KINDRED HEALTHCARE, INC
Form 10-K
March 08, 2006
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE

SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2005

OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE

SECURITIES EXCHANGE ACT OF 1934

Commission File Number: 001-14057

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

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

(502) 596-7300

(Registrant s telephone number, including area code)

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

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

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

Series A Warrants to Purchase Common Stock

Series B Warrants to Purchase Common Stock

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

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

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

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

Indicate by check mark whether the Registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes þ No ¨

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

The aggregate market value of the shares of the Registrant held by non-affiliates of the Registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2005, was approximately $1,195,564,000. For purposes of the foregoing calculation only, all directors and executive officers of the Registrant have been deemed affiliates.

Indicate by check mark whether the Registrant has filed all documents and reports required to be filed by Section 12, 13 or 15(d) of the Securities Exchange Act of 1934 subsequent to the distribution of securities under a plan confirmed by a court. Yes þ No ¨

As of January 31, 2006, there were 37,331,738 shares of the Registrant s common stock, $0.25 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Proxy Statement for the Annual Meeting of Shareholders to be held on May 25, 2006 are incorporated by reference into Part III of this Annual Report on Form 10-K.

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PART I

Item 1. ***Business***

GENERAL

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates hospitals, nursing centers, institutional pharmacies and a contract rehabilitation services business across the United States. At December 31, 2005, our hospital division operated 74 long-term acute care (LTAC) hospitals (5,694 licensed beds) in 24 states. Our health services division operated 242 nursing centers (30,869 licensed beds) in 28 states. We also operated a contract rehabilitation services business which provides rehabilitative services primarily in long-term care settings. Our pharmacy division operated an institutional pharmacy business with 39 pharmacies in 24 states and a pharmacy management business servicing substantially all of our hospitals. All references in this Annual Report on Form 10-K to Kindred, Company, we, us, or our mean Kindred Healthcare, Inc. and, unless the context otherwise requires, our consolidated subsidiaries.

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

Commonwealth Transaction. On February 28, 2006, we acquired the operations of the LTAC hospitals, skilled nursing facilities and assisted living facilities operated by Commonwealth Communities Holdings LLC and certain of its affiliates (collectively, Commonwealth) for a total purchase price of $125 million in cash (the Commonwealth Transaction).

Commonwealth s operations included five freestanding LTAC hospitals and one hospital-in-hospital with a total of 421 hospital beds. Three of these hospitals also operate co-located subacute units and traditional skilled nursing units with a total of 168 beds. In addition, we acquired the operations of nine skilled nursing facilities containing 1,316 beds and four assisted living facilities with a total of 215 beds. Two of these assisted living facilities share campuses with a Commonwealth skilled nursing facility. In the transaction, we also acquired Commonwealth s right to develop 95 additional LTAC beds in Massachusetts. All of the Commonwealth facilities are located in Massachusetts except for two freestanding assisted living facilities located in Maine.

In connection with the Commonwealth Transaction, we entered into a new master lease with an affiliate of Health Care REIT, Inc. (HCN) to lease four of the Commonwealth freestanding LTAC hospitals for an initial aggregate annual rental of approximately $6.3 million with a contingent annual rent escalator that should approximate 2.5%. We also acquired a two-year option to purchase the real estate related to the four freestanding LTAC hospitals from HCN for approximately $72.4 million. We made an initial payment of approximately $7.7 million to HCN at closing in connection with the hospital master lease. Substantially all of the $7.7 million payment will be amortized over the life of the hospital master lease. In addition, we entered into a new master lease with HCN to lease the nine Commonwealth skilled nursing facilities and the two co-located assisted living facilities for an initial aggregate annual rental of $10.7 million with a contingent annual rent escalator that should approximate 2.5%. Both master leases have a 15-year term with one 15-year renewal.

Plan of Reorganization. On March 1, 2001, the United States Bankruptcy Court for the District of Delaware (the Bankruptcy Court) approved our Fourth Amended Joint Plan of Reorganization (the Plan of Reorganization). On April 20, 2001 (the Effective Date), we emerged from proceedings under Chapter 11 of Title 11 of the United States Code (the Bankruptcy Code) pursuant to the terms of our Plan of Reorganization. In connection with our emergence, we changed our name to Kindred Healthcare, Inc. See Our 2001 Reorganization.

From the filing for protection under the Bankruptcy Code on September 13, 1999 through the Effective Date, we operated our businesses as a debtor-in-possession subject to the jurisdiction of the Bankruptcy Court.

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Accordingly, our consolidated financial statements were prepared in accordance with the American Institute of Certified Public Accountants Statement of Position 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 assume that assets will be realized and liabilities will be discharged in the normal course of business.

In connection with our emergence from bankruptcy, we reflected the terms of our Plan of Reorganization in our consolidated financial statements by adopting the fresh-start accounting provisions of SOP 90-7. Under fresh-start accounting, a new reporting entity is deemed to be created and the recorded amounts of assets and liabilities are adjusted to reflect their estimated fair values. For accounting purposes, the fresh-start adjustments were recorded in our consolidated financial statements as of April 1, 2001. Since fresh-start accounting materially changed the amounts previously recorded in our consolidated financial statements, a black line separates the post-emergence financial data from the pre-emergence financial data to signify the difference in the basis of preparation of the financial statements for each respective entity.

As used in this Annual Report on Form 10-K, the term Predecessor Company refers to us and our operations for periods prior to April 1, 2001, while the term Reorganized Company is used to describe us and our operations for periods thereafter.

Spin-off. On May 1, 1998, Ventas, Inc. (Ventas) completed the spin-off of its healthcare operations to its stockholders through the distribution of our former common stock (the Spin-off). Ventas retained ownership of substantially all of its real property and leases such real property to us. In anticipation of the Spin-off, we were incorporated on March 27, 1998 as a Delaware corporation. For accounting purposes, the consolidated historical financial statements of Ventas became our historical financial statements following the Spin-off. Any discussion concerning events prior to May 1, 1998 refers to our businesses as they were conducted by Ventas prior to the Spin-off.

Risk Factors. This Annual Report on Form 10-K includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the Securities Act), and Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act). See Item 1A Risk Factors.

Discontinued Operations

In recent years, we completed certain strategic divestitures to improve our future operating results. During 2005, we disposed of three unprofitable leased nursing centers, designated two owned nursing centers as held for sale and closed one nursing center.

During 2004, we purchased for resale two hospitals formerly leased from Ventas and three leased nursing centers from another landlord. In addition, we allowed leases on three other nursing centers to expire.

During 2003, we divested all of our Florida and Texas nursing center operations (the Florida and Texas Divestiture), acquired for resale eight additional nursing centers and two hospitals (collectively, the Ventas II Facilities) formerly leased from Ventas and completed certain other dispositions and contract terminations.

For accounting purposes, the operating results of these businesses and the losses associated with these transactions have been classified as discontinued operations in our consolidated statement of operations for all periods presented. Assets not sold at December 31, 2005 have been measured at the lower of carrying value or estimated fair value less costs of disposal and have been classified as held for sale in our consolidated balance sheet. At December 31, 2005, we held for sale two hospitals and one nursing center. We expect to dispose of these facilities in 2006. See notes 2 and 3 of the notes to consolidated financial statements.

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HEALTHCARE OPERATIONS

During 2005, we were organized into four operating divisions: the hospital division, the health services division, the rehabilitation division and the pharmacy division. The hospital division operates LTAC hospitals. The health services division operates nursing centers. The rehabilitation division provides rehabilitation services primarily in long-term care settings. The pharmacy division provides institutional pharmacy services to nursing centers and other healthcare providers and operates a pharmacy management business servicing substantially all of our hospitals. We believe that the independent focus of each division on the unique aspects of its business enhances its ability to attract patients, residents and non-affiliated customers, improve the quality of its operations and achieve operating efficiency objectives.

HOSPITAL DIVISION

Our hospital division provides LTAC services to medically complex patients through the operation of a national network of 74 hospitals with 5,694 licensed beds located in 24 states as of December 31, 2005. We operate the largest network of LTAC hospitals in the United States based upon fiscal 2005 revenues of approximately $1.6 billion (before eliminations). As a result of our commitment to the LTAC business, we have developed a comprehensive program of care for medically complex patients which allows us to deliver high quality care in a cost-effective manner.

A number of the hospital division s LTAC hospitals also provide outpatient services. Outpatient services may include diagnostic services, rehabilitation therapy, CT scanning, one-day surgery, laboratory, and X-ray.

In our hospitals, we treat critically ill, medically complex patients who suffer from multiple organ system failures or conditions such as neurological disorders, head injuries, brain stem and spinal cord trauma, cerebral vascular accidents, metabolic brain injuries, central nervous system disorders, developmental anomalies and cardiopulmonary disorders. In particular, we have a core competency in treating patients with pulmonary disorders, wound care issues and infectious disease. Medically complex patients often are dependent on technology, such as mechanical ventilators, total parenteral nutrition, respiratory or cardiac monitors and dialysis machines for continued life support. Many of our patients may require ventilator care during their length of stay. During 2005, the average length of stay for patients in our hospitals was approximately 30 days. Approximately 75% of our hospital patients are over 65 years of age.

