRITY AGREEMENT

In connection with the Government Settlement, the Company entered into a Corporate Integrity Agreement with the OIG. Under the Corporate Integrity Agreement, the Company will implement a comprehensive internal quality improvement program and a system of internal financial controls in its nursing centers and long-term hospitals and its regional and corporate offices.

The Company believes that the Corporate Integrity Agreement may differentiate

the Company's services and provide opportunities to promote strategic objectives with regulators, government relations, labor unions and referral sources. Under the Corporate Integrity Agreement, the Company has retained flexibility to design and implement the agreement's requirements that have enabled the Company to focus its efforts on developing improved systems and processes of providing quality healthcare.

The Corporate Integrity Agreement will become effective on the effective date of the Amended Plan and will apply to the Company and its subsidiaries and managed entities. The Corporate Integrity Agreement also will apply to newly acquired facilities after a phase-in period of six months.

As part of the Corporate Integrity Agreement, staff at the University of Wisconsin's Center for Health Services Research and Analysis ("CHSRA"), will assist in developing the internal quality improvement program. CHSRA also will monitor and evaluate the Company's program and report its findings to the OIG.

The Corporate Integrity Agreement includes six components:

(1) The Company will adopt and implement written standards on federal healthcare program requirements with respect to financial and quality of care issues.

(2) The Company will conduct training each year for all employees to promote compliance with federal healthcare requirements. Every employee will undergo a minimum two hours of general compliance training annually. At least two hours of specific training, tailored to issues affecting employees with certain job responsibilities, also will be provided annually, as well as a minimum of two hours of training for care-giving employees focused on quality care. In addition, the Company will continue to operate its internal compliance hotline.

(3) The Company will put in place a comprehensive internal quality improvement program, which will include establishing committees at the facility, regional and corporate levels to review quality-related data, direct quality improvement activities and implement and monitor corrective action plans. CHSRA will assist in program development and will evaluate its integrity and effectiveness for the OIG.

(4) The Company will enhance its current system of internal financial controls to promote compliance with federal healthcare program requirements on billing and related financial issues, including a variety of internal audit and compliance reviews. An independent review organization will be retained to evaluate the integrity and effectiveness of the Company's internal systems and will report annually its findings to the OIG.

(5) The Company will submit annual reports to the OIG demonstrating compliance with the terms of the Corporate Integrity Agreement.

(6) The Corporate Integrity Agreement contains standard penalty provisions for breach.

INFORMATION SYSTEMS

The Company's information systems strategy is focused on providing industry-leading, value-added business solutions which will allow the Company to operate efficiently and effectively under fixed reimbursement levels and increased regulatory compliance requirements. Information systems activities are determined by the operational strategies and priorities of each of the Company's operating divisions.

Across the enterprise, the Company's integrated financial system, installed in 1999, allows for timely monthly reporting of financial results. In addition, extensive data warehouse capabilities across each operating division provide the opportunity to present sophisticated clinical and financial management reporting at a local, regional and enterprise level, enhancing the Company's ability to manage operational performance. In 2000, a new integrated human resources and payroll system was installed in all of the Company's hospitals and the corporate office. Beginning in 2001, this system will begin to be implemented in the Company's nursing centers.

New education tracking and event reporting systems were developed in 2000 to support the Corporate Integrity Agreement. An internet-based distance learning tool also was implemented in 2000, providing a cost-effective method to deliver timely training to employees. Enterprise-wide access to various data through internet-based solutions has improved operating efficiencies and reduced administrative costs.

For the health services division, new information systems implemented in 2000 provide support for product line management and third-party reimbursement. The resident care system is an internally developed business application that captures patient assessment data to ensure that minimum data set assessment forms are filed accurately and timely with reimbursement sources in each state. The Company's clinical care management system blends clinical and financial results within the Company's data warehouse to provide a decision support platform for delivering high quality care in an economical manner. The Company's quality reporting system, based on the industry-standard quality indicators used by HCFA, allows each facility to monitor and manage the quality of care being delivered. A new internet-based patient referral system is enhancing the health services division's relationships with hospital discharge planners by facilitating the search to locate appropriate nursing centers for patients and automating the communication of critical patient data between the discharging and admitting facilities.

The Company's hospitals utilize VenTouch(TM), an internally developed electronic patient medical record system that was designed specifically for the long-term acute care environment. VenTouch(TM) is a software application that allows nurses, physicians and other clinicians to enter clinical information during the patient care delivery process and view an online electronic patient chart. In order to achieve compliance with the new regulations regarding electronically transmitted health data imposed by HIPAA and improve integration across all hospital patient care systems, the Company will be selecting and piloting a new integrated patient care system in 2001. The new patient care system will be integrated with the Company's billing and accounts receivable system. The billing system, which was installed in all hospitals in 1999, has resulted in improved accuracy and timeliness of accounts receivable collections and reduced bad debts. The Company also developed and implemented new information systems in 2000 to manage staffing levels and monitor quality indicators at the facility, regional and corporate levels.

The Company's information systems architecture provides a reliable, scalable infrastructure that is based on personal computers in the facilities connected by a wide-area network to the Company's centralized data center in Louisville, Kentucky. Enterprise systems management tools allow the Company to operate over 8,000 distributed personal computers and 600 centrally located servers on a continuous basis.

ADDITIONAL INFORMATION

Employees

As of December 31, 2000, the Company had approximately 38,700 full-time and 13,200 part-time and per diem employees. The Company has approximately 2,300 unionized employees under 25 collective bargaining agreements as of December 31, 2000.

Due to nationwide low unemployment rates, the Company has experienced difficulties in attracting and retaining qualified personnel, such as nurses, certified nurse assistants, nurse's aides and other important providers of healthcare. The Company's hospitals are particularly dependent on nurses for patient care. The Company may experience increases in its labor costs primarily due to higher wages and greater benefits

required to attract and retain qualified healthcare personnel. The Company's ability to control labor costs, which represent the largest component of the Company's operating expenses, will significantly impact its future operating results.

Liability Insurance

The Company's healthcare operations are insured by the Company's wholly owned captive insurance company, Cornerstone Insurance Company ("Cornerstone"). Cornerstone insures initial losses up to certain coverage levels. Coverages for losses in excess of those insured by Cornerstone are maintained through unrelated commercial insurance carriers.

The Company believes that its insurance is adequate in amount and coverage. There can be no assurance that in the future such insurance will be available at a reasonable price or that the Company will be able to maintain adequate levels of professional liability insurance coverage.

CAUTIONARY STATEMENTS

This Annual Report on Form 10-K/A includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Exchange Act. All statements regarding the Company's expected future financial position, results of operations, cash flows, liquidity, financing plans, business strategy, budgets, projected costs and capital expenditures, competitive position, growth opportunities, plans and objectives of management for future operations and words such as "anticipate," "believe," "plan," "estimate," "expect," "intend," "may" and other similar expressions are forward-looking statements. Such forward-looking statements are inherently uncertain, and stockholders must recognize that actual results may differ materially from the Company's expectations as a result of a variety of factors, including, without limitation, those discussed below.

Actual future results and trends for the Company may differ materially depending on a variety of factors discussed in this "Cautionary Statements" section and elsewhere in this Annual Report on Form 10-K/A. Such forward-looking statements are based on management's current expectations and include known and unknown risks, uncertainties and other factors, many of which the Company is unable to predict or control, that may cause the Company's actual results or performance to differ materially from any future results or performance expressed or implied by such forward-looking statements. Factors that may affect the plans or results of the Company include, without limitation, the following:

. the ability of the Company to continue as a going concern;

. delays or the inability to consummate the Amended Plan;

- the ability of the Company to make payments under the Amended Plan, if consummated;
- the ability of the Company to successfully negotiate and execute the Exit Facility;
- the ability of the Company to continue to operate pursuant to the terms of the DIP Financing;
- the ability of the Company to operate successfully under the Chapter 11 Cases;
- risks associated with operating a business in Chapter 11;
- adverse actions which may be taken by creditors and the outcome of various bankruptcy proceedings;
- adverse developments with respect to the Company's liquidity or results of operations;
- the Company's ability to attract patients given its current financial position;
- the ability of the Company to attract and retain key executives and other healthcare personnel;
- the effects of healthcare reform and government regulations, interpretation of regulations and changes in the nature and enforcement of regulations governing the healthcare industry;

36

- changes in Medicare and Medicaid reimbursement rates;
- national and regional economic conditions, including their effect on the availability and cost of labor, materials, and utilities;
- the Company's ability to control costs, including labor costs, in response to the prospective payment system, implementation of the Corporate Integrity Agreement and other regulatory actions;
- adverse developments with respect to the Company's settlement discussions with the Government concerning ongoing investigations; and
- the dramatic increase in the costs of defending and insuring against alleged patient care liability claims.

Many of these factors are beyond the control of the Company and its management. The Company cautions investors that any forward-looking statements made by the Company are not guarantees of future performance. The Company disclaims 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.

Risks Associated with Potential Defaults under the DIP Financing

If the Company is unable to comply with the covenants contained in the DIP Financing or is unable to obtain a waiver of any potential covenant violation, a number of serious financial and operational difficulties may occur, including the following:

- the Company's liquidity may be inadequate;
- the Company may be unable to make the required payments under the Master Lease Agreements;
- the Company may be unable to repay amounts currently owed to third-party payors including the Medicare program;
- the Company may be unable to invest adequate capital in its business to maintain its current facilities;
- the focus of the Company's senior management may be diverted from operational matters;
- the Company may be unable to attract and retain key executives and other healthcare personnel;
- the Company may experience a reduction in the census at its nursing centers and hospitals if patients and referral sources become concerned about the Company's ability to provide quality care; and
- suppliers to the Company may stop providing supplies or services to the Company or provide such supplies or services only on shortened payment or cash terms.

These difficulties, if they were to occur, would have a material adverse effect on the Company's liquidity, financial position and results of operations. See "--Proceedings under Chapter 11 of the Bankruptcy Code" and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Substantial Leverage and Ability to Meet Debt Service and Rent Requirements

The Company is highly leveraged and a substantial portion of its cash flow from operations is dedicated to the payment of rents related to its leased properties as well as principal and interest on outstanding indebtedness. During the pendency of the Chapter 11 Cases, the Company is not paying principal and interest on its Credit Agreement or the 1998 Notes. In accordance with the Stipulation, the Company is obligated to make aggregate monthly rent payments under the Master Lease Agreements of approximately $15.1 million. Under the HCFA Agreement, the Company is making monthly payments of approximately $2.0 million to HCFA through March 2004.

The ability of the Company to service its financial obligations is dependent upon, among other things, its ability to negotiate a sustainable capital structure and improve its future financial performance. If the Company

is unable to generate sufficient funds to meet its obligations, the Company may be required to refinance, restructure or otherwise amend some or all of such obligations, sell assets or raise additional equity. There is no assurance that such restructuring activities, sales of assets or issuances of equity can be accomplished or, if accomplished, would raise sufficient funds to meet these obligations. The Company's high degree of leverage and related financial covenants also:

- require the Company to dedicate a substantial portion of its cash flow to payments on its indebtedness, thereby reducing the availability of cash flow to fund working capital, capital expenditures and other general

corporate activities;

- could have a material adverse effect on its ability to withstand competitive pressures or adverse economic conditions (including adverse regulatory changes);

- could affect adversely the Company's ability to make material acquisitions, obtain future financing or take advantage of business opportunities that may arise; and

- increase the Company's vulnerability to a downturn in general economic conditions or in its businesses.

Potential Consequences of Failing to Pay Rent under Master Lease Agreements

In connection with the Chapter 11 Cases, the Company and Ventas entered into the Stipulation which provides for the payment by the Company of a reduced aggregate monthly rent of approximately $15.1 million. The Stipulation also continues to toll any statutes of limitations or other time constraints in a bankruptcy proceeding for claims that might be asserted by the Company against Ventas. The Stipulation automatically renews for a one-month period unless either party provides a 14-day notice of termination. The Stipulation also may be terminated prior to its expiration upon a payment default by the Company, the consummation of a plan of reorganization or the occurrence of certain defaults under the DIP Financing. The Stipulation also provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off.

The Company's failure to pay the rent due or otherwise comply with the Stipulation, in the absence of judicial relief, would result in an "Event of Default" under the Master Lease Agreements. Upon an Event of Default under the Master Lease Agreements, assuming Ventas were to be granted relief from the automatic stay by the Bankruptcy Court, the remedies available to Ventas include, without limitation, terminating the Master Lease Agreements, repossessing and reletting the leased properties and requiring the Company to (a) remain liable for all obligations under the Master Lease Agreements, including the difference between the rent under the Master Lease Agreements and the rent payable as a result of reletting the leased properties or (b) pay the net present value of the rent due for the balance of the terms of the Master Lease Agreements. Such remedies, however, would be subject to the supervision of the Bankruptcy Court. See "--Proceedings under Chapter 11 of the Bankruptcy Code" and "--Master Lease Agreements--Events of Default."

Healthcare Industry Risks

Dependence on Reimbursement Process; Medicare and Medicaid as Material Sources of Revenues

The Company derives a substantial portion of its revenues from third-party payors, including the Medicare and Medicaid programs. In 2000, the Company derived approximately two-thirds of its total revenues from the Medicare and Medicaid programs. Such programs are highly regulated and subject to frequent and substantial changes. The Budget Act has reduced the projected increase in Medicare payments and has made extensive changes in the Medicare and Medicaid programs. In addition, private payors, including managed care payors, increasingly are demanding discounted fee structures and the assumption by healthcare providers of all or a portion of the financial risk. Efforts to impose greater discounts and more stringent cost controls by private payors are continuing.

Net revenue realizable under third-party payor agreements are subject to change due to examination and retroactive adjustment by payors during the settlement process. Payors may disallow in whole or in part requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable or because additional supporting documentation is necessary. The Company recognizes revenues from third-party payors and accrues estimated settlement amounts in the period in which the related services are provided. The Company estimates these settlement balances by making determinations based on its prior settlement experience and its interpretation of the applicable reimbursement rules and regulations.

In the hospital division, the Company has filed numerous collection actions against insurers under Medicare supplement insurance policies to collect the difference between what Medicare would have paid and the hospitals' usual and customary charges. These disputes arise from differences in interpretation of the policy provisions and certain federal and state laws governing such policies. Various courts have issued various rulings on the different issues, some of which have been adverse to the Company and most of which have been appealed. See "Legal Proceedings."

There can be no assurances that adequate reimbursement levels will continue to be available for the services provided by the Company which are currently being reimbursed by Medicare, Medicaid or private payors. Significant limits on the scope of services reimbursed and on reimbursement rates could have a material adverse effect on the Company's liquidity, financial condition and results of operations.

Increased Costs and Unpredictability of Patient Care Liability Claims

The Company, consistent with others in the long-term care industry, is experiencing substantial increases in both the number and size of patient care liability claims. In addition to compensatory damages, plaintiff attorneys are increasingly seeking punitive damages and attorney's fees. As a result, general and professional liability costs have become increasingly expensive and unpredictable. If patient care liability claims continue to increase in number and size, the Company's liquidity, financial condition and results of operations could be materially adversely affected.

Availability of Healthcare Professionals

Due to nationwide low unemployment rates, the Company has experienced difficulties in attracting and retaining qualified personnel, such as nurses, certified nurse assistants, nurse's aides and other important providers of healthcare. The Company's hospitals are particularly dependent on nurses for patient care. The Company may experience increases in its labor costs primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel. The Company's ability to control labor costs, which represent the largest component of the Company's operating expenses, will significantly impact its future operating results.

Extensive Regulation

In the ordinary course of its business, the Company is subject regularly to inquiries, investigations and audits by federal and state agencies that oversee the Healthcare Regulations. See "--Governmental Regulation."

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services. In particular, the

Antikickback Amendments prohibit certain business practices and relationships that might affect the provisions and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by Medicare or other governmental programs. Sanctions for violating the Antikickback Amendments include criminal penalties and civil sanctions, including fines and possible exclusion from government programs such as the Medicare and Medicaid programs.

In addition, Section 1877 of the Social Security Act, which restricts referrals by physicians of Medicare and other government-program patients to providers of a broad range of designated health services with which

39

they have ownership or certain other financial arrangements, was amended effective January 1, 1995, to broaden significantly the scope of prohibited physician referrals under the Medicare and Medicaid programs to providers with which they have ownership or certain other financial arrangements. Many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. These laws and regulations are extremely complex and little judicial or regulatory interpretation exists. The Company does not believe its arrangements are in violation of the Self-Referral Prohibitions. There can be no assurance, however, that governmental officials charged with responsibility for enforcing the provisions of the Self-Referral Prohibitions will not assert that one or more of the Company's arrangements are in violation of such provisions.

The Budget Act also provides a number of antifraud and abuse provisions. The Budget Act contains additional civil monetary penalties for violations of the Antikickback Amendments and imposes an affirmative duty on providers to ensure that they do not employ or contract with persons excluded from the Medicare program. The Budget Act also provides a minimum ten year period for exclusion from participation in federal healthcare programs for persons convicted of a prior healthcare offense.

The Company believes that the regulatory environment surrounding the long-term care industry has intensified, particularly on large for-profit, multi-facility providers. The federal government has imposed intensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies, and other regulatory sanctions including terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. Such sanctions can have a material adverse effect on the Company's results of operations, liquidity and financial position. The Company vigorously contests such sanctions, and in several cases has obtained injunctions against such sanctions. While the Company generally has been successful to date in contesting such sanctions, these cases involve significant legal expense and the time of management, and there can be no assurance that the Company will be successful in the future.

In connection with the Government Settlement, the Company entered into the Corporate Integrity Agreement. Under the Corporate Integrity Agreement, the Company will implement a comprehensive internal quality improvement program and a system of internal financial controls in its nursing centers and long-term hospitals and its regional and corporate offices. The Corporate Integrity Agreement is intended to promote compliance with various healthcare regulations applicable to the Company. The Corporate Integrity Agreement also provides for third-party monitoring and reporting by the Company to the federal government.

The Company is unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations or the intensity of federal and state enforcement actions. Changes in the regulatory framework and sanctions from various enforcement actions could have a material adverse effect on the Company's liquidity, financial condition and results of operations.

Regulatory Changes

The Budget Act contained extensive changes to the Medicare and Medicaid programs intended to reduce the projected amount of increase in payments under those programs over a five year period. Virtually all spending reductions come from reimbursements to providers and changes in program components. The Budget Act has affected adversely the revenues in each of the Company's operating divisions.

The Budget Act established PPS for nursing centers for cost reporting periods beginning on or after July 1, 1998. While most nursing centers in the United States became subject to PPS during the first quarter of 1999, all of the Company's nursing centers adopted PPS on July 1, 1998. During the first three years, the per diem rates for nursing centers are based on a blend of facility-specific costs and federal costs. Thereafter, the per

diem rates are based solely on federal costs. The payments received under PPS cover all services for Medicare patients including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals.

The Budget Act also reduced payments made to the hospitals operated by the Company's hospital division by reducing TEFRA incentive payments, allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. The reductions in allowable costs for capital expenditures became effective October 1, 1997. The reductions in the TEFRA incentive payments and allowable costs for bad debts became effective between May 1, 1998 and September 1, 1998. The reductions in payments for services to patients transferred from a general acute care hospital became effective October 1, 1998. These reductions have had a material adverse impact on hospital revenues. In addition, these reductions also may affect adversely the hospital division's ability to develop additional long-term care hospitals in the future.

Under PPS, the volume of ancillary services provided per patient day to nursing center patients also has declined dramatically. As previously discussed, Medicare reimbursements to nursing centers under PPS include substantially all services provided to patients, including ancillary services. Prior to the implementation of PPS, the costs of such services were reimbursed under cost-based reimbursement rules. The decline in the demand for ancillary services is mostly attributable to efforts by nursing centers to reduce operating costs. As a result, many nursing centers are electing to provide ancillary services to their patients through internal staff or are seeking lower acuity patients who require less ancillary services. In response to PPS and a significant decline in the demand for ancillary services, the Company realigned its Vencare division in the fourth quarter of 1999 by integrating the physical rehabilitation, speech and occupational therapy businesses into the health services division and assigning the institutional pharmacy business to the hospital division. Vencare's respiratory therapy and other ancillary businesses were discontinued.

Since November 1999, various legislative and regulatory actions have provided

a measure of relief from some of the impact of the Budget Act. In November 1999, the BBRA was enacted. Effective April 1, 2000, the BBRA made a temporary 20% upward adjustment in the payment rates for the care of higher acuity patients and allowed nursing centers to transition more rapidly to the federal payment rates. The BBRA also imposed a two-year moratorium on certain therapy limitations for skilled nursing center patients covered under Medicare Part B. Effective October 1, 2000, the BBRA increased all PPS payment categories by 4% for two years.

In April 2000, HCFA published a proposed rule which set forth updates to the RUG payment rates used under PPS for nursing centers. On July 31, 2000, HCFA issued a final rule that indefinitely postponed any refinements to the RUG categories used under PPS. It also provided for the continuance of Medicare payment relief set forth in the BBRA, including the 20% upward adjustment for certain higher acuity RUG categories through September 30, 2001 and the scheduled 4% increase (effective October 2000) for all RUG categories through September 30, 2002.

In December 2000, BIPA was enacted to provide up to $35 billion in additional funding to the Medicare and Medicaid programs over the next five years. Under BIPA, the nursing component for each RUG category will increase by 16.66% over the current rates for skilled nursing care for the period April 1, 2001 through September 30, 2002. BIPA also will provide some relief from scheduled reductions to the annual inflation adjustments to the RUG payment rates through September 2001.

In addition, BIPA slightly increased payments for inpatient services and TEFRA incentive payments for long-term acute care hospitals. Allowable costs for bad debts also will be increased by 10%. Both of these provisions will become effective for cost reporting periods beginning September 1, 2001.

Despite the recent legislation and regulatory actions discussed above, Medicare revenues recorded under PPS in the Company's health services division have been substantially less than the cost-based reimbursement it received before the enactment of the Budget Act. In addition, the recent legislation did not impact materially the reductions in Medicare revenues received by the Company's hospitals as a result of the Budget Act.

41

There also continues to be state legislative proposals that would impose more limitations on government and private payments to providers of healthcare services such as the Company. By repealing the Boren Amendment, the Budget Act eased existing impediments on the states' ability to reduce their Medicaid reimbursement levels. Many states have enacted or are considering enacting measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. Some states also are considering regulatory changes that include a moratorium on the designation of additional long-term care hospitals. Regulatory changes in the Medicare and Medicaid reimbursement systems applicable to the hospital division also are being considered. There also are legislative proposals including cost caps and the establishment of Medicaid prospective payment systems for nursing centers.

The Company could be affected adversely by the continuing efforts of governmental and private third-party payors to contain the amount of reimbursement for healthcare services. There can be no assurance that payments under governmental and private third-party payor programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. In addition, there can be no assurance that facilities operated by the Company, or the provision of services and supplies by the Company, will meet the requirements

for participation in such programs.

There can be no assurance that future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs will not have a material adverse effect on the Company's results of operations, liquidity and financial position.

Risks Relating to State Regulation

The Company operates seven hospitals in Florida, a state which regulates hospital rates. These operations contribute a significant portion of the Company's revenues and operating income from its hospital division. Accordingly, the Company's hospital revenues and operating income could be materially adversely affected by Florida rate setting laws or other cost containment efforts. The Company also operates ten hospitals in Texas, eight hospitals in California, and five hospitals in Illinois which contribute a significant portion of the Company's revenues and operating income. Although Texas, California and Illinois do not currently regulate hospital rates, the adoption of such legislation or other cost containment measures in these or other states could have a material adverse effect on the hospital division's revenues and operating income. The Company is unable to predict whether and in what form such legislation may be adopted. There can be no assurance that future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs will not have a material adverse effect on the Company's results of operations, liquidity and financial position.

Highly Competitive Industry

The long-term healthcare services industry is highly competitive. The Company's nursing centers compete on a local and regional basis with other nursing centers and other long-term healthcare providers. Some facilities operated by the Company's competitors are located in newer facilities and may offer services not provided by the Company or are operated by entities having greater financial and other resources than the Company. The Company's hospitals face competition from general acute care hospitals and long-term care hospitals which provide services comparable to those offered by the Company's hospitals. Many general acute care hospitals and long-term hospitals are larger and more established than the Company's hospitals. The Company may experience increased competition from existing hospitals as well as hospitals converted, in whole or in part, to specialized care facilities. The long-term care industry is divided into a variety of competitive areas which market similar services. These competitors include nursing centers, hospitals, extended care centers, assisted living facilities, home health agencies and similar institutions. The Company's facilities generally operate in communities that also are served by similar facilities operated by its competitors. Certain of the Company's competitors are operated by not-for-profit, nontaxpaying or governmental agencies, which can finance capital expenditures on a tax-exempt basis, and which receive funds and charitable contributions unavailable to the Company. The Company's facilities compete based on factors such as its reputation for quality care; the commitment and expertise of its staff and physicians; the quality and comprehensiveness of its treatment programs; charges for services; and the physical appearance, location and condition of its facilities.

The Company also competes with other companies in providing rehabilitation therapy services and institutional pharmacy services. Many of these competing companies have greater financial and other resources than the Company. There can be no assurance that increased competition in the future will not adversely affect the Company's financial condition and results of operations.

Item 2. Properties

For information concerning the nursing centers and hospitals operated by the Company, see "Business--Health Services Division--Nursing Center Facilities," "Business--Hospital Division--Hospital Facilities," and "Business--Master Lease Agreements." The Company believes that its facilities are adequate for the Company's future needs in such locations.

In December 1998, the Company purchased an approximately 287,000 square foot building located in Louisville, Kentucky as its corporate headquarters to consolidate corporate employees from several locations.

Item 3. Legal Proceedings

Summary descriptions of various significant legal and regulatory activities follow.

On September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Chapter 11 Cases have been styled In re: Vencor, Inc., et al., Debtors and Debtors in Possession, Case Nos. 99-3199 (MFW) through 99-3327 (MFW), Chapter 11, Jointly Administered. On December 14, 2000, the Company filed its Amended Plan with the Bankruptcy Court. On March 1, 2001, the Bankruptcy Court approved the Company's Amended Plan and an order was entered confirming the Amended Plan on March 16, 2001. See "Business--Proceedings under Chapter 11 of the Bankruptcy Code" for further discussion of the Chapter 11 Cases.

On March 18, 1999, the Company served Ventas with a demand for mediation pursuant to the Spin-off Agreement. The Company was seeking a reduction in rent and other concessions under its Master Lease Agreements with Ventas. On March 31, 1999, the Company and Ventas entered into a standstill agreement which provided that both companies would postpone through April 12, 1999 any claims either may have against the other. On April 12, 1999, the Company and Ventas entered into a second standstill which provided that neither party would pursue any claims against the other or any other third party related to the Spin-off as long as the Company complied with certain rent payment terms. The second standstill was scheduled to terminate on May 5, 1999. Pursuant to a tolling agreement, the Company and Ventas also agreed that any statutes of limitations or other time-related constraints in a bankruptcy or other proceeding that might be asserted by one party against the other would be extended and tolled from April 12, 1999 until May 5, 1999 or until the termination of the second standstill. As a result of the Company's failure to pay rent, Ventas served the Company with notices of nonpayment under the Master Lease Agreements. Subsequently, the Company and Ventas entered into further amendments to the second standstill and the tolling agreement to extend the time during which no remedies may be pursued by either party and to extend the date by which the Company may cure its failure to pay rent.

In connection with the Chapter 11 Cases, the Company and Ventas entered into the Stipulation that provides for the payment by the Company of a reduced aggregate monthly rent of approximately $15.1 million. The Stipulation has been approved by the Bankruptcy Court. The Stipulation also continues to toll any statutes of limitations or other time constraints in a bankruptcy proceeding for claims that might be asserted by the Company against Ventas. The Stipulation automatically renews for one-month periods unless either party provides a 14-day notice of termination. The Stipulation also may be terminated prior to its expiration upon a payment default by the Company, the consummation of a plan of reorganization or the occurrence of certain defaults under the DIP Financing. The Stipulation also provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off. The

Stipulation will terminate upon the effective date of the Amended Plan.

The Company believes that the Amended Plan, if consummated, will resolve all material disputes between the Company and Ventas. The Amended Plan also provides for comprehensive mutual releases between the Company and Ventas, other than for obligations that the Company is assuming under the Amended Plan.

If the Amended Plan does not become effective and the Company and Ventas are unable to otherwise resolve their disputes or maintain an interim resolution, the Company may seek to pursue claims against Ventas arising out of the Spin-off and seek judicial relief barring Ventas from exercising any remedies based on the Company's failure to pay some or all of the rent to Ventas. The Company's failure to pay rent or otherwise comply with the Stipulation, in the absence of judicial relief, would result in an "Event of Default" under the Master Lease Agreements. Upon an Event of Default under the Master Lease Agreements, assuming Ventas were to be granted relief from the automatic stay by the Bankruptcy Court, the remedies available to Ventas include, without limitation, terminating the Master Lease Agreements, repossessing and reletting the leased properties and requiring the Company to (a) remain liable for all obligations under the Master Lease Agreements, including the difference between the rent under the Master Lease Agreements and the rent payable as a result of reletting the leased properties or (b) pay the net present value of the rent due for the balance of the terms of the Master Lease Agreements. Such remedies, however, would be subject to the supervision of the Bankruptcy Court.

The Company's subsidiary, formerly named TheraTx, Incorporated, is plaintiff in a declaratory judgment action entitled TheraTx, Incorporated v. James W. Duncan, Jr., et al., No. 1:95-CV-3193, filed in the United States District Court for the Northern District of Georgia and currently pending in the United States Court of Appeals for the Eleventh Circuit, No. 99-11451-FF. The defendants have asserted counterclaims against TheraTx under breach of contract, securities fraud, negligent misrepresentation and other fraud theories for allegedly not performing as promised under a merger agreement related to TheraTx's purchase of a company called PersonaCare, Inc. and for allegedly failing to inform the defendants/counterclaimants prior to the merger that TheraTx's possible acquisition of Southern Management Services, Inc. might cause the suspension of TheraTx's shelf registration under relevant rules of the Securities and Exchange Commission (the "Commission"). The court granted summary judgment for the defendants/counterclaimants and ruled that TheraTx breached the shelf registration provision in the merger agreement, but dismissed the defendants' remaining counterclaims. Additionally, the court ruled after trial that defendants/counterclaimants were entitled to damages and prejudgment interest in the amount of approximately $1.3 million and attorneys' fees and other litigation expenses of approximately $700,000. The Company and the defendants/counterclaimants both appealed the court's rulings. The Court of Appeals for the Eleventh Circuit affirmed the trial court's rulings with the exception of the damages award and certified the question of the proper calculation of damages under Delaware law to the Delaware Supreme Court. The Company is defending the action vigorously.

The Company is pursuing various claims against private insurance companies who issued Medicare supplement insurance policies to individuals who became patients of the Company's hospitals. After the patients' Medicare benefits are exhausted, the insurance companies become liable to pay the insureds' bills pursuant to the terms of these policies. The Company has filed numerous collection actions against various of these insurers to collect the difference between what Medicare would have paid and the hospitals' usual and customary charges. These disputes arise from differences in interpretation of the policy provisions and federal and state laws governing such policies. Various courts

have issued various rulings on the different issues, some of which have been adverse to the Company and most of which have been appealed. The Company intends to continue to pursue these claims vigorously. If the Company does not prevail on these issues, future results of operations and liquidity would be materially adversely affected.

