KINDRED HEALTHCARE, INC
Form 10-K
March 01, 2007
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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, 2006**

**OR**

**¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**Commission File Number: 001-14057**

# KINDRED HEALTHCARE, INC.

**(Exact name of registrant as specified in its charter)**

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

**(502) 596-7300**

**(Registrant s telephone number, including area code)**

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

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

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

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

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

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act.

Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨

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, 2006, was approximately $816,732,000. For purposes of the foregoing calculation only, all directors and executive officers of the Registrant have been deemed affiliates.

As of January 31, 2007, there were 39,992,049 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 31, 2007 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, 2006, our hospital division operated 81 long-term acute care ( LTAC ) hospitals (6,419 licensed beds) in 24 states. Our health services division operated 242 nursing centers (30,664 licensed beds) in 28 states. We also operated a contract rehabilitation services business that provides rehabilitative services primarily in long-term care settings. Our pharmacy division operated an institutional pharmacy business with 46 pharmacies in 26 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.

*Proposed Spin-Off Transaction.* On October 25, 2006, we signed a definitive agreement with AmerisourceBergen Corporation ( AmerisourceBergen ) to combine our respective institutional pharmacy businesses, Kindred Pharmacy Services ( KPS ) and PharMerica Long-Term Care ( PharMerica LTC ), into a new, independent, publicly traded company ( Newco ). The proposed transaction (the Proposed Pharmacy Transaction ) is intended to be tax-free to us and to the shareholders of both AmerisourceBergen and us. The Proposed Pharmacy Transaction is expected to be completed in the second quarter of 2007.

Under the terms of the Proposed Pharmacy Transaction, both KPS and PharMerica LTC are expected to each borrow up to $150 million and use such proceeds to fund a one-time cash distribution, intended to be tax-free, to their respective parent companies. Following the cash distribution, each institutional pharmacy business is expected to be spun off to the shareholders of their respective parent companies. Immediately thereafter, a stock-for-stock merger will be effected that would result in AmerisourceBergen shareholders and our shareholders each owning 50% of the new publicly traded company. The Proposed Pharmacy Transaction is subject to certain conditions, including the completion of a registration statement that will be filed with the Securities and Exchange Commission (the SEC ). The closing of the Proposed Pharmacy Transaction also will require the receipt of required regulatory approvals and the satisfaction of certain other conditions.

*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 $124 million in cash (the Commonwealth Transaction ).

Commonwealth operated 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 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.

*Spin-off from Ventas*. On May 1, 1998, Ventas, Inc. ( Ventas ) completed the spin-off of its healthcare operations to its stockholders through the distribution of our former common stock (the Spin-off ). Ventas retained ownership of substantially all of its real property and leases a portion of such real property to us. In

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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 have completed certain strategic divestitures to improve our future operating results. On August 7, 2006, we entered into definitive agreements with Health Care Property Investors, Inc. ( HCP ) to acquire the real estate related to 11 unprofitable leased nursing centers operated by us for resale in exchange for three hospitals previously owned by us (the HCP Transaction ). The HCP Transaction was completed on January 31, 2007. As part of the HCP Transaction, we will continue to operate the hospitals under a long-term lease arrangement with HCP. In addition, we paid HCP a one-time cash payment of approximately $36 million. We also amended our existing master lease with HCP to (1) terminate the current annual rent of approximately $9.9 million on the 11 nursing centers, (2) add the three hospitals to the master lease with a current annual rent of approximately $6.3 million and (3) extend the initial expiration date of the master lease until January 31, 2017 except for one hospital which has an expiration date of January 31, 2022.

On November 7, 2006, we entered into a definitive agreement to sell the real estate and related operations of these 11 nursing centers for $78 million. On February 1, 2007, we sold nine of the nursing centers and we expect to close on the sale of the other two remaining nursing centers during 2007. We generated approximately $74 million in proceeds from the initial sale transaction and expect to generate approximately $4 million in additional proceeds from the sale of the remaining two nursing centers.

These 11 nursing centers, which contain 1,754 licensed beds, generated pretax losses of approximately $1 million and $4 million for the years ended December 31, 2006 and 2005, respectively. We have accounted for the operations of these nursing centers as discontinued operations. We expect to record a pretax loss of approximately $11 million to $14 million in the first quarter of 2007 relating to these divestitures.

The sale of the remaining two nursing centers is subject to the receipt of required approvals and the satisfaction of other customary conditions to closing.

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.

For accounting purposes, the operating results of these businesses and the losses associated with these transactions have been classified as discontinued operations in our accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2006 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 accompanying consolidated balance sheet. See notes 3 and 4 of the notes to consolidated financial statements.

## HEALTHCARE OPERATIONS

We are 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

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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 efficiencies.

## HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 81 hospitals with 6,419 licensed beds located in 24 states as of December 31, 2006. We operate the largest network of LTAC hospitals in the United States based upon fiscal 2006 revenues of approximately $1.7 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 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 medically complex patients, including the critically ill, suffering from multiple organ system failures, most commonly of the cardiovascular, pulmonary, kidney, gastro-intestinal and cutaneous (skin) systems. In particular, we have a core competency in treating patients with cardio-pulmonary disorders, skin and wound conditions, and life-threatening infections. Prior to being admitted to our hospitals, many of our patients have undergone a major surgical procedure or developed a neurological disorder following head and spinal cord injury, cerebral vascular incident or metabolic instability. Our expertise lies in the ability to simultaneously deliver comprehensive and coordinated medical interventions directed at all affected organ systems, while maintaining a patient-centered, integrated care plan. Medically complex patients are characteristically dependent on technology for continued life support, including mechanical ventilation, total parenteral nutrition, respiratory or cardiac monitors and kidney dialysis machines. During 2006, the average length of stay for patients in our hospitals was approximately 32 days. Approximately 70% of our hospital patients are over 65 years old.

Our hospital division patients generally have conditions that require a high level of monitoring and specialized care, yet may not need the services of a traditional intensive care unit. Due to their severe medical conditions, these patients are not clinically appropriate for admission to other post-acute settings 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 25, 2007, the Centers for Medicare and Medicaid Services ( CMS ) issued proposed regulatory changes regarding Medicare reimbursement for LTAC hospitals (the 2007 Proposed Rule ). The 2007 Proposed Rule would be effective for discharges occurring on or after July 1, 2007 through June 30, 2008. The 2007 Proposed Rule is subject to a 60-day public comment period.

CMS projects an overall decrease in payments to all Medicare certified LTAC hospitals of 2.9% from the 2007 Proposed Rule. Included in this proposed decrease are (1) an increase to the standard federal payment rate of .71%; (2) revisions to payment methodologies impacting short-stay outliers which reduce payments by .9%; (3) adjustments to the wage index component of the federal payment resulting in projected reductions in payment of .5%; and (4) an extension of the policy known as the 25 Percent Rule to all LTAC hospitals, which CMS projects will reduce payments by 2.2%. We believe that the 2007 Proposed Rule, if adopted, could reduce Medicare reimbursement to our hospitals by approximately $20 million in the second half of 2007.

The proposed short-stay outlier revisions would create a new category for cases having lengths of stay less than a threshold which is based upon the average of a patient in a short-term hospital with the same diagnosis. Payment for such cases would be based upon the payment that the short-term acute care hospital would have received.

Currently, CMS has regulations governing payment to LTAC hospitals that are co-located with another hospital. Most co-located hospitals can admit up to 25% of its patients from its host hospital and be paid according to the Long-Term Care Prospective Payment System ( LTAC PPS ). Admissions that exceed this 25 Percent Rule are paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. CMS is currently phasing-in this policy which will become fully effective on September 1, 2008.

CMS is now proposing to expand this policy to all LTAC hospitals, regardless of whether they are co-located with another hospital. Under this proposal, all LTAC hospitals will be paid LTAC PPS rates for admissions from a single referral source up to 25%. Admissions beyond 25% would be paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. Under the proposal, the 25% threshold would not apply immediately to certain LTAC hospitals. Hospitals having fiscal years beginning on or after July 1, 2007 and before October 1, 2007, including most of our hospitals, will have their admission cap initially set at 50%. For most of our hospitals, this 50% cap would apply until September 1, 2008, after which the cap would be reduced to 25%.

CMS is also proposing that the annual update to the long-term care diagnostic related group ( DRG ) classifications and relative weights would be made in a budget neutral manner, effective October 1, 2007. As such, the estimated aggregate industry LTAC PPS payments would be unaffected by the annual recalibration of DRG payment weights.