Our hospital division patients generally have conditions which require a high level of monitoring and specialized care, yet may not need the services of a traditional intensive care unit. Due to their severe medical conditions, these patients are not clinically appropriate for admission to a nursing center and their medical conditions are periodically or chronically unstable. By providing a range of services required for the care of medically complex patients, we believe that our LTAC hospitals provide our patients with high quality, cost-effective care.

Our LTAC hospitals employ a comprehensive program of care for their patients which draws upon the talents of interdisciplinary teams, including physician specialists. The teams evaluate patients upon admission to determine treatment programs. Our hospital division has developed specialized treatment programs focused on the needs of medically complex patients. In addition to traditional medical services, most of our patients receive individualized treatment plans in rehabilitation, skin integrity management and clinical pharmacology. Where appropriate, the treatment programs may involve the services of several disciplines, such as pulmonary medicine, infectious disease and physical medicine.

Effective July 1, 2004, we reorganized substantially all of our hospital pharmacy and rehabilitation departments by transferring the related personnel and operations to our pharmacy division and rehabilitation division, respectively (the Hospital Services Reorganization). The historical operating results of our hospital, pharmacy and rehabilitation services segments were not restated to conform with this business realignment.

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Recent Developments

On January 19, 2006, the Centers for Medicare and Medicaid Services (CMS) issued proposed regulatory changes regarding Medicare reimbursement for LTAC hospitals (the Proposed Medicare Payment Rule). Based upon our historical Medicare patient volumes, we expect that the Proposed Medicare Payment Rule would reduce Medicare revenues to our hospitals associated with short stay outliers and high cost outliers between $115 million and $120 million on an annual basis. This estimate does not include the negative impact resulting from the elimination of the annual market basket adjustment to the Medicare payment rates that also is contained in the Proposed Medicare Payment Rule. The annual market basket adjustment has typically ranged between 3% and 4%, or approximately $25 million to $30 million in annual revenues. The Proposed Medicare Payment Rule would be effective for discharges occurring on or after July 1, 2006 through June 30, 2007. The Proposed Medicare Payment Rule is subject to a 60-day public comment period, and as such, is subject to change.

We are working in consultation with our trade associations and other advocacy groups during the 60-day public comment period to demonstrate the significant negative impact that the Proposed Medicare Payment Rule would have on our shared goal with CMS of ensuring that Medicare beneficiaries who need LTAC hospital services receive high quality care in the most appropriate setting. We also are continuing to evaluate the impact that the Proposed Medicare Payment Rule could have on our hospital operations and our hospital development activities. Depending on the final rule from CMS, we will evaluate our operational alternatives to mitigate the potential impact of these reimbursement reductions. If the Proposed Medicare Payment Rule becomes effective in its proposed form, it will have a material adverse effect on our financial position, results of operations and liquidity.

Hospital Division Strategy

Our goal is to be the leading operator of LTAC hospitals in terms of both quality of care and operating efficiency. Our strategies for achieving this goal include:

Maintaining High Quality of Care. The hospital division differentiates its hospitals through its ability to care for medically complex patients in a high-quality, cost-effective setting. We are committed to maintaining and improving the quality of our patient care by dedicating appropriate resources at each facility and continuing to refine our clinical initiatives and objectives. We continue to take steps to improve our quality indicators and maintain the quality of care at our hospitals, including:

- attracting and retaining high quality professional staff within each market. The hospital division believes that its future success will depend in part upon its continued ability to hire and retain qualified healthcare personnel and to promote leadership and development training. We continue to devote additional resources to improve our recruitment and retention.

- maintaining an integrated quality assurance and improvement program, administered by our chief medical officer, senior vice president of clinical operations, vice president of quality and risk management and director of quality management, which encompasses utilization review, quality improvement, infection control and risk management.

- maintaining a strategic outcomes program, which includes a concurrent review of all of our patient population against quality screenings, outcomes reporting and patient and family satisfaction surveys.

maintaining a program whereby our hospitals are reviewed by internal quality auditors for compliance with standards of the Joint Commission on Accreditation of Health Care Organizations (the Joint Commission).

engaging quality councils at the divisional, regional and hospital levels to analyze data, set quality goals and oversee all quality assurance and quality improvement activities throughout the division.

incorporating the clinical advice of our chief medical officer, medical advisory board and other physicians into our operational procedures.

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implementing an integrated risk management plan to improve quality and expand existing patient safety initiatives.

monitoring licensure and certification compliance through a vice president for quality and risk management.

Improving Operating Efficiency. The hospital division is continually focused on improving operating efficiency and controlling costs while maintaining quality patient care. Our hospital division seeks to improve operating efficiencies and control costs by standardizing key operating procedures and optimizing the skill mix of its staff based upon the clinical needs of each hospital s patients. The initiatives we have undertaken to control our costs and improve efficiency include:

managing labor costs by adjusting staffing to patient acuity and fluctuations in census, and reducing the use of contract labor,

increasing the standardization of operating processes and procedures,

improving physician participation in resource consumption, medical record documentation and intensity of service management,

managing pharmacy costs through the use of a medication control program and evaluating medical utilization through our pharmacy and therapeutic committees in each hospital and oversight by our pharmacy division,

centralizing administrative functions such as accounting, payroll, legal, reimbursement, compliance, and information systems, and

utilizing management information technology to aid in financial and clinical reporting as well as billing and collections.

Growing Through Business Development and Acquisitions. Our growth strategy is focused on the development and expansion of our services:

Freestanding Hospitals At December 31, 2005, we operated 58 freestanding hospitals (5,068 licensed beds) and we intend to add further freestanding hospitals in certain strategic markets. We currently have five freestanding hospitals under development.

Hospital-in-Hospital We have contracts with non-Kindred short-term acute care and other hospitals to operate LTAC hospitals within the host hospital. Under these arrangements, we lease space and purchase certain ancillary services from the host hospital and provide it with the option to discharge a portion of its clinically appropriate patients into the care of our hospital. These hospitals-in-hospitals (HIHs) also receive patients from general short-term acute care hospitals other than the host hospital. During the past three years, we added nine HIHs with 307 licensed beds.

Same-Store Growth We seek to expand capacity in existing hospitals based upon community demand and expanding market share. During the past three years, we expanded existing capacity at five hospitals by 117 licensed beds.

Growing Through Disciplined Acquisitions We seek growth opportunities through strategic acquisitions in selected target markets. During the past three years, we added four freestanding hospitals with 301 licensed beds.

Commonwealth Transaction In the Commonwealth Transaction, we added six hospitals in Massachusetts with a total of 421 licensed beds. We also acquired the right to develop 95 additional licensed beds in Massachusetts.

Expanding Program Development. We are a leading provider of long-term acute care to patients with pulmonary dysfunctions. In addition, we have developed and expanded other service areas such as wound care,

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post surgical care, acute rehabilitation and pain management where we believe opportunities exist to position our hospitals as centers of excellence in given markets. We intend to broaden our expertise beyond pulmonary services and to leverage our leadership position in pulmonary care to expand our market strength to other clinical services. We also intend to develop subacute programs and surgery programs in selected markets.

Increasing Patient Volume, Particularly Certain Higher Margin Commercial Patients. We are expanding our sales and marketing efforts to grow same-store admissions and take advantage of available capacity. In addition, we are developing an integrated sales and marketing strategy with our health services division to expand our admissions. We generally receive higher reimbursement rates from commercial insurers than from the Medicare and Medicaid programs. As a result, we work to expand relationships with insurers to increase commercial patient volume. Each of our hospitals employs specialized staff to focus on patient admissions and the patient referral process.

Improving Relationships with Referring Providers. Substantially all of the acute and medically complex patients admitted to our hospitals are transferred to us by other healthcare providers such as general short-term acute care hospitals, intensive care units, managed care programs, physicians, nursing centers and home care settings. Accordingly, we are focused on maintaining strong relationships with these providers. In order to maintain these relationships, we employ clinical liaisons who are responsible for coordinating admissions and assessing the nature of services necessary for the proper care of the patient. The clinical liaisons also are responsible for educating healthcare professionals from referral sources about the unique nature of the services provided by our LTAC hospitals.