A class action lawsuit entitled A. Carl Helwig v. Vencor, Inc., et al., was filed on December 24, 1997 in the United States District Court for the Western District of Kentucky (Civil Action No. 3-97CV-8354). The class action claims were brought by an alleged stockholder of the Company's predecessor against the Company and Ventas and certain current and former executive officers and directors of the Company and Ventas. The complaint alleges that the Company, Ventas and certain current and former executive officers of the Company and Ventas during a specified time frame violated Sections 10(b) and 20(a) of the Exchange Act, by, among other things, issuing to the investing public a series of false and misleading statements concerning Ventas' then current operations and the inherent value of its common stock. The complaint further alleges that as a result of these purported false and misleading statements concerning Ventas' revenues and successful acquisitions, the price of the common stock was artificially inflated. In particular, the complaint alleges that the defendants

issued false and misleading financial statements during the first, second and third calendar quarters of 1997 which misrepresented and understated the impact that changes in Medicare reimbursement policies would have on Ventas' core services and profitability. The complaint further alleges that the defendants issued a series of materially false statements concerning the purportedly successful integration of Ventas' acquisitions and prospective earnings per share for 1997 and 1998 which the defendants knew lacked any reasonable basis and were not being achieved. The suit seeks damages in an amount to be proven at trial, pre-judgment and post-judgment interest, reasonable attorneys' fees, expert witness fees and other costs, and any extraordinary equitable and/or injunctive relief permitted by law or equity to assure that the plaintiff has an effective remedy. In December 1998, the defendants filed a motion to dismiss the case. The court converted the defendants' motion to dismiss into a motion for summary judgment and granted summary judgment as to all defendants. The plaintiff appealed the ruling to the United States Court of Appeals for the Sixth Circuit. On April 24, 2000, the Sixth Circuit affirmed the district court's dismissal of the action on the grounds that the plaintiff failed to state a claim upon which relief could be granted. On July 14, 2000, the Sixth Circuit granted the plaintiff's petition for a rehearing en banc. The Company is defending this action vigorously.

A shareholder derivative suit entitled Thomas G. White on behalf of Vencor, Inc. and Ventas, Inc. v. W. Bruce Lunsford, et al., Case No. 98CI03669, was filed in June 1998 in the Jefferson County, Kentucky, Circuit Court. The suit was brought on behalf of the Company and Ventas against certain current and former executive officers and directors of the Company and Ventas. The complaint alleges that the defendants damaged the Company and Ventas by engaging in violations of the securities laws, engaging in insider trading, fraud and securities fraud and damaging the reputation of the Company and Ventas. The plaintiff asserts that such actions were taken deliberately, in bad faith and constitute breaches of the defendants' duties of loyalty and due care. The complaint is based on substantially similar assertions to those made in the class action lawsuit entitled A. Carl Helwig v. Vencor, Inc., et al., discussed above. The suit seeks unspecified damages, interest, punitive damages, reasonable attorneys' fees, expert witness fees and other costs, and any extraordinary equitable and/or injunctive relief permitted by law or equity to assure that the Company and Ventas have an effective remedy. The Company believes that the allegations in the complaint are without merit and intends to

defend this action vigorously.

A class action lawsuit entitled Jules Brody v. Transitional Hospitals Corporation, et al., Case No. CV-S-97-00747-PMP, was filed on June 19, 1997 in the United States District Court for the District of Nevada on behalf of a class consisting of all persons who sold shares of Transitional common stock during the period from February 26, 1997 through May 4, 1997, inclusive. The complaint alleges that Transitional purchased shares of its common stock from members of the investing public after it had received a written offer to acquire all of the Transitional common stock and without making the required disclosure that such an offer had been made. The complaint further alleges that defendants disclosed that there were "expressions of interest" in acquiring Transitional when, in fact, at that time, the negotiations had reached an advanced stage with actual firm offers at substantial premiums to the trading price of Transitional's stock having been made which were actively being considered by Transitional's Board of Directors. The complaint asserts claims pursuant to Sections 10(b), 14(e) and 20(a) of the Exchange Act, and common law principles of negligent misrepresentation and names as defendants Transitional as well as certain former senior executives and directors of Transitional. The plaintiff seeks class certification, unspecified damages, attorneys' fees and costs. In June 1998, the court granted the Company's motion to dismiss with leave to amend the Section 10(b) claim and the state law claims for misrepresentation. The court denied the Company's motion to dismiss the Section 14(e) and Section 20(a) claims, after which the Company filed a motion for reconsideration. On March 23, 1999, the court granted the Company's motion to dismiss all remaining claims and the case was dismissed. The plaintiff has appealed this ruling to the United States Court of Appeals for the Ninth Circuit. The Company is defending this action vigorously.

On April 14, 1999, a lawsuit entitled Lenox Healthcare, Inc., et al. v. Vencor, Inc., et al., Case No. BC 208750, was filed in the Superior Court of Los Angeles, California by Lenox Healthcare, Inc. ("Lenox") asserting various causes of action arising out of the Company's sale and lease of several nursing centers to Lenox in 1997. Lenox subsequently removed certain of its causes of action and refiled these claims before the

United States District Court for the Western District of Kentucky in a case entitled Lenox Healthcare, Inc. v. Vencor, Inc., et al., Case No. 3:99 CV-348-H. The Company asserted counterclaims, including RICO claims, against Lenox in the Kentucky action. The Company believes that the allegations made by Lenox in both complaints are without merit. Lenox and its subsidiaries filed for protection under Chapter 11 of the Bankruptcy Code on November 3, 1999. By virtue of both the Company's and Lenox's separate filings for Chapter 11 protection, the two Lenox actions and the Company's counterclaims were stayed. Subsequently, the parties entered into a settlement, which was approved by their respective bankruptcy courts, that requires the dismissal of the two above actions. Joint motions to dismiss have been filed by the parties in each court.

The Company was informed by the DOJ that the Company and Ventas are the subjects of investigations into various Medicare reimbursement issues, including hospital cost reporting issues, Vencare billing practices and various quality of care issues in the hospitals and nursing centers formerly operated by Ventas and currently operated by the Company. These investigations include some matters for which the Company indemnified Ventas in the Spin-off. In cases where neither the Company nor any of its subsidiaries are defendants but Ventas is the defendant, the Company had agreed to defend and indemnify Ventas for such claims as part of the Spin-off. The Stipulation entered into with Ventas provides that the Company will continue to fulfill its indemnification

obligations arising from the Spin-off. The Company has cooperated fully in the investigations.

The DOJ has informed the Company that it has intervened in several pending qui tam actions asserted against the Company and/or Ventas in connection with these investigations. In addition, the DOJ has filed proofs of claims with respect to certain alleged claims in the Chapter 11 Cases. The Company, Ventas and the DOJ have finalized the terms of the Government Settlement which will resolve all of the DOJ investigations including the pending qui tam actions. The Government Settlement provides that within 30 days after the Amended Plan becomes effective, the Government will move to dismiss with prejudice to the United States and the relators (except for certain claims which will be dismissed without prejudice to the United States in certain of the cases) the pending qui tam actions as against any or all of the Company and its subsidiaries, Ventas and any current or former officers, directors and employees of either entity. There can be no assurance that each court before which a qui tam action is pending will dismiss the case on the DOJ's motion. For a summary of the terms of the Government Settlement contained in the Amended Plan, see "Business--Proceedings under Chapter 11 of the Bankruptcy Code."

The following is a summary of the qui tam actions pending against the Company and/or Ventas in which the DOJ has intervened. In connection with the DOJ's intervention, the courts ordered these previously non-public actions to be unsealed. Certain of the actions described below name other defendants in addition to the Company and Ventas.

(a) The Company, Ventas and the Company's subsidiary, American X-Rays, Inc. ("AXR"), are defendants in a civil qui tam action styled United States ex rel. Doe v. American X-Rays Inc., et al., No. LR-C-95-332, pending in the United States District Court for the Eastern District of Arkansas and served on AXR on July 7, 1997. The DOJ intervened in the suit which was brought under the Federal Civil False Claims Act and added the Company and Ventas as defendants. The Company acquired an interest in AXR when Hillhaven was merged into the Company in September 1995 and purchased the remaining interest in AXR in February 1996. AXR provided portable X-ray services to nursing centers (including some of those operated by Ventas or the Company) and other healthcare providers. The civil suit alleges that AXR submitted false claims to the Medicare and Medicaid programs. The suit seeks damages in an amount of not less than $1,000,000, treble damages and civil penalties. The Company has defended this action vigorously. The court has dismissed the action based upon the possible pending settlement between the DOJ, the Company and Ventas. In a related criminal investigation, the United States Attorney's Office for the Eastern District of Arkansas ("USAO") indicted four former employees of AXR; those individuals were convicted of various fraud related counts in January 1999. AXR had been informed previously that it was not a target of the criminal investigation, and AXR was not indicted. However, the Company received several grand jury subpoenas for documents and witnesses which it moved to quash. The USAO has withdrawn the subpoenas which rendered the motion moot.

(b) The Company's subsidiary, Medisave Pharmacies, Inc. ("Medisave"), Ventas and Hillhaven (former parent company to Medisave), are the defendants in a civil qui tam action styled United States ex rel. Danley v. Medisave Pharmacies, Inc., et al., No. CV-N-96-00170-HDM, filed in the United States District Court for the District of Nevada on March 15, 1996. The plaintiff alleges that Medisave, an institutional pharmacy provider, formerly owned by Ventas and owned by the Company since the Spin-off: (a) charged the Medicare program for unit dose drugs when bulk drugs were

administered and charged skilled nursing facilities more for the same drugs for Medicare patients than for non-Medicare patients; (b) improperly claimed special dispensing fees that it was not entitled to under Medicaid; and (c) recouped unused drugs from skilled nursing facilities and returned these drugs to its stock without crediting Medicare or Medicaid, all in violation of the Federal Civil False Claims Act. The complaint also alleges that Medisave had a policy of offering kickbacks, such as free equipment, to skilled nursing centers to secure and maintain their business. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint. The defendants intend to defend this action vigorously.

(c) Ventas and the Company's subsidiary, Vencare, Inc. ("Vencare"), among others, are defendants in the action styled United States ex rel. Roberts v. Vencor, Inc., et al., No. 3:97CV-349-J, filed in the United States District Court for the Western District of Kansas on June 25, 1996 and consolidated with the action styled United States of America ex rel. Meharg, et al. v. Vencor, Inc., et al., No. 3:98SC-737-H, filed in the United States District Court for the Middle District of Florida on June 4, 1998. The complaint alleges that the defendants knowingly submitted and conspired to submit false claims and statements to the Medicare program in connection with their purported provision of respiratory therapy services to skilled nursing center residents. The defendants allegedly billed Medicare for respiratory therapy services and supplies when those services were not medically necessary, billed for services not provided, exaggerated the time required to provide services or exaggerated the productivity of their therapists. It is further alleged that the defendants presented false claims and statements to the Medicare program in violation of the Federal Civil False Claims Act, by, among other things, allegedly causing skilled nursing centers with which they had respiratory therapy contracts, to present false claims to Medicare for respiratory therapy services and supplies. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint. The defendants intend to defend this action vigorously.

(d) In United States ex rel. Kneepkens v. Gambro Healthcare, Inc., et al., No. 97-10400-GAO, filed in the United States District Court for the District of Massachusetts on October 15, 1998, the Company's subsidiary, Transitional, and two unrelated entities, Gambro Healthcare, Inc. and Dialysis Holdings, Inc., are defendants in this suit alleging that they violated the Federal Civil False Claims Act and the Medicare and Medicaid antikickback, antifraud and abuse regulations and committed common law fraud, unjust enrichment and payment by mistake of fact. Specifically, the complaint alleges that a predecessor to Transitional formed a joint venture with Damon Clinical Laboratories to create and operate a clinical testing laboratory in Georgia that was then used to provide lab testing for dialysis patients, and that the joint venture billed at below cost in return for referral of substantially all non-routine testing in violation of Medicare and Medicaid antikickback and antifraud regulations. It is further alleged that a predecessor to Transitional and Damon Clinical Laboratories used multiple panel testing of end stage renal disease rather than single panel testing that allegedly resulted in the generation of additional revenues from Medicare and that the entities allegedly added non-routine tests to tests otherwise ordered by physicians that were not requested or medically necessary but resulted in additional revenue from Medicare in violation of the antikickback and antifraud regulations. Transitional has moved to dismiss the case. Transitional disputes the allegations in the complaint and is defending the action vigorously.

(e) The Company and/or Ventas are defendants in the action styled United States ex rel. Huff and Dolan v. Vencor, Inc., et al., No. 97-4358 AHM

(Mcx), filed in the United States District Court for the Central District of California on June 13, 1997. The plaintiff alleges that the defendant violated the Federal Civil False Claims Act by submitting false claims to the Medicare, Medicaid and CHAMPUS

programs by allegedly: (a) falsifying patient bills and submitting the bills to the Medicare, Medicaid and CHAMPUS programs, (b) submitting bills for intensive and critical care not actually administered to patients, (c) falsifying patient charts in relation to the billing, (d) charging for physical therapy services allegedly not provided and pharmacy services allegedly provided by non-pharmacists, and (e) billing for sales calls made by nurses to prospective patients. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. Defendants dispute the allegations in the complaint. The Company, on behalf of itself and Ventas, intends to defend this action vigorously.

(f) Ventas is the defendant in the action styled United States ex rel. Brzycki v. Vencor, Inc., Civ. No. 97-451-JD, filed in the United States District Court for the District of New Hampshire on September 8, 1997. Ventas is alleged to have knowingly violated the Federal Civil False Claims Act by submitting and conspiring to submit false claims to the Medicare program. The complaint alleges that Ventas: (a) fabricated diagnosis codes by ordering medically unnecessary services, such as respiratory therapy; (b) changed referring physicians' diagnoses in order to qualify for Medicare reimbursement; and (c) billed Medicare for oxygen use by patients regardless of whether the oxygen was actually administered to particular patients. The complaint further alleges that Ventas paid illegal kickbacks to referring healthcare professionals in the form of medical consulting service agreements as an alleged inducement to refer patients, in violation of the Federal Civil False Claims Act, the antikickback and antifraud regulations and the Stark provisions. It is additionally alleged that Ventas consistently submitted Medicare claims for clinical services that were not performed or were performed at lower actual costs. The complaint seeks unspecified damages, civil penalties, attorneys' fees and costs. Ventas disputes the allegations in the complaint. The Company, on behalf of Ventas, intends to defend the action vigorously.

(g) United States ex rel. Lanford and Cavanaugh v. Vencor, Inc., et al., Civ. No. 97-CV-2845, was filed against Ventas in the United States District Court for the Middle District of Florida, on November 24, 1997. The United States of America intervened in this civil qui tam lawsuit on May 17, 1999. On July 23, 1999, the United States filed its amended complaint in the lawsuit and added the Company as a defendant. The lawsuit alleges that the Company and Ventas knowingly submitted false claims and false statements to the Medicare and Medicaid programs including, but not limited to, claims for reimbursement of costs for certain ancillary services performed in defendants' nursing centers and for third-party nursing center operators that the United States alleges are not properly reimbursable costs through the hospitals' cost reports. The lawsuit involves the Company's hospitals which were owned by Ventas prior to the Spin-off. The complaint does not specify the amount of damages sought. The Company and Ventas dispute the allegations in the amended complaint and intend to defend this action vigorously.

(h) In United States ex rel. Harris and Young v. Vencor, Inc., et al., filed in the Eastern District of Missouri on May 25, 1999, the defendants include the Company, Vencare, and Ventas. The defendants allegedly submitted and conspired to submit false claims for payment to the Medicare and CHAMPUS programs, in violation of the Federal Civil False Claims Act.

According to the complaint, the Company, through its subsidiary, Vencare, allegedly (a) over billed for respiratory therapy services, (b) rendered medically unnecessary treatment, and (c) falsified supply, clinical and equipment records. The defendants also allegedly encouraged or instructed therapists to falsify clinical records and over prescribe therapy services. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint and intends to defend this action vigorously. The action has been dismissed with prejudice as to the relator and without prejudice as to the United States.

(i) In United States ex rel. George Mitchell, et al. v. Vencor, Inc., et al., filed in the United States District Court for the Southern District of Ohio on August 13, 1999, the defendants, consisting of the Company and its two subsidiaries, Vencare and Vencor Hospice, Inc., are alleged to have violated the Federal Civil False Claims Act by obtaining improper reimbursement from Medicare concerning the treatment of hospice patients. Defendants are alleged to have obtained inflated Medicare reimbursement for admitting, treating and/or failing to discharge in a timely manner hospice patients who were not "hospice appropriate." The complaint further alleges that the defendants obtained inflated reimbursement

48

for providing medications for these hospice patients. The complaint alleges damages in excess of $1,000,000. The Company disputes the allegations in the complaint and intends to defend vigorously the action.

(j) In Gary Graham, on Behalf of the United States of America v. Vencor Operating, Inc. et. al., filed in the United States District Court for the Southern District of Florida on or about June 8, 1999, the defendants, including the Company, its subsidiary, Vencor Operating, Inc., Ventas, Hillhaven and Medisave, are alleged to have presented or caused to be presented false or fraudulent claims for payment to the Medicare program in violation of, among other things, the Federal Civil False Claims Act. The complaint alleges that Medisave, a subsidiary of the Company which was transferred from Ventas to the Company in the Spin-off, systematically up-charged for drugs and supplies dispensed to Medicare patients. The complaint seeks unspecified damages, civil penalties, interest, attorneys' fees and other costs. The Company disputes the allegations in the complaint and intends to defend this action vigorously.

(k) In United States, et al., ex rel. Phillips-Minks, et al. v. Transitional Corp., et al., filed in the United States District Court for Southern District of California on July 23, 1998, the defendants, including Transitional and Ventas, are alleged to have submitted and conspired to submit false claims and statements to Medicare, Medicaid, and other federal and state funded programs during a period commencing in 1993. The conduct complained of allegedly violates the Federal Civil False Claims Act, the California False Claims Act, the Florida False Claims Act, the Tennessee Health Care False Claims Act, and the Illinois Whistleblower Reward and Protection Act. The defendants allegedly submitted improper and erroneous claims to Medicare, Medicaid and other programs, for improper or unnecessary services and services not performed, inadequate collections efforts associated with billing and collecting bad debts, inflated and nonexistent laboratory charges, false and inadequate documentation of claims, splitting charges, shifting revenues and expenses, transferring patients to hospitals that are reimbursed by Medicare at a higher level, failing to return duplicate reimbursement payments, and improperly allocating hospital insurance expenses. In addition, the complaint alleges that the defendants were inconsistent in their reporting of cost report

data, paid kickbacks to increase patient referrals to hospitals, and incorrectly reported employee compensation resulting in inflated employee 401(k) contributions. The complaint seeks unspecified damages. The Company disputes the allegations in the complaint and intends to defend this action vigorously.

In connection with the Spin-off, liabilities arising from various legal proceedings and other actions were assumed by the Company and the Company agreed to indemnify Ventas against any losses, including any costs or expenses, it may incur arising out of or in connection with such legal proceedings and other actions. The indemnification provided by the Company also covers losses, including costs and expenses, which may arise from any future claims asserted against Ventas based on the former healthcare operations of Ventas. In connection with its indemnification obligation, the Company has assumed the defense of various legal proceedings and other actions. The Stipulation entered into with Ventas provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off.

The Company is a party to certain legal actions and regulatory investigations arising in the normal course of its business. The Company is unable to predict the ultimate outcome of pending litigation and regulatory investigations. In addition, there can be no assurance that the DOJ, HCFA or other regulatory agencies will not initiate additional investigations related to the Company's businesses in the future, nor can there be any assurance that the resolution of any litigation or investigations, either individually or in the aggregate, would not have a material adverse effect on the Company's results of operations, liquidity or financial position. In addition, the above litigation and investigations (as well as future litigation and investigations) are expected to consume the time and attention of the Company's management and may have a disruptive effect upon the Company's operations.

Item 4. Submission of Matters to a Vote of Security Holders

Not Applicable.

PART II

Item 5. Market for Registrant's Common Equity and Related Stockholder Matters

MARKET PRICE FOR COMMON STOCK AND DIVIDEND HISTORY

Since March 17, 2000, the Company's common stock has traded on the OTC Bulletin Board under the symbol "VCRIQ." The common stock traded on the OTC Bulletin Board under the symbol "VCRI" from June 10, 1999 until March 16, 2000. The common stock previously traded on the New York Stock Exchange ("NYSE") under the ticker symbol of "VC" until June 7, 1999. The number of shareholders of record on February 28, 2001 was 4,310. The prices in the table below, for the calendar quarters indicated, represent the high and low sales prices for the common stock as reported by the OTC Bulletin Board and the NYSE Composite Tape, as applicable, during 1999 and 2000. No cash dividends have been paid on the common stock during such periods.

Dividends cannot be declared on the Company's stock under the terms of the DIP Financing.

Sales Price

	of Common Stock	
	High	Low
1999		
First Quarter	$5.00	$0.81
Second Quarter	1.13	0.13
Third Quarter	0.26	0.06
Fourth Quarter	0.27	0.07
2000		
First Quarter	$0.24	$0.11
Second Quarter	0.13	0.07
Third Quarter	0.13	0.07
Fourth Quarter	0.09	0.03

50

Item 6. Selected Financial Data

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc.)
SELECTED FINANCIAL DATA
AS OF AND FOR THE YEARS ENDED DECEMBER 31
(In thousands, except for per share amounts and statistics)

	(Restated)				
	2000	1999	1998	1997	1996
Statement of Operations Data:					
Revenues	$ 2,888,542	$ 2,665,641	$ 2,999,739	$ 3,116,004	$ 2,577,783
Salaries, wages and benefits	1,623,955	1,566,227	1,753,023	1,788,053	1,490,938
Supplies	374,540	347,789	340,053	347,127	303,463
Rent	307,809	305,120	234,144	89,474	77,795
Other operating expenses	503,770	964,413	947,889	446,340	489,155
Depreciation and amortization	73,545	93,196	124,617	123,865	99,533
Interest expense	60,431	80,442	107,008	102,736	45,922
Investment income	(5,393)	(5,188)	(4,688)	(6,057)	(12,203)
	2,938,657	3,351,999	3,502,046	2,891,538	2,494,603
Income (loss) before reorganization costs and income taxes	(50,115)	(686,358)	(502,307)	224,466	83,180

Reorganization costs....	12,636	18,606	-	-	-
Income (loss) before income taxes...........	(62,751)	(704,964)	(502,307)	224,466	83,180
Provision for income taxes..................	2,000	500	76,099	89,338	35,175
Income (loss) from operations.............	(64,751)	(705,464)	(578,406)	135,128	48,005
Cumulative effect of change in accounting for start-up costs.....	-	(8,923)	-	-	-
Extraordinary loss on extinguishment of debt, net of income taxes....	-	-	(77,937)	(4,195)	-
Net income (loss)......	$ (64,751)	$ (714,387)	$ (656,343)	$ 130,933	$ 48,005
Earnings (loss) per common share:					
Basic:					
Income (loss) from operations............	$ (0.94)	$ (10.03)	$ (8.47)	$ 1.96	$ 0.69
Cumulative effect of change in accounting for start-up costs....	-	(0.13)	-	-	-
Extraordinary loss on extinguishment of debt..................	-	-	(1.14)	(0.06)	-
Net income (loss)......	$ (0.94)	$ (10.16)	$ (9.61)	$ 1.90	$ 0.69
Diluted:					
Income (loss) from operations............	$ (0.94)	$ (10.03)	$ (8.47)	$ 1.92	$ 0.68
Cumulative effect of change in accounting for start-up costs....	-	(0.13)	-	-	-
Extraordinary loss on extinguishment of debt..................	-	-	(1.14)	(0.06)	-
Net income (loss)......	$ (0.94)	$ (10.16)	$ (9.61)	$ 1.86	$ 0.68
Shares used in computing earnings (loss) per common share:					
Basic..................	70,229	70,406	68,343	68,938	69,704
Diluted................	70,229	70,406	68,343	70,359	70,702
Financial Position:					
Working capital (deficit)..............	$ 267,161	$ 195,011	$ (682,569)	$ 431,113	$ 316,615
Assets..................	1,334,414	1,235,974	1,774,372	3,334,739	1,968,856
Long-term debt..........	-	-	6,600	1,919,624	710,507
Long-term debt in default classified as current................	-	-	760,885	-	-
Liabilities subject to compromise............	1,260,373	1,159,417	-	-	-
Stockholders' equity (deficit)..............	(471,734)	(406,022)	307,747	905,350	797,091
Operating Data:					

Number of nursing centers:					
Owned or leased........	278	282	278	296	297
Managed................	34	13	13	13	16
Number of nursing center licensed beds:					
Owned or leased........	36,466	36,912	36,701	38,694	37,444
Managed................	3,723	1,661	1,661	1,689	2,175
Number of nursing center patient days (a).......	11,580,295	11,656,439	11,939,266	12,622,238	12,566,763
Nursing center occupancy % (a)..................	86.1	86.8	87.3	90.5	91.9
Number of hospitals.....	56	56	57	60	38
Number of hospital licensed beds..........	4,886	4,931	4,979	5,273	3,325
Number of hospital patient days...........	1,044,663	982,301	947,488	767,810	586,144
Hospital occupancy %....	60.8	56.9	54.0	52.9	53.7

(a) Excludes managed facilities.

51

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

The Selected Financial Data in Item 6 and the consolidated financial statements included herein set forth certain data with respect to the financial position, results of operations and cash flows of the Company which should be read in conjunction with the following discussion and analysis.

As discussed in the Notes to the Consolidated Financial Statements, the Company realigned its Vencare ancillary services business in the fourth quarter of 1999. Vencare's physical rehabilitation, speech and occupational therapies were integrated into the Company's health services division, and its institutional pharmacy business was assigned to the hospital division. Vencare's respiratory therapy and certain other ancillary businesses were discontinued. Financial and operating data presented in Item 6 and the following discussion and analysis reflect the realignment of the former Vencare businesses for all periods presented.

The consolidated financial statements have been prepared on the basis of accounting principles applicable to going concerns and contemplate the realization of assets and the settlement of liabilities and commitments in the normal course of business. The consolidated financial statements do not include any adjustments that might result from the resolution of the Chapter 11 Cases or other matters discussed herein.

General

The Company provides long-term healthcare services primarily through the operation of nursing centers and hospitals. At December 31, 2000, the Company's health services division operated 312 nursing centers (40,189 licensed beds) in 31 states and a rehabilitation therapy business. The Company's hospital division operated 56 hospitals (4,886 licensed beds) in 23 states and an institutional pharmacy business.

Reorganization. On September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Company currently is operating its businesses as a

debtor-in-possession subject to the jurisdiction of the Bankruptcy Court. The Company's recent operating losses, liquidity issues and the Chapter 11 Cases raise substantial doubt about the Company's ability to continue as a going concern. The ability of the Company to continue as a going concern and the appropriateness of using the going concern basis of accounting are dependent upon, among other things, (a) the Company's ability to comply with the terms of the DIP Financing, (b) consummation of the Amended Plan, (c) the Company's ability to achieve profitable operations after such consummation, and (d) the Company's ability to generate sufficient cash from operations to meet its obligations. The Amended Plan and other actions during the Chapter 11 Cases could change materially the amounts currently recorded in the consolidated financial statements. See Note 3 of the Notes to Consolidated Financial Statements.

Spin-off. On May 1, 1998, Ventas completed the Spin-off through the distribution of Vencor common stock to its stockholders. Ventas retained ownership of substantially all of its real property and leases such real property to the Company under the Master Lease Agreements. In anticipation of the Spin-off, the Company was incorporated on March 27, 1998. For accounting purposes, the consolidated historical financial statements of Ventas became the Company's historical financial statements following the Spin-off. Any discussion concerning events prior to May 1, 1998 refers to the Company's business as it was conducted by Ventas prior to the Spin-off.

52

Results of Operations

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

	Year Ended December 31,		
	2000	1999	1998
Revenues:			
Health services division:			
Nursing centers	$ 1,675,627	$ 1,594,244	$ 1,667,343
Rehabilitation services	135,036	195,731	264,574
Other ancillary services	-	43,527	168,165
Elimination	(77,191)	(128,267)	(124,500)
	1,733,472	1,705,235	1,975,582
Hospital division:			
Hospitals	1,007,947	850,548	919,847
Pharmacy	204,252	171,493	149,991
	1,212,199	1,022,041	1,069,838
	2,945,671	2,727,276	3,045,420
Elimination of pharmacy charges to Company nursing centers	(57,129)	(61,635)	(45,681)
	$ 2,888,542	$ 2,665,641	$ 2,999,739
Income (loss) from operations (restated):			
Operating income (loss):			
Health services division:			

Nursing centers	$ 278,738	$ 169,128	$ 213,036
Rehabilitation services	8,047	2,891	18,398
Other ancillary services	4,737	4,166	30,183
	291,522	176,185	261,617
Hospital division:			
Hospitals	205,858	132,050	247,272
Pharmacy	7,421	342	15,301
	213,279	132,392	262,573
Corporate overhead	(113,823)	(108,947)	(126,291)
Unusual transactions	(4,701)	(412,418)	(439,125)
Reorganization costs	(12,636)	(18,606)	-
Operating income (loss)	373,641	(231,394)	(41,226)
Rent	(307,809)	(305,120)	(234,144)
Depreciation and amortization	(73,545)	(93,196)	(124,617)
Interest, net	(55,038)	(75,254)	(102,320)
Loss before income taxes	(62,751)	(704,964)	(502,307)
Provision for income taxes	2,000	500	76,099
	$ (64,751)	$ (705,464)	$ (578,406)
Nursing center data:			
Revenue mix %:			
Medicare	27.9	26.1	29.3
Medicaid	48.8	48.7	44.7
Private and other	23.3	25.2	26.0
Patient days:			
Medicare	1,541,934	1,436,288	1,498,968
Medicaid	7,735,567	7,718,963	7,746,401
Private and other	2,302,794	2,501,188	2,693,897
	11,580,295	11,656,439	11,939,266
Average daily census	31,640	31,935	32,710
Occupancy %	86.1	86.8	87.3
Hospital data:			
Revenue mix %:			
Medicare	55.1	58.3	58.5
Medicaid	10.3	10.5	9.7
Private and other	34.6	31.2	31.8
Patient days:			
Medicare	704,152	669,976	647,283
Medicaid	134,754	119,849	121,538
Private and other	205,757	192,476	178,667
	1,044,663	982,301	947,488
Average daily census	2,854	2,691	2,596
Occupancy %	60.8	56.9	54.0

53

Regulatory Changes

The Budget Act contained extensive changes to the Medicare and Medicaid programs intended to reduce the projected amount of increase in payments under

those programs over a five year period. Virtually all spending reductions come from reimbursements to providers and changes in program components. The Budget Act has affected adversely the revenues in each of the Company's operating divisions.

The Budget Act established PPS for nursing centers for cost reporting periods beginning on or after July 1, 1998. While most nursing centers in the United States became subject to PPS during the first quarter of 1999, all of the Company's nursing centers adopted PPS on July 1, 1998. During the first three years, the per diem rates for nursing centers are based on a blend of facility-specific costs and federal costs. Thereafter, the per diem rates are based solely on federal costs. The payments received under PPS cover all services for Medicare patients including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals.

The Budget Act also reduced payments made to the hospitals operated by the Company's hospital division by reducing TEFRA incentive payments, allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. The reductions in allowable costs for capital expenditures became effective October 1, 1997. The reductions in the TEFRA incentive payments and allowable costs for bad debts became effective between May 1, 1998 and September 1, 1998. The reductions in payments for services to patients transferred from a general acute care hospital became effective October 1, 1998. These reductions have had a material adverse impact on hospital revenues. In addition, these reductions also may affect adversely the hospital division's ability to develop additional long-term care hospitals in the future.