On August 1, 2006, CMS issued rules to reweight LTAC hospital DRGs, among other things, beginning October 1, 2006. CMS estimated that the effect of this rule would decrease Medicare reimbursements to LTAC hospitals by an additional 1.3%. The revised DRG reweighting reduced our hospital Medicare revenues by approximately $1 million in the fourth quarter of 2006. Based upon our historical Medicare patient volumes, we expect the revised DRG reweighting will reduce Medicare revenues to our hospitals by approximately $3 million to $5 million on an annual basis.

On May 2, 2006, CMS issued final regulatory changes regarding Medicare reimbursement to LTAC hospitals (the 2006 Hospital Medicare Rule ). The 2006 Hospital Medicare Rule became effective for discharges occurring after June 30, 2006. The 2006 Hospital Medicare Rule reduced our hospital Medicare revenues by approximately $26 million in 2006. Based upon our historical Medicare patient volumes, we expect the 2006 Hospital Medicare Rule will reduce Medicare revenues to our hospitals associated with short-stay outliers and high cost outliers by approximately $42 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

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payment rates that also is contained in the 2006 Hospital Medicare Rule. The annual market basket adjustment has typically ranged between 3% and 4%, or approximately $25 million to $30 million annually. The 2006 Hospital Medicare Rule also extends until July 1, 2008 CMS s authority to impose a one-time prospective budget neutrality adjustment to LTAC hospital rates. This authority was previously scheduled to expire on October 1, 2006.

**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,
- maintaining an integrated quality assurance and improvement program, administered by our chief medical officer and senior vice president of clinical operations, 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 (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, and
- implementing an integrated risk management plan to improve quality and expand existing patient safety initiatives.

*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,

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,

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centralizing administrative functions such as accounting, payroll, legal, reimbursement, compliance, tax 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, 2006, we operated 63 freestanding hospitals (5,651 licensed beds) and we intend to add further freestanding hospitals in certain strategic markets. During 2006, we opened one freestanding hospital and we currently have nine freestanding hospitals under development.

Growing Through Selective Acquisitions We seek growth opportunities through strategic acquisitions in selected target markets. In the Commonwealth Transaction, we added six hospitals in Massachusetts with a total of 646 licensed beds. We also acquired the right to develop 95 additional licensed beds in Massachusetts.

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 four hospitals by 82 licensed beds.

Cluster Market Development We are increasingly focused on the opportunities available to us in markets where we operate multiple hospitals or which have affiliated nursing centers. These cluster markets present opportunities to collaborate between our hospitals and nursing centers by sharing clinical expertise and sales and marketing resources. We believe a more market focused approach will grow admissions and better educate the marketplace on our ability to care for medically complex post-acute patients.

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 eight HIHs with a total of 284 licensed beds.

*Expanding Program Development*. We are a leading provider of long-term acute care to patients with pulmonary dysfunctions. In addition, we have developed and continue to expand other inpatient and outpatient service areas such as wound care, 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 in selected markets.

*Increasing Patient Volume, Particularly Commercial Patients*. We have expanded 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 as a group 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

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settings. Accordingly, we are focused on maintaining strong relationships with these providers. In order to maintain these relationships, we employ clinical liaisons that 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 at the 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, | | |
|---|---|---|---|
| | 2006 | 2005 | 2004 |
| Revenues | $ 1,726,816 | $ 1,608,120 | $ 1,398,658 |
| Operating income | $ 388,422 | $ 419,546 | $ 328,950 |
| Hospitals in operation at end of period | 81 | 74 | 72 |
| Licensed beds at end of period | 6,419 | 5,694 | 5,569 |
| Admissions | 41,321 | 38,182 | 35,206 |
| Patient days | 1,316,632 | 1,158,141 | 1,119,882 |
| Revenues per admission | $ 41,790 | $ 42,117 | $ 39,728 |
| Revenues per patient day | $ 1,312 | $ 1,388 | $ 1,249 |
| Average daily census | 3,607 | 3,173 | 3,060 |
| Average length of stay | 31.9 | 30.3 | 31.8 |
| Occupancy % | 63.7 | 59.1 | 59.2 |
| Assets at end of period | $ 762,943 | $ 560,767 | $ 515,353 |

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 operational licensed beds, adjusted for the length of time each facility was in operation during each respective period.

**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 are more profitable to the hospital division than those covered by the Medicare and Medicaid programs. The following table sets forth the approximate percentages of our hospital admissions, 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, 2006 | 71% | 63% | 61% | 10% | 15% | 10% | 19% | 22% | 29% |
| 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 |

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For the year ended December 31, 2006, revenues of the hospital division totaled approximately $1.7 billion or 37% 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, 2006:

| | | 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) | 414 | | 1 | 1 | 2 |
| Louisiana | 168 | | 1 | | 1 |
| Massachusetts (1) | 755 | | 2 | 6 | 8 |
| Michigan (1) | 220 | | 1 | | 1 |
| Missouri (1) | 265 | | 2 | 1 | 3 |
| Nevada | 184 | 1 | 1 | 1 | 3 |
| New Jersey (1) | 117 | | | 3 | 3 |
| New Mexico | 61 | | 1 | | 1 |
| North Carolina (1) | 124 | | 1 | | 1 |
| Ohio | 202 | | | 3 | 3 |
| Oklahoma | 93 | | 1 | 1 | 2 |
| Pennsylvania | 225 | | 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 | 6,419 | 11 | 39 | 31 | 81 |

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

**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

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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 utilizes a pre-admission assessment system to evaluate clinical needs and other information in determining the appropriateness of each potential patient admission. After admission, each patient s case is reviewed by the 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 officer or administrator supervises and is responsible for the day-to-day operations at each of our hospitals. Each hospital or network of hospitals also employs a chief financial officer who monitors the financial matters of the hospital or network. Within selected markets having a significant concentration of hospitals, administrative functions such as billing and collections may be shared to improve efficiency. In addition, each hospital or network of hospitals employs a chief clinical officer to oversee the clinical operations and a director of quality management to oversee our quality assurance programs. We provide centralized services in the areas of information systems design and development, training, reimbursement expertise, legal advice, tax, 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 who 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 generally several competitors that provide similar services to those provided by our hospital division. In addition, several of the markets in which the hospital division operates have other LTAC hospitals that provide services comparable to those offered by our hospitals. Certain competing hospitals are operated by not-for-profit, non-taxpaying or governmental agencies, which can finance capital expenditures on a tax-exempt basis and receive funds and charitable contributions unavailable to our hospital division.

Competition for patients covered by non-government reimbursement sources is intense. The primary competitive factors in the LTAC 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

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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.

## HEALTH SERVICES DIVISION

Our health services division provides quality, cost-effective care through the operation of a national network of 242 nursing centers (30,664 licensed beds) located in 28 states. We operate the third largest network of nursing centers in the United States based upon our fiscal 2006 revenues of approximately $2.0 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.

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 to improve the delivery of the clinical and hospitality services offered to our patients and residents by adjusting the level of clinical and hospitality staffing, improving physician oversight through the selective use of nurse practitioners and improving clinical case management through the employment of clinical case managers.

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.

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

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

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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:

- improve recruitment, retention, management development, succession planning and employee satisfaction,
- expand the involvement of our medical directors and increase the use of nurse practitioners,
- 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 the number of 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 quality 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 executive directors, clinical liaisons, 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:

- focusing our sales and marketing plan on rehabilitation, medically complex and Alzheimer s patients,
- working to improve our relationships with existing local referral sources and identifying and developing new referral sources,
- expanding the use of central intake lines in key market areas to promote census growth,
- expanding the number of clinical liaisons and admission coordinators and implementing community outreach programs,
- focusing our sales and marketing efforts on new service lines and specialty program development, and

increasingly focusing on the opportunities available to us in markets where we operate multiple nursing centers or which have affiliated hospitals. These cluster markets present opportunities to collaborate between our nursing centers and hospitals by sharing clinical expertise and sales and marketing resources and to grow admissions and better educate the marketplace on our ability to care for medically complex post-acute patients.

*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:

increased our average occupancy levels, which leverages our revenues over the fixed costs associated with operating our nursing centers,

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

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enhanced our quality assurance, risk management and liability claims defense initiatives to address professional liability costs, and

developed a management information system to aid in financial and clinical reporting as well as billing and collections.