Selected Hospital Division Operating Data

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

	Year ended December 31,		
	2005	2004	2003
Revenues	$ 1,608,120	$ 1,398,658	$ 1,314,967
Operating income	$ 419,546	$ 328,950	$ 304,468
Hospitals in operation at end of period	74	72	64
Licensed beds at end of period	5,694	5,569	5,141
Admissions	38,182	35,206	32,033
Patient days	1,158,141	1,119,882	1,156,395
Revenues per admission	$ 42,117	$ 39,728	$ 41,050
Revenues per patient day	$ 1,388	$ 1,249	$ 1,137
Average daily census	3,173	3,060	3,168
Average length of stay	30.3	31.8	36.1
Occupancy %	59.1	59.2	65.8
Assets at end of period	$ 560,767	$ 515,353	$ 526,029

The term operating income is defined as earnings before interest, income taxes, depreciation, amortization, rent and corporate overhead. The term licensed beds refers to the maximum number of beds permitted in a facility under its license regardless of whether the beds are actually available for patient care. Patient days refers to the total number of days of patient care provided for the periods indicated. Average daily census

is computed by dividing each facility s patient days by the number of calendar days in the respective period. Average length of stay is computed by dividing each facility s patient days by the number of admissions in the respective period. 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.

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Sources of Hospital Revenues

The hospital division receives payment for its hospital services from third party payors, including government reimbursement programs such as Medicare and Medicaid and non-government sources such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. Patients covered by non-government payors generally will be more profitable to the hospital division than those covered by the 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		
Period	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues
Year ended December 31, 2005	76%	70%	67%	8%	10%	6%	16%	20%	27%
Year ended December 31, 2004	76	70	65	8	11	7	16	19	28
Year ended December 31, 2003	78	70	62	8	11	8	14	19	30

For the year ended December 31, 2005, revenues of the hospital division totaled approximately $1.6 billion or 38% of our total revenues (before eliminations). For more information regarding the reimbursement for our services, see Governmental Regulation Hospital Division Overview of Hospital Division Reimbursement.

Hospital Facilities

The following table lists by state the number of hospitals and related licensed beds we operated as of December 31, 2005:

		Number of facilities			
State	Licensed beds	Owned by us	Leased from Ventas (2)	Leased from other parties	Total
Arizona	159		2	1	3
California	885	5	5	1	11
Colorado	68		1		1
Florida (1)	595		6	2	8
Georgia (1)	72	1			1
Illinois (1)	545		4	1	5
Indiana	105		1	1	2
Kentucky (1)	404		1	1	2
Louisiana	168		1		1
Massachusetts (1)	109		2		2
Michigan (1)	220		1		1

Missouri (1)	265		2	1	3
Nevada	184	1	1	1	3
New Jersey (1)	73			2	2
New Mexico	92		1	1	2
North Carolina (1)	124		1		1
Ohio	142			2	2
Oklahoma	93		1	1	2
Pennsylvania	229		2	3	5
South Carolina (1)	59			1	1
Tennessee (1)	109		1	1	2
Texas	852	2	6	4	12
Washington (1)	80	1			1
Wisconsin	62	1			1
Totals	5,694	11	39	24	74

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

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Quality Assessment and Improvement

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

The hospital division has implemented a program whereby its hospitals are reviewed by internal quality auditors for compliance with standards of the Joint Commission. 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 Management and Operations

Each of our hospitals has a fully credentialed, multi-specialty medical staff to meet the needs of the medically complex, long-term acute patient. Our hospitals offer a broad range of physician services including pulmonology, internal medicine, infectious diseases, neurology, nephrology, cardiology, radiology and pathology. In addition, our hospitals have a multi-disciplinary team of healthcare professionals including a professional nursing staff trained to care for long-term acute patients, respiratory, physical, occupational and speech therapists, pharmacists, registered dietitians and social workers, to address the needs of medically complex patients.

Each hospital maintains a pre-admission assessment system to evaluate clinical needs and other information in determining the appropriateness of each potential patient admission. After admission, each patient s case is reviewed by the hospital s interdisciplinary team to determine a care plan. Where appropriate, the care plan may involve the services of several disciplines, such as pulmonary medicine, infectious disease and physical medicine.

A hospital chief executive supervises and is responsible for the day-to-day operations at each of our hospitals. Each hospital also employs a chief financial officer who monitors the financial matters of the hospital. In addition, each hospital employs either a chief operating officer or chief clinical officer to oversee the clinical operations of the hospital and a director of quality management to direct an integrated quality assurance program. We provide centralized services in the areas of information systems design and development, training, reimbursement expertise, legal advice, technical accounting support, purchasing and facilities management to each of our hospitals. We believe that this centralization improves efficiency and allows hospital staff to focus more time on patient care.

A divisional president and a chief financial officer manage the hospital division. The operations of the hospitals are divided into an east group and a west group, each headed by an executive vice president of the division that reports to the division president. Within each group there are two geographic regions with each region headed by a senior vice president, each of whom reports to an executive vice president. The clinical issues and quality concerns of the hospital division are managed by the division s chief medical officer and senior vice president of clinical operations.

Hospital Division Competition

In each geographic market that we serve, there are general short-term acute care hospitals, some of which provide similar services to those provided by our hospital division. In addition, several of the markets in which the hospital division operates have other LTAC hospitals which provide services comparable to those offered by our hospitals. Certain competing hospitals are operated by not-for-profit, nontaxpaying or governmental

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agencies, which can finance capital expenditures on a tax-exempt basis and receive funds and charitable contributions unavailable to our hospital division.

Competition for patients covered by non-government reimbursement sources is intense. The primary competitive factors in the LTAC business include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies have entered the LTAC market with licensed hospitals that compete with our hospitals. 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, preferred provider organizations and health maintenance organizations. Such organizations attempt to obtain discounts from established hospital charges. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations 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.

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HEALTH SERVICES DIVISION

Our health services division provides quality, cost-effective care through the operation of a national network of 242 nursing centers (30,869 licensed beds) located in 28 states. We operate the third largest network of nursing centers in the United States based upon our fiscal 2005 revenues of approximately $1.9 billion (before eliminations). Through our nursing centers, we provide patients and residents with long-term care services, a full range of pharmacy, medical and clinical services and routine services, including daily dietary, social and recreational services.

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

Consistent with industry trends, patients and residents admitted to our nursing centers are increasingly more acutely ill and require a more extensive level of care. This is particularly true with our Medicare population. To appropriately care for a more frail and unstable population, we are taking steps in certain nursing centers to improve physician oversight through the use of nurse practitioners.

We also monitor and enhance the quality of care at our nursing centers through the use of performance improvement committees as well as family satisfaction surveys. Our performance improvement committees oversee resident healthcare needs and resident and staff safety. Physicians serve on these committees as medical directors and advise on healthcare policies and practices. We regularly conduct surveys of residents and their families, and these surveys are reviewed by our performance improvement committees at each facility to promote quality care. Substantially all of our nursing centers are certified to provide services under the Medicare and Medicaid programs. Our nursing centers have been certified because the quality of our accommodations, equipment, services, safety, personnel, physical environment and policies and procedures meet or exceed the standards of certification set by those programs.

Effective January 1, 2004, we reorganized our rehabilitation services business into a separate operating division by transferring our internal rehabilitation personnel from our nursing centers and consolidating them with our external rehabilitation business (the Rehabilitation Services Reorganization). The historical operating results of our nursing center and rehabilitation services segments were not restated to conform with this business realignment.

Health Services Division Strategy

Our goal is to become the provider of choice in the markets we serve, which we believe will allow us to increase our census and enhance our payor mix. In addition, we have implemented several initiatives to improve our quality and address the needs of a more acute patient population. The principal elements of our health services division strategy are:

Providing Quality, Clinical-Based Services. The health services division is focused on qualitative and quantitative clinical performance indicators with the goal of providing quality care under the cost containment objectives imposed by government and private payors. In an effort to continually improve the quality of our services and enhance our ability to care for complex and higher acuity residents, we pursue initiatives to:

implement additional human resource programs to improve recruitment, retention, management development, succession planning and employee satisfaction,

expand the involvement of our medical directors and increase the use of nurse practitioners,

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expand our therapy services, wound care, complex medical care and palliative care programs to improve our ability to care for a more acute patient population,

improve our processes to monitor and promote our resident care objectives and align financial incentives with quality care,

increase our Reflections and Passages units to care for residents with Alzheimer s disease and other dementias,

increase the number of our transitional care and subacute units to treat patients with rehabilitation and complex medical needs,

maximize clinical outcomes by implementing the collaborative advice and recommendations of the chief medical officer, senior nursing staff and rehabilitation therapists, and

implement recommendations of our performance improvement committees established at the division, regional and district levels that analyze data, set quality goals and oversee all quality assurance and quality improvement activities throughout the division.

Enhancing Sales and Marketing Programs. We conduct our nursing center marketing efforts, which focus on the quality of care provided at our facilities, at the local market level through our nursing center administrators, admissions coordinators and/or the facility-based sales and marketing personnel. The marketing efforts of our nursing center personnel are supplemented by strategies provided by our regional and district marketing staffs. To better promote our services we are:

dedicating additional personnel and resources to improve sales and marketing initiatives,

expanding the use of central intake lines in key market areas to promote census growth,

expanding the number of nurse liaisons and admission coordinators and implementing community outreach programs,

enhancing our internet access sites for each facility to increase the awareness and availability of our services,

focusing our sales and marketing efforts on new service lines and specialty program development,

developing joint sales and marketing initiatives with our hospital division, and

working to improve our relationships with existing local referral sources and identifying and developing new referral sources.