Under PPS, the volume of ancillary services provided per patient day to nursing center patients also has declined dramatically. As previously discussed, Medicare reimbursements to nursing centers under PPS include substantially all services provided to patients, including ancillary services. Prior to the implementation of PPS, the costs of such services were reimbursed under cost-based reimbursement rules. The decline in the demand for ancillary services is mostly attributable to efforts by nursing centers to reduce operating costs. As a result, many nursing centers are electing to provide ancillary services to their patients through internal staff or are seeking lower acuity patients who require less ancillary services. In response to PPS and a significant decline in the demand for ancillary services, the Company realigned its Vencare division in the fourth quarter of 1999 by integrating the physical rehabilitation, speech and occupational therapy businesses into the health services division and assigning the institutional pharmacy business to the hospital division. Vencare's respiratory therapy and other ancillary businesses were discontinued.

Since November 1999, various legislative and regulatory actions have provided a measure of relief from some of the impact of the Budget Act. In November 1999, the BBRA was enacted. Effective April 1, 2000, the BBRA made a temporary 20% upward adjustment in the payment rates for the care of higher acuity patients and allowed nursing centers to transition more rapidly to the federal payment rates. The BBRA also imposed a two-year moratorium on certain therapy limitations for skilled nursing center patients covered under Medicare Part B. Effective October 1, 2000, the BBRA increased all PPS payment categories by 4% for two years.

In April 2000, HCFA published a proposed rule which set forth updates to the RUG payment rates used under PPS for nursing centers. On July 31, 2000, HCFA issued a final rule that indefinitely postponed any refinements to the RUG categories used under PPS. It also provided for the continuance of Medicare payment relief set forth in the BBRA, including the 20% upward adjustment for certain higher acuity RUG categories through September 30, 2001 and the

scheduled 4% increase (effective October 2000) for all RUG categories through September 30, 2002.

In December 2000, BIPA was enacted to provide up to $35 billion in additional funding to the Medicare and Medicaid programs over the next five years. Under BIPA, the nursing component for each RUG category will increase by 16.66% over the current rates for skilled nursing care for the period April 1, 2001 through

54

September 30, 2002. BIPA also will provide some relief from scheduled reductions to the annual inflation adjustments to the RUG payment rates through September 2001.

In addition, BIPA slightly increased payments for inpatient services and TEFRA incentive payments for long-term acute care hospitals. Allowable costs for bad debts also will be increased by 10%. Both of these provisions will become effective for cost reporting periods beginning September 1, 2001.

Despite the recent legislation and regulatory actions discussed above, Medicare revenues recorded under PPS in the Company's health services division have been substantially less than the cost-based reimbursement it received before the enactment of the Budget Act. In addition, the recent legislation did not impact materially the reductions in Medicare revenues received by the Company's hospitals as a result of the Budget Act.

There also continues to be state legislative proposals that would impose more limitations on government and private payments to providers of healthcare services such as the Company. By repealing the Boren Amendment, the Budget Act eased existing impediments on the states' ability to reduce their Medicaid reimbursement levels. Many states have enacted or are considering enacting measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. Some states also are considering regulatory changes that include a moratorium on the designation of additional long-term care hospitals. Regulatory changes in the Medicare and Medicaid reimbursement systems applicable to the hospital division also are being considered. There also are legislative proposals including cost caps and the establishment of Medicaid prospective payment systems for nursing centers.

The Company could be affected adversely by the continuing efforts of governmental and private third-party payors to contain the amount of reimbursement for healthcare services. There can be no assurance that payments under governmental and private third-party payor programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. In addition, there can be no assurance that facilities operated by the Company, or the provision of services and supplies by the Company, will meet the requirements for participation in such programs.

There can be no assurance that future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs will not have a material adverse effect on the Company's results of operations, liquidity and financial position.

Health Services Division--Nursing Centers

Revenues increased 5% in 2000 to $1.68 billion. Substantially all of the increase was attributable to increased Medicare and Medicaid funding and price increases to private payors. Medicaid and private payor rates both increased approximately 5% in 2000 compared to 1999. Medicare revenues per patient day grew 5% to $303 in 2000 from $290 in 1999 primarily as a result of

reimbursement increases associated with the BBRA. As previously discussed, the BBRA established, among other things, a 20% increase in Medicare payment rates for higher acuity patients effective April 1, 2000 and a 4% increase in all PPS payment categories effective October 1, 2000. As result of the phase-in of the provisions of the BBRA, Medicare revenues per patient day in the fourth quarter of 2000 averaged $321 or 10% higher than the same period in 1999.

Revenues declined 4% in 1999 to $1.59 billion. Medicaid rates increased approximately 5% in 1999 compared to 1998, while private payor rates were relatively unchanged. As previously discussed, all of the Company's nursing centers adopted PPS on July 1, 1998, resulting in substantially less Medicare reimbursement to the Company's nursing centers. Average Medicare revenues per patient day in 1999 declined 11% from $326 in 1998. Lower average Medicare reimbursement rates in 1999 resulted primarily from the full-year effect of PPS.

Same-store patient days were relatively unchanged during the last three years. Management believes that the Chapter 11 Cases have had little, if any, impact on nursing center patient days.

55

Nursing center operating income in 2000 totaled $279 million compared to $169 million in 1999. A substantial portion of the improvement resulted from operating efficiencies related to the fourth quarter 1999 Vencare realignment and growth in revenues. In addition, the provision for doubtful accounts declined in 2000 to $23 million from $51 million last year as a result of improved collection processes.

Nursing center operating income in 1999 declined 21% from $213 million in 1998. The decline was primarily attributable to reductions in Medicare reimbursement under PPS. While the Company achieved some operating efficiencies in 1999 in response to PPS, expenses related to professional liability risks and doubtful accounts increased substantially. Professional liability costs aggregated $45 million in 1999 compared to $18 million in 1998, while costs for doubtful accounts increased to $51 million in 1999 from $17 million in 1998.

Health Services Division--Rehabilitation Services

Revenues declined 31% in 2000 to $135 million and 26% in 1999 to $196 million. Revenue declines in both periods were primarily attributable to reduced customer demand for ancillary services in response to fixed reimbursement rates under PPS and the elimination of unprofitable external contracts. Approximately one-half of the revenue decline in 2000 was attributable to Company-operated nursing centers. Under PPS, the reimbursement for ancillary services provided to nursing center patients is a component of the total reimbursement allowed per nursing center patient. As a result, many nursing center customers (including the Company's nursing centers) have elected to provide ancillary services to their patients through internal staff and no longer contract with outside parties for ancillary services.

Rehabilitation services reported operating income of $8 million in 2000 compared to $3 million in 1999 and $18 million in 1998. Operating results for both 2000 and 1999 were adversely impacted by the decline in revenues. A significant portion of operating income in 2000 resulted from favorable adjustments for doubtful accounts based on collections from past due customers. In addition, effective January 1, 2000, revenues for rehabilitation services provided to Company-operated nursing centers approximated the costs of providing such services. Accordingly, fiscal 2000 operating results do not reflect any operating income related to intercompany transactions. Operating results in 1999 also were negatively impacted as a result of a $26 million

increase in the provision for doubtful accounts. Operating results in 1998 include a $12 million charge related to third-party reimbursements. While the health services division will continue to provide rehabilitation services to nursing center customers, revenues and operating income related to these services may continue to decline in 2001.

Health Services Division--Other Ancillary Services

Other ancillary services refers to certain ancillary businesses (primarily respiratory therapy) that were discontinued as part of the Vencare realignment in the fourth quarter of 1999. Operating results for 2000 reflect a $4 million favorable adjustment for doubtful accounts resulting from collections from discontinued customer accounts. See Note 4 of the Notes to Consolidated Financial Statements for a description of the Vencare realignment.

Hospital Division--Hospitals

Revenues increased 19% in 2000 to $1.0 billion and declined 8% in 1999 to $851 million. Revenues for both 2000 and 1999 were adversely impacted by certain third-party reimbursement issues.

Prior to September 1999, Medicare revenues recorded by the Company's hospitals included reimbursement for expenses related to certain costs associated with hospital-based ancillary services provided by the former Vencare division to its nursing center customers. As part of its ongoing investigations, the DOJ objected to including such costs on the Medicare cost reports filed by the Company's hospitals. Medicare revenues related to the reimbursement of such costs aggregated $18 million in 1999 and $47 million in 1998. In connection with the negotiation of the Government Settlement, the Company agreed to discontinue recording such revenues beginning September 1, 1999.

The Company provides care to patients covered by Medicare supplement insurance policies which generally become effective when a patient's Medicare benefits are exhausted. Disputes related to the level of payments to the Company's hospitals have arisen with private insurance companies issuing these policies as a result of different interpretations of policy provisions and federal and state laws governing the policies. While the Company continues to pursue favorable resolutions of these claims, provisions for loss aggregating $20 million and $19 million were recorded in 2000 and 1999, respectively. See "Legal Proceedings."

Revenues in 1999 were also reduced by adjustments for changes in estimates for certain third-party reimbursements aggregating $60 million.

Excluding the effect of the previously discussed third-party reimbursement issues, revenues grew 13% to $1.03 billion in 2000 and 4% to $912 million in 1999 compared to $873 million in 1998. The increase was primarily attributable to patient day growth of 6% in 2000 and 4% in 1999. In addition, price increases to private payors also contributed to revenue growth in 2000. Price increases in 1999 were not significant.

Hospital operating income in 2000 totaled $206 million compared to $132 million in 1999 and $247 million in 1998. Excluding the previously discussed third-party reimbursement issues, operating income totaled $226 million in 2000, $192 million in 1999 and $201 million in 1998. Growth in adjusted operating income in 2000 was primarily attributable to revenue growth. Adjusted operating income declined in 1999 compared to 1998 as a result of growth in labor costs.

Hospital Division--Pharmacy

Revenues increased 19% in 2000 to $204 million and 14% in 1999 to $171 million. The increase in both periods resulted primarily from growth in the number of nursing center customers and, in 1999, from price increases to Company-operated nursing centers.

The Company's pharmacies reported operating income of $7 million in 2000 compared to $342,000 in 1999 and $15 million in 1998. Operating income in 1999 was reduced by a $11 million increase in the provision for doubtful accounts compared to the prior year. Operating results in 1998 include the effect of approximately $8 million of charges recorded in the fourth quarter related to accounts receivable. Management believes that operating income in both 2000 and 1999 was adversely impacted by pricing pressures associated with PPS for external customers.

Corporate Overhead

Operating income for the Company's operating divisions excludes allocations of corporate overhead. These costs aggregated $114 million, $109 million and $126 million during each of the last three years, respectively. As a percentage of revenues (before eliminations), corporate overhead totaled 3.9% in 2000, 4.0% in 1999 and 4.1% in 1998.

Unusual Transactions

Operating results for each of the last three years include certain unusual transactions. These transactions are included in other operating expenses in the consolidated statement of operations (unless otherwise indicated) for the respective periods in which they were recorded. See Note 6 of the Notes to Consolidated Financial Statements.

2000

Operating results for 2000 include a $9.2 million write-off of an impaired investment recorded in the third quarter and a $4.5 million gain on the sale of a closed hospital recorded in the second quarter.

1999

The following table summarizes the pretax impact of unusual transactions recorded during 1999 (in millions):

	Quarters				
	First	Second	Third	Fourth	Year
(Income)/expense					
Asset valuation losses:					
Long-lived asset impairment...........				$330.4	$330.4
Investment in BHC.....................		$15.2			15.2
Cancellation of software development project................................		5.6			5.6
Realignment of Vencare division.........				56.3	56.3
Retirement plan curtailment.............				7.3	7.3

Corporate properties..................				(2.4)	(2.4)
	$ -	$20.8	$ -	$391.6	$412.4

Long-lived asset impairment--Statement of Financial Accounting Standards ("SFAS") No. 121 "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," ("SFAS 121"), requires impairment losses to be recognized for long-lived assets used in operations when indications of impairment are present and the estimate of undiscounted future cash flows is not sufficient to recover asset carrying amounts. SFAS 121 also requires that long-lived assets held for disposal be carried at the lower of carrying value or fair value less costs of disposal, once management has committed to a plan of disposal.

Operating results and related cash flows for 1999 did not meet management's expectations. These expectations were the basis upon which the Company valued its long-lived assets at December 31, 1998, in accordance with SFAS 121. In addition, certain events occurred in 1999 which had a negative impact on the Company's operating results and are expected to impact negatively its operations in the future. In connection with the negotiation of the Government Settlement, the Company agreed to exclude certain expenses from its hospital Medicare cost reports beginning September 1, 1999 for which the Company had been reimbursed in prior years. Medicare revenues related to the reimbursement of such costs aggregated $18 million in 1999 and $47 million in 1998. In addition, hospital revenues in 1999 were reduced by approximately $19 million as a result of disputes with certain insurers who issued Medicare supplement insurance policies to individuals who became patients of the Company's hospitals. The Company also reviewed the expected impact of the BBRA enacted in November 1999 (which provided a measure of relief for some of the impact of the Budget Act) and the realignment of the Vencare ancillary services business completed in the fourth quarter of 1999. The actual and expected future impact of these issues served as an indication to management that the carrying values of the Company's long-lived assets may be impaired.

In accordance with SFAS 121, management estimated the future undiscounted cash flows for each of its facilities and compared these estimates to the carrying values of the underlying assets. As a result of these estimates, the Company reduced the carrying amounts of the assets associated with 71 nursing centers and 21 hospitals to their respective estimated fair values. The determination of the fair values of the impaired facilities was based upon the net present value of estimated future cash flows.

A summary of the impairment charges follows (in millions):

	Goodwill	Property and Equipment	Total
Health services division......................	$ 18.3	$ 37.7	$ 56.0
Hospital division............................	198.9	75.5	274.4
	$217.2	$113.2	$330.4

Investment in BHC--In connection with the Transitional merger, the Company acquired a 44% voting equity interest (61% equity interest) in Behavioral Healthcare Corporation ("BHC"), an operator of psychiatric and behavioral clinics. In the second quarter of 1999, the Company wrote off its remaining investment in BHC aggregating $15.2 million as a result of deteriorating financial performance. See the discussion of unusual transactions recorded in 1998 for further information related to the Company's investment in BHC.

Cancellation of software development project--In the second quarter of 1999, the Company canceled a nursing center software development project and charged previously capitalized costs to operations.

Realignment of Vencare division--As discussed in Note 4 of the Notes to Consolidated Financial Statements, the Company realigned the Vencare ancillary services division in the fourth quarter of 1999. As a result, the Company recorded a charge aggregating $56.3 million, including the write-off of goodwill totaling $42.3 million. The remainder of the charge related to the write-down of certain equipment to net realizable value and the recording of employee severance costs.

Retirement plan curtailment--In December 1999, the Board of Directors approved the curtailment of benefits under the Company's supplemental executive retirement plan, resulting in an actuarially determined charge of $7.3 million. Under the terms of the curtailment, plan benefits were vested for each eligible participant through December 31, 1999 and the accrual of future benefits under the plan was substantially eliminated. The Board of Directors also deferred the time at which certain benefits would be paid by the Company. See "Executive Compensation--Supplemental Executive Retirement Plan."

Corporate properties--During 1999, the Company adjusted estimated property loss provisions recorded in the fourth quarter of 1998, resulting in a pretax credit of $2.4 million.

1998

The following table summarizes the pretax impact of unusual transactions recorded during 1998 (in millions):

	Quarters				
	First	Second	Third	Fourth	Year
(Income)/expense					
Asset valuation losses:					
Long-lived asset impairment........				$307.8	$ 307.8
Investment in BHC.................			$ 8.5	43.1	51.6
Wisconsin nursing center...........				27.5	27.5
Corporate properties...............		$ 8.8	2.9	15.1	26.8
Acquired entities..................				13.5	13.5
Gain on sale of investments..........			(98.5)	(13.0)	(111.5)
Losses from termination of construction projects...............			71.3		71.3
Spin-off transaction costs...........	$7.7	9.6			17.3
Write-off of clinical information systems............................				10.1	10.1
Doubtful accounts related to sold operations.........................			9.6		9.6
Settlement of litigation.............				7.8	7.8
Loss on sale and closure of home					

health and hospice businesses.......		7.3			7.3
	$7.7	$25.7	$ (6.2)	$411.9	$ 439.1

Long-lived asset impairment--As previously discussed, all of the Company's nursing centers became subject to PPS effective July 1, 1998. Revenues recorded under PPS in the Company's health services division were substantially less than the cost-based reimbursement it received before the enactment of the Budget Act.

The Budget Act also reduced payments to the Company's hospitals by reducing incentive payments pursuant to TEFRA, allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. These reductions, most of which became effective in 1998, had a material adverse impact on hospital revenues.

The Company provides ancillary services to both Company-operated and non-affiliated nursing centers. While most of the nursing center industry became subject to PPS on or after January 1, 1999, management believed that Vencare's ability to maintain services and revenues was impacted adversely during 1998, particularly in the third and fourth quarters, since nursing centers were reluctant to enter into ancillary service contracts while transitioning to the new fixed payment system under PPS. Medicare reimbursements to nursing centers under PPS include substantially all services provided to patients, including ancillary services. Management believes that the decline in demand for its Vencare services in 1998, particularly respiratory therapy and rehabilitation therapy, was mostly attributable to efforts by nursing center customers to reduce operating costs. In addition, as a result of these regulatory changes, many nursing centers began providing ancillary services to their patients through internal staff and no longer contracted with outside parties for ancillary services.

In January 1998, HCFA issued rules changing Medicare reimbursement guidelines for therapy services provided by the Company. Under these rules, HCFA established salary equivalency limits for speech and occupational therapy services and revised limits for physical and respiratory therapy services. The new limits became effective for services provided on or after April 10, 1998 and negatively impacted operating results of the Company's ancillary services businesses in 1998.

These significant regulatory changes and the impact of such changes on the Company's operating results in the third and fourth quarters of 1998 served as an indication to management that the carrying values of the assets of its nursing center and hospital facilities, as well as certain portions of its ancillary services business, may be impaired.

In accordance with SFAS 121, management estimated the future undiscounted cash flows for each of its facilities and ancillary services lines of business and compared these estimates to the carrying values of the underlying assets. As a result of these estimates, the Company reduced the carrying amounts of the assets associated with 110 nursing centers, 12 hospitals and a portion of the goodwill associated with its rehabilitation therapy business to their respective estimated fair values. The determination of the fair values of the impaired facilities and rehabilitation therapy business was based upon the net present value of estimated future cash flows.

A summary of the impairment charges follows (in millions):

	Goodwill	Property and Equipment	Total
Health services division:			
Nursing centers	$ 27.7	$ 71.6	$ 99.3
Ancillary services	99.2	0.2	99.4
Hospital division	74.4	34.7	109.1
	$201.3	$106.5	$307.8

In addition to the above impairment charges, the amortization period for the remaining goodwill associated with the Company's rehabilitation therapy business was reduced from forty years to seven years, effective October 1, 1998. Management believed that the provisions of the Budget Act altered the expected long-term cash flows and business prospects associated with this business to such an extent that a shorter amortization period was deemed appropriate. The change in the amortization period resulted in an additional pretax charge to operations of $6.4 million in the fourth quarter of 1998. In the fourth quarter of 1999, in connection with the realignment of Vencare, the Company wrote off all of the goodwill associated with the rehabilitation therapy business. See Note 6 of the Notes to Consolidated Financial Statements.

Investment in BHC--Subsequent to the Transitional merger, the Company had been unsuccessful in its attempts to sell its investment in BHC. In July 1998, the Company entered into an agreement to sell its interest in BHC for an amount less than its carrying value and accordingly, a provision for loss of $8.5 million was recorded during the third quarter. In November 1998, the agreement to sell the Company's interest in BHC was terminated by the prospective buyer, indicating to the Company that the carrying amount of its investment may be impaired. Following an independent appraisal, the Company recorded a $43.1 million write-down of the investment in the fourth quarter of 1998. The net carrying amount of the investment aggregated $20.0 million at December 31, 1998.

Wisconsin nursing center--The Company recorded an asset impairment charge of $27.5 million in the fourth quarter of 1998 related to a nursing center in Wisconsin that is leased from Ventas. The impairment resulted primarily from certain fourth quarter regulatory actions by state and federal agencies with respect to the operation of the facility. In the fourth quarter of 1998, the facility reported a pretax loss of $4.2 million and is not expected to generate positive cash flows in the future.

Corporate properties and acquired entities--During 1998, the Company recorded $26.8 million of charges related to the valuation of certain corporate assets, the most significant of which relates to previously capitalized amounts and expected property disposal losses associated with the cancellation of a corporate headquarters construction project. The Company also recorded $13.5 million of asset write-downs associated with the Hillhaven merger, the TheraTx merger and the Transitional merger, including provisions for obsolete or abandoned computer equipment and miscellaneous receivables.

Gain on sale of investments--In September 1998, the Company sold its investment in its assisted living affiliate, Atria Communities, Inc. for $177.5

million in cash and an equity interest in the surviving corporation, resulting in a gain of $98.5 million. In November 1998, the Company's investment in Colorado MEDtech, Inc. was sold at a gain of $13.0 million. Proceeds from the sale were $22.0 million.

Losses from termination of construction projects--In the third quarter of 1998, as a result of substantial reductions in Medicare reimbursement to the Company's nursing centers and hospitals in connection with the Budget Act, management determined to suspend all acquisition and development activities, terminate the construction of substantially all of its development properties, and close two recently acquired hospitals. Accordingly, the Company recorded pretax charges aggregating $71.3 million, of which $53.9 million related to the cancellation of construction projects and the remainder related to the planned closure of the hospitals. In connection with the construction termination charge, the Company decided that it would not replace certain facilities that previously were accounted for as assets intended for disposal. Accordingly, the $53.9 million charge discussed above included a $10.0 million reversal of a previously recorded valuation allowance (the amount necessary to reduce the carrying value to fair value less costs of disposal) related to such facilities.

Spin-off transaction costs--The Spin-off was completed on May 1, 1998. Direct costs related to the transaction totaled $17.3 million and primarily included costs for professional services.

Write-off of clinical information systems--During 1997, the Company began the installation of its proprietary clinical information system, VenTouch(TM), in several of its nursing centers. During the pilot process, the Company determined that VenTouch(TM) did not support effectively the nursing center processes, especially in facilities with lower acuity patients. Accordingly, management determined in the fourth quarter of 1998 to remove VenTouch(TM) from these facilities during 1999. A loss of $10.1 million was recorded to reflect the write-off of the equipment and estimated costs of removal from the facilities.

Doubtful accounts related to sold operations--In the third quarter of 1998, the Company recorded $9.6 million of additional provisions for doubtful accounts for accounts receivable associated with previously sold facilities.

Settlement of litigation--The Company settled a legal action entitled Highland Pines Nursing Center, Inc., et al. v. TheraTx, Incorporated, et al. (assumed in connection with the TheraTx merger) which resulted in a

payment of $16.2 million. Approximately $7.8 million of the settlement was charged to earnings in the fourth quarter of 1998, and the remainder of such costs had been previously accrued in connection with the purchase price allocation.

Loss on sale and closure of home health and hospice businesses--The Company began operating its home health and hospice businesses in 1996. These operations generally were unprofitable. In the second quarter of 1998, management decided to cease operations and either close or sell these businesses, resulting in a loss of $7.3 million.

Capital Costs

Upon completion of the Spin-off, the Company leased substantially all of its facilities. Prior thereto, the Company owned 271 facilities and leased 80 facilities from third parties. Depreciation and amortization, rent and net

interest costs aggregated $436 million in 2000, $474 million in 1999 and $461 million in 1998. Rent expense incurred by the Company in connection with the Master Lease Agreements aggregated $230 million in 2000, $225 million in 1999 and $148 million in 1998. In connection with the Spin-off in 1998, approximately $992 million of long-term debt was retained by Ventas.

During the pendency of the Chapter 11 Cases, the Company is continuing to record the entire contractual amount of interest expense related to the Credit Agreement and the rents due to Ventas under the Master Lease Agreements. No interest payments have been made related to the Credit Agreement since the filing of the Chapter 11 Cases. In accordance with the Stipulation with Ventas, the Company is paying a reduced aggregate monthly rent of approximately $15.1 million.

No interest costs have been recorded related to the 1998 Notes since the filing of the Chapter 11 Cases. Contractual interest expense for the 1998 Notes not recorded in the consolidated statement of operations aggregated $30 million in 2000 and $9 million in 1999.

Fourth Quarter Adjustments

Preparation of the financial statements requires a number of estimates and judgments that are based upon the best available evidence at the time. In addition, management regularly reviews the methods used to recognize revenues and allocate costs to ensure that the financial statements reflect properly the results of interim periods.

In addition to the unusual transactions previously discussed, during the fourth quarter of 1999 and 1998, the Company recorded certain adjustments which significantly impacted operating results. A summary of such adjustments follows (in millions):

	(Restated)					
	Health Services Division		Hospital Division			
	Nursing Centers	Ancillary Services	Hospitals	Pharmacy	Corporate	Total
1999						
(Income)/expense						
Provision for doubtful accounts.............	$40.2	$26.8	$ 6.5	$ 8.9		$ 82.4
Medicare supplement insurance disputes...			18.8			18.8
Third-party reimbursements and contractual allowances, including amounts due from government agencies and other payors that are subject to dispute.............	2.0		59.6			61.6
Professional liability risks...............	14.7	0.4	1.8	0.1		17.0
Employee benefits.....	(6.3)	(1.5)	(1.8)			(9.6)
Incentive						

compensation.........	2.2		(1.9)	(1.1)		(0.8)
Inventories...........	0.9			6.3		7.2
Other.................	1.7	(0.4)	2.0	(4.4)	$(2.8)	(3.9)
	$55.4	$25.3	$85.0	$ 9.8	$(2.8)	$172.7

	(Restated)					
	Health Services Division		Hospital Division			
	Nursing Centers	Ancillary Services	Hospitals	Pharmacy	Corporate	Total
1998						
(Income)/expense						
Provision for doubtful accounts..............	$14.0	$ 6.8	$ 5.7	$ 2.5		$29.0
Third-party reimbursements and contractual allowances, including amounts due from government agencies and other payors that are subject to dispute..............	4.8	11.5	11.4			27.7
Change in goodwill amortization period related to rehabilitation therapy business.............		6.4				6.4
Taxes other than income................					$ 6.4	6.4
Professional liability risks.................	3.5	0.2	1.8			5.5
Compensated absences...	2.1	1.3	(0.8)		0.7	3.3
Incentive compensation..........	(1.0)	(0.4)	(0.8)	(0.1)	(2.9)	(5.2)
Litigation and regulatory actions....					3.5	3.5
Miscellaneous receivables...........				5.2		5.2
Gain on sale of assets...............		(2.0)				(2.0)
Other.................	1.2	0.4	(1.0)	0.3	3.7	4.6
	$24.6	$24.2	$16.3	$ 7.9	$11.4	$84.4

The Company regularly reviews its accounts receivable and records provisions for loss based upon the best available evidence. Factors such as changes in collection patterns, the composition of patient accounts by payor type, the

status of ongoing disputes with third-party payors (including both government and non-government sources), the effect of increased regulatory activities, general industry conditions and the financial condition of the Company and its ancillary service customers, among other things, are considered by management in determining the expected collectibility of accounts receivable.

During 1999 and 1998, the Company recorded significant adjustments in the fourth quarter related to contractual allowances and doubtful accounts in each of its divisions. These adjustments represented changes in estimates resulting from management's assessment of its collection processes, the general financial deterioration of the long-term healthcare industry and, in 1999, the realignment of the Vencare businesses (including the cancellation of unprofitable contracts and the discontinuance of certain services) and the filing of the Chapter 11 Cases in September 1999.

In addition, the Company recorded a significant adjustment in the fourth quarter of 1999 related to professional liability risks. This adjustment was recorded based upon actuarially determined estimates completed in the fourth quarter and reflects substantial increases in claims and litigation activity in the Company's nursing center business during 1999. Management believes that cost increases for professional liability risks are negatively impacting other providers in the long-term healthcare industry and expects that the Company's operating results in the future may be impacted negatively by additional professional liability costs. See Note 10 of the Notes to Consolidated Financial Statements.

Income Taxes

Prior to 1998, management believed that recorded deferred tax assets ultimately would be realized. Management's conclusions at that time were based primarily on the existence of sufficient taxable income within the allowable carryback periods to realize the tax benefits of deductible temporary differences recorded at December 31, 1997. For the fourth quarter of 1998, the Company reported a pretax loss of $512 million. Additionally, the Company revised its operating budgets as a result of the Budget Act and the less than expected operating results in 1998. Based upon those revised forecasts, management did not believe that the

Company could generate sufficient taxable income to realize the net deferred tax assets recorded at December 31, 1998. Accordingly, the Company recorded a deferred tax valuation allowance aggregating $205 million in the fourth quarter of 1998. Deferred tax valuation allowances recorded in 1999 and 2000 totaled $155 million and $12 million, respectively. The deferred tax valuation allowance included in the consolidated balance sheet at December 31, 2000 totaled $372 million. See Note 9 of the Notes to Consolidated Financial Statements.

Consolidated Results

The Company reported a pretax loss from operations before reorganization costs of $50 million in 2000 compared to $686 million in 1999 and $502 million in 1998. Reorganization costs in 2000 and 1999 aggregating $13 million and $19 million, respectively, principally comprised professional fees and, in 1999, certain management incentive payments incurred in connection with the Company's restructuring activities.

The net loss from operations in 2000 totaled $65 million compared to $705 million in 1999 and $578 million in 1998 (including charges to record the deferred tax valuation allowance).

Effective January 1, 1999, the Company adopted the provisions of the American Institute of Certified Public Accountants Statement of Position ("SOP") 98-5, "Reporting on the Costs of Start-Up Activities" ("SOP 98-5"), which requires the Company to expense start-up costs, including organizational costs, as incurred. In accordance with the provision of SOP 98-5, the Company wrote off $8.9 million of such unamortized costs as a cumulative effect of a change in accounting principle in the first quarter of 1999. The pro forma effect of the change in accounting for start-up costs, assuming the change occurred on January 1, 1998, was not significant.

In conjunction with the Spin-off in 1998, the Company incurred an extraordinary loss on extinguishment of debt aggregating $78 million.

Liquidity

As previously discussed, on September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Company currently is operating its businesses as a debtor-in-possession subject to the jurisdiction of the Bankruptcy Court. See "Business--Proceedings under Chapter 11 of the Bankruptcy Code."

On September 14, 1999, the Company received approval from the Bankruptcy Court to pay pre-petition and post-petition employee wages, salaries, benefits and other employee obligations. The Bankruptcy Court also approved orders granting authority, among other things, to pay pre-petition claims of certain critical vendors, utilities and patient obligations. All other pre-petition liabilities have been classified in the Company's consolidated balance sheet as liabilities subject to compromise. The Company currently is paying the post-petition claims of all vendors and providers in the ordinary course of business.

In connection with the Chapter 11 Cases, the Company entered into the DIP Financing aggregating $100 million. The Bankruptcy Court granted final approval of the DIP Financing on October 1, 1999. The DIP Financing was initially comprised of a $75 million Tranche A Loan and a $25 million Tranche B Loan. Interest is payable at prime plus 2 1/2% on the Tranche A Loan and prime plus 4 1/2% on the Tranche B Loan.