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

divested 13 nursing centers with approximately 1,978 beds in the last three years,

divested nine under-performing nursing centers on February 1, 2007 and intend to divest two additional under-performing nursing centers in 2007,

entered into an agreement to lease eight nursing centers, containing 910 licensed bed, in the San Francisco Bay area, effective January 31, 2007,

acquired 11 nursing centers concentrated in Massachusetts as part of the Commonwealth Transaction,

expanded our traditional care units and other clinical programs to address the needs of higher acuity patients, and

made significant capital investments to improve our existing 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, | | |
|---|---|---|---|
| | **2006** | **2005** | **2004** |
| Revenues | $ 1,957,172 | $ 1,780,009 | $ 1,677,392 |
| Operating income | $ 246,866 | $ 216,515 | $ 222,971 |
| Nursing centers in operation at end of period: | | | |
| Owned or leased | 237 | 226 | 225 |
| Managed | 5 | 5 | 7 |
| Licensed beds at end of period: | | | |
| Owned or leased | 30,059 | 28,510 | 28,407 |
| Managed | 605 | 605 | 803 |
| Patient days (a) | 9,522,562 | 8,967,894 | 9,075,239 |
| Revenues per patient day (a) | $ 206 | $ 198 | $ 185 |
| Average daily census (a) | 26,089 | 24,570 | 24,796 |
| Occupancy % (a) | 87.8 | 86.2 | 86.9 |
| Assets at end of period | $ 427,376 | $ 385,864 | $ 366,164 |

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

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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, 2006 | 17% | 34% | 65% | 47% | 18% | 19% |
| Year ended December 31, 2005 | 17 | 33 | 66 | 49 | 17 | 18 |
| Year ended December 31, 2004 | 16 | 34 | 67 | 48 | 17 | 18 |

For the year ended December 31, 2006, revenues of the health services division totaled approximately $2.0 billion or 42% 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, 2006:

| | | Number of facilities | | | | |
|---|---|---|---|---|---|---|
| State | Licensed beds | 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 | 515 | | 4 | | | 4 |
| Connecticut (1) | 736 | | 6 | | | 6 |
| Georgia (1) | 685 | | 5 | | | 5 |
| Idaho | 862 | 1 | 8 | | | 9 |
| Indiana | 4,061 | | 15 | 11 | | 26 |
| Kentucky (1) | 1,689 | 1 | 11 | 2 | | 14 |
| Maine (1) | 779 | | 10 | | | 10 |
| Massachusetts (1) | 4,971 | | 27 | 12 | 3 | 42 |
| 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) | 2,737 | | 19 | 4 | | 23 |
| Ohio (1) | 1,892 | | 11 | 3 | | 14 |
| Oregon (1) | 254 | | 2 | | | 2 |
| Pennsylvania | 103 | | 1 | | | 1 |
| Rhode Island (1) | 201 | | 2 | | | 2 |
| Tennessee (1) | 1,349 | | 4 | 5 | | 9 |
| Utah | 740 | | 5 | | 1 | 6 |
| Vermont (1) | 310 | | 1 | | 1 | 2 |
| Virginia (1) | 629 | | 4 | | | 4 |
| Washington (1) | 817 | | 9 | | | 9 |
| Wisconsin (1) | 1,969 | | 11 | 1 | | 12 |
| Wyoming (1) | 451 | | 4 | | | 4 |
| Totals | 30,664 | 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.

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**Health Services Division Management and Operations**

Each of our nursing centers is managed by a state-licensed executive director who is supported by other professional personnel, including a director of nursing, nursing assistants, licensed practical nurses, staff development coordinator, activities director, social services director 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 with assistance from our regional and district teams. 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, 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 and improve quality resident care.

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

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, clinical 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

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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.

## 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 415 nursing centers, 88 hospitals and 56 other locations in 37 states under the name People*first* Rehabilitation. Approximately 75% of the rehabilitation division s revenues in 2006 were generated from contracts with our hospitals and nursing centers.

Our rehabilitation division employs over 6,400 therapists and had revenues of approximately $300 million (before eliminations) in 2006. 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 business realignments.

### Rehabilitation Division Strategy

Our goals are to be the leading contract rehabilitation services provider and employer of choice in the markets we serve and to increase our market share and name recognition 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

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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 specialized programs to promote the quality initiatives of our customers, including Alzheimer s disease and other dementia programs, pain management and pulmonary therapies.
- We promote the competencies of our therapists by providing extensive 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 customer s 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 through the use of our People*first* website.

**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, | | |
|---|---|---|---|
| | **2006** | **2005** | **2004** |
| Revenues: | | | |
| Company-operated | $ 225,936 | $ 200,187 | $ 165,987 |
| Non-affiliated | 74,170 | 62,586 | 62,439 |
| | $ 300,106 | $ 262,773 | $ 228,426 |
| Operating income | $ 30,362 | $ 32,052 | $ 31,431 |
| Number of customer contracts: | | | |
| Company-operated | 330 | 317 | 317 |
| Non-affiliated | 229 | 209 | 210 |
| Assets at end of period | $ 10,621 | $ 7,124 | $ 7,701 |

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**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, 2006, revenues of the rehabilitation division totaled approximately $300 million or 7% 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 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.

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**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, 2006:

| | Hospitals | | Nursing centers | | Other | Total | |
|---|---|---|---|---|---|---|---|
| | Company | | Company | | | Company | |
| State | operated | Non-affiliated | operated | Non-affiliated | Non-affiliated | operated | Non-affiliated |
| Alabama | | | 4 | | | 4 | |
| Arizona | 3 | | 6 | | | 9 | |
| California | 11 | | 18 | 10 | | 29 | 10 |
| Colorado | 1 | | 5 | 1 | | 6 | 1 |
| Connecticut | | | 6 | 8 | | 6 | 8 |
| Florida | 7 | | | 30 | 18 | 7 | 48 |
| Georgia | 1 | | 5 | | | 6 | |
| Iowa | | | | 1 | | | 1 |
| Idaho | | 2 | 9 | | 8 | 9 | 10 |
| Illinois | 5 | 1 | | 12 | 4 | 5 | 17 |
| Indiana | 2 | 2 | 27 | 2 | 7 | 29 | 11 |
| Kentucky | 2 | 1 | 14 | 9 | 1 | 16 | 11 |
| Louisiana | 1 | | | | | 1 | |
| Maine | | | 10 | 3 | | 10 | 3 |
| Massachusetts | 8 | | 44 | 5 | 4 | 52 | 9 |
| Michigan | 1 | | | | | 1 | |
| Missouri | 3 | | 2 | 1 | | 5 | 1 |
| Montana | | | 2 | | 2 | 2 | 2 |
| Nebraska | | | 1 | | | 1 | |
| Nevada | 3 | 2 | 2 | 2 | | 5 | 4 |
| New Hampshire | | | 3 | | 1 | 3 | 1 |
| New Jersey | 1 | | | | | 1 | |
| New Mexico | 1 | 1 | | | | 1 | 1 |
| North Carolina | 1 | 1 | 23 | 40 | 2 | 24 | 43 |
| Ohio | 3 | 1 | 15 | 9 | 2 | 18 | 12 |
| Oklahoma | 2 | | | | | 2 | |
| Oregon | | | 2 | | | 2 | |
| Pennsylvania | 5 | | 1 | 9 | | 6 | 9 |
| Rhode Island | | | 2 | | | 2 | |
| Tennessee | 1 | | 16 | 6 | | 17 | 6 |
| Texas | 12 | 1 | | 5 | 2 | 12 | 8 |
| Utah | | | 6 | | 1 | 6 | 1 |
| Vermont | | | 2 | 3 | | 2 | 3 |
| Virginia | | | 4 | 2 | | 4 | 2 |
| Washington | 1 | | 9 | 2 | 4 | 10 | 6 |
| Wisconsin | 1 | | 12 | 1 | | 13 | 1 |
| Wyoming | | | 4 | | | 4 | |
| Totals | 76 | 12 | 254 | 161 | 56 | 330 | 229 |

**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

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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 12 facilities. An area rehabilitation director reports to a region rehabilitation director. The six nursing center regions are determined predominately by geography. In our hospitals, the on-site manager reports to a regional rehabilitation director. The four 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 46 institutional pharmacies in 26 states that serve approximately 102,600 patients and residents of long-term care facilities. We serve over 1,000 facilities including skilled nursing centers (including 236 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 that we serve.

Our pharmacy division is the third largest institutional pharmacy company in the United States based upon fiscal 2006 revenues of approximately $653 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.

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

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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 radius of 120 miles or less 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. 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. We also assist the hospitals in obtaining and maintaining applicable regulatory licenses, certifications and accreditations.

**Proposed Pharmacy Transaction**

On October 25, 2006, we signed a definitive agreement for the Proposed Pharmacy Transaction. The Proposed Pharmacy Transaction is intended to be tax-free to us and to the shareholders of both AmerisourceBergen and us. The Proposed Pharmacy Transaction is expected to be completed in the second quarter of 2007.