Increasing Operating Efficiency. The health services division continually seeks to improve operating efficiency with a view to maintaining high-quality care. We believe that operating efficiency is critical to maintaining our position as a leading provider of nursing center services in the United States. To improve operating efficiency we have:

centralized administrative functions such as accounting, payroll, legal, reimbursement, compliance and information systems, enhanced our quality assurance, risk management and liability claims defense initiatives to address professional liability costs, developed a management information system to aid in financial and clinical reporting as well as billing and collections, and focused additional resources to enhance our recruiting and retention of quality personnel.

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Repositioning Nursing Center Assets. The health services division continually seeks ways to divest unprofitable facilities and improve its existing portfolio. To reposition our nursing center portfolio, we have

- divested 43 nursing centers with approximately 6,200 beds in the last three years,
- acquired nine nursing centers concentrated in Massachusetts as part of the Commonwealth Transaction,
- expanded our service line capacity and programs to address the needs of higher acuity patients, and
- made significant capital investments to improve our facilities.

Selected Health Services Division Operating Data

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

	Year ended December 31,		
	2005	2004	2003
Revenues	$ 1,859,498	$ 1,755,095	$ 1,615,553
Operating income	$ 224,090	$ 234,785	$ 217,750
Nursing centers in operation at end of period:			
Owned or leased	237	236	236
Managed	5	7	7
Licensed beds at end of period:			
Owned or leased	30,264	30,161	30,184
Managed	605	803	803
Patient days (a)	9,457,066	9,578,634	9,632,240
Revenues per patient day (a)	$ 197	$ 183	$ 168
Average daily census (a)	25,910	26,171	26,390
Occupancy % (a)	85.6	86.4	86.9
Assets at end of period	$ 385,864	$ 366,164	$ 379,435

(a) Excludes managed facilities.

Sources of Nursing Center Revenues

Nursing center revenues are derived principally from the Medicare and Medicaid programs and from private payment residents. Consistent with the nursing center industry, changes in the mix of the patient and resident population among these three categories significantly affect the

profitability of our nursing center operations. Although Medicare and higher acuity patients and residents generally produce the most revenue per patient day, profitability with respect to higher acuity patients and residents is reduced by the costs associated with the higher level of nursing care and other services generally required. In addition, these patients and residents usually have a significantly shorter length of stay.

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

	Medicare		Medicaid		Private and other	
Period	Patient days	Revenues	Patient days	Revenues	Patient days	Revenues
Year ended December 31, 2005	16%	33%	67%	49%	17%	18%
Year ended December 31, 2004	16	33	68	49	16	18
Year ended December 31, 2003	16	33	68	48	16	19

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For the year ended December 31, 2005, revenues of the health services division totaled approximately $1.9 billion or 44% of our total revenues (before eliminations). For more information regarding the reimbursement for our nursing center services, see Governmental Regulation Health Services Division Overview of Health Services Division Reimbursement.

Nursing Center Facilities

The following table lists by state the number of nursing centers and related licensed beds we operated as of December 31, 2005:

State	Licensed beds	Number of facilities: Owned by us	Leased from Ventas (2)	Leased from other parties	Managed	Total
Alabama (1)	588		3	1		4
Arizona	823		5	1		6
California	2,097	4	11	3		18
Colorado	695		4	1		5
Connecticut (1)	736		6			6
Georgia (1)	685		5			5
Idaho	862	1	8			9
Indiana	4,292		15	12		27
Kentucky (1)	1,705	1	11	2		14
Maine (1)	779		10			10
Massachusetts (1)	3,499		27	2	3	32
Missouri (1)	220			2		2
Montana (1)	331		2			2
Nebraska (1)	163		1			1
Nevada	180		2			2
New Hampshire (1)	512		3			3
North Carolina (1)	2,752		19	4		23
Ohio (1)	1,992		11	4		15
Oregon (1)	254		2			2
Pennsylvania	103		1			1
Rhode Island (1)	201		2			2
Tennessee (1)	2,500		4	12		16
Utah	740		5		1	6
Vermont (1)	310		1		1	2
Virginia (1)	629		4			4
Washington (1)	817		9			9
Wisconsin (1)	1,953		11	1		12
Wyoming (1)	451		4			4
Totals	30,869	6	186	45	5	242

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

Health Services Division Management and Operations

Each of our nursing centers is managed by a state-licensed executive director/administrator who is supported by other professional personnel, including a director of nursing, nursing assistants, licensed practical

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nurses, staff development coordinator, activities director, social services director and business office manager. The directors of nursing are state-licensed nurses who supervise our nursing staffs that include registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing center and on the type of care provided by the nursing center. The nursing centers contract with physicians who provide medical director services and serve on performance improvement committees. We provide our facilities with centralized information systems, federal and state reimbursement expertise, state licensing and certification maintenance, as well as legal, finance and accounting, purchasing and facilities management support. The centralization of these services improves operating efficiencies and permits facility staff to focus on the delivery of quality care.

Our health services division is managed by a divisional president and a chief financial officer. Our nursing center operations are divided into three geographic regions, each of which is headed by an operational senior vice president. These three operational senior vice presidents report to the divisional president. The clinical issues and quality concerns of the health services division are overseen by the division s chief medical officer and senior vice president of clinical operations with assistance from our regional and district teams. The sales and marketing efforts for the division are led by our senior vice president of sales and marketing. Regional and/or district staff also support the health services division in the areas of nursing, dietary services, federal and state reimbursement, human resources management, maintenance, sales and financial services.

Quality Assessment and Improvement

Quality of care is monitored and enhanced by performance improvement committees as well as family satisfaction surveys. These committees oversee resident healthcare needs and resident 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 our nursing centers periodically to review practices and recommend improvements where necessary in the level of care provided and to ensure compliance with requirements under applicable Medicare and Medicaid regulations. Surveys of residents families are conducted on a regular basis which provide an opportunity for families 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 resident care.

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

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

Health Services Division Competition

Our nursing centers compete with other nursing centers and similar long-term care facilities primarily on the basis of quality of care, reputation, location and physical appearance and, in the case of private payment residents, the charges for our services. Our nursing centers also compete on a local and regional basis with other nursing centers as well as with facilities providing similar services, including hospitals, extended care centers, assisted living facilities, home health agencies and similar institutions. Some competitors may operate newer facilities and may provide services that we do not offer. Our competitors include government-owned, religious organization-owned, secular not-for-profit and for-profit institutions. Many of these competitors have greater financial and other resources than we do. Although there is limited, if any, price competition

with respect to Medicare and Medicaid residents (since revenues received for services provided to such residents are based generally on fixed rates), there is significant price competition for private payment residents.

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REHABILITATION DIVISION

Our rehabilitation division provides rehabilitative services primarily in long-term care settings, but our customers also include hospitals, school districts, outpatient clinics, home health agencies, assisted living facilities and hospice providers, including the hospitals and nursing centers that we operate. We provide rehabilitative services to 366 nursing centers, 80 hospitals and 80 other locations in 37 states under the name People*first* Rehabilitation. Approximately 76% of the rehabilitation division s revenues in 2005 were generated from contracts with our hospitals and nursing centers.

Our rehabilitation division employs over 5,500 therapists and had revenues of approximately $263 million (before eliminations) in 2005. We are organized into four geographic regions with significant customer concentrations in the southeast.

Our rehabilitation division provides contract therapy services, including physical, occupational and speech therapies, to residents and patients of nursing centers, assisted living facilities and hospitals. In addition to the standard physical, occupational and speech therapies, we provide specialized rehabilitation programs designed to meet the specific needs of the residents and patients we serve. Our specialized care programs are designed to deal with dementias and Alzheimer s disease, wound care, pain management and pulmonary therapies. Other programs we offer include fall prevention and continence improvement.

We also provide our customers with the clinical expertise necessary to facilitate positive outcomes for their residents and patients. Clinical services provided to our customers include medical record completion and documentation review, clinical audit processes, updates regarding reimbursement changes and clinical care strategies. We also offer our customers various marketing and management services to strengthen their rehabilitation programs, including invoicing systems, reimbursement specialists and a claims tracking system.

We believe that outsourcing therapy services allows our customers to fulfill the continuing need for full-time and part-time therapists and also offers our customers the ability to improve the quality of care provided to their residents and patients.

On January 1, 2004, we reorganized our rehabilitation services business into a separate operating division by completing the Rehabilitation Services Reorganization. On July 1, 2004, the rehabilitation division began providing services to our hospital division as part of the Hospital Services Reorganization. Internal personnel from the hospital division were transferred to the rehabilitation division in conjunction with the Hospital Services Reorganization. The historical operating results of our nursing center, hospital and rehabilitation services segments have not been restated to conform with these new business realignments.