Available aggregate borrowings under the Tranche A Loan were initially limited to $45 million in September 1999 and increased to $65 million in October 1999, $70 million in November 1999 and $75 million thereafter. Pursuant to the most recent amendment to the DIP Financing, the aggregate borrowing limitations under the Tranche A Loan are limited to approximately $48 million until maturity and are reduced for asset sales made by the Company. In addition, Tranche B Loan aggregate borrowings are limited to $23 million as a result of the most recent amendment to the DIP Financing. Borrowings under the Tranche B Loan require the approval of lenders holding at least 75% of the credit exposure under the DIP Financing. The DIP Financing is

secured by substantially all of the assets of the Company and its subsidiaries, including certain owned real property. The DIP Financing contains standard representations and warranties and other affirmative and restrictive covenants. At December 31, 2000, there were no outstanding borrowings under the DIP Financing.

Since the consummation of the DIP Financing, the Company and the DIP Lenders have agreed to several amendments to the DIP Financing. In the most recent amendment to the DIP Financing, the parties agreed, among other things, to

extend the maturity date of the DIP Financing until March 31, 2001 and to revise and update certain financial covenants. At December 31, 2000, the Company was in compliance with the terms of the DIP Financing.

The Company expects to terminate the DIP Financing on or prior to the effective date of the Amended Plan.

The Company reported a net loss from operations in 1998 aggregating $578 million, resulting in certain financial covenant violations under the Company's $1.0 billion Credit Agreement. Prior to the commencement of the Chapter 11 Cases, the Company received a series of temporary waivers of these covenant violations. The waivers generally included certain borrowing limitations under the $300 million revolving credit portion of the Credit Agreement. The final waiver was scheduled to expire on September 24, 1999.

The Company was informed on April 9, 1999 by HCFA that the Medicare program had made a demand for repayment of approximately $90 million of reimbursement overpayments. On April 21, 1999, the Company reached an agreement with HCFA to extend the repayment of such amounts over 60 monthly installments. Under the HCFA Agreement, non-interest bearing monthly payments of approximately $1.5 million commenced in May 1999. Beginning in December 1999, interest began to accrue on the balance of the overpayments at a statutory rate approximating 13.4%, resulting in a monthly payment of approximately $2.0 million through March 2004. If the Company is delinquent with two consecutive payments, the HCFA Agreement will be defaulted and all subsequent Medicare reimbursement payments to the Company may be withheld. Amounts due under the HCFA Agreement aggregated $63.4 million at December 31, 2000 and have been classified as liabilities subject to compromise in the Company's consolidated balance sheet. The Company has received Bankruptcy Court approval to continue to make the monthly payments under the HCFA Agreement during the pendency of the Chapter 11 Cases. Under the Amended Plan, if consummated, the Company has agreed to repay the remaining balance of the obligations pursuant to the terms of the HCFA Agreement.

On May 3, 1999, the Company elected not to make the interest payment of approximately $14.8 million due on the 1998 Notes. The failure to pay interest resulted in an event of default under the 1998 Notes.

In accordance with SOP 90-7 "Financial Reporting by Entities in Reorganization Under the Bankruptcy Code" ("SOP 90-7"), outstanding borrowings under the Credit Agreement ($511 million) and the principal amount of the 1998 Notes ($300 million) have been presented as liabilities subject to compromise in the Company's consolidated balance sheet at December 31, 2000. If the Chapter 11 Cases had not been filed, the Company would have reported a working capital deficit approximating $942 million at December 31, 2000. The consolidated financial statements do not include any adjustments that might result from the resolution of the Chapter 11 Cases or other matters discussed herein. During the pendency of the Chapter 11 Cases, the Company is continuing to record the contractual amount of interest expense related to the Credit Agreement. No interest costs have been recorded related to the 1998 Notes since the filing of the Chapter 11 Cases. Contractual interest expense for the 1998 Notes not recorded in the consolidated statement of operations aggregated $30 million in 2000 and $9 million in 1999.

As previously reported, the Company was informed by the DOJ that the Company and Ventas are the subjects of ongoing investigations into various Medicare reimbursement issues, including hospital cost reporting issues, Vencare billing practices and various quality of care issues in the hospitals and nursing centers

formerly operated by Ventas and currently operated by the Company. In connection with the Amended Plan, the claims of the DOJ will be settled through the Government Settlement. The Government Settlement also provides for the dismissal of certain pending claims and lawsuits filed against the Company. See "Business--Proceedings under Chapter 11 of the Bankruptcy Code" and "Legal Proceedings."

As a result of the uncertainty related to the Chapter 11 Cases, the original report of the Company's independent accountants, PricewaterhouseCoopers LLP, referred to the Company's ability to continue as a going concern at December 31, 2000 and December 31, 1999. As a result of the Company's net loss in 1998, its working capital deficiency and its covenant defaults under the Credit Agreement at December 31, 1998, the report of the Company's former independent accountants, Ernst & Young LLP, refers to the Company's ability to continue as a going concern at December 31, 1998.

Cash provided by operations before reorganization costs totaled $194 million for 2000 compared to $247 million for 1999 and $323 million for 1998. Cash flows in 1999 and 1998 were unusually high due to growth in amounts due to third parties. Overpayments from third-party payors resulted from the Medicare program continuing to reimburse the Company's nursing centers under the prior cost-based reimbursement system after the Company's nursing centers had converted to PPS.

In January 2000, the Company filed its hospital cost reports for the year ended August 31, 1999. These documents are filed annually in settlement of amounts due to or from the various agencies administering the reimbursement programs. These cost reports indicated amounts due from the Company aggregating $58 million. This liability arose during 1999 as part of the Company's routine settlement of Medicare reimbursement overpayments. Such amounts were classified as liabilities subject to compromise in the consolidated balance sheet and, accordingly, no funds were disbursed by the Company in settlement of such pre-petition liabilities. Under the terms of the Amended Plan, the Company believes that this obligation will be discharged.

On or prior to the effective date of the Amended Plan, the Company intends to execute definitive agreements related to the Exit Facility in accordance with the terms of a commitment letter. The Exit Facility will constitute a general working capital facility for general corporate purposes, including any payments under the HCFA Agreement and other pre-petition liabilities payable pursuant to the Amended Plan. The Exit Facility is expected to consist of a five-year $120 million revolving credit facility and provide for $40 million of letter of credit availability. Direct borrowings under the Exit Facility will bear interest, at the option of the Company, at (a) prime (or, if higher, the federal funds rate plus 1/2%) plus 3% or (b) one, two, three or six month LIBOR plus 4%. The Exit Facility will be secured by substantially all of the assets of the Company and its subsidiaries, including certain owned real property.

The consummation of the Exit Facility is subject to various conditions, including but not limited to, the negotiation of definitive documentation and consummation of the Amended Plan. There can be no assurance that such conditions will be satisfied or that the Exit Facility will be executed.

Capital Resources

Excluding acquisitions, capital expenditures totaled $80 million for 2000 compared to $111 million for 1999 and $267 million for 1998. Planned capital expenditures in 2001 (excluding acquisitions) are expected to approximate $75 million. Management believes that its capital expenditure program is adequate to expand, improve and equip existing facilities.

Capital expenditures during the last three years were financed primarily through internally generated funds. At December 31, 2000, the estimated cost to complete and equip construction in progress approximated $8 million.

Proceeds from the sale of assets totaled $15 million in 2000, $12 million in 1999 and $237 million in 1998. Substantially all of the proceeds in 1998 were used to reduce long-term debt.

66

At December 31, 1999, the Company was a party to certain interest rate swap agreements that eliminated the impact of changes in interest rates on $100 million of floating rate debt outstanding. The agreements provided for fixed rates on $100 million of floating rate debt at 6.4% plus 3/8% to 1 1/8% and expired in May 2000. The Company was not a party to any interest rate swap agreements at December 31, 2000.

Other Information

Effects of Inflation and Changing Prices

The Company derives a substantial portion of its revenues from the Medicare and Medicaid programs. In recent years, significant cost containment measures enacted by Congress and certain state legislators have limited the Company's ability to recover its cost increases through increased pricing of its healthcare services. Medicare revenues in the Company's nursing centers are subject to fixed payments under PPS. Medicaid reimbursement rates in many states in which the Company operates nursing centers also are based on fixed payment systems. In addition, by repealing the Boren Amendment, the Budget Act eases existing impediments on the states' ability to reduce Medicaid reimbursement levels to the Company's nursing centers. Medicare revenues in the Company's hospitals also have been reduced by the Budget Act.

During 2000, the BBRA provided a measure of relief to the Medicare reimbursement reductions imposed by the Budget Act. The enactment of BIPA in December 2000 will provide additional Medicare reimbursement beginning in April 2001. Management believes that these legislative actions will have a positive impact on the Company's revenues in 2001, particularly in the health services division.

Management believes, however, that its operating margins may continue to be under pressure because of continuing regulatory scrutiny and growth in operating expenses in excess of anticipated increases in payments by third-party payors. In addition, as a result of competitive pressures, the Company's ability to maintain operating margins through price increases to private patients is limited.

Litigation

The Company is a party to certain material litigation and regulatory actions as well as various lawsuits and claims arising in the ordinary course of business. See "Legal Proceedings."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The Company's only significant exposure to market risk is changes in the levels of various interest rates. In this regard, changes in LIBOR interest rates affect the interest paid on its borrowings. In addition, the interest rates on borrowings under the DIP Financing are affected by changes in the federal funds rate and the prime rate of Morgan Guaranty Trust Company of New York. To mitigate the impact of fluctuations in these interest rates, the

Company generally maintained a portion of its borrowings on a fixed rate, long-term basis. Prior to its financial difficulties, the Company also entered into interest rate swap transactions. The Company was not a party to any interest rate swap agreements at December 31, 2000.

As previously discussed, the Company filed the Chapter 11 Cases on September 13, 1999. Accordingly, all amounts disclosed in the table below are subject to compromise in connection with the Chapter 11 Cases. While the fair values of the Company's debt obligations have declined significantly as a result of the Chapter 11 Cases, such amounts do not reflect any adjustments that might result from resolutions of the Chapter 11 Cases or other matters discussed herein.

Under the Bankruptcy Code, actions to collect pre-petition indebtedness against the Company are subject to an automatic stay and other contractual obligations against the Company may not be enforced. In addition, the Company may assume or reject executory contracts under the Bankruptcy Code.

67

The following table provides information about the Company's financial instruments that are sensitive to changes in interest rates. The table constitutes a forward-looking statement. The table presents principal cash flows and related weighted average interest rates by expected maturity date.

Interest Rate Sensitivity
Principal (Notional) Amount by Expected Maturity
Average Interest Rate
(Dollars in thousands)

	Expected Maturities							Fa Val
	2001	2002	2003	2004	2005	Thereafter	Total	12/3
Liabilities:								
Long-term debt, including amounts due within one year:								
Fixed rate............	$17,958	$ 19,619	$21,503	$ 5,717	$300,047	$3,825	$368,669	$118
Average interest rate..	11.9%	11.9%	10.5%	9.3%	8.9%	8.6%		
Variable rate..........	$66,768	$128,640	$96,509	$177,344	$ 41,647	$ -	$510,908	$418
Average interest rate (a)								

(a) Interest is payable, depending on the debt instrument, certain leverage ratios and other factors, at a rate of LIBOR plus 3/4% to 3 1/2% or prime plus 2% to 3 1/2%.

Item 8. Financial Statements and Supplementary Data

The information required by this Item 8 is included in appendix pages F-2 through F-49 of this Annual Report on Form 10-K/A.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

The Company, upon approval of its Board of Directors, appointed PricewaterhouseCoopers LLP ("PwC") as its independent auditors for the fiscal

year ending December 31, 1999 to replace Ernst & Young LLP ("Ernst & Young") effective November 2, 1999. The Board of Directors was advised by counsel that the participation of Ernst & Young in the Company's Spin-off presented a potential conflict of interest that would significantly jeopardize the ability of Ernst & Young to be approved as independent auditors for the Company by the Bankruptcy Court. The audit report of Ernst & Young on the consolidated financial statements of the Company and its subsidiaries as of and for the year ended December 31, 1998, did not contain any adverse opinion or disclaimer of opinion, nor was it qualified or modified as to audit scope or accounting principles. The opinion of Ernst & Young for the year ended December 31, 1998 was modified as to uncertainty by the inclusion of an explanatory "going concern" paragraph resulting from the Company's net loss in 1998, working capital deficiency and covenant defaults under its Credit Agreement.

In connection with the audit for the year ended December 31, 1998 and the subsequent interim period through November 2, 1999, there were no disagreements with Ernst & Young on any accounting principles or practices, financial statement disclosures, or auditing scope or procedures, which if not resolved to the satisfaction of Ernst & Young, would have caused it to make a reference to the subject matter of the disagreement in their report.

In connection with the audit of the Company's consolidated financial statements for the year ended December 31, 1998, Ernst & Young informed the Company and the Audit and Compliance Committee of its Board of Directors of a condition that it believed constituted a material weakness in the Company's internal controls. Ernst & Young communicated that certain of the Company's account reconciliations had not been completed on a timely basis. Additionally, Ernst & Young stated that there was a lack of appropriate follow up and resolution of reconciling items, including adjustments of the accounting records on a timely basis, and there was a lack of evidence of review of the reconciliations by an independent person. The Company did

reconcile all accounts and recorded the appropriate adjustments prior to the filing of its Annual Report on Form 10-K for the year ended December 31, 1998. Ernst & Young advised the Company that, in completing its audit, it considered the aforementioned material weakness in determining the nature, timing and extent of procedures performed to enable it to issue its opinion on the consolidated financial statements. The Company has authorized Ernst & Young to respond fully to the inquiries of PwC concerning these matters.

The Company requested that Ernst & Young furnish it with a letter addressed to the Commission stating whether or not it agrees with the statements set forth above. A copy of such letter dated November 5, 1999 was filed with the Commission on a Current Report on Form 8-K filed by the Company.

PART IV

Item 14. Exhibits, Financial Statement Schedules, and Reports on Form 8-K

(a)(1) Index to Consolidated Financial Statements and Financial Statement Schedules:

Page

Report of PricewaterhouseCoopers LLP.. F-2
Report of Ernst & Young LLP... F-3
Consolidated Financial Statements (restated):
  Consolidated Statement of Operations for the years ended December 31, 2000, 1999 and 1998.. F-4
  Consolidated Balance Sheet, December 31, 2000 and 1999................. F-5
  Consolidated Statement of Stockholders' Equity (Deficit) for the years ended December 31, 2000, 1999 and 1998................................ F-6
  Consolidated Statement of Cash Flows for the years ended December 31, 2000, 1999 and 1998.. F-7
  Notes to Consolidated Financial Statements............................. F-8
  Quarterly Consolidated Financial Information (Unaudited)................ F-48
Financial Statement Schedule (a):
  Schedule II--Valuation and Qualifying Accounts for the years ended December 31, 2000, 1999 and 1998...................................... F-49

(a) All other schedules have been omitted because the required information is not present or not present in material amounts.

(a)(2) Index to Exhibits:

EXHIBIT INDEX

Exhibit Number	Description of Document
2.1	Fourth Amended Joint Plan of Reorganization of Vencor, Inc. and Affiliated Debtors under Chapter 11 of the Bankruptcy Code. Exhibit 2.1 to the Current Report on Form 8-K of the Company dated March 19, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference.
2.2	Order Confirming the Fourth Amended Joint Plan of Reorganization of Vencor, Inc. and Affiliated Debtors under Chapter 11 of the Bankruptcy Code, as entered by the United States Bankruptcy Court for the District of Delaware on March 16, 2001. Exhibit 2.2 to the Current Report on Form 8-K of the Company dated March 19, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference.
3.1	Restated Certificate of Incorporation of the Company. Exhibit 3.1 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
3.2	Amended and Restated Bylaws of the Company. Exhibit 3.2 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
4.1	Articles IV and X of the Restated Certificate of Incorporation of the Company is included in Exhibit 3.1.
4.2	Indenture dated April 30, 1998, among Vencor, Inc., Vencor Operating, Inc. and PNC Bank, National Association, as Trustee. Exhibit 4.1 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.
4.3	Instrument of Resignation, Appointment and Acceptance, dated as of September 16, 1999 among Vencor Operating, Inc., Vencor, Inc., The Chase Manhattan Bank (successor to PNC Bank, National Association) and

	HSBC Bank USA, as Successor Trustee. Exhibit 4.3 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
4.4	Form of 9 7/8% Guaranteed Senior Subordinated Notes due 2005 (included in Exhibit 4.2).

Exhibit Number	Description of Document
4.5	Form of the Company's 8 5/8% Senior Subordinated Notes due 2007. Exhibit 4.1 to the Ventas, Inc. Current Report on Form 8-K dated July 21, 1997 (Comm. File No. 1-10989) is hereby incorporated by reference.
4.6	Indenture dated as of July 21, 1997, between the Company and the Bank of New York, as Trustee. Exhibit 4.2 to the Ventas, Inc. Current Report of Form 8-K dated July 21, 1997 (Comm. File No. 1-10989) is hereby incorporated by reference.
10.1	Credit Agreement dated as of April 29, 1998 among Vencor, Inc., Vencor Operating, Inc., the Lenders party thereto, the Swingline Bank party thereto, the LC Issuing Banks party thereto, the Senior Managing Agents, Managing Agents and Co-Agents party thereto, Morgan Guaranty Trust Company of New York and NationsBank, N.A. Exhibit 10.1 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.
10.2	Amendment No. 1 dated as of September 30, 1998 to the Credit Agreement dated as of April 29, 1998 among Vencor Operating, Inc., Vencor, Inc., the Lenders, Swingline Bank, LC Issuing Banks, Senior Managing Agents, Managing Agents and Co-Agents party thereto, Morgan Guaranty Trust Company of New York, as Documentation Agent and Collateral Agent, and NationsBank, N.A., as Administrative Agent. Exhibit 10.2 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.3	Waiver No. 2 to the Credit Agreement dated as of March 31, 1999 among Vencor Operating, Inc., Vencor, Inc., the Lenders, Swingline Bank and LC Issuing Banks party thereto, the Senior Managing Agents, Managing Agents and Co-Agents party thereto and Morgan Guaranty Trust Company of New York, as Documentation Agent and Collateral Agent, and NationsBank, N.A., as Administrative Agent. Exhibit 99.2 to the Current Report on Form 8-K of the Company dated March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.4	Waiver No. 3 dated as of May 28, 1999, under the Credit Agreement dated as of April 29, 1998 among Vencor Operating, Inc., Vencor, Inc., the Lenders, Swingline Bank and LC Issuing Banks party thereto, the Senior Managing Agents, Managing Agents and Co-Agents party thereto and Morgan Guaranty Trust Company of New York, as Documentation Agent and Collateral Agent, and NationsBank, N.A., as Administrative Agent. Exhibit 99.2 to the Current Report on Form 8-K of the Company dated May 28, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.5 Waiver No. 4 dated as of July 30, 1999, under the Credit Agreement dated as of April 29, 1998 among Vencor Operating, Inc., Vencor, Inc., the Lenders, Swingline Bank and LC Issuing Banks party thereto, the Senior Managing Agents, Managing Agents and Co-Agents party thereto and Morgan Guaranty Trust Company of New York, as Documentation Agent and Collateral Agent, and NationsBank, N.A., as Administrative Agent. Exhibit 10.2 to the Company's Form 10-Q for the quarterly period ended June 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.6 Waiver No. 5 dated as of August 27, 1999, under the Credit Agreement dated as of April 29, 1998 among Vencor Operating, Inc., Vencor, Inc., the Lenders, Swingline Bank and LC Issuing Banks party thereto, the Senior Managing Agents, Managing Agents and Co-Agents party thereto and Morgan Guaranty Trust Company of New York, as Documentation Agent and Collateral Agent, and NationsBank, N.A., as Administrative Agent. Exhibit 10.2 to the Company's Form 10-Q for the quarterly period ended September 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.7 Debtor-in-Possession Credit Agreement dated as of September 13, 1999, among Vencor, Inc., Vencor Operating, Inc. and each of the subsidiaries of Vencor, Inc. party thereto, the Lenders party thereto, the LC Issuing Banks party thereto and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended September 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.8	First Amendment to Debtor-in-Possession Credit Agreement and First Amendment to Security Agreement dated October 21, 1999 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature page thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.8 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.9	Second Amendment to Debtor-in-Possession Credit Agreement dated November 19, 1999 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.9 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.10	Third Amendment to Debtor-in-Possession Credit Agreement dated December 23, 1999 among Vencor, Inc., Vencor Operating, Inc. and each

of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.10 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.11 Fourth Amendment to Debtor-in-Possession Credit Agreement dated February 9, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.11 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.12 Fifth Amendment to Debtor-in-Possession Credit Agreement dated February 23, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.12 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.13 Sixth Amendment to Debtor-in-Possession Credit Agreement dated April 7, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended March 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.14 Seventh Amendment to Debtor-in-Possession Credit Agreement dated April 26, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.4 to the Company's Form 10-Q for the quarterly period ended March 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.15 Eighth Amendment to Debtor-in-Possession Credit Agreement dated June 8, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended June 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document

10.16 Amendment to Debtor-in-Possession Credit Agreement to Extend Plan Filing Date dated July 11, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.5 to the Company's Form 10-Q for the quarterly period ended June 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.17 Amendment to Debtor-in-Possession Credit Agreement dated August 16, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.2 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.18 Twelfth Amendment and Consent to Debtor-in-Possession Credit Agreement dated September 22, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.19 Thirteenth Amendment and Consent to Debtor-in-Possession Credit Agreement dated October 23, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent. Exhibit 10.4 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.20 Fourteenth Amendment to Debtor-in-Possession Credit Agreement dated November 22, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent.

10.21 Fifteenth Amendment to Debtor-in-Possession Credit Agreement dated December 20, 2000 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent.

10.22 Sixteenth Amendment and Consent to Debtor-in-Possession Credit Agreement dated January 19, 2001 among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries listed on the signature pages thereof, the Lenders listed on the signature pages thereof and Morgan Guaranty Trust Company of New York as Arranger, Collateral Agent and Administrative Agent.

10.23 Master Trust Agreement dated January 17, 2000 by and between Vencor, Inc. and Norwest Bank Minnesota, National Association. Exhibit 10.5 to the Company's Form 10-Q for the quarterly period ended March 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.24	Vencor Retirement Savings Plan Amended and Restated effective as of March 1, 2000. Exhibit 10.6 to the Company's Form 10-Q for the quarterly period ended March 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.25	Retirement Savings Plan for Certain Employees of Vencor and its Affiliates Amended and Restated effective as of March 1, 2000. Exhibit 10.7 to the Company's Form 10-Q for the quarterly period ended March 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.26	Amendment No. 1 to the Vencor Retirement Savings Plan dated September 26, 2000. Exhibit 10.8 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.27	Amendment No. 1 to the Retirement Savings Plan for Certain Employees for Vencor and its Affiliates dated September 26, 2000. Exhibit 10.9 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.28	Tax Allocation Agreement dated as of April 30, 1998 by and between Vencor, Inc. and Ventas, Inc. Exhibit 10.9 to the Company's Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.29	Transition Services Agreement dated as of April 30, 1998 by and between Vencor, Inc. and Ventas, Inc. Exhibit 10.10 to the Company's Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.30	Agreement of Indemnity-Third Party Leases dated as of April 30, 1998 by and between Vencor, Inc. and its subsidiaries and Ventas, Inc. Exhibit 10.11 to the Company's Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.31	Agreement of Indemnity-Third Party Contracts dated as of April 30, 1998 by and between Vencor, Inc. and its subsidiaries and Ventas, Inc. Exhibit 10.12 to the Company's Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.32	Form of Indemnification Agreement between Vencor, Inc. and certain of its officers and employees. Exhibit 10.31 to the Ventas, Inc. Form 10-K for the year ended December 31, 1995 (Comm. File No. 1-10989) is hereby incorporated by reference.
10.33	Amended and Restated Agreement and Plan of Merger. Appendix A to

Amendment No. 2 to the Ventas, Inc. Registration Statement on Form S-4 (Reg. No. 33-59345) is hereby incorporated by reference.

10.34 Agreement and Plan of Merger dated as of February 9, 1997 among TheraTx, Incorporated, Vencor, Inc. and Peach Acquisition Corp. ("Peach"). Exhibit (c)(1) to the Statement on Schedule 14D-1 of Ventas, Inc. and Peach, dated February 14, 1997 (Comm. File No. 1-10989) is hereby incorporated by reference.

10.35 Amendment No. 1 to Agreement and Plan of Merger dated as of February 28, 1997 among TheraTx, Incorporated, Vencor, Inc. and Peach. Exhibit (c)(3) of Amendment No. 2 to the Statement on Schedule 14D-1 of Ventas, Inc. and Peach, dated March 3, 1997 (Comm. File No. 1-10989) is hereby incorporated by reference.

10.36 Asset Purchase Agreement between Transitional Hospitals Corporation and Behavioral Healthcare Corporation, dated October 22, 1996. Exhibit 99.1 to the Current Report on Form 8-K of Transitional dated October 22, 1996 (Comm. File No. 1-7008) is hereby incorporated by reference.

10.37 Agreement and Plan of Merger between Transitional Hospitals Corporation and Behavioral Healthcare Corporation, dated October 22, 1996. Exhibit 99.2 to the Current Report on Form 8-K of Transitional dated October 22, 1996 (Comm. File No. 1-7008) is hereby incorporated by reference.

10.38 First Amendment to Asset Purchase Agreement between Transitional Hospitals Corporation and Behavioral Healthcare Corporation, dated November 30, 1996. Exhibit 99.1 to the Current Report on Form 8-K of Transitional dated December 16, 1996 (Comm. File No. 1-7008) is hereby incorporated by reference.

10.39 Amendment to Agreement and Plan of Merger between Transitional Hospitals Corporation and Behavioral Healthcare Corporation, dated November 30, 1996. Exhibit 99.2 to the Current Report on Form 8-K of Transitional dated December 16, 1996 (Comm. File No. 1-7008) is hereby incorporated by reference.

10.40* Vencor, Inc. 1998 Incentive Compensation Plan. Exhibit 10.23 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.41*	Vencor, Inc. 1998 Stock Option Plan for Non-Employee Directors. Exhibit 10.24 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.
10.42*	Vencor, Inc. Deferred Compensation Plan dated April 30, 1998. Exhibit 10.25 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.
10.43*	Vencor, Inc. Supplemental Executive Retirement Plan dated January 1,

1998, as amended. Exhibit 10.27 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.

10.44* Amendment No. Two to Supplemental Executive Retirement Plan dated as of January 15, 1999. Exhibit 10.48 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.45* Amendment No. Three to Supplemental Executive Retirement Plan dated as of December 31, 1999. Exhibit 10.49 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.46* Vencor, Inc. 2000 Long-Term Incentive Plan, dated effective as of January 1, 2000.

10.47* Form of Vencor Operating, Inc. Change-in-Control Severance Agreement. Exhibit 10.28 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.

10.48* Form of Vencor, Inc. Promissory Note. Exhibit 10.29 to the Company's Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference.

10.49* Form of Non-Transferable Full Recourse Secured Promissory Note dated as of September 28, 1998 made by certain executive officers in favor of Vencor Operating, Inc. Exhibit 10.6 to the Company's Form 10-Q for the quarterly period ended September 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.50* Employment Agreement dated as of February 12, 1999 between Vencor Operating, Inc. and Edward L. Kuntz. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.51* Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and Richard A. Schweinhart. Exhibit 10.57 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.52* Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Richard E. Chapman. Exhibit 10.58 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.53* Employment Agreement dated as of January 4, 1999 between Vencor Operating, Inc. and Donald D. Finney. Exhibit 10.4 to the Company's Form 10-Q for the quarterly period ended March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.54* Amendment No. 1 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and Donald D. Finney. Exhibit 10.60 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.55* Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.63 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.56* Amendment to Employment Agreement dated as of September 28, 1998

between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.64 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.57* Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.65 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.58*	Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and James H. Gillenwater, Jr. Exhibit 10.66 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.59*	Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.67 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.60*	Amendment to Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.68 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.61*	Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.69 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.62*	Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.70 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.63*	Amendment to Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.71 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.64*	Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.72 to the Company's Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.65*	Employment Agreement dated as of November 9, 1998 between Vencor Operating, Inc. and William M. Altman.
10.66*	Form of Vencor, Inc. Retention Agreement. Exhibit 10.3 to the Company's Form 10-Q for the quarterly period ended June 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.67* Form of Agreement regarding Preferred Stock dated as of August 17, 1999 between Vencor Operating, Inc., Vencor, Inc. and certain officers of the Company. Exhibit 10.9 to the Company's Form 10-Q for the quarterly period ended September 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.68 Distribution Agreement between the Company and Ventas, Inc. Exhibit 10.2 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.69 Form of Master Lease Agreement between the Company and Ventas, Inc. Exhibit 10.3 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.70 Form of First Amendment to Master Lease Agreement dated December 31, 1998 between the Company and Ventas, Inc. Exhibit 10.47 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.71 Second Amendment to Master Lease Agreement No. 1 dated April 12, 1999 by and among Ventas, Inc., Ventas Realty, Limited Partnership, Vencor Operating, Inc. and the Company. Exhibit 10.48 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.72	Second Amendment to Master Lease Agreement No. 2 dated April 12, 1999 by and among Ventas, Inc., Ventas Realty, Limited Partnership, Vencor Operating, Inc. and the Company. Exhibit 10.49 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.73	Second Amendment to Master Lease Agreement No. 3 dated April 12, 1999 by and among Ventas, Inc., Ventas Realty, Limited Partnership, Vencor Operating, Inc. and the Company. Exhibit 10.50 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.74	Second Amendment to Master Lease Agreement No. 4 dated April 12, 1999 by and among Ventas, Inc., Ventas Realty, Limited Partnership, Vencor Operating, Inc. and the Company. Exhibit 10.51 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.75	Development Agreement between the Company and Ventas, Inc. Exhibit 10.4 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.76	Participation Agreement between the Company and Ventas, Inc. Exhibit 10.5 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.77	Agreement and Plan of Reorganization between the Company and Ventas,

Inc. Exhibit 10.1 to the Company's Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.78 Standstill Agreement dated March 31, 1999 between the Company and Ventas, Inc. Exhibit 99.3 to the Current Report on Form 8-K of the Company dated March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.79 Second Standstill Agreement dated April 12, 1999 between the Company and Ventas, Inc. Exhibit 10.57 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.80 Amendment Number 1 to the Second Standstill Agreement dated April 12, 1999 dated as of May 5, 1999 between the Company and Ventas, Inc. Exhibit 10.12 to the Company's Form 10-Q for the quarterly period ended March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.81 Tolling Agreement dated April 12, 1999 between the Company and Ventas, Inc. Exhibit 10.58 to the Company's Form 10-K for the year ended December 31, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.82 Amendment Number 2 to the Second Standstill Agreement dated April 12, 1999 and Amendment Number 1 to the Tolling Agreement dated April 12, 1999 dated as of May 8, 1999 between the Company and Ventas, Inc. Exhibit 10.13 to the Company's Form 10-Q for the quarterly period ended March 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.83 Amendment Number 4 to the Second Standstill Agreement dated April 12, 1999 and Amendment Number 3 to the Tolling Agreement dated April 12, 1999. Exhibit 99.2 to the Current Report on Form 8-K of the Company dated June 7, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.84 Amendment Number 5 to the Second Standstill Agreement dated April 12, 1999 and Amendment Number 4 to the Tolling Agreement dated April 12, 1999. Exhibit 99.2 to the Current Report on Form 8-K of the Company dated July 7, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

Exhibit Number	Description of Document
10.85	Amendment Number 6 to the Second Standstill Agreement dated April 12, 1999 and Amendment Number 5 to the Tolling Agreement dated April 12, 1999. Exhibit 10.15 to the Company's Form 10-Q for the quarterly period ended June 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.
10.86	Amendment Number 7 to the Second Standstill Agreement dated April 12, 1999 and Amendment Number 6 to the Tolling Agreement dated April 12,

1999. Exhibit 10.6 to the Company's Form 10-Q for the quarterly period ended September 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.87 Stipulation Agreement by and among Ventas, Inc., Ventas Realty, Limited Partnership, Vencor Operating, Inc. and Vencor, Inc. Exhibit 10.7 to the Company's Form 10-Q for the quarterly period ended September 30, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.88 Tax Stipulation by and among Vencor, Inc., Vencor Operating, Inc. and each of Vencor's subsidiaries a party thereto, Ventas, Inc., Ventas Realty, Limited Partnership and Ventas LP Realty, L.L.C. Exhibit 10.6 to the Company's Form 10-Q for the quarterly period ended June 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.89 Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and Vencor, Inc. Exhibit 10.7 to the Company's Form 10-Q for the quarterly period ended September 30, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference.