Under the terms of the Proposed Pharmacy Transaction, both KPS and PharMerica LTC are expected to each borrow up to $150 million and use such proceeds to fund a one-time cash distribution, intended to be tax-free, to their respective parent companies. Following the cash distribution, each institutional pharmacy business is expected to be spun off to the shareholders of their respective parent companies. Immediately thereafter, a stock-for-stock merger will be effected that would result in AmerisourceBergen shareholders and our shareholders each owning 50% of the new publicly traded company. The Proposed Pharmacy Transaction is subject to certain conditions, including the completion of a registration statement to be filed with the SEC. The closing of the Proposed Pharmacy Transaction also will require the receipt of required regulatory approvals and the satisfaction of certain other conditions.

**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

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competitive price. We have remained flexible to meet our customers needs while offering a high level of services expected by our customers. We also have implemented 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:

- use management information systems that allow us to maintain service standards, achieve or exceed regulatory compliance and navigate the rapidly changing billing complexities of individual state Medicaid programs and Medicare Part D,
- 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 expanded recruiting resources.

*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 2006, we acquired two institutional pharmacy businesses in Iowa servicing approximately 2,000 customer beds and an institutional pharmacy business in Kentucky servicing approximately 2,600 customer beds. 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.
- New Pharmacies We opened seven new pharmacies during 2006 and 2005. We anticipate opening three new pharmacies in 2007 to service new customers and markets.
- External Pharmacy Business We have significantly increased the non-affiliated beds we service and we 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 Our 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, | | |
|---|---|---|---|
| | **2006** | **2005** | **2004** |
| Revenues | $ 652,608 | $ 522,225 | $ 360,035 |
| Operating income | $ 48,461 | $ 56,837 | $ 37,062 |

| | | | |
|---|---|---|---|
| Institutional pharmacies in operation at end of period | 46 | 39 | 33 |
| Number of customer licensed beds at end of period: | | | |
| Company-operated | 30,232 | 28,657 | 28,634 |
| Non-affiliated | 72,339 | 64,625 | 37,561 |
| Total | 102,571 | 93,282 | 66,195 |
| Assets at end of period | $ 225,684 | $ 188,914 | $ 60,146 |

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**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 December 2003, Congress enacted Medicare Part D that 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. On January 1, 2006, Medicare Part D became effective. Most of our nursing center residents whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for the Medicare Part D drug benefit. Accordingly, since January 1, 2006, Medicaid is no longer a primary payor for the pharmacy services provided to these residents. See Governmental Regulation Pharmacy Division Overview of Pharmacy Division Reimbursement.

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, 2006 | 57% | 9% | 34% |
| Year ended December 31, 2005 | 16 | 45 | 39 |
| Year ended December 31, 2004 | 21 | 50 | 29 |

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.

For the year ended December 31, 2006, revenues of the pharmacy division totaled approximately $653 million or 14% 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, 2006. All of our pharmacy locations are leased.

| State | Institutional pharmacies | Approximate square footage | Institutional beds serviced |
|---|---|---|---|
| Alabama | 1 | 5,000 | 1,050 |
| Arizona | 2 | 21,000 | 3,467 |
| California | 5 | 55,250 | 22,369 |
| Colorado | 1 | 7,100 | 1,682 |
| Connecticut | 1 | 7,900 | 2,630 |
| Florida | 4 | 31,750 | 8,499 |
| Georgia | 1 | 6,350 | 827 |
| Idaho | 1 | 5,750 | 1,581 |
| Illinois | 1 | 16,750 | 5,744 |
| Indiana | 2 | 20,550 | 6,288 |
| Iowa | 3 | 13,000 | 3,382 |
| Kentucky | 1 | 6,000 | 2,720 |
| Maine | 1 | 10,200 | 2,776 |
| Massachusetts | 1 | 15,250 | 6,200 |
| Montana | 1 | 300 | 223 |
| Nevada | 2 | 10,850 | 1,522 |
| New Hampshire | 1 | 7,500 | 1,284 |
| North Carolina | 3 | 20,000 | 6,200 |
| Ohio | 1 | 10,100 | 3,294 |
| Pennsylvania | 2 | 21,500 | 6,640 |
| Tennessee | 3 | 28,850 | 7,597 |
| Texas | 3 | 22,750 | 1,059 |
| Utah | 1 | 8,000 | 1,450 |
| Virginia | 2 | 15,800 | 1,338 |
| Washington | 1 | 6,800 | 1,069 |
| Wisconsin | 1 | 9,150 | 1,680 |
| Totals | 46 | 383,450 | 102,571 |

**Sales and Marketing**

The pharmacy division s business development 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, 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 providing a complete breadth of customer services.

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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 assists the hospitals in obtaining and maintaining 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 vice president of clinical services.

**Pharmacy Division Competition**

As of December 31, 2006, our pharmacies served customers in geographic markets that are generally limited to a radius of 120 miles or less of our pharmacy locations. In each geographic market, there are national, regional and local institutional pharmacies and numerous local retail pharmacies that 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 LTC. 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 pricing, the quality and range of services offered, and clinical expertise.

**MASTER LEASE AGREEMENTS**

At December 31, 2006, we leased from Ventas and its affiliates 39 LTAC hospitals and 186 nursing centers under four Master Lease Agreements (the Master Lease Agreements ). Under the Master Lease Agreements, 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 Agreement 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 Agreement 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 were in substantially the same form as the other Master Lease Agreements with certain modifications requested by

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Ventas s lenders and required to be made by us pursuant to the Master Lease Agreements. On May 10, 2006, we entered into a Master Lease Combination Amendment and Agreement (the Combination Agreement ) with Ventas through its affiliate, Ventas Realty, Limited Partnership. The Combination Agreement recombined and merged the CMBS Lease and Master Lease No. 1A into Master Lease Agreement No. 1. As a result of the Combination Agreement, the CMBS Lease and Master Lease No. 1A ceased to exist as separate agreements since the nursing centers and hospitals covered by the CMBS Lease and Master Lease No. 1A were recombined into Master Lease Agreement No. 1. Our aggregate lease obligations to Ventas were unchanged by the Combination Agreement.

*Rent Reset*. On October 12, 2006, Ventas exercised a one-time right to reset rent under each of the Master Lease Agreements. These new aggregate annual rents of approximately $239 million became effective retroactively to July 19, 2006 and were determined as fair market rentals by the final independent appraisers engaged in connection with the rent reset process under each of the Master Lease Agreements. Aggregate annual Ventas rents prior to the rent reset approximated $206 million. As required, Ventas paid us a reset fee of approximately $4.6 million that will be amortized as a reduction of rent expense over the remaining original terms of the Master Lease Agreements. In connection with the exercise of the rent reset, the new annual rents were allocated among the facilities subject to the Master Lease Agreements in accordance with the determinations made by the final appraisers during the rent reset process. The new contingent annual rent escalator is 2.7% for Master Lease Agreements Nos. 1, 3 and 4. The new contingent annual rent escalator for Master Lease Agreement No. 2 is based upon the Consumer Price Index (the CPI ) with a floor of 2.25% and a ceiling of 4%. Prior to the rent reset, the contingent annual Ventas rent escalator under each Master Lease Agreement was 3.5%.

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 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 six to 21 leased properties. 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 are currently analyzing whether to renew the leases for 56 nursing centers and eight hospitals that expire in April 2008 under the Master Lease Agreements. These facilities are held in seven renewal bundles. At our option, all, but not less than all, of the leased properties in each bundle may be extended for one five-year renewal term beyond the initial term at the then existing rental rate plus the then existing escalator amount per annum. The rental rate will escalate each year during the renewal term at the applicable escalation rate. The renewal notices for these bundles of leased properties must be delivered to Ventas on or before April 29, 2007.

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

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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 $239 million. We paid rents to Ventas (including amounts classified as discontinued operations) approximating $214 million for the year ended December 31, 2006, $188 million for the year ended December 31, 2005 and $182 million for the year ended December 31, 2004.

Each Master Lease Agreement provides for rent escalations each May 1 if the patient revenues for the leased properties meet certain criteria as measured using the preceding calendar year revenues as compared to the base period. 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. In connection with the exercise of the rent reset by Ventas, the rent escalations were modified. The new contingent annual rent escalator is 2.7% for Master Lease Agreements Nos. 1, 3 and 4. The new contingent annual rent escalator for Master Lease Agreement No. 2 is based upon the CPI with a floor of 2.25% and a ceiling of 4%. Prior to the rent reset, the contingent annual Ventas rent escalator under each Master Lease Agreement was 3.5%.

**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,

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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,

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 event 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

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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 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.