Rehabilitation Division Strategy

Our goals are to be a leading provider of contract rehabilitation services in the markets we serve and to increase our market share through the expansion of our rehabilitation programs, quality initiatives, and clinical, compliance and recruiting efforts. Our strategies for achieving these goals include:

Maintaining Quality Care and Customer Satisfaction. Our rehabilitation division is committed to providing effective and efficient care to the residents and patients of the nursing centers, assisted living facilities and hospitals that we serve. In this regard, we have taken the following measures to improve the operating efficiency of our customers and to enhance and maintain the quality of care provided to their residents and patients:

We have developed specialized programs to promote the quality initiatives of our customers, including Alzheimer s disease and other dementia programs, pain management and pulmonary therapies.

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We promote the competencies of our therapists by providing formal training and implementing best practices.

We take an integrated approach of delivering our services as a key member of the customer s interdisciplinary care team and work to enhance our customers quality objectives.

We have developed a proprietary nationwide clinical tracking system that allows us to access clinical documentation, provide quality assurance, identify industry trends, track patient outcomes and streamline invoicing and managing reporting.

Effective Recruiting and Retention of Qualified Therapists. The healthcare industry is facing a shortage of qualified therapists. We believe that in order to provide the most effective and efficient care to the patients and residents we serve we must recruit and retain qualified therapists. We offer competitive incentive and recognition programs for our therapists and have increased our recruiting infrastructure to reduce open positions, decrease contract labor and improve productivity. We also promote continuing education opportunities to improve patient care and to enhance the personal knowledge, growth and satisfaction of our therapists and encourage their participation in a culture of quality.

Growing Through Business Development and External Contract Sales. Our growth strategy is focused on the expansion of rehabilitation programs for the customers we currently serve and the development of additional external business in markets where we have a significant presence or where we believe appropriate demand exists for our services. We also believe opportunities exist for new program development in the subacute and wound care areas. We intend to increase our market share by demonstrating our value proposition that the quality clinical care and strong customer service provided by People*first* Rehabilitation will enhance the quality and clinical objectives of our customers. We also intend to promote greater brand recognition of our People*first* services by expanding our sales and marketing strategies and launching our division-specific website tool.

Selected Rehabilitation Division Operating Data

The following table sets forth certain operating and financial data for the rehabilitation division (dollars in thousands):

	Year ended December 31,		
	2005	2004	2003
Revenues:			
Company-operated	$ 200,187	$ 165,987	$
Non-affiliated	62,586	62,439	43,483
	$ 262,773	$ 228,426	$ 43,483
Operating income (loss)	$ 32,052	$ 31,431	$ (1,763)
Number of customer contracts:			
Company-operated	317	317	
Non-affiliated	209	210	216
Assets at end of period	$ 7,124	$ 7,701	$ 8,009

Sources of Rehabilitation Division Revenues

The rehabilitation division receives payment for its services from the nursing centers, assisted living facilities and hospitals that we serve. The payments are based upon negotiated patient per diem rates or a negotiated fee schedule based upon the types of services rendered. For the year ended December 31, 2005, revenues of the rehabilitation division totaled approximately $263 million or 6% of our total revenues (before eliminations). As a provider of services to other healthcare providers, trends and developments in healthcare reimbursement will impact our revenues and growth. Changes in the reimbursement provided by Medicare or Medicaid to our customers can impact the demand and price for our services. For more information regarding the

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reimbursement for our rehabilitation services, see Governmental Regulation Rehabilitation Division Overview of Rehabilitation Division Reimbursement, and Governmental Regulation Health Services Division Overview of Health Services Division Reimbursement.

Geographic Coverage

The following table lists by state the number of hospitals, nursing centers and other rehabilitation customer contracts we serviced as of December 31, 2005:

	Hospitals		Nursing centers		Other	Total	
State	Company operated	Non-affiliated	Company operated	Non-affiliated	Non-affiliated	Company operated	Non-affiliated
Alabama			4			4	
Arizona	3		6		1	9	1
Arkansas				2			2
California	12	1	19	11		31	12
Colorado	1		5	1		6	1
Connecticut			6	7	2	6	9
Florida	7			21	21	7	42
Georgia	1		6			7	
Idaho		2	9		11	9	13
Illinois	5	1		1	5	5	7
Indiana	2	2	28		9	30	11
Kentucky	2	1	14	9	1	16	11
Louisiana	1					1	
Maine			10	3		10	3
Massachusetts	2		33	2	4	35	6
Michigan	1					1	
Missouri	3		2			5	
Mississippi				1			1
Montana			2		1	2	1
Nebraska			1			1	
Nevada	3	2	2	1	1	5	4
New Hampshire			3		1	3	1
New Mexico	2					2	
North Carolina	1		23	39	1	24	40
Ohio	2	1	15	4	1	17	6
Oklahoma	2					2	
Oregon			2	3	3	2	6
Pennsylvania	5		1		4	6	4
Rhode Island			2			2	
Tennessee	1		16			17	
Texas	12			5	2	12	7
Utah			6		4	6	4
Vermont			2	4		2	4
Virginia			4	2		4	2
Washington	1		10	3	5	11	8

Wisconsin	1		12			13	
Wyoming			4		3	4	3
Totals	70	10	247	119	80	317	209

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Sales and Marketing

The rehabilitation division s marketing and sales strategy focuses on the outsourcing needs of long-term care facilities and hospitals by emphasizing the broad range of rehabilitation programs, clinical expertise, and competitive pricing that we can provide. The rehabilitation division s new business efforts are led by the vice president of business development and five directors of business development in geographically defined regions.

Rehabilitation Division Management and Operations

Each of our rehabilitation programs is customized to meet the needs of our customers and their residents and patients. Generally, an on-site program manager who is also a therapist leads our rehabilitation programs and, in our nursing centers, reports to an area rehabilitation director who has responsibility for the overall management of eight to twelve facilities. An area rehabilitation director reports to a region rehabilitation director. The seven nursing center regions are determined predominately by geography. In our hospitals, the on-site manager reports to a region rehabilitation director. The three hospital regions are determined by geography. We provide our program staff with centralized information systems, as well as legal, accounting, human resources, payroll, recruiting and purchasing support. The centralization of these services improves operating efficiencies and permits program staff to focus on the delivery of high quality, medically appropriate rehabilitation services.

A divisional president and a chief financial officer manage our rehabilitation division. Our rehabilitation operations are divided into two business lines, nursing centers and hospitals, each of which is headed by an operational senior vice president and an operational senior director, respectively. These two operational managers report to the divisional president. The clinical issues and quality concerns of the rehabilitation division are managed by the vice president of clinical services.

Rehabilitation Division Competition

In each geographic market that we serve, there are national, regional and local rehabilitation service providers that provide services comparable to those offered by us. Some of our competitors may have greater financial and other resources than us and may be more established in the markets in which we compete. In addition, many long-term care facilities and hospitals may not elect to outsource rehabilitation services thereby reducing our potential customer base. While there are several large rehabilitation providers, the market generally is highly fragmented and is primarily comprised of smaller independent providers.

We believe our rehabilitation division generally competes on its reputation for providing quality service, pricing and clinical expertise.

PHARMACY DIVISION

Our pharmacy division operates an institutional pharmacy business servicing long-term care facilities and a pharmacy management business servicing substantially all of our hospitals. Our pharmacy business provides a full array of institutional pharmacy services to nursing centers and specialized care centers, including the nursing centers and hospitals that we operate. We operate 39 institutional pharmacies in 24 states that serve approximately 93,300 patients and residents of long-term care facilities. We serve 934 facilities including skilled nursing centers (including 226 Kindred nursing centers), assisted living facilities, psychiatric hospitals and other institutional healthcare facilities. Over the past three years, we have substantially increased the number of non-affiliated beds we serve.

Our pharmacy division is the third largest institutional pharmacy company in the United States based upon fiscal 2005 revenues of approximately $522 million (before eliminations). We are organized into five geographic regions with significant bed concentrations in California, Florida, Illinois, Indiana, Massachusetts, North Carolina, Pennsylvania and Tennessee.

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The pharmacy division s core business is providing pharmaceutical dispensing services to residents of nursing centers and assisted living facilities. We purchase, repackage and dispense pharmaceuticals, both prescription and non-prescription, in accordance with physician orders and deliver such medication to the healthcare facility for administration to the patient or resident. We typically service facilities within a 120-mile radius of our pharmacy locations at least once each day. Each pharmacy provides 24-hour, seven-day per week on-call pharmacist services for emergency dispensing, delivery and/or consultation.

Computerized medical records and documentation are critical to our distribution system. We can provide computerized physician orders and medication administration records for each patient or resident on a monthly basis as requested. Data from these records are formulated into monthly management reports on patient or resident care and quality assurance. This system improves efficiency in nursing time, reduces drug waste and lowers adverse drug reactions.