10.90 Charter for the Audit and Compliance Committee of the Board of Directors of Vencor, Inc. effective as of November 8, 2000.

10.91 Other Debt Instruments--Copies of debt instruments for which the related debt is less than 10% of total assets will be furnished to the Commission upon request.

16 Letter from Ernst & Young LLP regarding a change in certifying accountants. Exhibit 16 to the Current Report on Form 8-K of the Company dated November 2, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference.

21 List of Subsidiaries.

23.1 Consent of PricewaterhouseCoopers LLP.

23.2 Consent of Ernst & Young LLP.

----

* Compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 14(c) of Annual Report on Form 10-K.

(b) Reports on Form 8-K.

The Company filed a Current Report on Form 8-K on October 2, 2000 announcing that it had filed its first plan of reorganization with the Bankruptcy Court. The Company filed a Current Report on Form 8-K on October 26, 2000 announcing that the Bankruptcy Court had approved an amendment to the DIP Financing to extend its maturity until January 31, 2001. This Current Report also reported that the Bankruptcy Court also approved an amendment to the commitment letter among the Company and certain of the DIP Lenders to extend the date by which Bankruptcy Court approval must be obtained for the commitment letter to be effective through January 31, 2001.

(c) Exhibits.

The response to this portion of Item 14 is submitted as a separate section of this Report.

(d) Financial Statement Schedules.

The response to this portion of Item 14 is included in appendix page F-49 of this Report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: August 28, 2001

Kindred Healthcare, Inc.

/s/ Edward L. Kuntz
By: ________________________________
Edward L. Kuntz
Chairman of the Board,
Chief Executive Officer and
President

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ James Bolin James Bolin	Director	August 28, 2001
/s/ Michael J. Embler Michael J. Embler	Director	August 28, 2001
/s/ Garry N. Garrison Garry N. Garrison	Director	August 28, 2001
/s/ Isaac Kaufman Isaac Kaufman	Director	August 28, 2001
John H. Klein	Director	
/s/ Edward L. Kuntz Edward L. Kuntz	Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)	August 28, 2001
/s/ Richard A. Lechleiter Richard A. Lechleiter	Vice President, Finance, Corporate Controller and Treasurer (Principal Accounting Officer)	August 28, 2001

/s/ Richard A. Schweinhart Richard A. Schweinhart	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	August 28, 2001
David Tepper	Director	

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS
AND FINANCIAL STATEMENT SCHEDULES

	Page
Report of PricewaterhouseCoopers LLP	F-2
Report of Ernst & Young LLP	F-3
Consolidated Financial Statements (restated):	
Consolidated Statement of Operations for the years ended December 31, 2000, 1999 and 1998	F-4
Consolidated Balance Sheet, December 31, 2000 and 1999	F-5
Consolidated Statement of Stockholders' Equity (Deficit) for the years ended December 31, 2000, 1999 and 1998	F-6
Consolidated Statement of Cash Flows for the years ended December 31, 2000, 1999 and 1998	F-7
Notes to Consolidated Financial Statements	F-8
Quarterly Consolidated Financial Information (Unaudited)	F-48
Financial Statement Schedule (a):	
Schedule II--Valuation and Qualifying Accounts for the years ended December 31, 2000, 1999 and 1998	F-49

(a) All other schedules have been omitted because the required information is not present or not present in material amounts.

REPORT OF PRICEWATERHOUSECOOPERS LLP

To the Board of Directors and Stockholders
of Kindred Healthcare, Inc.:

In our opinion, the consolidated financial statements listed in the accompanying index, after the restatement described in Note 2, present fairly, in all material respects, the financial position of Kindred Healthcare, Inc. (formerly Vencor, Inc.) and its subsidiaries at December 31, 2000 and December 31, 1999, and the results of their operations and their cash flows for each of the two years in the period ended December 31, 2000, in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated

financial statements. These financial statements and financial statement schedule are the responsibility of the Company's management; our responsibility is to express an opinion on these financial statements and financial statement schedule based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our original report, we included an explanatory paragraph regarding to the Company's ability to continue as a going concern. As discussed in Note 22 to the consolidated financial statements, the Company emerged from bankruptcy effective April 20, 2001, alleviating substantial doubt about the Company's ability to continue as a going concern.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky
March 16, 2001, except for Note 22,
as to which the date is April 20,
2001, and Notes 2 and 10, as to
which the date is August 22, 2001

REPORT OF ERNST & YOUNG LLP

To the Board of Directors and Stockholders
Kindred Healthcare, Inc.

We have audited the accompanying consolidated statements of operations, stockholders' equity and cash flows of Kindred Healthcare, Inc. (formerly Vencor, Inc.) for the year ended December 31, 1998. Our audit also included the 1998 financial statement schedule listed on page F-1. These financial statements and schedule for 1998 are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Kindred Healthcare, Inc. at December 31, 1998 and the consolidated results of its operations and its cash flows for the year ended December 31, 1998 in conformity with accounting principles generally accepted in the United States. Also, in our opinion, the related financial statement schedule for 1998, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

The accompanying 1998 consolidated financial statements have been prepared assuming that the Company will continue as a going concern. As more fully described in Note 3, the Company incurred a net loss in 1998 and was not in compliance with certain covenants of a loan agreement at December 31, 1998. In addition, the Company had a working capital deficiency at December 31, 1998. These conditions raise substantial doubts about the Company's ability to continue as a going concern. The 1998 consolidated financial statements do not include adjustments, if any, to reflect the possible future effects on the recoverability and classification of recorded asset amounts or the amounts and classifications of liabilities that may result from the outcome of this uncertainty.

/s/ Ernst & Young LLP

Louisville, Kentucky
April 13, 1999, except for Note 2,
as to which the date is August 22,
2001

F-3

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
CONSOLIDATED STATEMENT OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2000, 1999 AND 1998
(In thousands, except per share amounts)

	(Restated--see Note 2)		
	2000	1999	1998
Revenues	$2,888,542	$2,665,641	$2,999,739
Salaries, wages and benefits	1,623,955	1,566,227	1,753,023
Supplies	374,540	347,789	340,053
Rent	307,809	305,120	234,144
Other operating expenses	503,770	964,413	947,889
Depreciation and amortization	73,545	93,196	124,617
Interest expense	60,431	80,442	107,008
Investment income	(5,393)	(5,188)	(4,688)
	2,938,657	3,351,999	3,502,046
Loss before reorganization costs and income taxes	(50,115)	(686,358)	(502,307)
Reorganization costs	12,636	18,606	-
Loss before income taxes	(62,751)	(704,964)	(502,307)
Provision for income taxes	2,000	500	76,099
Loss from operations	(64,751)	(705,464)	(578,406)
Cumulative effect of change in accounting for start-up costs	-	(8,923)	-
Extraordinary loss on extinguishment of debt, net of income tax benefit of $48,789	-	-	(77,937)
Net loss	(64,751)	(714,387)	(656,343)

Preferred stock dividend requirements......	(1,046)	(1,046)	(697)
Loss available to common stockholders.........................	$ (65,797)	$ (715,433)	$ (657,040)
Loss per common share:			
Basic:			
Loss from operations..................	$ (0.94)	$ (10.03)	$ (8.47)
Cumulative effect of change in accounting for start-up costs.........	-	(0.13)	-
Extraordinary loss on extinguishment of debt..............................	-	-	(1.14)
Net loss............................	$ (0.94)	$ (10.16)	$ (9.61)
Diluted:			
Loss from operations..................	$ (0.94)	$ (10.03)	$ (8.47)
Cumulative effect of change in accounting for start-up costs.........	-	(0.13)	-
Extraordinary loss on extinguishment of debt..............................	-	-	(1.14)
Net loss............................	$ (0.94)	$ (10.16)	$ (9.61)
Shares used in computing loss per common share:			
Basic..................................	70,229	70,406	68,343
Diluted................................	70,229	70,406	68,343

See accompanying notes.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
CONSOLIDATED BALANCE SHEET
DECEMBER 31, 2000 AND 1999
(In thousands, except per share amounts)

	(Restated)	
	2000	1999
ASSETS		
Current assets:		
Cash and cash equivalents.........................	$ 184,642	$ 148,350
Accounts receivable less allowance for loss of $139,445--2000 and $180,055--1999................	322,483	324,135
Inventories.......................................	29,707	28,956
Insurance subsidiary investments..................	62,453	16,483
Other...	96,567	73,960
	695,852	591,884
Property and equipment, at cost:		
Land..	26,380	26,002
Buildings...	248,175	215,508
Equipment...	389,824	330,925

Construction in progress (estimated cost to complete and equip after December 31, 2000--$8 million)	29,207	42,725
	693,586	615,160
Accumulated depreciation	(300,881)	(243,526)
	392,705	371,634
Goodwill less accumulated amortization of $28,779--2000 and $17,817--1999	159,277	173,818
Other	86,580	98,638
	$ 1,334,414	$ 1,235,974
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)		
Current liabilities:		
Accounts payable	$ 115,468	$ 101,219
Salaries, wages and other compensation	184,860	159,482
Due to third-party payors	44,561	52,205
Other accrued liabilities	83,802	83,967
	428,691	396,873
Professional liability risks	101,209	72,785
Deferred credits and other liabilities	14,132	11,178
Liabilities subject to compromise	1,260,373	1,159,417
Series A preferred stock (subject to compromise)	1,743	1,743
Contingencies		
Stockholders' equity (deficit):		
Preferred stock, $1.00 par value; authorized 10,000 shares; none issued and outstanding	-	-
Common stock, $0.25 par value; authorized 180,000 shares; issued 70,261 shares--2000 and 70,278 shares--1999	17,565	17,570
Capital in excess of par value	667,168	667,078
Accumulated deficit	(1,156,467)	(1,090,670)
	(471,734)	(406,022)
	$ 1,334,414	$ 1,235,974

See accompanying notes.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY (DEFICIT)
FOR THE YEARS ENDED DECEMBER 31, 2000, 1999 AND 1998
(In thousands)

Shares	Par	Capital

	Common Stock	Common Treasury Stock	Value Common Stock	in Excess of Par Value	Retained Earnings (Deficit)	Common Treasury Stock	Total
					(Restated)		
Balances, December 31, 1997	73,470	(6,159)	$18,368	$ 766,078	$ 281,803	$(160,899)	$ 905,350
Net loss					(656,343)		(656,343)
Non-cash spin-off transactions with Ventas, Inc.:							
Property and equipment, net				(953,534)			(953,534)
Long-term debt				991,768			991,768
Common treasury stock	(5,917)	5,917	(1,479)	(156,390)		157,869	-
Series A preferred stock				(17,700)			(17,700)
Deferred income taxes				15,907			15,907
Issuance of common stock in connection with employee benefit plans	2,593	242	648	14,396		3,030	18,074
Preferred stock dividend requirements					(697)		(697)
Other				4,922			4,922
Balances, December 31, 1998	70,146	-	17,537	665,447	(375,237)	-	307,747
Net loss					(714,387)		(714,387)
Issuance of common stock in connection with employee benefit plans	132		33	309			342
Preferred stock dividend requirements					(1,046)		(1,046)
Other				1,322			1,322
Balances, December 31, 1999	70,278	-	17,570	667,078	(1,090,670)	-	(406,022)
Net loss					(64,751)	-	(64,751)
Issuance (forfeiture) of common stock in connection with employee benefit plans	(17)		(5)	35			30
Preferred stock dividend requirements					(1,046)		(1,046)
Other				55			55
Balances, December 31, 2000	70,261	-	$17,565	$ 667,168	$(1,156,467)	$ -	$(471,734)

See accompanying notes.

F-6

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2000, 1999 AND 1998
(In thousands)

	(Restated)		
	2000	1999	1998
Cash flows from operating activities:			
Net loss	$ (64,751)	$(714,387)	$(656,343)
Adjustments to reconcile net loss to net cash provided by operating activities:			
Depreciation and amortization	73,545	93,196	124,617
Provision for doubtful accounts	28,911	114,578	55,561
Deferred income taxes	-	-	71,496
Extraordinary loss on extinguishment of debt	-	-	126,726
Unusual transactions	4,701	411,615	506,003
Gain on sale of investment in Atria Communities, Inc	-	-	(98,461)
Reorganization costs	12,636	18,606	-
Cumulative effect of change in accounting for start-up costs	-	8,923	-
Other	17,166	19,247	2,173
Change in operating assets and liabilities:			
Accounts receivable	(21,590)	90,428	43,649
Inventories and other assets	(20,154)	5,868	(11,920)
Accounts payable	15,639	25,580	52,437
Income taxes	2,961	6,431	(17,167)
Due to third-party payors	(4,278)	99,370	155,333
Other accrued liabilities	149,279	67,616	(30,908)
Net cash provided by operating activities before reorganization costs	194,065	247,071	323,196
Payment of reorganization costs	(8,525)	(15,684)	-
Net cash provided by operating activities	185,540	231,387	323,196
Cash flows from investing activities:			
Purchase of property and equipment	(79,988)	(111,493)	(267,288)
Other acquisitions	-	-	(24,227)
Sale of investment in Atria Communities, Inc	-	-	177,500
Sale of investment in Colorado MEDtech, Inc	-	-	22,001
Sale of other assets	15,241	12,289	37,827
Surety bond deposits	(4,647)	(17,213)	-
Series A preferred stock loans	-	-	(15,930)
Net change in investments	(46,904)	6,377	13,164
Other	1,731	(2,548)	(5,203)
Net cash used in investing activities	(114,567)	(112,588)	(62,156)
Cash flows from financing activities:			

Net change in borrowings under revolving lines of credit...........................	-	55,000	(251,146)
Issuance of long-term debt..................	-	-	700,000
Net proceeds from senior subordinated notes offerings..................................	-	-	294,000
Redemption of senior subordinated notes......	-	-	(732,547)
Repayment of long-term debt.................	(18,696)	(26,776)	(281,316)
Payment of debtor-in-possession deferred financing costs...........................	(1,226)	(3,752)	-
Payment of other deferred financing costs....	-	(2,068)	(11,334)
Other.......................................	(14,759)	(27,404)	227
Net cash used in financing activities......	(34,681)	(5,000)	(282,116)
Change in cash and cash equivalents..........	36,292	113,799	(21,076)
Cash and cash equivalents at beginning of period.....................................	148,350	34,551	55,627
Cash and cash equivalents at end of period....	$ 184,642	$ 148,350	$ 34,551
Supplemental information:			
Interest payments...........................	$ 11,930	$ 35,783	$ 129,395
Income tax refunds..........................	(713)	(5,931)	(31,576)

See accompanying notes.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1--ACCOUNTING POLICIES

Reporting Entity

Kindred Healthcare, Inc. ("Kindred" or the "Company") (formerly Vencor, Inc.) provides long-term healthcare services primarily through the operation of nursing centers and hospitals. At December 31, 2000, the Company's health services division operated 312 nursing centers (40,189 licensed beds) in 31 states and a rehabilitation therapy business. The Company's hospital division operated 56 hospitals (4,886 licensed beds) in 23 states and an institutional pharmacy business.

The Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") on September 13, 1999. The Company currently is operating its businesses as a debtor-in-possession subject to the jurisdiction of the United States Bankruptcy Court in Delaware (the "Bankruptcy Court"). Accordingly, the consolidated financial statements of the Company have been prepared in accordance with the American Institute of Certified Public Accountants Statement of Position ("SOP") 90-7, "Financial Reporting by Entities in Reorganization Under the Bankruptcy Code" ("SOP 90-7") and generally accepted accounting principles applicable to a going concern, which assumes that assets will be realized and liabilities will be discharged in the normal course of business. The consolidated financial statements do not include any adjustments that might result from the resolution of the Chapter 11 Cases (as defined) or other matters discussed in the accompanying notes. The Company's recent operating losses, liquidity issues and the Chapter 11 Cases raise substantial doubt about the Company's ability to continue as a going

concern. The ability of the Company to continue as a going concern and the appropriateness of using the going concern basis of accounting are dependent upon, among other things, (a) the Company's ability to comply with the terms of the DIP Financing (as defined), (b) consummation of the Amended Plan (as defined), (c) the Company's ability to achieve profitable operations after such consummation, and (d) the Company's ability to generate sufficient cash from operations to meet its obligations. The Amended Plan and other actions during the Chapter 11 Cases could change materially the amounts currently recorded in the consolidated financial statements. See Note 3.

On May 1, 1998, Ventas, Inc. ("Ventas" or the "Company's predecessor") completed the spin-off of its healthcare operations to its stockholders through the distribution of the Company's common stock (the "Spin-off"). Ventas retained ownership of substantially all of its real property and leases such real property to the Company under four master lease agreements. In anticipation of the Spin-off, the Company was incorporated on March 27, 1998 as a Delaware corporation. For accounting purposes, the consolidated historical financial statements of Ventas became the Company's historical financial statements following the Spin-off. Any discussion concerning events prior to May 1, 1998 refers to the Company's business as it was conducted by Ventas prior to the Spin-off. See Notes 3 and 17.

Basis of Presentation

The consolidated financial statements include all subsidiaries. Significant intercompany transactions have been eliminated. Investments in affiliates in which the Company has a 50% or less interest are accounted for by either the equity or cost method.

The accompanying consolidated financial statements have been prepared in accordance with generally accepted accounting principles and include amounts based upon the estimates and judgments of management. Actual amounts may differ from these estimates.

Impact of Recent Accounting Pronouncements

Beginning in 1998, the Company adopted the provisions of Statement of Financial Accounting Standards ("SFAS") No. 130 "Reporting Comprehensive Income," ("SFAS 130"), which established new rules for the

NOTE 1--ACCOUNTING POLICIES (Continued)

Impact of Recent Accounting Pronouncements (Continued)

reporting of comprehensive income and its components. SFAS 130 requires, among other things, unrealized gains or losses on the Company's available-for-sale securities, which prior to adoption were reported as changes in common stockholders' equity, to be disclosed as other comprehensive income. There were no significant comprehensive income items for the years ended December 31, 2000, 1999 and 1998.

Beginning in 1998, the Company adopted the provisions of SFAS No. 131, "Disclosures about Segments of an Enterprise and Related Information," which requires revised disclosures for segments of a company based upon management's

approach to defining business operating segments. See Note 8.

Effective January 1, 1999, the Company adopted SOP 98-5, "Reporting on the Costs of Start-Up Activities" ("SOP 98-5"), which requires the Company to expense start-up costs, including organizational costs, as incurred. In accordance with the provisions of SOP 98-5, the Company wrote off $8.9 million of such unamortized costs as a cumulative effect of a change in accounting principle in the first quarter of 1999. The pro forma effect of the change in accounting for start-up costs, assuming the change occurred on January 1, 1998, was not significant.

In the first quarter of 1999, the Company adopted SOP 98-1, "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use" ("SOP 98-1"). SOP 98-1 provides guidance on accounting for the costs of computer software developed or obtained for internal use. The adoption of SOP 98-1 did not have a material effect on the Company's consolidated financial position or results of operations.

In December 1999, the Securities and Exchange Commission issued Staff Accounting Bulletin No. 101, "Revenue Recognition in Financial Statements" ("SAB 101"). SAB 101 provides guidance on revenue recognition and related disclosures and was effective beginning October 1, 2000. The Company was previously following the requirements provided under SAB 101 and, accordingly, the implementation of this pronouncement had no impact on the Company's financial position or results of operations.

In June 1998, the Financial Accounting Standards Board ("FASB") issued SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities," ("SFAS 133") which was required to be adopted in fiscal years beginning after June 15, 1999. In June 1999, FASB delayed the effective date of SFAS 133 for one year. Management has determined that the adoption of SFAS 133 on January 1, 2001 will not have a material impact on the Company's financial position or results of operations.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Revenues

Revenues are recorded based upon estimated amounts due from patients and third-party payors for healthcare services provided, including anticipated settlements under reimbursement agreements with Medicare, Medicaid and other third-party payors.

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

	2000	1999	1998
Medicare	$1,050,758	$ 918,395	$1,038,669
Medicaid	925,356	902,032	869,923
Private and other	969,557	906,849	1,136,828
	2,945,671	2,727,276	3,045,420
Elimination	(57,129)	(61,635)	(45,681)
	$2,888,542	$2,665,641	$2,999,739

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 1--ACCOUNTING POLICIES (Continued)

Cash and Cash Equivalents

Cash and cash equivalents include unrestricted highly liquid investments with an original maturity of three months or less when purchased. Carrying values of cash and cash equivalents approximate fair value due to the short-term nature of these instruments.

Accounts Receivable

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies and individual patients. Amounts recorded include estimated provisions for loss related to uncollectible accounts and disputed items that have continuing significance, such as third-party reimbursements that continue to be claimed in current cost reports.

Inventories

Inventories consist primarily of medical supplies and are stated at the lower of cost (first-in, first-out) or market.

Property and Equipment

Depreciation expense, computed by the straight-line method, was $60.9 million in 2000, $68.9 million in 1999 and $90.9 million in 1998. Depreciation rates for buildings range generally from 20 to 45 years. Estimated useful lives of equipment vary from 5 to 15 years.

Goodwill

Effective January 1, 2000, costs in excess of the fair value of identifiable net assets of acquired entities are amortized using the straight-line method principally over 20 years. Prior thereto, such costs were amortized over 40 years. Amortization expense recorded for 2000, 1999 and 1998 totaled $11.7 million, $23.3 million and $27.2 million, respectively.

Effective October 1, 1998, the Company reduced the amortization period for goodwill related to its rehabilitation therapy business to seven years. In the fourth quarter of 1999, in connection with the realignment of its former Vencare division, the Company wrote off all of the goodwill associated with its rehabilitation therapy business. See Note 4.

Long-Lived Assets

The Company regularly reviews the carrying value of certain long-lived assets and the related identifiable intangible assets with respect to any events or circumstances that indicate impairment or adjustment to the amortization period. If such circumstances suggest the recorded amounts cannot be recovered, calculated based upon estimated future cash flows (undiscounted), the carrying values of such assets are reduced to fair value. See Note 6.

Professional Liability Risks

Provisions for loss for professional liability risks are based upon actuarially determined estimates. To the extent that subsequent claims information varies from management's estimates, earnings are charged or credited.

NOTE 1--ACCOUNTING POLICIES (Continued)

Derivative Instruments

Prior to May 15, 2000, the Company was a party to interest rate swap agreements that eliminated the impact of changes in interest rates on certain outstanding floating rate debt. Each interest rate swap agreement was associated with all or a portion of the principal balance of a specific debt obligation. These agreements involved the exchange of amounts based on variable rates for amounts based on fixed interest rates over the life of the agreement, without an exchange of the notional amount upon which the payments were based. The differential paid or received as interest rates changed was accrued and recognized as an adjustment of interest expense related to the debt, and the related amount payable to or receivable from counterparties was included in accrued interest. The fair values of the swap agreements were not recognized in the consolidated financial statements. Gains and losses on terminations of interest rate swap agreements were deferred (included in other assets) and amortized as an adjustment to interest expense over the remaining term of the original contract life of the terminated swap agreement.

Earnings per Common Share

Basic earnings per common share are based upon the weighted average number of common shares outstanding. No incremental shares are included in the calculations of the diluted loss per common share since the result would be antidilutive.

NOTE 2--RESTATEMENT OF PREVIOUSLY ISSUED FINANCIAL STATEMENTS

On August 14, 2001, the Company announced that it will restate certain of its previously issued consolidated financial statements. The Company recently determined that an oversight related to the allowance for professional liability risks had occurred in its consolidated financial statements beginning in 1998. The oversight resulted in the understatement of the provision for professional liability claims in 1998, 1999 and 2000 because the Company did not record a reserve for claims incurred but not reported at the respective balance sheet dates. The cumulative understatement of professional liability claims reserves approximated $5 million at December 31, 1998, $28 million at December 31, 1999 and $39 million at December 31, 2000. The restatement had no effect on previously reported cash flows from operations.

The consolidated financial statements included herein amend those previously included in the Company's Annual Report on Form 10-K for the year ended December 31, 2000. Consolidated financial statement information and related disclosures included in these amended financial statements reflect, where appropriate, changes resulting from the restatement.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 2--RESTATEMENT OF PREVIOUSLY ISSUED FINANCIAL STATEMENTS (Continued)

The effect of the restatement on the Company's previously issued audited consolidated financial statements follows (in thousands, except per share amounts):

	For the year ended December 31,					
	2000		1999		1998	
	As previously reported	As restated	As previously reported	As restated	As previously reported	As restat
Loss from operations....	$ (53,582)	$ (64,751)	$ (683,249)	$ (705,464)	$(572,908)	$(578,
Net loss................	(53,582)	(64,751)	(692,172)	(714,387)	(650,845)	(656,
Loss per common share:						
Basic:						
Loss from operations..	$ (0.78)	$ (0.94)	$ (9.72)	$ (10.03)	$ (8.39)	$ (8
Net loss.............	(0.78)	(0.94)	(9.85)	(10.16)	(9.53)	(9
Diluted:						
Loss from operations..	$ (0.78)	$ (0.94)	$ (9.72)	$ (10.03)	$ (8.39)	$ (8
Net loss.............	(0.78)	(0.94)	(9.85)	(10.16)	(9.53)	(9

	December 31, 2000		December 31, 1999	
	As previously reported	As restated	As previously reported	As restated
Professional liability risks..................	$ 62,327	$ 101,209	$ 45,072	$ 72,785
Total liabilities.......	1,765,523	1,804,405	1,612,540	1,640,253
Accumulated deficit.....	(1,117,585)	(1,156,467)	(1,062,957)	(1,090,670)
Stockholders' deficit...	(432,852)	(471,734)	(378,309)	(406,022)

The Company has revised its professional liability risks disclosure in Note 10 for the impact of the restatement.

In addition, in Note 12, the Company has revised its disclosure of future minimum lease payments under non-cancelable operating leases to exclude contingent rentals.

NOTE 3--PROCEEDINGS UNDER CHAPTER 11 OF THE BANKRUPTCY CODE

On September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Chapter 11 cases have been consolidated for purposes of joint

administration under Case Nos. 99-3199 (MFW) through 99-3327 (MFW) (collectively, the "Chapter 11 Cases"). The Company currently is operating its businesses as a debtor-in-possession subject to the jurisdiction of the Bankruptcy Court.

On March 1, 2001, the Bankruptcy Court approved the Company's fourth amended plan of reorganization filed with the Bankruptcy Court on December 14, 2000, as modified at the confirmation hearing (the "Amended Plan"). The order confirming the Amended Plan was entered on March 16, 2001. The Amended Plan must be effective no later than May 1, 2001.

In connection with the confirmation hearing, the Company entered into a commitment letter for a $120 million senior exit facility with a lending group led by Morgan Guaranty Trust Company of New York (the "Exit Facility"). The Exit Facility will be available to fund the Company's obligations under the Amended Plan and its ongoing operations following emergence from bankruptcy.

NOTE 3--PROCEEDINGS UNDER CHAPTER 11 OF THE BANKRUPTCY CODE (Continued)

The consummation of the Amended Plan is subject to a number of material conditions including, without limitation, the negotiation and execution of definitive agreements for the Exit Facility. There can be no assurance that the Amended Plan will be consummated. See Notes 21 and 22.

In connection with the Chapter 11 Cases, the Company entered into a $100 million debtor-in-possession financing agreement (the "DIP Financing"). The Bankruptcy Court granted final approval of the DIP Financing on October 1, 1999. The DIP Financing was initially comprised of a $75 million tranche A revolving loan (the "Tranche A Loan") and a $25 million tranche B revolving loan (the "Tranche B Loan"). Interest is payable at prime plus 2 1/2% on the Tranche A Loan and prime plus 4 1/2% on the Tranche B Loan.

Available aggregate borrowings under the Tranche A Loan were initially limited to $45 million in September 1999 and increased to $65 million in October 1999, $70 million in November 1999 and $75 million thereafter. Pursuant to the most recent amendment to the DIP Financing, the aggregate borrowing limitations under the Tranche A Loan are limited to approximately $48 million until maturity and are reduced for asset sales made by the Company. In addition, Tranche B Loan aggregate borrowings are limited to $23 million as a result of the most recent amendment to the DIP Financing. Borrowings under the Tranche B Loan require the approval of lenders holding at least 75% of the credit exposure under the DIP Financing. The DIP Financing is secured by substantially all of the assets of the Company and its subsidiaries, including certain owned real property. The DIP Financing contains standard representations and warranties and other affirmative and restrictive covenants. At December 31, 2000, there were no outstanding borrowings under the DIP Financing.

Since the consummation of the DIP Financing, the Company and the lenders under the DIP Financing (the "DIP Lenders") have agreed to several amendments to the DIP Financing. In the most recent amendment to the DIP Financing, the parties agreed, among other things, to extend the maturity date of the DIP Financing until March 31, 2001 and to revise and update certain financial covenants. In addition, the most recent amendment extends the period of time

for the Company to file the appropriate pleadings to request confirmation and consummation of the Amended Plan through March 31, 2001. At December 31, 2000, the Company was in compliance with the terms of the DIP Financing.

The Company expects to terminate the DIP Financing on or prior to the effective date of the Amended Plan.

Events Leading to Reorganization

The Company reported a net loss from operations in 1998 aggregating $578 million, resulting in certain financial covenant violations under the Company's $1.0 billion bank credit facility (the "Credit Agreement"). Prior to the commencement of the Chapter 11 Cases, the Company received a series of temporary waivers of these covenant violations. The waivers generally included certain borrowing limitations under the $300 million revolving credit portion of the Credit Agreement. The final waiver was scheduled to expire on September 24, 1999.

The Company was informed on April 9, 1999 by the Health Care Financing Administration ("HCFA") that the Medicare program had made a demand for repayment of approximately $90 million of reimbursement overpayments. On April 21, 1999, the Company reached an agreement with HCFA to extend the repayment of such amounts over 60 monthly installments (the "HCFA Agreement"). Under the HCFA Agreement, non-interest bearing monthly payments of approximately $1.5 million commenced in May 1999. Beginning in December 1999, interest began to accrue on the balance of the overpayments at a statutory rate approximating 13.4%, resulting in a monthly payment of approximately $2.0 million through March 2004. If the Company is

NOTE 3--PROCEEDINGS UNDER CHAPTER 11 OF THE BANKRUPTCY CODE (Continued)

Events Leading to Reorganization (Continued)

delinquent with two consecutive payments, the HCFA Agreement will be defaulted and all subsequent Medicare reimbursement payments to the Company may be withheld. Amounts due under the HCFA Agreement aggregated $63.4 million at December 31, 2000 and have been classified as liabilities subject to compromise in the Company's consolidated balance sheet. The Company has received Bankruptcy Court approval to continue to make the monthly payments under the HCFA Agreement during the pendency of the Chapter 11 Cases.

On May 3, 1999, the Company elected not to make the interest payment of approximately $14.8 million due on the $300 million 9 7/8% Guaranteed Senior Subordinated Notes due 2005 (the "1998 Notes"). The failure to pay interest resulted in an event of default under the 1998 Notes.