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## GOVERNMENTAL REGULATION

### Medicare and Medicaid

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

We could be affected adversely by the continuing efforts of governmental and private third party payors to contain healthcare costs. We cannot assure you that reimbursement payments under governmental and private third party payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. In addition, we cannot assure you that the facilities operated by us, or the provision of goods and services offered by us, will meet the requirements for participation in such programs. In addition, we cannot assure you that future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs will not have a material adverse effect on our financial position, results of operations and liquidity. See Item 1A Risk Factors Changes in the reimbursement rates or methods of payment from third party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a substantial reduction in our revenues and operating margins.

### Federal, State and Local Regulation

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, and the confidentiality and security of health-related information. In particular, various laws including anti-kickback, anti-fraud and abuse amendments codified under the Social Security Act prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients the cost of whose care will be paid by Medicare or other governmental programs. Sanctions for violating these anti-kickback, anti-fraud and abuse amendments under the Social Security Act include criminal penalties, civil sanctions, fines and possible exclusion from government programs such as Medicare and Medicaid.

In the ordinary course of our business, we are subject regularly to inquiries, investigations and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. Such sanctions could have a material adverse effect on our financial position, results of operations and liquidity. We vigorously contest such sanctions where appropriate; however, these cases can involve significant legal expense and consume our resources.

Section 1877 of the Social Security Act, commonly known as Stark I, states that a physician who has a financial relationship with a clinical laboratory generally is prohibited from referring patients to that laboratory. The Omnibus Budget Reconciliation Act of 1993 contains provisions, commonly known as Stark II, amending

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Section 1877 to expand greatly the scope of Stark I. Effective January 1995, Stark II broadened the referral limitations of Stark I to include, among other designated health services, inpatient and outpatient hospital services. Under Stark I and Stark II, a financial relationship is defined as an ownership interest or a compensation arrangement. If such a financial relationship exists, the entity generally is prohibited from claiming payment for services under the Medicare or Medicaid programs. Compensation arrangements generally are exempted from Stark I and Stark II if, among other things, the compensation to be paid is set in advance, does not exceed fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. The U.S. Department of Health and Human Services has issued regulations that describe some of the conduct and business relationships permissible under the anti-kickback amendments. The fact that a given business arrangement does not fall within one of these safe harbors does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable criteria, however, risk increased scrutiny and possible sanctions by enforcement authorities. These laws and regulations, however, are complex, and there is limited judicial or regulatory interpretation. We believe that business practices of providers and financial relationships between providers have become subject to increased scrutiny as healthcare reform efforts continue on the federal and state levels. Many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of payment for the care. While we do not believe our arrangements are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing the provisions of these prohibitions will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations.

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

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

*HIPAA*. The federal Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, broadens the scope of existing fraud and abuse laws to include all health plans, whether or not they are reimbursed under federal programs. In addition, HIPAA also mandates the adoption of regulations aimed at standardizing transaction formats and billing codes for documenting medical services, dealing with claims submissions and protecting the privacy and security of individually identifiable health information. HIPAA regulations that standardize transactions and code sets became final in 2000. These regulations require standard formatting for healthcare providers, like us, that submit claims electronically. We believe that we are in compliance with the HIPAA transaction and code set standards.

The HIPAA privacy regulations apply to protected health information, which is defined generally as individually identifiable health information transmitted or maintained in any form or medium, excluding certain education records and student medical records. The privacy regulations seek to limit the use and disclosure of most paper and oral communications, as well as those in electronic form, regarding an individual s past, present

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or future physical or mental health or condition, or relating to the provision of healthcare to the individual or payment for that healthcare, if the individual can or may be identified by such information. HIPAA provides for the imposition of civil or criminal penalties if protected health information is improperly disclosed. We believe that we are in compliance with the HIPAA privacy regulations.

HIPAA s security regulations were finalized in February 2003. We were required to comply with the HIPAA security regulations by April 20, 2005. The security regulations require us to ensure the confidentiality, integrity, and availability of all electronic protected health information that we create, receive, maintain or transmit. We must protect against reasonably anticipated threats or hazards to the security of such information and the unauthorized use or disclosure of such information. Our HIPAA compliance committee oversees the measures we have undertaken to comply with the HIPAA security regulations. We believe that we are in compliance with the HIPAA security regulations.

Final HIPAA unique health identifier standards for healthcare providers were published in January 2004 with an effective date of May 23, 2005. These standards require us to obtain a national provider identifier ( NPI ) and to begin using this identifier by May 23, 2007. We have established working groups to address issues associated with the NPI and to bring us into compliance by May 2007. Many systems will require vendor intervention to accomplish these changes. We cannot be certain that certain vendors will meet the imposed deadline. Failure to meet the deadline could result in delayed reimbursement.

Sanctions for failing to comply with HIPAA health information practices provisions include criminal penalties and civil sanctions. At this time, we anticipate that we will be able to comply with the HIPAA requirements that have been adopted. Although HIPAA was intended ultimately to reduce administrative expenses and burdens faced within the healthcare industry, we believe that it may cause significant and, in some cases, costly changes. We cannot assure you that our compliance with the HIPAA regulations will not have an adverse affect on our financial position, results of operations and liquidity.

*Certificates of Need and State Licensing.* Certificate of need, or CON, regulations control the development and expansion of healthcare services and facilities in certain states. Certain states also require regulatory approval prior to certain changes in ownership of a hospital or nursing center. Certain states that do not have CON programs may have other laws or regulations that limit or restrict the development or expansion of healthcare facilities. We operate hospitals in 12 states and nursing centers in 20 states that require state approval for the expansion of our facilities and services under CON programs. To the extent that CONs or other similar approvals are required for expansion of the operations of our hospitals or nursing centers, either through facility acquisitions, expansion or provision of new services or other changes, such expansion could be affected adversely by the failure or inability to obtain the necessary approvals, changes in the standards applicable to such approvals or possible delays and expenses associated with obtaining such approvals.

We are required to obtain state licenses to operate each of our hospitals and nursing centers and to ensure their participation in government programs. Once a hospital or nursing center becomes licensed and operational, it must continue to comply with federal, state and local licensing requirements in addition to local building and life-safety codes. All of our hospitals and nursing centers have the necessary licenses.

**Hospital Division**

*General Regulations.* The hospital division is subject to various federal and state regulations. In order to receive Medicare reimbursement, each hospital must meet the applicable conditions of participation set forth by the U.S. Department of Health and Human Services relating to the type of hospital, its equipment, personnel and standard of medical care, as well as comply with state and local laws and regulations. We have developed a management system to facilitate our compliance with these various standards and requirements. Among other things, each hospital employs a person who is responsible for an ongoing quality assessment and improvement program. Hospitals undergo periodic on-site Medicare certification surveys, which generally are limited in

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frequency if the hospital is accredited by the Joint Commission. As of December 31, 2006, 80 hospitals operated by the hospital division were certified as Medicare LTAC providers and one hospital has a pending Medicare certification. In addition, 70 hospitals also were certified by their respective state Medicaid programs. A loss of certification could affect adversely a hospital s ability to receive payments from the Medicare and Medicaid programs.

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

*Accreditation by the Joint Commission*. Hospitals may receive accreditation from the Joint Commission, a national commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. Generally, hospitals and certain other healthcare facilities are required to have been in operation at least four months in order to be eligible for accreditation by the Joint Commission. After conducting on-site surveys, the Joint Commission awards accreditation for up to three years to hospitals found to be in substantial compliance with Joint Commission standards. Accredited hospitals also are periodically resurveyed, at the option of the Joint Commission, upon a major change in facilities or organization and after merger or consolidation. As of December 31, 2006, all of the hospitals operated by the hospital division were accredited by the Joint Commission or were in the process of seeking accreditation. The hospital division intends to seek and obtain Joint Commission accreditation for any additional facilities it may operate in the future.

*Peer Review*. Federal regulations provide that admission to and utilization of hospitals by Medicare and Medicaid patients must be reviewed by peer review organizations or quality improvement organizations in order to ensure efficient utilization of hospitals and services. A quality improvement organization may conduct such review either prospectively or retroactively and may, as appropriate, recommend denial of payments for services provided to a patient. The review is subject to administrative and judicial appeals. Each of the hospitals operated by our hospital division employs a clinical professional to administer the hospital s integrated quality assurance and improvement program. Denials by quality improvement organizations historically have not had a material adverse effect on the hospital division s operating results.