The pharmacy division also provides various supplemental healthcare services that complement our core pharmacy services. Federal and state regulations mandate that long-term care facilities maintain and improve the quality of resident care by retaining consultant pharmacist services to monitor and report on prescription drug therapy. The federal Omnibus Budget Reconciliation Act of 1987, as amended (OBRA), further standardized care by mandating additional standards relating to planning, monitoring and reporting on the progress of prescription drug therapy as well as facility-wide drug usage. Our clinical pharmacists work closely with nursing staff and facility medical directors to ensure compliance with these regulations. We also offer a number of programs that assist long-term care facilities in enhancing care, reducing costs and complying with federal and state regulations.

On July 1, 2004, the pharmacy division began providing pharmacy management services to our hospital division as part of the Hospital Services Reorganization. Internal pharmacy personnel from the hospital division were transferred to the pharmacy division in conjunction with the realignment of these services.

Pharmacy Division Strategy

Our goal is to remain a highly reliable and efficient provider of institutional pharmacy services, which will enable us to expand our market share. Our strategies for achieving this goal include:

Maintaining Focus on Customer Satisfaction. The pharmacy division differentiates its operations by focusing on supplying our customers with the most effective medication delivered in a timely manner and at a competitive price. We have remained flexible to meet our customers needs while offering the same services as larger providers. We also are implementing a customer service program to improve customer satisfaction. We have focused these efforts to assist our customers with the transition issues associated with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Part D).

Improving Operating Efficiency. The pharmacy division is focused on improving operating efficiencies and controlling costs. To improve our operating efficiency, we:

have implemented management information systems that allow us to maintain service standards, achieve regulatory compliance and navigate the rapidly changing billing complexities of individual state Medicaid programs and Medicare Part B,

strive to lower pharmaceutical costs by negotiating favorable purchasing arrangements through group purchasing organizations or directly with certain pharmaceutical manufacturers, and

have developed programs to reduce turnover and leverage newly expanded recruiting resources.

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Growing Through Business Development and External Contract Sales. As in the past, we will continue to seek acquisitions and strategic opportunities to enhance shareholder value. Our growth strategy is focused on the development of additional pharmacies and the continued expansion of our services in existing markets:

Growing Through Disciplined Acquisitions We look to acquire local or regional institutional pharmacy providers to expand our market penetration. During 2005, we acquired an institutional pharmacy business in Pennsylvania servicing approximately 7,800 customer beds, an institutional pharmacy business in California servicing approximately 7,300 customer beds and an institutional pharmacy in Illinois servicing approximately 8,600 customer beds. During 2004, we acquired an institutional pharmacy business in Iowa servicing approximately 1,400 customer beds.

New Pharmacies We opened two new pharmacies in both 2005 and 2004. We anticipate opening four to six new pharmacies in 2006 to service new customers and markets.

External Pharmacy Business During the past three years, we have significantly increased the non-affiliated beds we service and are aggressively pursuing continued growth in this area. We continue to expand our sales and marketing resources to promote same-store growth.

Expand our Pharmacy Management Services As a result of the Hospital Services Reorganization, the pharmacy division provides pharmacy management services to our hospitals. We intend to seek opportunities to expand our pharmacy management services with additional unaffiliated customers in the future.

Selected Pharmacy Division Operating Data

The following table sets forth certain operating and financial data for the pharmacy division (dollars in thousands):

	Year ended December 31,		
	2005	**2004**	**2003**
Revenues	$ 522,225	$ 360,035	$ 272,433
Operating income	$ 56,837	$ 37,062	$ 26,493
Institutional pharmacies in operation at end of period	39	33	30
Number of customer licensed beds at end of period:			
Company-operated	28,657	28,634	28,280
Non-affiliated	64,625	37,561	33,127
Total	93,282	66,195	61,407
Assets at end of period	$ 188,914	$ 60,146	$ 43,198

Sources of Pharmacy Revenues

The pharmacy division receives payment for its services from third party payors, including government reimbursement programs such as Medicare and Medicaid and non-government sources such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. In the last three years, the pharmacy division derived a substantial portion of its annual revenue from state Medicaid programs and from skilled nursing facilities for residents covered by Medicare Part A. The balance consists of private pay, insurance and other payors (including managed care).

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

Period	Medicare	Medicaid	Private and other
Year ended December 31, 2005	16%	45%	39%
Year ended December 31, 2004	21	50	29
Year ended December 31, 2003	23	52	25

The healthcare industry is experiencing the effects of cost containment efforts by federal and state governments and other third party payors to control utilization of pharmaceuticals and negotiate reduced payment schedules with providers. These cost containment measures, combined with increased pricing pressure from managed care payors and other customers, generally have resulted in reduced rates of reimbursement for the products and services we provide.

In most states, Medicaid reimbursement is based upon a discount from the average wholesale price plus a dispensing fee. Under the federal prospective payment system for nursing centers, Medicare Part A reimburses nursing centers on a fixed dollar per day basis for care (including the cost of pharmaceuticals) provided to residents in various acuity levels.

In December 2003, Congress enacted Medicare Part D which includes a major expansion of the Medicare program through the introduction of a prescription drug benefit. Under Medicare Part D, Medicare beneficiaries who previously were entitled to benefits under a state Medicaid program (so-called dual eligibles) now have their outpatient prescription drug costs covered by Medicare Part D, subject to certain limitations. Effective January 1, 2006, most of the nursing center residents we serve whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for the Medicare Part D drug benefit. Accordingly, Medicaid will no longer be a primary payor for the pharmacy services provided to these residents. See Governmental Regulation Pharmacy Division Overview of Pharmacy Division Reimbursement.

For the year ended December 31, 2005, revenues of the pharmacy division totaled approximately $522 million or 12% of our total revenues (before eliminations). For more information regarding the reimbursement for our pharmacy services, see Governmental Regulation Pharmacy Division Overview of Pharmacy Division Reimbursement.

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Pharmacy Locations

The following table lists by state the number of institutional pharmacies we operated as of December 31, 2005. All of our pharmacy locations are leased.

State	Institutional pharmacies	Approximate sq. footage	Institutional beds serviced
Alabama	1	5,000	695
Arizona	1	3,550	2,816
California	5	55,250	22,314
Colorado	1	2,700	955
Connecticut	1	7,900	1,425
Florida	4	27,100	6,984
Georgia	1	6,350	1,069
Idaho	1	5,750	1,661
Illinois	1	10,350	8,412
Indiana	2	20,550	6,238
Iowa	1	6,250	1,454
Maine	1	10,200	2,572
Massachusetts	1	12,950	6,480
Montana	1	300	223
Nevada	2	10,850	1,455
New Hampshire	1	7,500	1,094
North Carolina	3	20,000	5,144
Ohio	1	10,100	2,506
Pennsylvania	2	17,850	7,990
Tennessee	4	29,500	7,397
Utah	1	8,000	1,093
Virginia	1	7,950	824
Washington	1	2,800	817
Wisconsin	1	9,150	1,664
Totals	39	297,900	93,282

Sales and Marketing

The pharmacy division s new business efforts are led by a vice president of sales and marketing and regional account executives. Each account executive is assigned to individual pharmacies within one of our five geographic regions and works closely with the pharmacy managers to understand the needs and opportunities in the local markets.

The pharmacy division s strategy primarily focuses on adding customer beds from smaller independent nursing facilities or small regional chains. In addition, with our recent growth and expanded capabilities, we also look to develop relationships with regional and national healthcare

providers. New opportunities generally develop because of service issues with a facility s current pharmacy provider. The pharmacy division s sales strategy emphasizes building relationships with facility level management, particularly the administrator and the director of nursing.

Although price is always a significant consideration, we believe that timely and effective service is a critical element in selecting a pharmacy provider. The pharmacy division is focused on remaining flexible to handle individual customer demands, while increasing our capacity to offer a complete breadth of services comparable to that of our larger competitors.

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Pharmacy Management Business

Effective July 1, 2004, we completed the Hospital Services Reorganization under which the pharmacy personnel in our hospital division were transferred to the pharmacy division. Under this arrangement, the pharmacy division provides pharmacy management services to our hospitals. These services generally entail the overall management of the hospital pharmacy operations, including the ordering, receipt, storage and dispensing of pharmaceuticals to the hospital s patients pursuant to the clinical guidelines established by the hospital. The pharmacy division also works with the hospitals to obtain and maintain applicable regulatory licenses, certifications and accreditations.

Pharmacy Division Management and Operations

Each of our pharmacy locations employs licensed pharmacists to meet the dispensing and consulting needs of our customers. A pharmacy manager is responsible for managing the day to day operations of each of our pharmacies, including financial oversight as well as clinical and quality management. We provide centralized services in the areas of information systems, training, reimbursement expertise, legal advice, technical accounting support, purchasing and facilities management to each of our pharmacies. We believe that this centralization improves efficiency and allows pharmacy staff to focus on providing quality customer service.