In accordance with SOP 90-7, outstanding borrowings under the Credit Agreement ($511 million) and the principal amount of the 1998 Notes ($300 million) have been presented as liabilities subject to compromise in the Company's consolidated balance sheet at December 31, 2000. If the Chapter 11 Cases had not been filed, the Company would have reported a working capital deficit approximating $942 million at December 31, 2000. The consolidated financial statements do not include any adjustments that might result from the resolution of the Chapter 11 Cases or other matters discussed herein. During the pendency of the Chapter 11 Cases, the Company is continuing to record the

contractual amount of interest expense related to the Credit Agreement. No interest costs have been recorded related to the 1998 Notes since the filing of the Chapter 11 Cases. Contractual interest expense for the 1998 Notes not recorded in the consolidated statement of operations aggregated $30 million in 2000 and $9 million in 1999.

As previously reported, the Company was informed by the United States Department of Justice (the "DOJ") that the Company and Ventas are the subjects of ongoing investigations into various Medicare reimbursement issues, including hospital cost reporting issues, Vencare billing practices and various quality of care issues in the hospitals and nursing centers formerly operated by Ventas and currently operated by the Company. In connection with the Amended Plan, the claims of the DOJ will be settled through a government settlement entered into with the Company and Ventas (the "Government Settlement"). The Government Settlement also provides for the dismissal of certain pending claims and lawsuits filed against the Company. See Note 20.

Agreements with Ventas

On March 18, 1999, the Company served Ventas with a demand for mediation pursuant to the Agreement and Plan of Reorganization governing the Spin-off (the "Spin-off Agreement"). The Company was seeking a reduction in rent and other concessions under its lease agreements with Ventas (the "Master Lease Agreements"). Shortly thereafter, the Company and Ventas entered into a series of standstill and tolling agreements which provided that both companies would postpone any claims either may have against the other and extend any applicable statutes of limitation.

As a result of the Company's failure to pay rent, Ventas served the Company with notices of nonpayment under the Master Lease Agreements. Subsequently, the Company and Ventas entered into further amendments to the second standstill and the tolling agreements to extend the time during which no remedies may be pursued by either party and to extend the date by which the Company may cure its failure to pay rent.

In connection with the Chapter 11 Cases, the Company and Ventas entered into a stipulation (the "Stipulation") that provides for the payment by the Company of a reduced aggregate monthly rent of

approximately $15.1 million. The Stipulation has been approved by the Bankruptcy Court. The difference between the base rent under the Master Lease Agreements and the reduced aggregate monthly rent is being accrued as an administrative expense subject to compromise in the Chapter 11 Cases.

The Stipulation also continues to toll any statutes of limitations for claims that might be asserted by the Company against Ventas and provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off. The Stipulation automatically renews for one-month periods unless either party provides a 14-day notice of termination. The Stipulation will be terminated upon the effective date of the Amended Plan. See Note 20.

On May 31, 2000, the Company announced that the Bankruptcy Court had approved a tax stipulation agreement between the Company and Ventas (the "Tax Stipulation"). The Tax Stipulation provides that certain refunds of federal, state and local taxes received by either party on or after September 13, 1999 will be held by the recipient of such refunds in segregated interest bearing accounts. The Tax Stipulation requires notification before either party can withdraw funds from the segregated accounts and will terminate upon the effective date of the Amended Plan.

The Company believes that the Amended Plan, if consummated, will resolve all material disputes between the Company and Ventas. The Amended Plan also provides for comprehensive mutual releases between the Company and Ventas, other than for obligations that the Company is assuming under the Amended Plan.

If the Amended Plan does not become effective and the Company and Ventas are unable to otherwise resolve their disputes or maintain an interim resolution, the Company may seek to pursue claims against Ventas arising out of the Spin-off and seek judicial relief barring Ventas from exercising any remedies based on the Company's failure to pay some or all of the rent to Ventas. The Company's failure to pay rent or otherwise comply with the Stipulation, in the absence of judicial relief, would result in an "Event of Default" under the Master Lease Agreements. Upon an Event of Default under the Master Lease Agreements, assuming Ventas were to be granted relief from the automatic stay by the Bankruptcy Court, the remedies available to Ventas include, without limitation, terminating the Master Lease Agreements, repossessing and reletting the leased properties and requiring the Company to (a) remain liable for all obligations under the Master Lease Agreements, including the difference between the rent under the Master Lease Agreements and the rent payable as a result of reletting the leased properties or (b) pay the net present value of the rent due for the balance of the terms of the Master Lease Agreements. Such remedies, however, would be subject to the supervision of the Bankruptcy Court.

General

On September 14, 1999, the Company received approval from the Bankruptcy Court to pay pre-petition and post-petition employee wages, salaries, benefits and other employee obligations. The Bankruptcy Court also approved orders granting authority, among other things, to pay pre-petition claims of certain critical vendors, utilities and patient obligations. All other pre-petition liabilities are classified in the consolidated balance sheet as liabilities subject to compromise. The Company currently is paying the post-petition claims of all vendors and providers in the ordinary course of business.

Under the Bankruptcy Code, actions to collect pre-petition indebtedness against the Company are subject to an automatic stay and other contractual obligations against the Company may not be enforced. The automatic

NOTE 3--PROCEEDINGS UNDER CHAPTER 11 OF THE BANKRUPTCY CODE (Continued)

General (Continued)

stay does not necessarily apply to certain actions against Ventas for which the Company has agreed to indemnify Ventas in connection with the Spin-off. In addition, the Company may assume or reject executory contracts, including lease obligations, under the Bankruptcy Code. Parties affected by these rejections

may file claims with the Bankruptcy Court in accordance with the reorganization process.

Liabilities Subject to Compromise

A substantial portion of pre-petition liabilities are subject to settlement under the Amended Plan. "Liabilities subject to compromise" refers to liabilities incurred prior to the commencement of the Chapter 11 Cases. These liabilities, consisting primarily of long-term debt, amounts due to third-party payors and certain accounts payable and accrued liabilities, represent the Company's estimate of known or potential claims to be resolved in connection with the Chapter 11 Cases. Such claims remain subject to future adjustments based on assertions of additional claims, negotiations, actions of the Bankruptcy Court, further developments with respect to disputed claims, future rejection of executory contracts or unexpired leases, determination as to the value of any collateral securing claims and other events. Proposed payment terms for these amounts are set forth in the Amended Plan.

All pre-petition liabilities, other than those for which the Company has received Bankruptcy Court approval to pay, have been classified in the consolidated balance sheet as liabilities subject to compromise. A summary of the principal categories of claims classified as liabilities subject to compromise under the Chapter 11 Cases follows (in thousands):

	December 31, 2000	December 31, 1999
Long-term debt:		
Credit Agreement	$ 510,908	$ 506,114
1998 Notes	300,000	300,000
Amounts due under the HCFA Agreement	63,405	80,296
8 5/8% Senior Subordinated Notes	2,391	2,391
Unamortized deferred financing costs	(10,306)	(12,626)
Other	2,873	4,592
	869,271	880,767
Due to third-party payors	116,062	112,694
Accounts payable	36,053	33,693
Income taxes	13,478	-
Accrued liabilities:		
Interest	90,655	45,521
Ventas rent	81,902	33,884
Other	52,952	52,858
	225,509	132,263
	$1,260,373	$1,159,417

Substantially all of the liabilities subject to compromise would have been classified as current liabilities if the Chapter 11 Cases had not been filed.

KINDRED HEALTHCARE, INC.

NOTE 4--VENCARE REALIGNMENT

During 1999, the Company operated its Vencare ancillary services business which provided respiratory and rehabilitation therapies and medical and pharmacy management services to nursing centers and other healthcare providers. As a result of significant declines in the demand for ancillary services caused by the Balanced Budget Act of 1997 (the "Budget Act"), management completed a realignment of its Vencare division in the fourth quarter of 1999. Vencare's physical rehabilitation, speech and occupational therapies were integrated into the Company's nursing center division and the division was renamed the health services division. Vencare's institutional pharmacy business was assigned to the hospital division. Vencare's respiratory therapy and other ancillary businesses have been discontinued.

In connection with the realignment, the Company recorded a charge aggregating $56.3 million in the fourth quarter of 1999. See Note 6.

NOTE 5--BUSINESS COMBINATIONS

Acquisitions of healthcare facilities (including certain previously leased facilities) and other related businesses, have been accounted for by the purchase method. Accordingly, the aggregate purchase price of these transactions has been allocated to tangible and identifiable intangible assets acquired and liabilities assumed based upon their respective fair values. The consolidated financial statements include the operations of acquired entities since the respective acquisition dates. The pro forma effect of these acquisitions on the Company's results of operations prior to consummation was not significant.

The following is a summary of acquisitions consummated during 1998 under the purchase method of accounting (in thousands):

Fair value of assets acquired	$32,286
Fair value of liabilities assumed	(8,059)
Net cash paid for acquisitions	$24,227

The purchase price paid in excess of the fair value of identifiable net assets of acquired entities aggregated $7.9 million.

NOTE 6--UNUSUAL TRANSACTIONS

Operating results for each of the last three years include certain unusual transactions. These transactions are included in other operating expenses in the consolidated statement of operations (unless otherwise indicated) for the respective periods in which they were recorded.

2000

Operating results for 2000 include a $9.2 million write-off of an impaired investment recorded in the third quarter and a $4.5 million gain on the sale of a closed hospital recorded in the second quarter.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

1999

The following table summarizes the pretax impact of unusual transactions recorded during 1999 (in millions):

	Quarters				
	First	Second	Third	Fourth	Year
(Income)/expense					
Asset valuation losses:					
Long-lived asset impairment..........				$330.4	$330.4
Investment in BHC....................		$15.2			15.2
Cancellation of software development project..............................		5.6			5.6
Realignment of Vencare division.........				56.3	56.3
Retirement plan curtailment............				7.3	7.3
Corporate properties...................				(2.4)	(2.4)
	$ -	$20.8	$ -	$391.6	$412.4

Long-lived asset impairment--SFAS No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of" ("SFAS 121"), requires impairment losses to be recognized for long-lived assets used in operations when indications of impairment are present and the estimate of undiscounted future cash flows is not sufficient to recover asset carrying amounts. SFAS 121 also requires that long-lived assets held for disposal be carried at the lower of carrying value or fair value less costs of disposal, once management has committed to a plan of disposal.

Operating results and related cash flows for 1999 did not meet management's expectations. These expectations were the basis upon which the Company valued its long-lived assets at December 31, 1998, in accordance with SFAS 121. In addition, certain events occurred in 1999 which had a negative impact on the Company's operating results and are expected to impact negatively its operations in the future. In connection with the negotiation of the Government Settlement, the Company agreed to exclude certain expenses from its hospital Medicare cost reports beginning September 1, 1999 for which the Company had been reimbursed in prior years. Medicare revenues related to the reimbursement of such costs aggregated $18 million in 1999 and $47 million in 1998. In addition, hospital revenues in 1999 were reduced by approximately $19 million as a result of disputes with certain insurers who issued Medicare supplement insurance policies to individuals who became patients of the Company's hospitals. The Company also reviewed the expected impact of the Balanced Budget Refinement Act (the "BBRA") enacted in November 1999 (which provided a measure of relief for some impact of the Budget Act) and the realignment of the Vencare ancillary services business completed in the fourth quarter of 1999. The actual and expected future impact of these issues served as an indication to

management that the carrying values of the Company's long-lived assets may be impaired.

In accordance with SFAS 121, management estimated the future undiscounted cash flows for each of its facilities and compared these estimates to the carrying values of the underlying assets. As a result of these estimates, the Company reduced the carrying amounts of the assets associated with 71 nursing centers and 21 hospitals to their respective estimated fair values. The determination of the fair values of the impaired facilities was based upon the net present value of estimated future cash flows.

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

A summary of the impairment charges follows (in millions):

	Goodwill	Property and Equipment	Total
Health services division	$ 18.3	$ 37.7	$ 56.0
Hospital division	198.9	75.5	274.4
	$ 217.2	$113.2	$330.4

Investment in BHC--In connection with the acquisition of Transitional Hospitals Corporation ("Transitional") in 1997, the Company acquired a 44% voting equity interest (61% equity interest) in Behavioral Healthcare Corporation ("BHC"), an operator of psychiatric and behavioral clinics. In the second quarter of 1999, the Company wrote off its remaining investment in BHC aggregating $15.2 million as a result of deteriorating financial performance. See the discussion of unusual transactions recorded in 1998 for further information related to the Company's investment in BHC.

Cancellation of software development project--In the second quarter of 1999, the Company canceled a nursing center software development project and charged previously capitalized costs to operations.

Realignment of Vencare division--As discussed in Note 4, the Company realigned the Vencare ancillary services division in the fourth quarter of 1999. As a result, the Company recorded a charge aggregating $56.3 million, including the write-off of goodwill totaling $42.3 million. The remainder of the charge related to the write-down of certain equipment to net realizable value and the recording of employee severance costs.

Retirement plan curtailment--In December 1999, the Board of Directors approved the curtailment of benefits under the Company's supplemental executive retirement plan, resulting in an actuarially determined charge of $7.3 million. Under the terms of the curtailment, plan benefits were vested for each eligible participant through December 31, 1999 and the accrual of future benefits under the plan was substantially eliminated. The Board of Directors also deferred the

time at which certain benefits would be paid by the Company.

Corporate properties--During 1999, the Company adjusted estimated property loss provisions recorded in the fourth quarter of 1998, resulting in a pretax credit of $2.4 million.

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

1998

The following table summarizes the pretax impact of unusual transactions recorded during 1998 (in millions):

	Quarters				
	First	Second	Third	Fourth	Year
(Income)/expense					
Asset valuation losses:					
Long-lived asset impairment......				$307.8	$ 307.8
Investment in BHC................			$ 8.5	43.1	51.6
Wisconsin nursing center.........				27.5	27.5
Corporate properties.............		$ 8.8	2.9	15.1	26.8
Acquired entities................				13.5	13.5
Gain on sale of investments........			(98.5)	(13.0)	(111.5)
Losses from termination of construction projects............			71.3		71.3
Spin-off transaction costs.........	$7.7	9.6			17.3
Write-off of clinical information systems..........................				10.1	10.1
Doubtful accounts related to sold operations.......................			9.6		9.6
Settlement of litigation...........				7.8	7.8
Loss on sale and closure of home health and hospice businesses.....		7.3			7.3
	$7.7	$25.7	$ (6.2)	$411.9	$ 439.1

Long-lived asset impairment--The Budget Act established, among other things, a new Medicare prospective payment system ("PPS") for nursing centers. All of the Company's nursing centers became subject to PPS effective July 1, 1998. During the first three years, the per diem rates for nursing centers are based on a blend of facility-specific and federal costs. Thereafter, the per diem rates will be based solely on federal costs. The revenues recorded under PPS in the Company's health services division were substantially less than the cost-based reimbursement it received before the enactment of the Budget Act.

The Budget Act also reduced payments to the Company's hospitals by reducing incentive payments pursuant to the Tax Equity and Fiscal Responsibility Act of

1982 ("TEFRA"), allowable costs for capital expenditures and bad debts, and payments for services to patients transferred from a general acute care hospital. The reductions in allowable costs for capital expenditures became effective in the fourth quarter of 1997. The reductions in TEFRA incentive payments and allowable costs for bad debts became effective in the third and fourth quarters of 1998. The reduction for payments for services to patients transferred from a general acute care hospital became effective in the fourth quarter of 1998. These reductions had a material adverse impact on hospital revenues in 1998.

The Company provides ancillary services to both Company-operated and non-affiliated nursing centers. While most of the nursing center industry became subject to PPS on or after January 1, 1999, management believed that Vencare's ability to maintain services and revenues was impacted adversely during 1998, particularly in the third and fourth quarters, since nursing centers were reluctant to enter into ancillary service contracts while transitioning to the new fixed payment system under PPS. Medicare reimbursements to nursing centers under PPS include substantially all services provided to patients, including ancillary services. Management believes that the decline in demand for its Vencare services in 1998, particularly respiratory

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

therapy and rehabilitation therapy, was mostly attributable to efforts by nursing center customers to reduce operating costs. In addition, as a result of these regulatory changes, many nursing centers began providing ancillary services to their patients through internal staff and no longer contracted with outside parties for ancillary services.

In January 1998, HCFA issued rules changing Medicare reimbursement guidelines for therapy services provided by the Company. Under these rules, HCFA established salary equivalency limits for speech and occupational therapy services and revised limits for physical and respiratory therapy services. The new limits became effective for services provided on or after April 10, 1998 and negatively impacted operating results of the Company's ancillary services businesses in 1998.

These significant regulatory changes and the impact of such changes on the Company's operating results in the third and fourth quarters of 1998 served as an indication to management that the carrying values of the assets of its nursing center and hospital facilities, as well as certain portions of its ancillary services business, may be impaired.

In accordance with SFAS 121, management estimated the future undiscounted cash flows for each of its facilities and ancillary services lines of business and compared these estimates to the carrying values of the underlying assets. As a result of these estimates, the Company reduced the carrying amounts of the assets associated with 110 nursing centers, 12 hospitals and a portion of the goodwill associated with its rehabilitation therapy business to their respective estimated fair values. The determination of the fair values of the impaired facilities and rehabilitation therapy business was based upon the net present value of estimated future cash flows.

A summary of the impairment charges follows (in millions):

	Goodwill	Property and Equipment	Total
Health services division:			
Nursing centers	$ 27.7	$ 71.6	$ 99.3
Ancillary services	99.2	0.2	99.4
Hospital division	74.4	34.7	109.1
	$201.3	$106.5	$307.8

In addition to the above impairment charges, the amortization period for the remaining goodwill associated with the Company's rehabilitation therapy business was reduced from forty years to seven years, effective October 1, 1998. Management believed that the provisions of the Budget Act altered the expected long-term cash flows and business prospects associated with this business to such an extent that a shorter amortization period was deemed appropriate. The change in the amortization period resulted in an additional pretax charge to operations of $6.4 million in the fourth quarter of 1998. In the fourth quarter of 1999, in connection with the realignment of Vencare, the Company wrote off all of the goodwill associated with the rehabilitation therapy business.

Investment in BHC--Subsequent to the Transitional merger, the Company had been unsuccessful in its attempts to sell its investment in BHC. In July 1998, the Company entered into an agreement to sell its interest in BHC for an amount less than its carrying value and accordingly, a provision for loss of $8.5 million was recorded during the third quarter. In November 1998, the agreement to sell the Company's interest in BHC was

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

terminated by the prospective buyer, indicating to the Company that the carrying amount of its investment may be impaired. Following an independent appraisal, the Company recorded a $43.1 million write-down of the investment in the fourth quarter of 1998. The net carrying amount of the investment aggregated $20.0 million at December 31, 1998.

Wisconsin nursing center--The Company recorded an asset impairment charge of $27.5 million in the fourth quarter of 1998 related to a nursing center in Wisconsin that is leased from Ventas. The impairment resulted primarily from certain fourth quarter regulatory actions by state and federal agencies with respect to the operation of the facility. In the fourth quarter of 1998, the facility reported a pretax loss of $4.2 million and is not expected to generate positive cash flows in the future.

Corporate properties and acquired entities--During 1998, the Company recorded $26.8 million of charges related to the valuation of certain corporate assets, the most significant of which relates to previously capitalized amounts and

expected property disposal losses associated with the cancellation of a corporate headquarters construction project. The Company also recorded $13.5 million of asset write-downs associated with the acquisition of The Hillhaven Corporation ("Hillhaven"), TheraTx, Incorporated ("TheraTx") and Transitional, including provisions for obsolete or abandoned computer equipment and miscellaneous receivables.

Gain on sale of investments--In September 1998, the Company sold its investment in its assisted living affiliate, Atria Communities, Inc. ("Atria") for $177.5 million in cash and an equity interest in the surviving corporation, resulting in a gain of $98.5 million. In November 1998, the Company's investment in Colorado MEDtech, Inc. was sold at a gain of $13.0 million. Proceeds from the sale were $22.0 million.

Losses from termination of construction projects--In the third quarter of 1998, as a result of substantial reductions in Medicare reimbursement to the Company's nursing centers and hospitals in connection with the Budget Act, management determined to suspend all acquisition and development activities, terminate the construction of substantially all of its development properties, and close two recently acquired hospitals. Accordingly, the Company recorded pretax charges aggregating $71.3 million, of which $53.9 million related to the cancellation of construction projects and the remainder related to the planned closure of the hospitals. In connection with the construction termination charge, the Company decided that it would not replace certain facilities that previously were accounted for as assets intended for disposal. Accordingly, the $53.9 million charge discussed above included a $10.0 million reversal of a previously recorded valuation allowance (the amount necessary to reduce the carrying value to fair value less costs of disposal) related to such facilities.

Spin-off transaction costs--The Spin-off was completed on May 1, 1998. Direct costs related to the transaction totaled $17.3 million and primarily included costs for professional services.

Write-off of clinical information systems--During 1997, the Company began the installation of its proprietary clinical information system, VenTouch(TM), in several of its nursing centers. During the pilot process, the Company determined that VenTouch(TM) did not support effectively the nursing center processes, especially in facilities with lower acuity patients. Accordingly, management determined in the fourth quarter of 1998 to remove VenTouch(TM) from these facilities during 1999. A loss of $10.1 million was recorded to reflect the write-off of the equipment and estimated costs of removal from the facilities.

Doubtful accounts related to sold operations--In the third quarter of 1998, the Company recorded $9.6 million of additional provisions for doubtful accounts for accounts receivable associated with previously sold facilities.

NOTE 6--UNUSUAL TRANSACTIONS (Continued)

Settlement of litigation--The Company settled a legal action entitled Highland Pines Nursing Center, Inc., et al. v. TheraTx, Incorporated, et al. (assumed in connection with the TheraTx merger) which resulted in a payment of $16.2 million. Approximately $7.8 million of the settlement was charged to

earnings in the fourth quarter of 1998, and the remainder of such costs had been previously accrued in connection with the purchase price allocation.

Loss on sale and closure of home health and hospice businesses--The Company began operating its home health and hospice businesses in 1996. These operations generally were unprofitable. In the second quarter of 1998, management decided to cease operations and either close or sell these businesses, resulting in a loss of $7.3 million.

NOTE 7--FOURTH QUARTER ADJUSTMENTS

In addition to the unusual transactions discussed in Note 6, during the fourth quarter of 1999 and 1998, the Company recorded certain adjustments which significantly impacted operating results. A summary of such adjustments follows (in millions):

	(Restated)					
	Health Services Division		Hospital Division			
	Nursing Centers	Ancillary Services	Hospitals	Pharmacy	Corporate	Total
1999						
(Income)/expense						
Provision for doubtful accounts	$40.2	$26.8	$ 6.5	$ 8.9		$ 82.4
Medicare supplement insurance disputes			18.8			18.8
Third-party reimbursements and contractual allowances, including amounts due from government agencies and other payors that are subject to dispute	2.0		59.6			61.6
Professional liability risks	14.7	0.4	1.8	0.1		17.0
Employee benefits	(6.3)	(1.5)	(1.8)			(9.6)
Incentive compensation	2.2		(1.9)	(1.1)		(0.8)
Inventories	0.9			6.3		7.2
Other	1.7	(0.4)	2.0	(4.4)	$(2.8)	(3.9)
	$55.4	$25.3	$85.0	$ 9.8	$(2.8)	$172.7

NOTE 7--FOURTH QUARTER ADJUSTMENTS (Continued)

	(Restated)					
	Health Services Division		Hospital Division			
	Nursing Centers	Ancillary Services	Hospitals	Pharmacy	Corporate	Total
1998						
(Income)/expense						
Provision for doubtful accounts	$ 14.0	$ 6.8	$ 5.7	$2.5		$29.0
Third-party reimbursements and contractual allowances, including amounts due from government agencies and other payors that are subject to dispute	4.8	11.5	11.4			27.7
Change in goodwill amortization period related to rehabilitation therapy business		6.4				6.4
Taxes other than income					$ 6.4	6.4
Professional liability risks	3.5	0.2	1.8			5.5
Compensated absences	2.1	1.3	(0.8)		0.7	3.3
Incentive compensation	(1.0)	(0.4)	(0.8)	(0.1)	(2.9)	(5.2)
Litigation and regulatory actions					3.5	3.5
Miscellaneous receivables				5.2		5.2
Gain on sale of assets		(2.0)				(2.0)
Other	1.2	0.4	(1.0)	0.3	3.7	4.6
	$ 24.6	$24.2	$16.3	$7.9	$11.4	$84.4

The Company regularly reviews its accounts receivable and records provisions for loss based upon the best available evidence. Factors such as changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third-party payors (including both government and non-government sources), the effect of increased regulatory activities, general industry conditions and the financial condition of the Company and its ancillary service customers, among other things, are considered by management in determining the expected collectibility of accounts receivable.

During 1999 and 1998, the Company recorded significant adjustments in the fourth quarter related to contractual allowances and doubtful accounts in each of its divisions. These adjustments represented changes in estimates resulting from management's assessment of its collection processes, the general financial deterioration of the long-term healthcare industry and, in 1999, the realignment of the Vencare businesses (including the cancellation of unprofitable contracts and the discontinuance of certain services) and the filing of the Chapter 11 Cases in September 1999.

In addition, the Company recorded a significant adjustment in the fourth quarter of 1999 related to professional liability risks. This adjustment was recorded based upon actuarially determined estimates completed in the fourth quarter and reflects substantial increases in claims and litigation activity in the Company's nursing center business during 1999.

NOTE 8--BUSINESS SEGMENT DATA

The Company operates two business segments: the health services division and the hospital division. The health services division operates nursing centers and a rehabilitation therapy business. The hospital division operates hospitals and an institutional pharmacy business.

The following table represents the Company's revenues, operating results, capital expenditures and assets by operating segment and gives effect to the realignment of the former Vencare businesses for all periods presented. The Company defines operating income as earnings before interest, income taxes, depreciation, amortization and rent. Operating income reported for each of the Company's business segments excludes allocations of corporate overhead.

	2000	1999	1998
	(In thousands)		
Revenues:			
Health services division:			
Nursing centers	$1,675,627	$1,594,244	$1,667,343
Rehabilitation services	135,036	195,731	264,574
Other ancillary services	-	43,527	168,165
Elimination	(77,191)	(128,267)	(124,500)
	1,733,472	1,705,235	1,975,582
Hospital division:			
Hospitals	1,007,947	850,548	919,847
Pharmacy	204,252	171,493	149,991
	1,212,199	1,022,041	1,069,838
	2,945,671	2,727,276	3,045,420
Elimination of pharmacy charges to Company nursing centers	(57,129)	(61,635)	(45,681)
	$2,888,542	$2,665,641	$2,999,739
Income (loss) from operations (restated):			
Operating income (loss):			
Health services division:			
Nursing centers	$ 278,738	$ 169,128	$ 213,036
Rehabilitation services	8,047	2,891	18,398
Other ancillary services	4,737	4,166	30,183
	291,522	176,185	261,617

Hospital division:			
Hospitals	205,858	132,050	247,272
Pharmacy	7,421	342	15,301
	213,279	132,392	262,573
Corporate overhead	(113,823)	(108,947)	(126,291)
Unusual transactions	(4,701)	(412,418)	(439,125)
Reorganization costs	(12,636)	(18,606)	-
Operating income (loss)	373,641	(231,394)	(41,226)
Rent	(307,809)	(305,120)	(234,144)
Depreciation and amortization	(73,545)	(93,196)	(124,617)
Interest, net	(55,038)	(75,254)	(102,320)
Loss before income taxes	(62,751)	(704,964)	(502,307)
Provision for income taxes	2,000	500	76,099
	$ (64,751)	$ (705,464)	$ (578,406)
Capital expenditures:			
Health services division	$ 28,451	$ 42,144	$ 126,880
Hospital division	23,675	23,918	55,789
Corporate:			
Information systems	25,475	40,777	47,541
Other	2,387	4,654	37,078
	$ 79,988	$ 111,493	$ 267,288
Assets at end of period:			
Health services division	$ 494,636	$ 489,316	
Hospital division	354,302	337,218	
Corporate	485,476	409,440	
	$1,334,414	$1,235,974	

NOTE 9--INCOME TAXES

Provision for income taxes consists of the following (in thousands):

	2000	1999	1998
			(Restated)
Current:			
Federal	$ -	$ -	$ 2,131
State	2,000	500	355
	2,000	500	2,486
Deferred	-	-	73,613
	$2,000	$500	$76,099

====== ==== =======

Reconciliation of federal statutory tax expense to the provision for income taxes follows (in thousands):

	(Restated)		
	2000	1999	1998
Income tax benefit at federal rate.........	$(21,963)	$(249,861)	$(175,807)
State income tax benefit, net of federal income tax benefit........................	(2,197)	(24,985)	(17,581)
Merger related costs......................	-	-	5,943
Goodwill amortization.....................	3,997	8,541	8,823
Write-off of goodwill.....................	-	99,902	77,482
Gain on sale of Atria.....................	-	-	(37,908)
Acquisition costs and merger adjustments...	-	-	8,851
Valuation allowance.......................	12,222	154,933	205,066
Reorganization costs......................	7,372	4,672	-
Other items, net..........................	2,569	7,298	1,230
	$ 2,000	$ 500	$ 76,099

A summary of deferred income taxes by source included in the consolidated balance sheet at December 31 follows (in thousands):

	2000		1999	
	Assets (Restated)	Liabilities	Assets (Restated)	Liabilities
Depreciation...............	$ -	$28,047	$ -	$11,275
Insurance..................	33,747	-	21,335	-
Doubtful accounts..........	140,526	-	143,193	-
Property...................	102,865	-	105,555	-
Compensation...............	21,785	-	16,234	-
Subsidiary net operating losses (expiring in 2020)....................	79,915	-	56,087	-
Other......................	47,484	26,054	47,086	18,216
	426,322	$54,101	389,490	$29,491
Reclassification of deferred tax liabilities..	(54,101)		(29,491)	
Net deferred tax assets....	372,221		359,999	
Valuation allowance........	(372,221)		(359,999)	
	$ -		$ -	

F-26

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 9--INCOME TAXES (Continued)

Prior to 1998, management believed that recorded deferred tax assets ultimately would be realized. Management's conclusions at that time were based primarily on the existence of sufficient taxable income within the allowable carryback periods to realize the tax benefits of deductible temporary differences recorded at December 31, 1997. For the fourth quarter of 1998, the Company reported a pretax loss of $512 million. Additionally, the Company revised its operating budgets as a result of the Budget Act and the less than expected operating results in 1998. Based upon those revised forecasts, management did not believe that the Company could generate sufficient taxable income to realize the net deferred tax assets recorded at December 31, 1998. Accordingly, the Company recorded a deferred tax asset valuation allowance aggregating $205 million in the fourth quarter of 1998. Deferred tax valuation allowances recorded in 1999 and 2000 totaled $155 million and $12 million, respectively. The deferred tax valuation allowance included in the consolidated balance sheet at December 31, 2000 totaled $372 million.

At the time of the Spin-off, the Company recorded both a deferred tax asset and a valuation allowance for identical amounts in connection with the difference in book and tax basis of the Company's investment in Atria which resulted from the Spin-off. The valuation allowance was recorded due to the litigation and other uncertainties associated with the realization of the deferred tax asset, based upon the available evidence at the time of the Spin-off. During the third quarter of 1998, upon favorable resolution of such litigation and completion of the Atria sale, the Company adjusted the valuation allowance that had been recorded in the second quarter of 1998.

NOTE 10--PROFESSIONAL LIABILITY RISKS

The Company insures a substantial portion of its professional and general liability risks primarily through a wholly owned insurance subsidiary. Provisions for such risks were $47.2 million for 2000, $61.3 million for 1999 and $22.2 million for 1998.