*Overview of Hospital Division Reimbursement*

**Medicare Reimbursement of Short-term Acute Care Hospitals** Medicare reimburses general short-term acute care hospitals under a prospective payment system. Under the short-term acute care prospective payment system, Medicare inpatient costs are reimbursed based upon a fixed payment amount per discharge using DRGs. The DRG payment under the short-term prospective payment system is based upon the national average cost of treating a Medicare patient s condition. Although the average length of stay varies for each DRG, the average stay for all Medicare patients subject to the short-term prospective payment system is approximately six days. An additional outlier payment is made for patients with higher treatment costs but these payments are designed only to cover marginal costs. Hospitals that are certified by Medicare as LTAC hospitals are excluded from the short-term prospective payment system.

**Medicare Reimbursement of Long-term Acute Care Hospitals** The Medicare payment system for LTAC hospitals is based upon a prospective payment system specifically for LTAC hospitals. On October 1, 2002, the final regulations for LTAC PPS became effective. Because of our Medicare cost reporting periods, this

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new payment system did not become effective for substantially all of our LTAC hospitals until September 1, 2003. Prior to October 2002, LTAC hospitals were reimbursed on a reasonable cost-based payment system.

LTAC PPS is based upon discharged-based DRGs similar to the system used to pay short-term acute care hospitals. While the clinical system which groups procedures and diagnoses is identical to the prospective payment system for short-term acute care hospitals, LTAC PPS utilizes different rates and formulas. Three types of payments are used in the new system: (a) short-stay outlier payment, which provides for patients whose length of stay is less than 5/6th of the geometric mean length of stay for that DRG, based upon the lesser of (1) a per diem based upon the average payment for that DRG, (2) the estimated costs, (3) the full DRG payment, or (4) a blend of an amount comparable to what would otherwise be paid under the short-term acute care inpatient payment system ( IPPS DRG ) computed as a per diem, capped at the full IPPS DRG comparable payment amount and a per diem based upon the average payment for that DRG under LTAC PPS; (b) DRG fixed payment which provides a single payment for all patients with a given DRG, regardless of length of stay, cost of care or place of discharge; and (c) high cost outlier that will provide a partial coverage of costs for patients whose cost of care far exceeds the DRG reimbursement. For patients in the high cost outlier category, Medicare will reimburse 80% of the costs incurred above the DRG reimbursement plus a fixed cost outlier threshold per discharge.

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

LTAC PPS maintains LTAC hospitals as a distinct provider type, separate from short-term acute care hospitals. Only providers certified as LTAC hospitals may be paid under this system. To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be at least 25 days. Under the previous system, compliance with the 25-day average length of stay threshold was based upon all patient discharges.

On January 25, 2007, CMS issued the 2007 Proposed Rule. The 2007 Proposed Rule would be effective for discharges occurring on or after July 1, 2007 through June 30, 2008. The 2007 Proposed Rule is subject to a 60-day public comment period.

CMS projects an overall decrease in payments to all Medicare certified LTAC hospitals of 2.9% from the 2007 Proposed Rule. Included in this proposed decrease are (1) an increase to the standard federal payment rate of .71%; (2) revisions to payment methodologies impacting short-stay outliers which reduce payments by .9%; (3) adjustments to the wage index component of the federal payment resulting in projected reductions in payment of .5%; and (4) an extension of the policy known as the 25 Percent Rule to all LTAC hospitals, which CMS projects will reduce payments by 2.2%. We believe that the 2007 Proposed Rule, if adopted, could reduce Medicare reimbursement to our hospitals by approximately $20 million in the second half of 2007.

The proposed short-stay outlier revisions would create a new category for cases having lengths of stay less than a threshold which is based upon the average of a patient in a short-term hospital with the same diagnosis. Payment for such cases would be based upon the payment that the short-term acute care hospital would have received.

Currently, CMS has regulations governing payment to LTAC hospitals that are co-located with another hospital, such as a HIH. Most co-located hospitals can admit up to 25% of its patients from its host hospital and be paid according to LTAC PPS. Admissions that exceed this 25 Percent Rule are paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. CMS is currently phasing-in this policy which will become fully effective on September 1, 2008.

CMS is now proposing to expand this policy to all LTAC hospitals, regardless of whether they are co-located with another hospital . Under this proposal, all LTAC hospitals will be paid LTAC PPS rates for

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admissions from a single referral source up to 25%. Admissions beyond 25% would be paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. Under the proposal, the 25% threshold would not apply immediately to certain LTAC hospitals. Hospitals having fiscal years beginning on or after July 1, 2007 and before October 1, 2007, including most of our hospitals, will have their admission cap initially set at 50%. For most of our hospitals, this 50% cap would apply until September 1, 2008, after which the cap would be reduced to 25%.

CMS is also proposing that the annual update to the DRG classifications and relative weights would be made in a budget neutral manner, effective October 1, 2007. As such, the estimated aggregate industry LTAC PPS payments would be unaffected by the annual recalibration of DRG payment weights.

On August 1, 2006, CMS issued rules to reweight LTAC hospital DRGs, among other things, beginning October 1, 2006. CMS estimated that the effect of this rule would decrease Medicare reimbursements to LTAC hospitals by an additional 1.3%. The revised DRG reweighting reduced our hospital Medicare revenues by approximately $1 million in the fourth quarter of 2006. Based upon our historical Medicare patient volumes, we expect the revised DRG reweighting will reduce Medicare revenues to our hospitals by approximately $3 million to $5 million on an annual basis.

On May 2, 2006, CMS issued the 2006 Hospital Medicare Rule. The 2006 Hospital Medicare Rule became effective for discharges occurring after June 30, 2006. The 2006 Hospital Medicare Rule reduced our hospital Medicare revenues by approximately $26 million in 2006. Based upon our historical Medicare patient volumes, we expect the 2006 Hospital Medicare Rule will reduce Medicare revenues to our hospitals associated with short-stay outliers and high cost outliers by approximately $42 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 2006 Hospital Medicare Rule. The annual market basket adjustment has typically ranged between 3% and 4%, or approximately $25 million to $30 million annually. The 2006 Hospital Medicare Rule also extends until July 1, 2008 CMS s authority to impose a one-time prospective budget neutrality adjustment to LTAC hospital rates. This authority was previously scheduled to expire on October 1, 2006.

On August 1, 2005, CMS published the final rules related to the DRG weights and the geometric length-of-stay thresholds that took effect for hospital Medicare discharges occurring on or after October 1, 2005. In connection with the final rules, CMS estimated that these changes could result in an aggregate reduction in payments to LTAC hospitals of approximately 4.2%. These changes reduced our hospital Medicare revenues by approximately $9 million in the fourth quarter of 2005 and $34 million for 2006.

CMS is currently evaluating various certification criteria for designating a hospital as a LTAC hospital. If such certification criteria were developed and enacted into legislation, our hospitals may not be able to maintain their status as LTAC hospitals or may need to adjust their operations.

Prior to the implementation of LTAC PPS, our hospitals received interim cash payments as a result of submitting interim and final patient bills twice each month. Under LTAC PPS, a provider will choose one of two methods of receiving interim cash payments: (1) by billing each patient at the earlier of the time of discharge or 60 days from the time of admission or (2) by electing a periodic interim payment methodology which estimates the total annual LTAC PPS reimbursement by hospital and converts that amount into a bi-weekly cash payment. We have elected the periodic interim payment method. In addition, each hospital must comply with regulations established by CMS regarding the timing and accuracy of claims submissions to maintain its eligibility to receive periodic interim payments.

We cannot predict the ultimate long-term impact of LTAC PPS. This payment system is subject to significant change. Slight variations in patient acuity could significantly change Medicare revenues generated under LTAC PPS. In addition, our hospitals may not be able to appropriately adjust their operating costs as

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patient acuity levels change or to changes in reimbursement rates. In addition, we cannot assure you that LTAC PPS will not have a material adverse effect on revenues from non-government third party payors. Various factors, including a reduction in average length of stay, have negatively impacted revenues from non-government third party payors.

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

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

**Limitations on Payments to HIHs** In August 2004, CMS announced regulatory changes applicable to LTAC hospitals that are operated as an HIH. These regulatory changes also apply to freestanding LTACs located within 250 yards of an acute care hospital. Once fully phased in, the new rules generally limit Medicare payments to the HIH if the Medicare admissions to the HIH from the host hospital exceed 25% of the total Medicare discharges for the HIH s cost reporting period. There are limited exceptions for admissions from rural and urban dominant hospitals.

This rule establishes a four-year transition period. In the first year (for cost report periods beginning on or after October 1, 2004), HIHs are not subject to the Medicare payment limitation as long as the percent of Medicare admissions from the host hospital during the cost reporting period are less than the percentage of Medicare admissions from the host hospital for the fiscal 2004 cost reporting period (the Base Year Percentage ). In the second year, the admission threshold will be the lesser of (a) the Base Year Percentage or (b) 75%. The third year admission threshold will be the lesser of (a) the Base Year Percentage or (b) 50% and the final year admission threshold will limit Medicare admissions from the host hospital to 25%. For ten of our HIHs, the first year of transition did not begin until September 1, 2005 because of their respective cost reporting periods.