A divisional president, chief operating officer and chief financial officer manage the pharmacy division. Each region is headed by a senior regional director of pharmacy operations, each of whom reports to the chief operating officer. Our hospital management operations are managed by a vice president of hospital pharmacy operations. The clinical issues and quality concerns of the pharmacy division are managed by the division s vice president of clinical services.

Pharmacy Division Competition

As of December 31, 2005, our pharmacies served customers in geographic markets that are generally limited to a 120-mile radius of our pharmacy locations. In each geographic market, there are national, regional and local institutional pharmacies and numerous local retail pharmacies which provide services comparable to those offered by our pharmacies. Some of our competitors may have greater financial and other resources than us and may be more established than our pharmacies in the markets in which we compete. The institutional pharmacy market is dominated by two large providers: Omnicare, Inc. and PharMerica (a subsidiary of AmerisourceBergen). Together, these two companies account for more than half of the institutional pharmacy market. The remaining market is highly fragmented and is primarily comprised of smaller independent providers.

We believe our institutional pharmacies generally compete on service, pricing and clinical expertise.

MASTER LEASE AGREEMENTS

Under our Plan of Reorganization, we assumed the original master lease agreements with Ventas and its affiliates and simultaneously amended and restated the agreements into four new master leases (the Master Leases). Under the Master Leases, Ventas has a right to sever properties from the existing leases in order to create additional leases, a device adopted to facilitate its financing flexibility. In such circumstances, our aggregate lease obligations remain unchanged. Ventas exercised this severance right in December 2001 with respect to Master Lease No. 1 to create a new lease of 40 nursing centers (the CMBS Lease) and mortgaged these properties in connection with a securitized mortgage financing, which has subsequently been retired. In September 2004, Ventas exercised this severance right with respect to Master Lease No. 1 to create a new lease of one hospital and seven nursing centers (Master Lease No. 1A). The CMBS Lease and Master Lease No. 1A are in substantially the same form as the other Master Leases with certain modifications requested by Ventas s lenders and required to be made by us pursuant to the Master Leases.

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The Master Leases, the CMBS Lease and Master Lease No. 1A are referred to collectively as, the Master Lease Agreements.

The following summary description of the Master Lease Agreements is qualified in its entirety by reference to the Master Lease Agreements as filed with the Securities and Exchange Commission (the SEC).

Term and Renewals

Each Master Lease Agreement includes land, buildings, structures and other improvements on the land, easements and similar appurtenances to the land and improvements, and permanently affixed equipment, machinery and other fixtures relating to the operation of the leased properties. There are several bundles of leased properties under each Master Lease Agreement, with each bundle containing approximately 6 to 21 leased properties. Other than the CMBS Lease, which has only nursing center properties, most bundles contain both nursing centers and hospitals. All leased properties within a bundle have base terms ranging from 10 to 15 years beginning from May 1, 1998, subject to certain exceptions.

At our option, 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 at the then existing rental rate plus the then existing escalation amount per annum. We may further extend the term for two additional five-year renewal terms beyond the first renewal term at the greater of the then existing rental rate plus the then existing escalation amount per annum or the then fair market value rental rate. The rental rate during the first renewal term and any additional renewal term in which rent due is based upon the then existing rental rate will escalate each year during such term(s) at the applicable escalation rate.

We may not extend the Master Lease Agreements beyond the base term or any previously exercised renewal term if, at the time we seek such extension and at the time such extension takes effect, (1) an event of default has occurred and is continuing or (2) a Medicare/Medicaid event of default (as described below) and/or a licensed bed event of default (as described below) has occurred and is continuing with respect to three or more leased properties subject to a particular Master Lease Agreement. The base term and renewal term of each Master Lease Agreement are subject to termination upon default by us (subject to certain exceptions) and certain other conditions described in the Master Lease Agreements.

Rental Amounts and Escalators

Each Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. Accordingly, in addition to rent, we are required to pay the following: (1) all insurance required in connection with the leased properties and the business conducted on the leased properties, (2) certain taxes levied on or with respect to the leased properties (other than taxes on the net income of Ventas) and (3) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

Under each Master Lease Agreement, the aggregate annual rent is referred to as base rent. Base rent equals the sum of current rent and accrued rent. We are obligated to pay the portion of base rent that is current rent, and unpaid accrued rent will be paid as set forth below. From the effective date of the Master Lease Agreements through April 30, 2004, base rent equaled the current rent.

Under the Master Lease Agreements, the annual aggregate base rent owed by us currently approximates $190 million. We paid rents to Ventas (including amounts classified as discontinued operations) approximating $188 million for the year ended December 31, 2005, $182 million for the year ended December 31, 2004 and $186 million for the year ended December 31, 2003.

Each Master Lease Agreement provides for rent escalations each May 1 if the patient revenues for the leased properties meet certain criteria measured upon the preceding calendar year revenues. As such, the annual

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aggregate base rent will escalate at an annual rate of 3 1/2%. As a result of the amendments to the Master Lease Agreements entered into in connection with the transactions with Ventas in 2003, all annual rent escalators will be payable in cash.

Reset Rights

Ventas has a one-time option to reset the rent and the related rent escalators under each of the Master Lease Agreements to the Fair Market Rental of the leased properties. Fair Market Rental is determined through an appraisal procedure set forth in the Master Lease Agreements.

Generally, the Master Lease Agreements provide that Ventas can initiate the rent reset procedure under each Master Lease Agreement at any time between January 20, 2006 and July 19, 2007 by delivering a reset proposal notice (the Reset Proposal Notice) to us proposing the Fair Market Rental (as defined below) for the balance of the lease term. If we and Ventas are unable to reach an agreement on the Fair Market Rental within 30 days following delivery of the Reset Proposal Notice, we and Ventas each must select an appraiser. Under the terms of the Master Lease Agreements, these two appraisers then will have ten days to select a third independent appraiser (the Independent Appraiser). The Independent Appraiser will have 60 days to complete its determination of Fair Market Rental and the annual rent escalator, which determination will be final and binding on the parties. Within 30 days following the Independent Appraiser s determination, Ventas may elect to exercise its right to reset Fair Market Rental by sending us a final exercise notice (the Final Exercise Notice).

Alternatively, Ventas may decide not to exercise its rent reset option, in which event the rent and existing 3 1/2% contingent annual escalator would remain at their then current levels under the Master Lease Agreements. Provided that Ventas exercises its rent reset right in accordance with the Master Lease Agreements, the rent reset will become effective on the later of July 19, 2006 or the date of delivery of the Reset Proposal Notice, which can be no later than July 19, 2007.

As a condition to exercising its rent reset right, upon delivery of the Final Exercise Notice, Ventas is required to pay us a reset fee equal to a prorated portion of approximately $5 million based upon the proportion of base rent payable under the Master Lease Agreement(s) with respect to which rent is reset to the total base rent payable under all of the Master Lease Agreements.

Fair Market Rental is defined under each Master Lease Agreement as the annual amount per annum that a willing tenant would pay, and a willing landlord would accept, at arm s length, for leasing of the leased properties (or, if applicable, any one or more, but less than all, of the leased properties) for the period of the term (including, without limitation, any extended terms) remaining from and after the date as of which the Fair Market Rental is being determined. The Fair Market Rental may include therein such escalations of rent as would be paid by such a tenant, and accepted by such a landlord, as part of an arm s length transaction entered into as of the Fair Market Rental determination date; provided, however, that, in addition to such other market factors as may be applicable in determining the Fair Market Rental, the Fair Market Rental shall be determined on the basis, and on the assumptions, that (a) the Fair Market Rental may not include therein any rent, or method of rent calculation, that would adversely affect any landlord by virtue of it being a real estate investment trust or the ability of any such landlord to satisfy the requirements for maintaining its status as a real estate investment trust (and, without limitation of the foregoing, the Fair Market Rental shall not include any rent that would fail to qualify as rents from real property for purposes of Section 856(d) of the Internal Revenue Code), (b) the Fair Market Rental amount is to be paid absolutely net to the landlord, without any rights of deduction, set-off or abatement, (c) all of the leased properties as to which the Fair Market Rental is being determined are in good condition and repair (given their respective ages and prevailing health care industry standards with respect to what is considered good condition and repair), without any deferred maintenance (but allowing for ordinary wear and tear), are in material compliance with any and all applicable laws, codes, ordinances and regulations and have in full force and effect, for the benefit of the tenant, the facilities and the leased properties, any and all necessary or appropriate material authorizations for use thereof in accordance with the respective primary

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intended uses applicable thereto, (d) the tenant has complied, and shall be required to comply, with the requirements of the Master Lease Agreement, (e) the respective replacement costs of the leased properties as to which Fair Market Rental is being determined are not determinative of the Fair Market Rental of such leased properties, and (f) the aforesaid tenant shall have available to it, with respect to each leased property as to which the Fair Market Rental is being determined, such remaining term as then remains, and such number of extended terms as then remain unexercised, with respect to such leased property under the terms of the Master Lease Agreement. Notwithstanding anything to the contrary contained in the Master Lease Agreement, Fair Market Rental shall take into account, for each of the applicable leased properties, the market conditions, market levels of earnings before interest, income taxes, depreciation, amortization, rent and management fees (EBITDARM), the ratio of market levels of EBITDARM to market levels of rent, and the actual levels of EBITDARM at the applicable leased properties, in each case that are prevailing or measured, as applicable, as of the date as of which the Fair Market Rental is being determined, as well as historical levels of EBITDARM at the applicable leased properties (including the EBITDARM of the leased properties measured as of April 20, 2001).