The allowance for professional liability risks aggregated $119.1 million and $95.4 million at December 31, 2000 and 1999, respectively, including $17.9 million and $22.6 million, respectively, classified as a current liability. The Company also maintains reinsurance contracts with an unrelated insurer. Reinsurance recoverables related to these risks (included in accounts receivable and noncurrent assets) aggregated $21.7 million and $34.8 million at December 31, 2000 and 1999, respectively.

At December 31, 2000 and 1999, investments held for the payment of claims and expenses related to self-insured risks aggregated $64.6 million and $18.8 million, respectively, including $2.1 million and $2.3 million, respectively, classified as a noncurrent asset.

F-27

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 11--LONG-TERM DEBT

Capitalization

All long-term debt has been classified as liabilities subject to compromise. A summary of long-term debt at December 31 follows (in thousands):

	2000	1999
Senior collateralized debt, 8% to 8.75% (rates generally floating) payable in periodic installments through 2017	$ 1,746	$ 1,851
Term A Loan, 7.9% to 8.6% (rates generally floating) payable in periodic installments through 2003	224,623	224,623
Term B Loan, 8.4% to 9.1% (rates generally floating) payable in periodic installments through 2005	226,491	226,491
Bank revolving credit agreement due 2003 (floating rates averaging 10%)	59,794	55,000
9 7/8% Guaranteed Senior Subordinated Notes due 2005	300,000	300,000
8 5/8% Senior Subordinated Notes due 2007	2,391	2,391
Amounts due to HCFA, 13.4% payable in monthly installments through 2004	63,405	80,296
Unamortized deferred financing costs	(10,306)	(12,626)
Other	1,127	2,741
Total debt, average life of four years (rates averaging 9.5%)	869,271	880,767
Amounts subject to compromise	(869,271)	(880,767)
Long-term debt	$ -	$ -

In accordance with SOP 90-7, unamortized deferred financing costs have been classified as reductions of long-term debt subject to compromise.

In connection with the Chapter 11 Cases, the Company entered into the DIP Financing with the DIP Lenders. At December 31, 2000, the Company was in compliance with the terms of the DIP Financing.

In connection with the Spin-off, the Company consummated the $1.0 billion Credit Agreement which includes: (a) a five-year $300 million revolving credit facility (the "Revolving Credit Facility"), (b) a $250 million Term A Loan (the "Term A Loan") payable in various installments over five years, (c) a $250 million Term B Loan (the "Term B Loan") payable in installments of 1% per year with the outstanding balance due in seven years and (d) a $200 million Bridge Loan (the "Bridge Loan") which was repaid in September 1998 primarily from the proceeds of the sale of the Company's investment in Atria. Interest is payable, depending on certain leverage ratios and other factors, at a rate of prime plus 2% to 3 1/2% for the Revolving Credit Facility, LIBOR plus 3/4% to 3% for the Term A Loan, and LIBOR plus 2 1/4% to 3 1/2% for the Term B Loan.

On April 30, 1998, the Company completed the private placement of $300 million aggregate principal amount of the 1998 Notes, which are not callable by the Company until 2002. On September 10, 1998, the Company exchanged the 1998 Notes for publicly registered securities having identical terms and conditions.

Approximately $831 million of debt subject to compromise would have been classified as current liabilities if the Chapter 11 Cases had not been filed.

Refinancing Activities

In connection with the Spin-off, the Company refinanced substantially all of its long-term debt, resulting in after-tax losses of $78 million in 1998.

NOTE 11--LONG-TERM DEBT (Continued)

Other Information

At December 31, 1999, the Company was a party to certain interest rate swap agreements that eliminated the impact of changes in interest rates on $100 million of floating rate debt outstanding. The agreements provided for fixed rates on $100 million of floating rate debt at 6.4% plus 3/8% to 1 1/8% and expired in May 2000. The fair value of the swap agreements, or the estimated amount the Company would have paid to terminate the agreements based on current interest rates, was not recognized in the consolidated financial statements. The Company was not a party to any interest rate swap agreements at December 31, 2000.

Under the Bankruptcy Code, actions to collect pre-petition indebtedness against the Company are subject to an automatic stay and other contractual obligations against the Company may not be enforced. In addition, the Company may assume or reject executory contracts under the Bankruptcy Code.

If the Chapter 11 Cases had not been filed, the scheduled maturities of long-term debt in years 2002 through 2005 would be $148 million, $118 million, $183 million and $342 million, respectively.

The estimated fair value of the Company's long-term debt was $537 million and $485 million at December 31, 2000 and 1999, respectively, compared to carrying amounts aggregating $880 million and $893 million. The estimate of fair value at December 31, 1999 includes the effect of the interest rate swap agreements and is based upon the quoted market prices for the same or similar issues of long-term debt, or on rates available to the Company for debt of the same remaining maturities. The estimated fair value of the interest rate swap agreements was $157,000 (payable position) at December 31, 1999.

NOTE 12--LEASES

The Company leases real estate and equipment under cancelable and non-cancelable arrangements. The Company may assume or reject executory contracts, including lease agreements, under the Bankruptcy Code. The Company has not rejected any lease agreements since the Chapter 11 Cases were filed. Future minimum payments and related sublease income under non-cancelable operating leases are as follows (in thousands):

Minimum Payments	Sublease

	Ventas	Other	Total	Income
	(Restated)			
2001	$ 231,135	$46,823	$ 277,958	$4,343
2002	231,135	31,537	262,672	2,514
2003	231,135	23,762	254,897	2,157
2004	231,135	13,950	245,085	1,571
2005	231,135	12,420	243,555	1,571
Thereafter	1,034,673	58,058	1,092,731	7,092

Sublease income aggregated $2.4 million, $2.4 million and $6.9 million for 2000, 1999 and 1998, respectively.

NOTE 13--CONTINGENCIES

Management continually evaluates contingencies based upon the best available evidence. In addition, allowances for loss are provided currently for disputed items that have continuing significance, such as certain third-party reimbursements and deductions that continue to be claimed in current cost reports and tax returns.

NOTE 13--CONTINGENCIES (Continued)

Management believes that allowances for losses have been provided to the extent necessary and that its assessment of contingencies is reasonable.

Principal contingencies are described below:

Revenues--Certain third-party payments are subject to examination by agencies administering the programs. The Company is contesting certain issues raised in audits of prior year cost reports.

Professional liability risks--The Company has provided for loss for professional liability risks based upon actuarially determined estimates. Actual settlements may differ from the provisions for loss.

Guarantees of indebtedness--Letters of credit and guarantees of indebtedness aggregated $3.3 million at December 31, 2000.

Income taxes--The Company is contesting adjustments proposed by the Internal Revenue Service for years 1995 through 1997. In addition, the Company claims that it is entitled to certain prior year tax refunds currently held by Ventas.

Litigation--The Company is a party to certain material litigation and regulatory actions as well as various suits and claims arising in the ordinary course of business. See Note 20.

NOTE 14--CAPITAL STOCK

Plan Descriptions

The Company has plans under which options to purchase common stock may be granted to officers, employees and certain non-employee directors. Options have been granted at not less than market price on the date of grant. Exercise provisions vary, but most options are exercisable in whole or in part beginning one to four years after grant and ending ten years after grant. Activity in the plans is summarized below:

	Shares under Option	Option Price per Share	Weighted Average Exercise Price
Balances, December 31, 1997.....	4,395,170	$0.20 to $43.88	$26.77
Granted......................	6,422,132	3.81 to 10.98	7.00
Exchange offer:			
Canceled....................	(5,721,027)	6.12 to 16.87	10.14
Issued......................	4,631,694	5.50	5.50
Exercised....................	(48,431)	0.12 to 10.96	2.69
Canceled or expired..........	(855,904)	3.67 to 16.58	8.22
Balances, December 31, 1998.....	8,823,634	0.08 to 16.58	5.72
Granted......................	423,000	0.63 to 4.50	2.50
Exercised....................	(7,031)	0.34	0.34
Canceled or expired..........	(1,196,924)	0.34 to 16.58	6.19
Balances, December 31, 1999.....	8,042,679	0.08 to 15.09	5.50
Canceled or expired..........	(1,813,066)	0.39 to 14.93	6.98
Balances, December 31, 2000.....	6,229,613	$0.08 to $15.09	$ 5.07

NOTE 14--CAPITAL STOCK (Continued)

Plan Descriptions (Continued)

A summary of stock options outstanding at December 31, 2000 follows:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2000	Remaining Contractual Life	Weighted Average Exercise Price	Number Exercisable at December 31, 2000	Weighted Average Exercise Price
$0.08 to $10.72.........	296,414	1 to 4 years	$5.81	296,414	$5.81
$5.50 to $15.09.........	3,280,849	5 to 7 years	5.76	2,935,149	5.72
$0.63 to $5.50..........	2,652,350	8 to 10 years	4.14	1,659,800	4.32

	6,229,613	$5.07	4,891,363	$5.25

The weighted average remaining contractual life of options outstanding at December 31, 2000 approximated seven years. Shares of common stock available for future grants were 6,001,333, 3,824,628 and 2,670,846 at December 31, 2000, 1999 and 1998, respectively. The number of options exercisable at December 31, 1999 and December 31, 1998 was 5,347,955 and 1,321,370, respectively.

In connection with the Spin-off, options outstanding prior thereto were bifurcated on a one-for-one basis between the Company and Ventas, and corresponding option prices were adjusted in proportion to the fair values of the respective common stocks immediately following the Spin-off. Option data for periods prior to the Spin-off have not been restated.

On December 19, 1998, the Company completed the exchange of employee stock options. The exchange offer entitled employees to exchange outstanding stock options for a reduced number of options with an exercise price equal to the closing price of the Company's common stock on November 9, 1998. Exchange ratios were calculated using a Black-Scholes option valuation model. The exchange resulted in the cancellation of options to purchase approximately 5.7 million shares and the issuance of options to purchase approximately 4.6 million shares.

In connection with the Spin-off, the Company adopted an employee incentive compensation and a stock option plan for non-employee directors. These plans replaced similar plans in effect prior to the Spin-off.

Statement No. 123 Data

The Company has elected to follow Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees" ("APB 25") and related interpretations in accounting for its employee stock options because, as discussed below, the alternative fair value accounting provided for under SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123"), requires use of option valuation models that were not developed for use in valuing employee stock options. Under APB 25, because the exercise price of the Company's employee stock options is equal to the market price of the underlying stock on the date of grant, no compensation expense is recognized.

Pro forma information regarding net income and earnings per share is required by SFAS 123, which also requires that the information be determined as if the Company has accounted for its employee stock options granted subsequent to December 31, 1994 under the fair value method of SFAS 123. The fair value of such options was estimated at the date of grant using a Black-Scholes option valuation model with the following weighted average assumptions: risk-free interest rate of 5.90% for 2000, 5.30% for 1999 and 4.96% for 1998; no dividend yield; expected term of seven years and volatility factors of the expected market price of the Company's common stock of .85 for 2000, .82 for 1999 and .42 for 1998.

NOTE 14--CAPITAL STOCK (Continued)

Statement No. 123 Data (Continued)

A Black-Scholes option valuation model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly subjective assumptions including the expected stock price volatility. Because the Company's employee stock options have characteristics significantly different from those of traded options, and because the changes in the subjective input assumptions can affect materially the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

For purposes of pro forma disclosures, the estimated fair value of the options is amortized to expense over the respective vesting period. The weighted average fair values of options granted during 1999 and 1998 under a Black-Scholes valuation model were $1.92 and $2.62, respectively. There were no options granted during 2000. Pro forma information follows (in thousands except per share amounts):

	2000	1999	1998
Pro forma loss available to common stockholders........................	$(71,296)	$(725,319)	$(663,440)
Pro forma loss per common share:			
Basic...............................	$ (1.02)	$ (10.30)	$ (9.71)
Diluted.............................	$ (1.02)	$ (10.30)	$ (9.71)

NOTE 15--EMPLOYEE BENEFIT PLANS

The Company maintains defined contribution retirement plans covering employees who meet certain minimum eligibility requirements. Benefits are determined as a percentage of a participant's contributions and generally are vested based upon length of service. Retirement plan expense was $8.8 million for 2000, $10.8 million for 1999 and $12.7 million for 1998. Amounts equal to retirement plan expense are funded annually.

The Company also established a supplemental executive retirement plan in 1998 covering certain officers under which benefits are determined based primarily upon participants' compensation and length of service to the Company. The cost of the plan aggregated $300,000 for 2000 and $11.0 million for 1999. In January 1999, the Company funded $3.7 million of plan obligations to participants through the purchase of annuities. As discussed in Note 6, the plan was curtailed by the Board of Directors in December 1999.

NOTE 16--ACCRUED LIABILITIES

A summary of other accrued liabilities at December 31 follows (in thousands):

	2000	1999
Patient accounts..	$24,490	$23,893
Professional liability risks............................	17,888	22,632
Taxes other than income.................................	16,723	11,353
Other...	24,701	26,089

	$83,802	$83,967

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 17--TRANSACTIONS WITH VENTAS

For the purpose of governing certain of the ongoing relationships between the Company and Ventas after the Spin-off and to provide mechanisms for an orderly transition, the Company and Ventas entered into various agreements. The most significant agreements are as follows:

Master Lease Agreements

Ventas retained substantially all of the real property, buildings and other improvements (primarily nursing centers and long-term acute care hospitals) in the Spin-off and leases them to the Company under four master lease agreements which set forth the material terms governing the lease of each of the leased properties. In August 1998, the Company and Ventas entered into a fifth lease agreement with respect to a nursing center in Corydon, Indiana (the "Corydon Lease"). The provisions of the Corydon Lease, except for the provisions relating to rental amounts and the termination date, are substantially similar to the terms of the other master lease agreements with Ventas. The four master lease agreements, as amended, and the Corydon Lease shall be referred to herein collectively as the "Master Lease Agreements" and each, a "Master Lease Agreement."

Each Master Lease Agreement includes land, buildings, structures and other improvements on the land, easements and similar appurtenances to the land and improvements, permanently affixed equipment, and machinery and other fixtures relating to the operation of the leased properties. There are multiple bundles of leased properties under each Master Lease Agreement (other than the Corydon Lease) with each bundle containing approximately seven to twelve leased properties. All leased properties within a bundle have the same primary terms, ranging from 10 to 15 years (the "Base Term"). At the option of the Company, all, but not less than all, of the leased properties in a bundle may be extended for one five-year renewal term beyond the Base Term (the "First Renewal Term") at the then existing rental rate plus 2% per annum. At the option of the Company, all, but not less than all, of the leased properties in a bundle may be extended for two additional five-year renewal terms beyond the First Renewal Term (together with the First Renewal Term, the "Renewal Term") at the then fair market value rental rate. The Base Term and Renewal Term of each leased property are subject to termination upon default by either party and certain other conditions described in the Master Lease Agreements.

The Master Lease Agreements are structured as triple-net leases or absolute-net leases. In addition to the aggregate annual rent plus 2% per annum escalator over the previous twelve-month period if certain lessee revenue parameters are obtained, the Company is required to pay all insurance, taxes, utilities and maintenance related to the leased properties. Rent expense related to Ventas in 2000, 1999 and in 1998 (eight months) aggregated $230 million, $225 million and $148 million, respectively. In connection with the Chapter 11 Cases, the Company and Ventas entered into the Stipulation which provides for the payment by the Company of a reduced aggregate monthly rent of

approximately $15.1 million beginning in September 1999. The difference between the $19.3 million aggregate monthly rent under the Master Lease Agreements and the reduced monthly rent under the Stipulation is being accrued as an administrative expense subject to compromise in the Chapter 11 Cases. During the pendency of the Chapter 11 Cases, the Company is recording the entire contractual amount of the aggregate monthly rent.

An "Event of Default" will be deemed to have occurred under any Master Lease Agreement if, among other things, the Company fails to pay rent or other amounts within five days after notice; the Company fails to comply with covenants continuing for 30 days or, so long as diligent efforts to cure such failure are being made, such longer period (not to exceed 180 days) as is necessary to cure such failure; certain bankruptcy or insolvency events occur, including filing a petition of bankruptcy or a petition for reorganization under the Bankruptcy Code; the Company ceases to operate any leased property as a provider of healthcare services for a

NOTE 17--TRANSACTIONS WITH VENTAS (Continued)

Master Lease Agreements (Continued)

period of 30 days; the Company loses any required healthcare license, permit or approval; the Company fails to maintain insurance; the Company creates or allows to remain certain liens; a reduction occurs in the number of licensed beds in excess of 10% of the number of licensed beds in the applicable facility on the date the applicable facility was leased; certification for reimbursement under Medicare with respect to a participating facility is revoked; there is any breach of any material representation or warranty of the Company; the Company becomes subject to regulatory sanctions and has failed to cure or satisfy such regulatory sanctions within its specified cure period in any material respect with respect to any facility; or there is any default under any guaranty of the lease or under certain indemnity agreements between the Company and Ventas.

Except as noted below, upon an Event of Default under a particular Master Lease Agreement, Ventas may, at its option, exercise the following remedies: (a) after not less than ten days' notice to the Company, terminate the Master Lease Agreement, repossess the leased property and relet the leased property to a third party and require the Company pay to Ventas, as liquidated damages, the net present value of the rent for the balance of the term, discounted at the prime rate; (b) without terminating the Master Lease Agreement, repossess the leased property and relet the leased property with the Company remaining liable under the Master Lease Agreement for all obligations to be performed by the Company thereunder, including the difference, if any, between the rent under the Master Lease Agreement and the rent payable as a result of the reletting of the leased property; and (c) seek any and all other rights and remedies available under law or in equity.

Certain Events of Default are considered facility-specific events of default. A facility-specific event of default is caused by (a) the loss of any required healthcare license, permit or approval, (b) a reduction in the number of licensed beds in excess of 10% of the number of licensed beds in the applicable facility or a revocation of certification for reimbursement under Medicare with respect to any facility that participates in such programs, or (c) the Company

becoming subject to regulatory sanctions and failing to cure or satisfy such regulatory sanctions within its specified cure period. Upon the occurrence of a facility-specific event of default, Ventas may, if it so desires, terminate the related Master Lease Agreement with respect to only the applicable facility that is the subject of the facility-specific event of default and collect liquidated damages attributable to such facility multiplied by the number of years remaining on the applicable lease; provided, however, that upon the occurrence of the fifth facility-specific event of default, determined on a cumulative basis, Ventas would be permitted to exercise all of the rights and remedies set forth in the Master Lease Agreement with respect to all facilities covered under the Master Lease Agreement, without regard to the facility from which such fifth facility-specific event of default emanated.

Any remedies provided under the Master Lease Agreements currently are subject to the supervision of the Bankruptcy Court. See Note 3.

Development Agreement

Under the terms of the Development Agreement, the Company, if it so desires, will complete the construction of certain development properties substantially in accordance with the existing plans and specifications for each such property. Upon completion of each such development property, Ventas has the option to purchase the development property from the Company at a purchase price equal to the amount of the Company's actual costs in acquiring, developing and improving such development property prior to the purchase date. If Ventas purchases the development property, the Company will lease the development property from Ventas. The annual base rent under such a lease will be ten percent of the actual costs incurred by the Company in acquiring and developing the development property. The other terms of the lease for the

NOTE 17--TRANSACTIONS WITH VENTAS (Continued)

Development Agreement (Continued)

development property will be substantially similar to those set forth in the Master Lease Agreements. Since the Spin-off, the Company has sold one skilled nursing center to Ventas under the Development Agreement for $6.2 million.

Participation Agreement

Under the terms and conditions of the Participation Agreement, the Company has a right of first offer to become the lessee of any real property acquired or developed by Ventas which is to be operated as a hospital, nursing center or other healthcare facility, provided that the Company and Ventas negotiate a mutually satisfactory lease arrangement.

The Participation Agreement also provides, subject to certain terms, that the Company will provide Ventas with a right of first offer to purchase or finance any healthcare related real property that the Company determines to sell or mortgage to a third party, provided that the Company and Ventas negotiate mutually satisfactory terms for such purchase or mortgage.

Transition Services Agreement

The Transition Services Agreement provided that the Company provide Ventas

with transitional administrative and support services, including but not limited to finance and accounting, human resources, risk management, legal, and information systems support through December 31, 1998. Ventas paid the Company $1.6 million in 1998 under the Transition Services Agreement.

Tax Allocation Agreement

The Tax Allocation Agreement provides that Ventas will be liable for taxes of the Ventas consolidated group attributable to periods prior to the Spin-off with respect to the portion of such taxes attributable to the property held by Ventas after the Spin-off and the Company will be liable for such pre-distribution taxes with respect to the portion of such taxes attributable to the property held by the Company after the Spin-off. The Tax Allocation Agreement further provides that Ventas will be liable for any taxes attributable to the Spin-off except that the Company will be liable for any such taxes to the extent that the Company derives certain future tax benefits as a result of the payment of such taxes. Ventas and its subsidiaries are liable for taxes payable with respect to periods after the Spin-off that are attributable to Ventas operations and the Company and its subsidiaries are liable for taxes payable with respect to periods after the Spin-off that are attributable to the Company's operations. If, in connection with a tax audit or filing of an amended return, a taxing authority adjusts the tax liability of either the Company or Ventas with respect to taxes for which the other party was liable under the Tax Allocation Agreement, such other party would be liable for the resulting tax assessment or would be entitled to the resulting tax refund. During 1998, $6.7 million was received from Ventas under the Tax Allocation Agreement. At December 31, 1998, the Company owed Ventas $5.9 million for a tax settlement under the Tax Allocation Agreement (which was repaid to Ventas in January 1999). This transaction had no impact on earnings.

The Company and Ventas disagree with respect to certain interpretations of the Tax Allocation Agreement described above. On May 31, 2000, the Company announced that the Bankruptcy Court had approved a tax stipulation agreement between the Company and Ventas (the "Tax Stipulation"). The Tax Stipulation provides that certain refunds of federal, state and local taxes received by either party on or after September 13, 1999 will be held by the recipient of such refunds in segregated interest bearing accounts. The Tax Stipulation requires notification before either party can withdraw funds from the segregated accounts and will terminate upon the effective date of the Amended Plan.

NOTE 18--OTHER RELATED PARTY TRANSACTIONS

In connection with the Spin-off, the Company loaned certain executive officers an amount equal to the estimated personal income taxes payable by them as a result of the Spin-off (the "Tax Loans"). Each Tax Loan is evidenced by a promissory note which has a term of ten years and bears interest at 5.77% per annum. Principal on the Tax Loans is scheduled to be repaid in ten equal annual installments which began on June 15, 1999. Interest is payable quarterly; however, any interest payment on the Tax Loans is forgiven if the officer remains in his or her position with the Company on the date on which such interest payment is due. Moreover, in the event of a change in control of the Company, the entire balance of the Tax Loan will be forgiven. The terms of the Tax Loans with certain former executive officers were amended in connection

with their severance agreements to provide that the payment of the principal and interest on the Tax Loans be deferred until the fifth anniversary of their respective date of termination. All Tax Loans made to current executive officers have been repaid in full.

As part of the Spin-off, the Company issued $17.7 million of its 6% Series A Non-Voting Convertible Preferred Stock (the "Preferred Stock") to Ventas as part of the consideration for the assets transferred from Ventas to the Company. The Preferred Stock (par value $1,000) includes a ten-year mandatory redemption provision and is convertible into common stock at a price of $12.50 per share. In connection with the purchases of the Preferred Stock, the Company loaned certain officers 90% of the purchase price ($15.9 million) of the Preferred Stock (the "Preferred Stock Loans"). Each Preferred Stock Loan is evidenced by a promissory note which has a ten year term and bears interest at 5.74%, payable annually. No principal payments are due under the promissory notes until their maturity. The promissory notes are secured by a first priority security interest in the Preferred Stock purchased by each such officer. As of December 31, 2000, $15.7 million of these loans remained outstanding. The terms of the Preferred Stock Loans with certain former officers were amended in connection with their severance agreements to provide, generally, that (a) the Preferred Stock Loan will not be due and payable until April 30, 2008, (b) payments on the Preferred Stock Loan will be deferred until the fifth anniversary of the date of termination, (c) interest payments will be forgiven if the average closing price of the common stock for the 90 days prior to any interest payment date is less than $8.00 and (d) during the five-day period following the expiration of the fifth anniversary of the date of termination, the former officer will have the right to put the Preferred Stock underlying the Preferred Stock Loan to the Company at par.

In August 1999, the Company entered into agreements with certain officers which permit such officer to put the Preferred Stock to the Company for an amount equal to the outstanding principal and interest on the officer's Preferred Stock Loan (the "Preferred Stock Agreements"). The officer could put the Preferred Stock to the Company after January 1, 2000. During the Chapter 11 Cases, the Company cannot honor the terms of the Preferred Stock Agreements. The Preferred Stock Agreements were entered into with each officer employed by the Company in August 1999 who owned the Preferred Stock.

NOTE 19--FAIR VALUE DATA

A summary of fair value data at December 31 follows (in thousands):

	2000		1999	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Cash and cash equivalents...............	$184,642	$184,642	$148,350	$148,350
Insurance subsidiary investments........	62,453	62,453	16,483	16,483
Restricted funds (included in other current assets).......................	10,674	10,674	9,522	9,522
Long-term debt, including amounts due within one year..................................	879,577	537,330	893,393	485,314
Interest rate swap agreements (included in long-term debt)................................	-	-	-	157

F-36

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 20--LITIGATION

Summary descriptions of various significant legal and regulatory activities follow.

On September 13, 1999, the Company and substantially all of its subsidiaries filed voluntary petitions for protection under Chapter 11 of the Bankruptcy Code. The Chapter 11 Cases have been styled In re: Vencor, Inc., et al., Debtors and Debtors in Possession, Case Nos. 99-3199 (MFW) through 99-3327 (MFW), Chapter 11, Jointly Administered. On December 14, 2000, the Company filed its Amended Plan with the Bankruptcy Court. On March 1, 2001, the Bankruptcy Court approved the Company's Amended Plan and an order was entered confirming the Amended Plan on March 16, 2001. See Note 3 for further discussion of the Chapter 11 Cases.

On March 18, 1999, the Company served Ventas with a demand for mediation pursuant to the Spin-off Agreement. The Company was seeking a reduction in rent and other concessions under its Master Lease Agreements with Ventas. On March 31, 1999, the Company and Ventas entered into a standstill agreement which provided that both companies would postpone through April 12, 1999 any claims either may have against the other. On April 12, 1999, the Company and Ventas entered into a second standstill which provided that neither party would pursue any claims against the other or any other third party related to the Spin-off as long as the Company complied with certain rent payment terms. The second standstill was scheduled to terminate on May 5, 1999. Pursuant to a tolling agreement, the Company and Ventas also agreed that any statutes of limitations or other time-related constraints in a bankruptcy or other proceeding that might be asserted by one party against the other would be extended and tolled from April 12, 1999 until May 5, 1999 or until the termination of the second standstill. As a result of the Company's failure to pay rent, Ventas served the Company with notices of nonpayment under the Master Lease Agreements. Subsequently, the Company and Ventas entered into further amendments to the second standstill and the tolling agreement to extend the time during which no remedies may be pursued by either party and to extend the date by which the Company may cure its failure to pay rent.

In connection with the Chapter 11 Cases, the Company and Ventas entered into the Stipulation that provides for the payment by the Company of a reduced aggregate monthly rent of approximately $15.1 million. The Stipulation has been approved by the Bankruptcy Court. The Stipulation also continues to toll any statutes of limitations or other time constraints in a bankruptcy proceeding for claims that might be asserted by the Company against Ventas. The Stipulation automatically renews for one-month periods unless either party provides a 14-day notice of termination. The Stipulation also may be terminated prior to its expiration upon a payment default by the Company, the consummation of a plan of reorganization or the occurrence of certain defaults under the DIP Financing. The Stipulation also provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off. The Stipulation will terminate upon the effective date of the Amended Plan.

The Company believes that the Amended Plan, if consummated, will resolve all material disputes between the Company and Ventas. The Amended Plan also provides for comprehensive mutual releases between the Company and Ventas, other than for obligations that the Company is assuming under the Amended Plan.

If the Amended Plan does not become effective and the Company and Ventas are unable to otherwise resolve their disputes or maintain an interim resolution, the Company may seek to pursue claims against Ventas arising out of the Spin-off and seek judicial relief barring Ventas from exercising any remedies based on the Company's failure to pay some or all of the rent to Ventas. The Company's failure to pay rent or otherwise comply with the Stipulation, in the absence of judicial relief, would result in an "Event of Default" under the Master Lease Agreements. Upon an Event of Default under the Master Lease Agreements, assuming Ventas were to be granted relief from the automatic stay by the Bankruptcy Court, the remedies available to Ventas include, without limitation, terminating the Master Lease Agreements, repossessing and reletting the leased

NOTE 20--LITIGATION (Continued)

properties and requiring the Company to (a) remain liable for all obligations under the Master Lease Agreements, including the difference between the rent under the Master Lease Agreements and the rent payable as a result of reletting the leased properties or (b) pay the net present value of the rent due for the balance of the terms of the Master Lease Agreements. Such remedies, however, would be subject to the supervision of the Bankruptcy Court.

The Company's subsidiary, formerly named TheraTx, Incorporated, is plaintiff in a declaratory judgment action entitled TheraTx, Incorporated v. James W. Duncan, Jr., et al., No. 1:95-CV-3193, filed in the United States District Court for the Northern District of Georgia and currently pending in the United States Court of Appeals for the Eleventh Circuit, No. 99-11451-FF. The defendants have asserted counterclaims against TheraTx under breach of contract, securities fraud, negligent misrepresentation and other fraud theories for allegedly not performing as promised under a merger agreement related to TheraTx's purchase of a company called PersonaCare, Inc. and for allegedly failing to inform the defendants/counterclaimants prior to the merger that TheraTx's possible acquisition of Southern Management Services, Inc. might cause the suspension of TheraTx's shelf registration under relevant rules of the Securities and Exchange Commission (the "Commission"). The court granted summary judgment for the defendants/counterclaimants and ruled that TheraTx breached the shelf registration provision in the merger agreement, but dismissed the defendants' remaining counterclaims. Additionally, the court ruled after trial that defendants/counterclaimants were entitled to damages and prejudgment interest in the amount of approximately $1.3 million and attorneys' fees and other litigation expenses of approximately $700,000. The Company and the defendants/counterclaimants both appealed the court's rulings. The Court of Appeals for the Eleventh Circuit affirmed the trial court's rulings with the exception of the damages award and certified the question of the proper calculation of damages under Delaware law to the Delaware Supreme Court. The Company is defending the action vigorously.

The Company is pursuing various claims against private insurance companies who issued Medicare supplement insurance policies to individuals who became patients of the Company's hospitals. After the patients' Medicare benefits are exhausted, the insurance companies become liable to pay the insureds' bills pursuant to the terms of these policies. The Company has filed numerous collection actions against various of these insurers to collect the difference between what Medicare would have paid and the hospitals' usual and customary

charges. These disputes arise from differences in interpretation of the policy provisions and federal and state laws governing such policies. Various courts have issued various rulings on the different issues, some of which have been adverse to the Company and most of which have been appealed. The Company intends to continue to pursue these claims vigorously. If the Company does not prevail on these issues, future results of operations and liquidity would be materially adversely affected.