Patients transferred after they have reached the short-term acute care outlier payment status are not counted toward the admission threshold. Patients admitted prior to meeting the admission threshold, as well as Medicare patients admitted from a non-host hospital, are eligible for the full payment under LTAC PPS. These rules allowed HIHs that were under development to qualify for the four-year transition if the HIH was certified as an acute care hospital before October 1, 2004 and was designated as a LTAC hospital before October 1, 2005. HIHs certified after October 1, 2004 are subject to the 25% admission threshold immediately.

If the HIH s admissions from the host hospital exceed 25% (or the applicable transition percentages) in a cost reporting period, Medicare will pay the lesser of (1) the amount payable under LTAC PPS or (2) an amount equivalent to what Medicare would otherwise pay under the prospective payment system for short-term acute care hospitals.

We continue to evaluate the impact of these regulations on our operations and patient referral patterns. We do not believe that these regulations will significantly impact our ongoing HIH operations. We also consider the impact of these regulations as we pursue HIH development activities.

**Health Services Division**

*General Regulations*. The development and operation of nursing centers and the provision of healthcare services are subject to federal, state and local laws relating to the adequacy of medical care, equipment,

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

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

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

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

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

*Overview of Health Services Division Reimbursement*

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

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Medicare payments to our nursing centers are based upon certain resource utilization grouping ( RUG ) payment rates developed by CMS that provide various levels of reimbursement based upon patient activity.

The Balanced Budget Act established a Medicare prospective payment system ( PPS ) for nursing centers for cost reporting periods beginning on or after July 1, 1998. The payments received under PPS cover substantially all services for Medicare residents including all ancillary services, such as respiratory therapy, physical therapy, occupational therapy, speech therapy and certain covered pharmaceuticals.

Prior to the implementation of PPS, the costs of ancillary services were reimbursed under cost-based reimbursement rules. Various legislative and regulatory actions provided a measure of relief from the impact of the Balanced Budget Act. In April 2000, the Balanced Budget Refinement Act (the BBRA ) implemented a 20% upward adjustment in the payment rates for the care of higher acuity patients. The 20% upward adjustment in the payment rates for the care of higher acuity patients under the BBRA remained in effect until a revised RUGs payment system was established by CMS. Nursing center revenues associated with the 20% upward adjustment approximated $38 million and $36 million for the years ended December 31, 2005 and 2004, respectively. On July 28, 2005, CMS published the final rules related to the revised RUGs payment system for nursing centers. Among other things, these rules provided for a 3.1% inflation update to all RUGs categories effective October 1, 2005. In addition, effective January 1, 2006, these rules increased the indexing of RUG categories, expanded the total RUG categories from 44 to 53 and eliminated the 20% payment add-on for the care of higher acuity patients that had been in effect since 2000 under the BBRA.

In December 2000, the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 ( BIPA ) was enacted. Among other things, BIPA extended the two-year moratorium on an outpatient therapy cap for nursing center patients under the BBRA through December 31, 2002. Except for the period from September 2003 through December 2003, the implementation of the therapy cap was delayed through calendar year 2005. On February 1, 2006, Congress passed the budget reconciliation package, or the Deficit Reduction Act of 2005. This legislation allows, among other things, an annual $1,740 Medicare Part B outpatient therapy cap that was effective on January 1, 2006. The legislation also required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. The exception process, which was set to expire on January 1, 2007, was included in the Tax Relief and Health Care Act of 2006, and will continue to function as an exception to the Medicare Part B outpatient therapy cap until January 1, 2008.

On January 1, 2006, Medicare Part D implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit. Under Medicare Part D, dual eligible patients have their outpatient prescription drug costs covered by this new Medicare benefit, subject to certain limitations. Most of the nursing center residents we serve whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for the new Medicare drug benefit. Accordingly, Medicaid is no longer a primary payor for the pharmacy services provided to these residents. See Pharmacy Division Overview of Pharmacy Division Reimbursement.

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

The health services division provides to eligible individuals Medicaid-covered services consisting of nursing care, room and board and social services. In addition, states may at their option cover other services such as physical, occupational and speech therapies and pharmaceuticals. Medicaid programs also are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may materially increase or decrease the level of program payments

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to nursing centers operated by the health services division. We believe that the payments under many of these programs may not be sufficient on an overall basis to cover the costs of serving certain patients participating in these programs. In addition, budgetary pressures impacting state fiscal budgets may further reduce Medicaid payments to our nursing centers from current levels. Furthermore, OBRA mandates an increased emphasis on ensuring quality resident care, which has resulted in additional expenditures by nursing centers.

There continue to be legislative and regulatory proposals that would impose further limitations on government and private payments to providers of healthcare services. By repealing the federal payment standard for Medicaid reimbursement levels, often referred to as the Boren Amendment, the Balanced Budget Act eased existing impediments on the ability of states to reduce their Medicaid reimbursement levels. Many states are considering or have enacted measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. As several states face budgetary issues, we anticipate further pressure on Medicaid rates that could negatively impact payments to our nursing center operations.

As noted above, Medicare Part D also impacts payments made by Medicaid programs for pharmaceuticals for certain dual eligible residents. See Pharmacy Division Overview of Pharmacy Division Reimbursement.

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

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

**Rehabilitation Division**

*General Regulations*. The rehabilitation division is subject to various federal and state regulations. Therapists and other healthcare professionals we employ are required to be individually licensed or certified under applicable state law. We take measures to ensure that our therapists and other healthcare professionals are properly licensed. In addition, we require our therapists and other employees to participate in continuing education programs. The failure to obtain, maintain or renew any required license or certifications by our therapists, our other healthcare professionals or us could adversely affect our operations, including our financial results.

As noted above, the rehabilitation division is subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit, among other things, certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Such laws include the antifraud and anti-kickback laws discussed previously. In addition, some states restrict certain business relationships between physicians and ancillary service providers. Some states also prohibit business corporations from practicing therapy services through therapists directly employed by the corporation or otherwise providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to contract with long-term care facilities,

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hospitals and other providers participating in Medicare, Medicaid and other federal healthcare programs as well as civil and criminal penalties. These laws vary considerably from state to state.

*Overview of Rehabilitation Division Reimbursement*

The rehabilitation division receives payment for its services from the skilled 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 type of service rendered.

As noted above, various federal and state laws and regulations govern reimbursement to long-term care facilities, hospitals and other healthcare providers participating in Medicare, Medicaid and other federal healthcare programs. Though these laws and regulations are generally not applicable to our rehabilitation division, they are applicable to our customers. If our customers fail to comply with these laws and regulations they could be subject to possible sanctions, including loss of licensure or eligibility to participate in reimbursement programs as well as civil and criminal penalties, which could adversely affect our operations, including our financial results. In addition, there continue to be legislative and regulatory proposals to contain healthcare costs by imposing further limitations on government and private payments to providers of healthcare services.

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. This legislation allows, among other things, an annual $1,740 Medicare Part B outpatient therapy cap, effective January 1, 2006. The legislation also required CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. The exception process, which was set to expire on January 1, 2007, was included in the Tax Relief and Health Care Act of 2006, and will continue to function as an exception to the Medicare Part B outpatient therapy cap until January 1, 2008.

Reductions in the reimbursement provided to our customers by Medicare or Medicaid could negatively impact the demand and price for our services and could have a material adverse effect on our rehabilitation revenues and growth prospects.

**Pharmacy Division**

*General Regulations*. Our institutional pharmacy operations are subject to extensive federal, state and local regulation relating to, among other things, operational requirements, reimbursement, documentation, licensure, certification and regulation of controlled substances. Our institutional pharmacies also are subject to federal and state laws that govern financial arrangements between healthcare providers, including the federal anti-kickback statutes and the federal physician self-referral statutes discussed above.

The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the U.S. Food and Drug Administration. Additionally, under the Comprehensive Drug Abuse Prevention and Control Act of 1970, which is administered by the U.S. Drug Enforcement Administration, dispensers of controlled substances must register with the Drug Enforcement Administration, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties.

States generally require that the state board of pharmacy license a pharmacy operating within the state. Such licensure typically also applies to states where the operator does not have a pharmacy but delivers prescription pharmaceuticals to patients or residents across state lines. At December 31, 2006, we maintained the necessary licenses for each pharmacy we operate. In addition, our pharmacies are registered with the appropriate federal and state authorities pursuant to statutes governing the regulation of controlled substances. In addition, we believe that we comply with all relevant requirements of the Prescription Drug Marketing Act for the transfer and shipment of pharmaceuticals.