Under each Master Lease Agreement, Ventas has a right to sever properties from the existing leases in order to create additional leases, a device adopted to facilitate its financing flexibility. However, for purposes of the rent reset right, the additional leases are disregarded and the Fair Market Rental is determined for each of the four original Master Lease Agreements.

On January 20, 2006, Ventas announced a delay in the delivery of the Reset Proposal Notice until it had completed its review of the Proposed Medicare Payment Rule. Ventas had previously indicated it would deliver the Reset Proposal Notice on January 20, 2006. We cannot assure you that Ventas will not exercise its rights under the rent reset or that the ultimate outcome of the rent reset will not have a material adverse effect on our financial position, results of operations and liquidity.

Use of the Leased Property

The Master Lease Agreements require that we utilize the leased properties solely for the provision of healthcare services and related uses and as Ventas may otherwise consent. We are responsible for maintaining or causing to be maintained all licenses, certificates and permits necessary for the leased properties to comply with various healthcare and other regulations. We also are obligated to operate continuously each leased property as a provider of healthcare services.

Events of Default

Under each Master Lease Agreement, an Event of Default will be deemed to occur if, among other things:

- we fail to pay rent or other amounts within five days after notice,
- we fail to comply with covenants, which failure continues for 30 days or, so long as diligent efforts to cure such failure are being made, such longer period (not over 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,

an event of default arises from our failure to pay principal or interest on any indebtedness exceeding $50 million,

the maturity of any indebtedness exceeding $50 million is accelerated,

we cease to operate any leased property as a provider of healthcare services for a period of 30 days,

a default occurs under any guaranty of any lease or the indemnity agreements with Ventas,

we or our subtenant lose any required healthcare license, permit or approval or fail to comply with any legal requirements as determined by a final unappealable determination,

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we fail to maintain insurance,

we create or allow to remain certain liens,

we breach any material representation or warranty,

a reduction occurs in the number of licensed beds in a facility, generally in excess of 10% (or less than 10% if we have voluntarily banked licensed beds) of the number of licensed beds in the applicable facility on the commencement date (a licensed bed event of default),

Medicare or Medicaid certification with respect to a participating facility is revoked and re-certification does not occur for 120 days (plus an additional 60 days in certain circumstances) (a Medicare/Medicaid event of default),

we become subject to regulatory sanctions as determined by a final unappealable determination and fail to cure such regulatory sanctions within the specified cure period for any facility,

we fail to cure a breach of any permitted encumbrance within the applicable cure period and, as a result, a real property interest or other beneficial property right of Ventas is at material risk of being terminated, or

we fail to cure the breach of any of the obligations of Ventas as lessee under any existing ground lease within the applicable cure period and, if such breach is a non-monetary, non-material breach, such existing ground lease is at material risk of being terminated.

Remedies for an Event of Default

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

(1) after not less than ten days notice to us, terminate the Master Lease Agreement to which such Event of Default relates, repossess any leased property, relet any leased property to a third party and require that we pay to Ventas, as liquidated damages, the net present value of the rent for the balance of the term, discounted at the prime rate,

(2) without terminating the Master Lease Agreement to which such Event of Default relates, repossess the leased property and relet the leased property with us remaining liable under such Master Lease Agreement for all obligations to be performed by us thereunder, including the difference, if any, between the rent under such Master Lease Agreement and the rent payable as a result of the reletting of the leased property, and

(3) seek any and all other rights and remedies available under law or in equity.

In addition to the remedies noted above, under the Master Lease Agreements, in the case of a facility-specific event of default Ventas may terminate a Master Lease Agreement as to the leased property to which the Event of Default relates, and may, but need not, terminate the entire Master Lease Agreement. Each of the Master Lease Agreements includes special rules relative to Medicare/Medicaid events of default and a licensed bed events of default. In the event a Medicare/Medicaid event of default and/or a licensed bed event of default occurs and is continuing (a) with respect to not more than two properties at the same time under a Master Lease Agreement that covers 41 or more properties and (b) with respect to not more than one property at the same time under a Master Lease Agreement that covers 21 to and including 40 properties, Ventas may not exercise termination or dispossession remedies against any property other than the property or properties to which the event of default relates. Thus, in the event Medicare/Medicaid events of default and licensed bed events of default would occur and be continuing (a) with respect to one property under a Master Lease Agreement that covers less than 20 properties, (b) with respect to two or more properties at the same time under a Master Lease Agreement that covers 21 to and including 40 properties, or (c) with respect to three or more properties at the

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same time under a Master Lease Agreement that covers 41 or more properties, then Ventas would be entitled to exercise all rights and remedies available to it under the Master Lease Agreements.

Assignment and Subletting

Except as noted below, the Master Lease Agreements provide that we 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 by virtue of a change of control, without the consent of Ventas, which may not be unreasonably withheld if the proposed assignee (1) is a creditworthy entity with sufficient financial stability to satisfy its obligations under the related Master Lease Agreement, (2) has not less than four years experience in operating healthcare facilities, (3) has a favorable business and operational reputation and character, and (4) has all licenses, permits, approvals and authorizations to operate the facility 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. We 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.

In addition, each Master Lease Agreement allows us to assign or sublease (a) without the consent of Ventas, 10% of the nursing center facilities in each Master Lease Agreement and (b) with Ventas s consent (which consent will not be unreasonably withheld, delayed or conditioned), two hospitals in each Master Lease Agreement, if either (i) the applicable regulatory authorities have threatened to revoke an authorization necessary to operate such leased property or (ii) we cannot profitably operate such leased property. Any such proposed assignee/sublessee must satisfy the requirements listed above and it must have all licenses, permits, approvals and other authorizations required to operate the leased properties in accordance with the applicable permitted use. With respect to any assignment or sublease made under this provision, Ventas agrees to execute a nondisturbance and attornment agreement with such proposed assignee or subtenant. Upon any assignment or subletting, we will not be released from our obligations under the applicable Master Lease Agreement.

Subject to certain exclusions, we must pay to Ventas 80% of any consideration received by us on account of an assignment and 80% (50% in the case of existing subleases) of sublease rent payments (approximately equal to revenue net of specified allowed expenses attributable to a sublease, and specifically defined in the Master Lease Agreements), provided that Ventas s right to such payments will be subordinate to that of our lenders.

Ventas will have the right to approve the purchaser at a foreclosure of one or more of our leasehold mortgages by our lenders. Such approval will not be unreasonably withheld so long as such purchaser is creditworthy, reputable and has four years experience in operating healthcare facilities. Any dispute regarding whether Ventas has unreasonably withheld its consent to such purchaser will be subject to expedited arbitration.

Transactions with Ventas

In December 2004, we acquired two hospitals from Ventas. In the transaction, we paid $21 million to purchase the facilities and $0.5 million in lease termination fees. The annual rent of approximately $1 million on these facilities terminated on the closing of the transaction.

In June 2003, we acquired 15 Florida nursing centers and one Texas nursing center from Ventas for approximately $60 million and a $4 million lease termination fee. In addition, we amended the Master Lease Agreements to: (1) pay incremental rent aggregating $64 million in varying amounts generally over seven years, the net present value of which approximated $44 million using a discount rate of 11%, (2) provide that all annual escalators under the Master Lease Agreements will be paid in cash at all times, and (3) expand certain cooperation and information sharing provisions of the Master Lease Agreements. The annual rent of approximately $9 million on the acquired facilities terminated upon the closing of the purchase transaction.

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For accounting purposes, the $44 million present value rent obligation to Ventas was recorded as long-term debt in our consolidated balance sheet. During 2005, 2004 and 2003, we paid $5 million, $4 million and $2 million, respectively, of principal and $4 million, $4 million and $2 million, respectively, of interest to Ventas under this arrangement.

In December 2003, we acquired the Ventas II Facilities. In connection with this transaction, we paid $79 million to purchase the Ventas II Facilities and $6 million in lease termination fees. The annual rent of approximately $5 million on the Ventas II Facilities terminated upon the closing of the purchase transaction.

GOVERNMENTAL REGULATION

Medicare and Medicaid

Medicare is a federal progr