A class action lawsuit entitled A. Carl Helwig v. Vencor, Inc., et al., was filed on December 24, 1997 in the United States District Court for the Western District of Kentucky (Civil Action No. 3-97CV-8354). The class action claims were brought by an alleged stockholder of the Company's predecessor against the Company and Ventas and certain current and former executive officers and directors of the Company and Ventas. The complaint alleges that the Company, Ventas and certain current and former executive officers of the Company and Ventas during a specified time frame violated Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 (the "Exchange Act"), by, among other things, issuing to the investing public a series of false and misleading statements concerning Ventas' then current operations and the inherent value of its common stock. The complaint further alleges that as a result of these purported false and misleading statements concerning Ventas' revenues and successful acquisitions, the price of the common stock was artificially inflated. In particular, the complaint alleges that the defendants issued false and misleading financial statements during the first, second and third calendar quarters of 1997 which misrepresented and understated the impact that changes in Medicare reimbursement policies would have on Ventas' core services and profitability. The complaint

NOTE 20--LITIGATION (Continued)

further alleges that the defendants issued a series of materially false statements concerning the purportedly successful integration of Ventas' acquisitions and prospective earnings per share for 1997 and 1998 which the defendants knew lacked any reasonable basis and were not being achieved. The suit seeks damages in an amount to be proven at trial, pre-judgment and post-judgment interest, reasonable attorneys' fees, expert witness fees and other costs, and any extraordinary equitable and/or injunctive relief permitted by law or equity to assure that the plaintiff has an effective remedy. In December 1998, the defendants filed a motion to dismiss the case. The court converted the defendants' motion to dismiss into a motion for summary judgment and granted summary judgment as to all defendants. The plaintiff appealed the ruling to the United States Court of Appeals for the Sixth Circuit. On April 24, 2000, the Sixth Circuit affirmed the district court's dismissal of the action on the grounds that the plaintiff failed to state a claim upon which relief could be granted. On July 14, 2000, the Sixth Circuit granted the plaintiff's petition for a rehearing en banc. The Company is defending this action vigorously.

A shareholder derivative suit entitled Thomas G. White on behalf of Vencor, Inc. and Ventas, Inc. v. W. Bruce Lunsford, et al., Case No. 98CI03669, was filed in June 1998 in the Jefferson County, Kentucky, Circuit Court. The suit was brought on behalf of the Company and Ventas against certain current and former executive officers and directors of the Company and Ventas. The complaint alleges that the defendants damaged the Company and Ventas by engaging in violations of the securities laws, engaging in insider trading,

fraud and securities fraud and damaging the reputation of the Company and Ventas. The plaintiff asserts that such actions were taken deliberately, in bad faith and constitute breaches of the defendants' duties of loyalty and due care. The complaint is based on substantially similar assertions to those made in the class action lawsuit entitled A. Carl Helwig v. Vencor, Inc., et al., discussed above. The suit seeks unspecified damages, interest, punitive damages, reasonable attorneys' fees, expert witness fees and other costs, and any extraordinary equitable and/or injunctive relief permitted by law or equity to assure that the Company and Ventas have an effective remedy. The Company believes that the allegations in the complaint are without merit and intends to defend this action vigorously.

A class action lawsuit entitled Jules Brody v. Transitional Hospitals Corporation, et al., Case No. CV-S-97-00747-PMP, was filed on June 19, 1997 in the United States District Court for the District of Nevada on behalf of a class consisting of all persons who sold shares of Transitional common stock during the period from February 26, 1997 through May 4, 1997, inclusive. The complaint alleges that Transitional purchased shares of its common stock from members of the investing public after it had received a written offer to acquire all of the Transitional common stock and without making the required disclosure that such an offer had been made. The complaint further alleges that defendants disclosed that there were "expressions of interest" in acquiring Transitional when, in fact, at that time, the negotiations had reached an advanced stage with actual firm offers at substantial premiums to the trading price of Transitional's stock having been made which were actively being considered by Transitional's Board of Directors. The complaint asserts claims pursuant to Sections 10(b), 14(e) and 20(a) of the Exchange Act, and common law principles of negligent misrepresentation and names as defendants Transitional as well as certain former senior executives and directors of Transitional. The plaintiff seeks class certification, unspecified damages, attorneys' fees and costs. In June 1998, the court granted the Company's motion to dismiss with leave to amend the Section 10(b) claim and the state law claims for misrepresentation. The court denied the Company's motion to dismiss the Section 14(e) and Section 20(a) claims, after which the Company filed a motion for reconsideration. On March 23, 1999, the court granted the Company's motion to dismiss all remaining claims and the case was dismissed. The plaintiff has appealed this ruling to the United States Court of Appeals for the Ninth Circuit. The Company is defending this action vigorously.

NOTE 20--LITIGATION (Continued)

On April 14, 1999, a lawsuit entitled Lenox Healthcare, Inc., et al. v. Vencor, Inc., et al., Case No. BC 208750, was filed in the Superior Court of Los Angeles, California by Lenox Healthcare, Inc. ("Lenox") asserting various causes of action arising out of the Company's sale and lease of several nursing centers to Lenox in 1997. Lenox subsequently removed certain of its causes of action and refiled these claims before the United States District Court for the Western District of Kentucky in a case entitled Lenox Healthcare, Inc. v. Vencor, Inc., et al., Case No. 3:99 CV-348-H. The Company asserted counterclaims, including RICO claims, against Lenox in the Kentucky action. The Company believes that the allegations made by Lenox in both complaints are without merit. Lenox and its subsidiaries filed for protection under Chapter 11 of the Bankruptcy Code on November 3, 1999. By virtue of both the Company's and Lenox's separate filings for Chapter 11 protection, the two Lenox actions and the Company's counterclaims were stayed. Subsequently, the parties entered into

a settlement, which was approved by their respective bankruptcy courts, that requires the dismissal of the two above actions. Joint motions to dismiss have been filed by the parties in each court.

The Company was informed by the DOJ that the Company and Ventas are the subjects of investigations into various Medicare reimbursement issues, including hospital cost reporting issues, Vencare billing practices and various quality of care issues in the hospitals and nursing centers formerly operated by Ventas and currently operated by the Company. These investigations include some matters for which the Company indemnified Ventas in the Spin-off. In cases where neither the Company nor any of its subsidiaries are defendants but Ventas is the defendant, the Company had agreed to defend and indemnify Ventas for such claims as part of the Spin-off. The Stipulation entered into with Ventas provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off. The Company has cooperated fully in the investigations.

The DOJ has informed the Company that it has intervened in several pending qui tam actions asserted against the Company and/or Ventas in connection with these investigations. In addition, the DOJ has filed proofs of claims with respect to certain alleged claims in the Chapter 11 Cases. The Company, Ventas and the DOJ have finalized the terms of the Government Settlement which will resolve all of the DOJ investigations including the pending qui tam actions. The Government Settlement provides that within 30 days after the Amended Plan becomes effective, the Government will move to dismiss with prejudice to the United States and the relators (except for certain claims which will be dismissed without prejudice to the United States in certain of these cases) the pending qui tam actions as against any or all of the Company and its subsidiaries, Ventas and any current or former officers, directors and employees of either entity. There can be no assurance that each court before which a qui tam action is pending will dismiss the case on the DOJ's motion.

The following is a summary of the qui tam actions pending against the Company and/or Ventas in which the DOJ has intervened. In connection with the DOJ's intervention, the courts ordered these previously non-public actions to be unsealed. Certain of the actions described below name other defendants in addition to the Company and Ventas.

(a) The Company, Ventas and the Company's subsidiary, American X-Rays, Inc. ("AXR"), are defendants in a civil qui tam action styled United States ex rel. Doe v. American X-Rays Inc., et al., No. LR-C-95-332, pending in the United States District Court for the Eastern District of Arkansas and served on AXR on July 7, 1997. The DOJ intervened in the suit which was brought under the Federal Civil False Claims Act and added the Company and Ventas as defendants. The Company acquired an interest in AXR when The Hillhaven Corporation was merged into the Company in September 1995 and purchased the remaining interest in AXR in February 1996. AXR provided portable X-ray services to nursing centers (including some of those operated by Ventas or the Company) and other healthcare

providers. The civil suit alleges that AXR submitted false claims to the Medicare and Medicaid programs. The suit seeks damages in an amount of not

less than $1,000,000, treble damages and civil penalties. The Company has defended this action vigorously. The court has dismissed the action based upon the possible pending settlement between the DOJ, the Company and Ventas. In a related criminal investigation, the United States Attorney's Office for the Eastern District of Arkansas ("USAO") indicted four former employees of AXR; those individuals were convicted of various fraud related counts in January 1999. AXR had been informed previously that it was not a target of the criminal investigation, and AXR was not indicted. However, the Company received several grand jury subpoenas for documents and witnesses which it moved to quash. The USAO has withdrawn the subpoenas which rendered the motion moot.

(b) The Company's subsidiary, Medisave Pharmacies, Inc. ("Medisave"), Ventas and Hillhaven (former parent company to Medisave), are the defendants in a civil qui tam action styled United States ex rel. Danley v. Medisave Pharmacies, Inc., et al., No. CV-N-96-00170-HDM, filed in the United States District Court for the District of Nevada on March 15, 1996. The plaintiff alleges that Medisave, an institutional pharmacy provider, formerly owned by Ventas and owned by the Company since the Spin-off: (1) charged the Medicare program for unit dose drugs when bulk drugs were administered and charged skilled nursing facilities more for the same drugs for Medicare patients than for non-Medicare patients; (2) improperly claimed special dispensing fees that it was not entitled to under Medicaid; and (3) recouped unused drugs from skilled nursing facilities and returned these drugs to its stock without crediting Medicare or Medicaid, all in violation of the Federal Civil False Claims Act. The complaint also alleges that Medisave had a policy of offering kickbacks, such as free equipment, to skilled nursing centers to secure and maintain their business. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint. The defendants intend to defend this action vigorously.

(c) Ventas and the Company's subsidiary, Vencare, Inc. ("Vencare"), among others, are defendants in the action styled United States ex rel. Roberts v. Vencor, Inc., et al., No. 3:97CV-349-J, filed in the United States District Court for the Western District of Kansas on June 25, 1996 and consolidated with the action styled United States of America ex rel. Meharg, et al. v. Vencor, Inc., et al., No. 3:98SC-737-H, filed in the United States District Court for the Middle District of Florida on June 4, 1998. The complaint alleges that the defendants knowingly submitted and conspired to submit false claims and statements to the Medicare program in connection with their purported provision of respiratory therapy services to skilled nursing center residents. The defendants allegedly billed Medicare for respiratory therapy services and supplies when those services were not medically necessary, billed for services not provided, exaggerated the time required to provide services or exaggerated the productivity of their therapists. It is further alleged that the defendants presented false claims and statements to the Medicare program in violation of the Federal Civil False Claims Act, by, among other things, allegedly causing skilled nursing centers with which they had respiratory therapy contracts, to present false claims to Medicare for respiratory therapy services and supplies. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint. The defendants intend to defend this action vigorously.

(d) In United States ex rel. Kneepkens v. Gambro Healthcare, Inc., et al., No. 97-10400-GAO, filed in the United States District Court for the District of Massachusetts on October 15, 1998, the Company's subsidiary, Transitional, and two unrelated entities, Gambro Healthcare, Inc. and Dialysis Holdings, Inc., are defendants in this suit alleging that they violated the Federal Civil False Claims Act and the Medicare and Medicaid

antikickback, antifraud and abuse regulations and committed common law fraud, unjust enrichment and payment by mistake of fact. Specifically, the complaint alleges that a predecessor to

NOTE 20--LITIGATION (Continued)

Transitional formed a joint venture with Damon Clinical Laboratories to create and operate a clinical testing laboratory in Georgia that was then used to provide lab testing for dialysis patients, and that the joint venture billed at below cost in return for referral of substantially all non-routine testing in violation of Medicare and Medicaid antikickback and antifraud regulations. It is further alleged that a predecessor to Transitional and Damon Clinical Laboratories used multiple panel testing of end stage renal disease rather than single panel testing that allegedly resulted in the generation of additional revenues from Medicare and that the entities allegedly added non-routine tests to tests otherwise ordered by physicians that were not requested or medically necessary but resulted in additional revenue from Medicare in violation of the antikickback and antifraud regulations. Transitional has moved to dismiss the case. Transitional disputes the allegations in the complaint and is defending the action vigorously.

(e) The Company and/or Ventas are defendants in the action styled United States ex rel. Huff and Dolan v. Vencor, Inc., et al., No. 97-4358 AHM (Mcx), filed in the United States District Court for the Central District of California on June 13, 1997. The plaintiff alleges that the defendant violated the Federal Civil False Claims Act by submitting false claims to the Medicare, Medicaid and CHAMPUS programs by allegedly: (1) falsifying patient bills and submitting the bills to the Medicare, Medicaid and CHAMPUS programs, (2) submitting bills for intensive and critical care not actually administered to patients, (3) falsifying patient charts in relation to the billing, (4) charging for physical therapy services allegedly not provided and pharmacy services allegedly provided by non-pharmacists, and (5) billing for sales calls made by nurses to prospective patients. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. Defendants dispute the allegations in the complaint. The Company, on behalf of itself and Ventas, intends to defend this action vigorously.

(f) Ventas is the defendant in the action styled United States ex rel. Brzycki v. Vencor, Inc., Civ. No. 97-451-JD, filed in the United States District Court for the District of New Hampshire on September 8, 1997. Ventas is alleged to have knowingly violated the Federal Civil False Claims Act by submitting and conspiring to submit false claims to the Medicare program. The complaint alleges that Ventas: (1) fabricated diagnosis codes by ordering medically unnecessary services, such as respiratory therapy; (2) changed referring physicians' diagnoses in order to qualify for Medicare reimbursement; and (3) billed Medicare for oxygen use by patients regardless of whether the oxygen was actually administered to particular patients. The complaint further alleges that Ventas paid illegal kickbacks to referring healthcare professionals in the form of medical consulting service agreements as an alleged inducement to refer patients, in violation of the Federal Civil False Claims Act, the antikickback and antifraud regulations and the Stark provisions. It is additionally alleged that Ventas consistently submitted Medicare claims for clinical services that

were not performed or were performed at lower actual costs. The complaint seeks unspecified damages, civil penalties, attorneys' fees and costs. Ventas disputes the allegations in the complaint. The Company, on behalf of Ventas, intends to defend the action vigorously.

(g) United States ex rel. Lanford and Cavanaugh v. Vencor, Inc., et al., Civ. No. 97-CV-2845, was filed against Ventas in the United States District Court for the Middle District of Florida, on November 24, 1997. The United States of America intervened in this civil qui tam lawsuit on May 17, 1999. On July 23, 1999, the United States filed its amended complaint in the lawsuit and added the Company as a defendant. The lawsuit alleges that the Company and Ventas knowingly submitted false claims and false statements to the Medicare and Medicaid programs including, but not limited to, claims for reimbursement of costs for certain ancillary services performed in defendants' nursing centers and for third-party nursing center operators that the United States alleges are not properly reimbursable costs through the hospitals' cost reports. The lawsuit involves the Company's hospitals which were owned by Ventas prior to the Spin-off. The complaint does not specify the amount of damages sought. The Company and Ventas dispute the allegations in the amended complaint and intend to defend this action vigorously.

NOTE 20--LITIGATION (Continued)

(h) In United States ex rel. Harris and Young v. Vencor, Inc., et al., filed in the Eastern District of Missouri on May 25, 1999, the defendants include the Company, Vencare, and Ventas. The defendants allegedly submitted and conspired to submit false claims for payment to the Medicare and CHAMPUS programs, in violation of the Federal Civil False Claims Act. According to the complaint, the Company, through its subsidiary, Vencare, allegedly (1) over billed for respiratory therapy services, (2) rendered medically unnecessary treatment, and (3) falsified supply, clinical and equipment records. The defendants also allegedly encouraged or instructed therapists to falsify clinical records and over prescribe therapy services. The complaint seeks treble damages, other unspecified damages, civil penalties, attorneys' fees and other costs. The Company disputes the allegations in the complaint and intends to defend this action vigorously. The action has been dismissed with prejudice as to the relator and without prejudice as to the United States.

(i) In United States ex rel. George Mitchell, et al. v. Vencor, Inc., et al., filed in the United States District Court for the Southern District of Ohio on August 13, 1999, the defendants, consisting of the Company and its two subsidiaries, Vencare and Vencor Hospice, Inc., are alleged to have violated the Federal Civil False Claims Act by obtaining improper reimbursement from Medicare concerning the treatment of hospice patients. Defendants are alleged to have obtained inflated Medicare reimbursement for admitting, treating and/or failing to discharge in a timely manner hospice patients who were not "hospice appropriate." The complaint further alleges that the defendants obtained inflated reimbursement for providing medications for these hospice patients. The complaint alleges damages in excess of $1,000,000. The Company disputes the allegations in the complaint and intends to defend vigorously the action.

(j) In Gary Graham, on Behalf of the United States of America v. Vencor Operating, Inc. et. al., filed in the United States District Court for the Southern District of Florida on or about June 8, 1999, the defendants, including the Company, its subsidiary, Vencor Operating, Inc., Ventas, Hillhaven and Medisave, are alleged to have presented or caused to be presented false or fraudulent claims for payment to the Medicare program in violation of, among other things, the Federal Civil False Claims Act. The complaint alleges that Medisave, a subsidiary of the Company which was transferred from Ventas to the Company in the Spin-off, systematically up-charged for drugs and supplies dispensed to Medicare patients. The complaint seeks unspecified damages, civil penalties, interest, attorneys' fees and other costs. The Company disputes the allegations in the complaint and intends to defend this action vigorously.

(k) In United States, et al., ex rel. Phillips-Minks, et al. v. Transitional Corp., et al., filed in the United States District Court for Southern District of California on July 23, 1998, the defendants, including Transitional and Ventas, are alleged to have submitted and conspired to submit false claims and statements to Medicare, Medicaid, and other federal and state funded programs during a period commencing in 1993. The conduct complained of allegedly violates the Federal Civil False Claims Act, the California False Claims Act, the Florida False Claims Act, the Tennessee Health Care False Claims Act, and the Illinois Whistleblower Reward and Protection Act. The defendants allegedly submitted improper and erroneous claims to Medicare, Medicaid and other programs, for improper or unnecessary services and services not performed, inadequate collections efforts associated with billing and collecting bad debts, inflated and nonexistent laboratory charges, false and inadequate documentation of claims, splitting charges, shifting revenues and expenses, transferring patients to hospitals that are reimbursed by Medicare at a higher level, failing to return duplicate reimbursement payments, and improperly allocating hospital insurance expenses. In addition, the complaint alleges that the defendants were inconsistent in their reporting of cost report data, paid kickbacks to increase patient referrals to hospitals, and incorrectly reported employee compensation resulting in inflated employee 401(k) contributions. The complaint seeks unspecified

NOTE 20--LITIGATION (Continued)

damages. The Company disputes the allegations in the complaint and intends to defend this action vigorously.

In connection with the Spin-off, liabilities arising from various legal proceedings and other actions were assumed by the Company and the Company agreed to indemnify Ventas against any losses, including any costs or expenses, it may incur arising out of or in connection with such legal proceedings and other actions. The indemnification provided by the Company also covers losses, including costs and expenses, which may arise from any future claims asserted against Ventas based on the former healthcare operations of Ventas. In connection with its indemnification obligation, the Company has assumed the defense of various legal proceedings and other actions. The Stipulation entered into with Ventas provides that the Company will continue to fulfill its indemnification obligations arising from the Spin-off.

The Company is a party to certain legal actions and regulatory investigations

arising in the normal course of its business. The Company is unable to predict the ultimate outcome of pending litigation and regulatory investigations. In addition, there can be no assurance that the DOJ, HCFA or other regulatory agencies will not initiate additional investigations related to the Company's businesses in the future, nor can there be any assurance that the resolution of any litigation or investigations, either individually or in the aggregate, would not have a material adverse effect on the Company's results of operations, liquidity or financial position. In addition, the above litigation and investigations (as well as future litigation and investigations) are expected to consume the time and attention of the Company's management and may have a disruptive effect upon the Company's operations.

NOTE 21--COURT APPROVAL OF PLAN OF REORGANIZATION

On March 1, 2001, the Bankruptcy Court approved the Amended Plan. The order confirming the Amended Plan was entered on March 16, 2001. The Amended Plan must be effective no later than May 1, 2001.

In connection with the confirmation hearing, the Company entered into a commitment letter for the Exit Facility. The Exit Facility will be available to fund the Company's obligations under the Amended Plan and its ongoing operations following emergence from bankruptcy.

The consummation of the Amended Plan is subject to a number of material conditions including, without limitation, the negotiation and execution of definitive agreements for the Exit Facility. There can be no assurance that the Amended Plan will be consummated.

Amended Plan of Reorganization

The Amended Plan represents a consensual arrangement among Ventas, the Company's senior bank lenders (the "Senior Lenders"), holders of the 1998 Notes, the DOJ, acting on behalf of the Department of Health and Human Services' Office of the Inspector General (the "OIG") and HCFA (collectively, the "Government") and the advisors to the official committee of unsecured creditors.

The Company distributed its disclosure materials soliciting approval of the Amended Plan on December 29, 2000. Voting on the Amended Plan concluded on February 15, 2001 (other than for Ventas, which voted prior to the confirmation hearing) and the Company received the requisite acceptances from various creditor classes to confirm the Amended Plan.

NOTE 21--COURT APPROVAL OF PLAN OF REORGANIZATION (Continued)

Amended Plan of Reorganization (Continued)

The following is a summary of certain material provisions of the Amended Plan. The summary does not purport to be complete and is qualified in its entirety by reference to all of the provisions of the Amended Plan, including all exhibits and documents described therein, as filed with the Bankruptcy Court and as may otherwise be amended, modified or supplemented.

The Amended Plan provides for, among other things, the following distributions:

Senior Lender Claims--The Senior Lenders will receive, in the aggregate, new senior subordinated secured notes in the principal amount of $300 million, bearing interest at the rate of LIBOR plus 4 1/2%, with a maturity of seven years (the "New Senior Secured Notes"). The interest on the New Senior Secured Notes will begin to accrue approximately two quarters following the effective date of the Amended Plan and, in lieu of interest payments, the Company will pay a $25.9 million obligation under the Government Settlement within the first two full fiscal quarters following the effective date of the Amended Plan as described below. In addition, holders of the Senior Lender claims will receive an aggregate distribution of 65.51% of the new common stock (the "New Common Stock") of the reorganized Company (subject to dilution from stock issuances occurring after the effective date of the Amended Plan).

Senior Subordinated Noteholder Claims--The holders of the 1998 Notes and the remaining $2.4 million of the Company's 8 5/8% Senior Subordinated Notes due 2007 (collectively, the "Subordinated Noteholder Claims") will receive, in the aggregate, 24.50% of the New Common Stock (subject to dilution from stock issuances occurring after the effective date of the Amended Plan). In addition, the holders of the Subordinated Noteholder Claims will receive, in the aggregate, warrants issued by the Company for the purchase of an aggregate of 7,000,000 shares of New Common Stock, with a five-year term, which will consist of warrants to purchase 2,000,000 shares at a price per share of $30.00, and warrants to purchase 5,000,000 shares at a price per share of $33.33.

Ventas Claim--Ventas will receive the following treatment under the Amended Plan:

The four master leases and the Corydon Lease with Ventas will be assumed and simultaneously amended and restated as of the effective date of the Amended Plan (the "Amended Leases"). The principal economic terms of the Amended Leases are as follows:

(1) A decrease of $52 million in the aggregate minimum rent from the annual rent as of May 1, 1999 to a new initial aggregate minimum rent of $174.6 million as of the first month after the effective date of the Amended Plan.

(2) Annual aggregate minimum rent payable in cash will escalate at an annual rate of 3.5% over the prior period annual aggregate minimum rent for the period from May 1, 2001 through April 30, 2004. Thereafter, annual aggregate minimum rent payable in cash will escalate at an annual rate of 2%, plus an additional annual accrued escalator amount of 1.5% of the prior period annual aggregate minimum rent which will accrete from year to year (with an interest accrual at LIBOR plus 4 1/2%). All accrued rent will be payable upon the repayment or refinancing of the New Senior Secured Notes, after which the annual aggregate minimum rent payable in cash will escalate at an annual rate of 3.5% and there will be no further accrual feature.

(3) A one-time option, that can be exercised by Ventas 5 1/4 years after the effective date of the Amended Plan, to reset the annual aggregate minimum rent under one or more of the Amended Leases to the then current fair market rental in exchange for a payment of $5 million (or a pro rata portion thereof if fewer than all of the Amended Leases are reset) to the Company.

NOTE 21--COURT APPROVAL OF PLAN OF REORGANIZATION (Continued)

Amended Plan of Reorganization (Continued)

(4) Under the Amended Leases, the "Event of Default" provisions also will be substantially modified and will provide Ventas with more flexibility in exercising remedies for events of default.

In addition to the Amended Leases, Ventas will receive a distribution of 9.99% of the New Common Stock (subject to dilution from stock issuances occurring after the effective date of the Amended Plan).

Ventas also will enter into a tax escrow agreement with the Company as of the effective date that will provide for the escrow of approximately $30 million of federal, state and local refunds until the expiration of the applicable statutes of limitation for the auditing of the refund applications. The escrowed funds will be available for the payment of certain tax deficiencies during the escrow period except that all interest paid by the government in connection with any refund or earned on the escrowed funds will be distributed equally to the parties. At the end of the escrow period, the Company and Ventas will each be entitled to 50% of any proceeds remaining in the escrow account.

All agreements and indemnification obligations between the Company and Ventas, except those modified by the Amended Plan, will be assumed by the Company as of the effective date of the Amended Plan.

United States Claims--The claims of the Government (other than claims of the Internal Revenue Service and criminal claims, if any) will be settled through a government settlement with the Company and Ventas which will be effectuated through the Amended Plan.

Under the Government Settlement, the Company will pay the Government a total of $25.9 million, which will be paid as follows:

(1) $10 million on the effective date of the Amended Plan, and

(2) an aggregate of $15.9 million during the first two full fiscal quarters following the effective date, plus accrued interest at the rate of 6% per annum beginning as of the effective date of the Amended Plan.

Under the Government Settlement, Ventas will pay the Government a total of $103.6 million, which will be paid as follows:

(1) $34 million on the effective date of the Amended Plan, and

(2) the remainder paid over five years, bearing interest at the rate of 6% per annum beginning as of the effective date of the Amended Plan.

In addition, the Company will repay the remaining balance of the obligations under the HCFA Agreement (approximately $63.4 million as of December 31, 2000) pursuant to the terms previously agreed to by the Company. As previously announced, the Company has entered into a Corporate Integrity Agreement with the OIG as part of the overall Government Settlement. The Government Settlement also provides for the dismissal of certain pending claims and lawsuits filed against the Company. See Note 20.

General Unsecured Creditors Claims--The general unsecured creditors of the Company will be paid the full amount of their allowed claims existing as of the date of the Company's filing for protection under the Bankruptcy Code. These amounts will be paid in equal quarterly installments over three years beginning at the end of the first full fiscal quarter following the effective date. The

Company will pay interest on these claims at the rate of 6% per annum from the effective date of the Amended Plan, subject to certain exceptions. A convenience class of unsecured creditors, consisting of creditors holding allowed claims in an amount less than or equal to $3,000, will be paid in full within 30 days of the effective date of the Amended Plan.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

NOTE 21--COURT APPROVAL OF PLAN OF REORGANIZATION (Continued)

Amended Plan of Reorganization (Continued)

Preferred Stockholder and Common Stockholder Claims--The holders of preferred stock and common stock of the Company will not receive any distributions under the Amended Plan. The preferred stock and common stock will be canceled on the effective date of the Amended Plan.

NOTE 22--EMERGENCE FROM PROCEEDINGS UNDER CHAPTER 11

On April 20, 2001, the Company and its subsidiaries emerged from proceedings under the Bankruptcy Code pursuant to the terms of the Amended Plan described in Note 21.

On the date of emergence, the Company entered into a five-year $120 million senior revolving credit facility (including a $40 million letter of credit subfacility) with a lending group led by Morgan Guaranty Trust Company of New York (the "Credit Facility"). The Credit Facility constitutes a working capital facility for general corporate purposes including payments related to the Company's obligations under the Amended Plan. Direct borrowings under the Credit Facility will bear interest, at the option of the Company, at (a) prime (or, if higher, the federal funds rate plus 1/2%) plus 3% or (b) one, two, three or six month LIBOR plus 4%. The Credit Facility is collateralized by substantially all of the assets of the Company and its subsidiaries, including certain owned real property.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION (UNAUDITED)
(In thousands, except per share amounts)

	2000			
	First	Second	Third	Fourth
Revenues	$715,456	$713,424	$717,253	$ 742,409
Net loss (restated)	(18,564)	(7,985)	(29,357)	(8,845)
Loss per common share (restated):				
Basic	(0.27)	(0.12)	(0.42)	(0.13)
Diluted	(0.27)	(0.12)	(0.42)	(0.13)
Market prices (a):				
High	0.24	0.13	0.13	0.09

Low	0.11	0.07	0.07	0.03

	1999			
	First	Second	Third	Fourth
Revenues	$700,232	$688,892	$681,924	$ 594,593
Net loss (restated):				
Loss from operations (b)	(20,224)	(46,085)	(47,996)	(591,159)(c)
Cumulative effect of change in accounting for start-up costs	(8,923)	-	-	-
Net loss	(29,147)	(46,085)	(47,996)	(591,159)
Loss per common share (restated):				
Basic:				
Loss from operations	(0.29)	(0.66)	(0.69)	(8.39)
Cumulative effect of change in accounting for start-up costs	(0.13)	-	-	-
Net loss	(0.42)	(0.66)	(0.69)	(8.39)
Diluted:				
Loss from operations	(0.29)	(0.66)	(0.69)	(8.39)
Cumulative effect of change in accounting for start-up costs	(0.13)	-	-	-
Net loss	(0.42)	(0.66)	(0.69)	(8.39)
Market prices (a):				
High	5.00	1.13	0.26	0.27
Low	0.81	0.13	0.06	0.07

(a) Vencor common stock is traded on the OTC Bulletin Board under the ticker symbol of VCRIQ (formerly VCRI). The Company's common stock was delisted from the New York Stock Exchange on June 7, 1999.

(b) Includes the effect of certain unusual transactions and a charge to establish a deferred tax valuation allowance. See Notes 6 and 9 of the Notes to Consolidated Financial Statements for a description of these transactions.

(c) Includes certain year-end adjustments. See Note 7 of the Notes to Consolidated Financial Statements for a description of these adjustments.

KINDRED HEALTHCARE, INC.
(Formerly Vencor, Inc., a Debtor-in-Possession)
SCHEDULE II--VALUATION AND QUALIFYING ACCOUNTS
FOR THE YEARS ENDED DECEMBER 31, 2000, 1999 AND 1998
(In thousands)

		Additions			
	Balance at Beginning of Period	Charged to Costs and Expenses	Acquisitions	Deductions or Payments	Balance at End of Period
Allowances for loss on accounts receivable:					
Year ended December 31, 1998	$ 57,023	$ 64,008(a)	$ -	$(14,560)	$106,471

Year ended December 31, 1999.............	106,471	114,578	-	(40,994)	180,055
Year ended December 31, 2000.............	180,055	28,911	-	(69,521)	139,445
Allowances for loss on assets held for disposition:					
Year ended December 31, 1998.............	31,422	64,676(b)	-	(18,172)	77,926
Year ended December 31, 1999.............	77,926	10,135(c)	-	(13,245)	74,816
Year ended December 31, 2000.............	74,816	2,405	-	(52,377)	24,844

(a) Includes unusual charges of $8.4 million.

(b) Reflects provision for loss associated with the sale or closure of home health and hospice operations, planned disposal of canceled construction projects and corporate office properties, and closure of two hospitals.

(c) Included in unusual transactions related to corporate properties.