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Federal law and regulations contain a variety of requirements relating to the supply of prescription drugs under the Medicaid program. States are given authority, subject to certain standards, to limit or specify conditions for the coverage of certain drugs. Federal Medicaid law also establishes standards affecting pharmacy practice (including requirements for resident counseling, drug utilization and regimen reviews for Medicaid residents) and imposes requirements relating to prescription drugs furnished to Medicaid residents (including the establishment of upper limits on payment levels). Moreover, states have substantial discretion to set administrative, coverage, eligibility, and payment policies under their state Medicaid programs. Some states have enacted freedom of choice or any willing provider requirements, which may prohibit a nursing center from requiring their residents to purchase pharmacy or other ancillary services or supplies from a particular provider. Such laws may increase the competition that we face in providing services to residents of long-term care facilities.

The Medicare and Medicaid programs establish certain requirements for participation of providers and suppliers in the programs. Nursing centers and suppliers of medical equipment and supplies (which pass along a portion of their reimbursement to our institutional pharmacy division) are subject to specified standards.

*Overview of Pharmacy Division Reimbursement*

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. The pharmacy division derives a substantial portion of its annual revenue from skilled nursing centers for residents covered by Medicare Part A, Medicare Part D, and, through 2005, from state Medicaid programs. The balance is comprised of private pay, insurance and other payors, including managed care. 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.

The sources and amounts of our revenues will be determined by a number of factors, including the case mix of our customers residents and the rates of reimbursement among payors. Changes in the case mix of the residents as well as the payor mix among private pay, Medicare and Medicaid may affect our profitability.

The Medicare program historically consisted of three parts: (1) Medicare Part A, which covers, among other things, in-patient hospital, skilled long-term care, home healthcare and certain other types of healthcare services; (2) Medicare Part B, which covers physicians services, outpatient services and certain items and services provided by medical suppliers; and (3) a managed care option for beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, known as Medicare Part C. Under Medicare Part B, we are entitled to payment for products that replace a bodily function, home medical equipment and supplies and a limited number of specifically designated prescription drugs. In December 2003, Congress enacted a major expansion of the Medicare program through the introduction of a prescription drug benefit under the new Medicare Part D. As discussed below, Medicare Part D provides coverage for prescription drugs that are not otherwise covered by Medicare Part A or Part B for those beneficiaries that enroll.

Until the implementation of Medicare Part D on January 1, 2006, the reimbursement rates for pharmacy services under Medicaid continued to be determined on a state-by-state basis subject to review by CMS and applicable federal law. Although Medicaid programs vary from state to state, they generally have provided for the payment of certain pharmacy services, up to established limits, at rates determined in accordance with each state s regulations. The federal Medicaid statute specifies a variety of requirements that the state plan must meet, including the requirements related to eligibility, coverage of services, payment and administration. For residents eligible for Medicaid, we billed the individual state Medicaid program or, in certain circumstances, the state designated managed care or other similar organization. Federal regulations and the regulations of certain states

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establish upper limits for reimbursement for certain prescription drugs under Medicaid. In most states, pharmacy services were priced at the lower of usual and customary charges or costs (which generally is defined as a function of average wholesale price and may include a profit percentage) plus a dispensing fee. Most states establish a fixed dispensing fee that is adjusted to reflect associated costs on an annual or less frequent basis.

Under Medicare Part D, which became effective on January 1, 2006, Medicare beneficiaries enrolled in prescription drug plans offered by private prescription drug plan sponsors ( PDPs ), are provided coverage for outpatient prescription drugs (collectively, Part D Plans ). Part D Plans consist of plans providing the drug benefit on a stand-alone basis through a PDP and Medicare Advantage plans providing drug coverage as a supplement to an existing medical benefit under a Medicare Advantage plan, most commonly a health maintenance organization plan. Medicare beneficiaries generally have to pay a premium to enroll in a Part D Plan, with the premium amount varying from plan to plan, although CMS will provide various federal subsidies to Part D Plans to reduce the cost for qualifying beneficiaries.

On January 21, 2005, CMS issued final regulations on Medicare Part D. Medicare beneficiaries who 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. Most of the nursing center residents we serve whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for Medicare Part D. As such, since January 1, 2006, Medicaid is no longer a primary payor for the pharmacy services provided to these residents.

Pursuant to Medicare Part D, CMS will provide premium and cost-sharing subsidies to Part D Plans with respect to dual eligible residents of nursing centers. As a result, such dual eligibles will not be required to pay a premium for enrollment in a Part D Plan, so long as the premium for the Part D Plan in which they are enrolled is at or below the premium subsidy. Medicare Part D also makes available partial premium and cost-sharing subsidies for certain other classes of low-income enrollees who do not qualify for Medicaid.

Dual eligible residents of nursing centers generally will be entitled to have their prescription drug costs covered by a Part D Plan, provided that the prescription drugs which they are taking are either on the Part D Plan s formulary, or an exception to the plan s formulary is granted. CMS reviews the formularies of Part D Plans and requires their formularies to include the types of drugs most commonly needed by Medicare beneficiaries. CMS also reviews the formulary exceptions criteria of the plans that provide for coverage of drugs determined by the plan to be medically appropriate for the enrollee.

We obtain reimbursement for drugs we provide to enrollees of a given Part D Plan in accordance with the terms of agreements negotiated between us and the Part D Plan. Accordingly, Medicare Part D may negatively impact the pricing and payment for our services. Moreover, the transition to Medicare Part D has resulted in a generally slower payment cycle as we attempt to properly bill and collect payments from various Part D Plans.

Medicare Part D does not alter federal reimbursement for residents of nursing centers whose stay at the nursing center is covered under Medicare Part A. Accordingly, Medicare s fixed per diem payments to nursing centers under PPS continue to include a portion attributable to the expected cost of drugs provided to such residents, and we will continue to receive reimbursement for drugs provided to such residents from the nursing center, in accordance with the terms of the agreements we have negotiated with each nursing center.

CMS has expressed some concerns about the payment of certain access or performance rebates by pharmaceutical manufacturers to institutional pharmacies with respect to prescriptions dispensed under Medicare Part D. Specifically, CMS has stated that while such rebates could create significant fraud and abuse concerns, they are not prohibited. We believe that the discounts and rebate arrangements in our contracts with pharmaceutical manufacturers comply with applicable laws. We are not aware of any information from the Office of Inspector General of the U.S. Department of Health and Human Services that would suggest that an

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institutional pharmacy s reliance on the discount safe harbor regulation under the federal anti-kickback statute to encompass discounts and/or rebates on drugs provided to Part D Plan enrollees is unwarranted. Beginning in 2007, CMS is requiring Part D Plans to have policies and procedures in place, as part of their drug utilization management program, to protect beneficiaries and reduce costs when institutional pharmacies receive incentives from drug manufacturers to increase market share through access/performance rebates. As part of this requirement, CMS directs Part D Plans to require institutional pharmacies to fully disclose to the Part D Plan any and all discounts and rebates or any other direct or indirect remuneration received from pharmaceutical manufacturers or other parties when such remuneration is designed to directly or indirectly influence utilization of Medicare Part D drugs. It is possible that the impact of these reporting requirements and others imposed by CMS could directly or indirectly have a material adverse effect on the results of operations of our institutional pharmacies.

The first year of Medicare Part D resulted in significant challenges to our institutional pharmacy business as well as the institutional pharmacy industry. These challenges included, but were not limited to, the inability of the Medicare Part D program to accurately reflect dual eligible residents, inaccurate reimbursement associated with Medicare co-payments and extensive prior authorization and other processes mandated by the PDPs. We cannot assure you that the challenges presented by Medicare Part D and the regulations promulgated under Medicare Part D will not have a material adverse effect on our institutional pharmacy business.

It is not possible to quantify at this time the effect of changes in legislation, the interpretation or administration of such legislation or any other governmental initiatives impacting our institutional pharmacy business and the business of our principal customers. Accordingly, we cannot assure you that the impact of any current or future healthcare legislation or regulation will not adversely affect our institutional pharmacy business.

## ADDITIONAL INFORMATION

### Employees

As of December 31, 2006, we had approximately 40,800 full-time and 14,200 part-time and per diem employees. We had approximately 2,900 unionized employees under 22 collective bargaining agreements as of December 31, 2006.

The healthcare industry currently is facing a shortage of qualified personnel, such as nurses, pharmacists, certified nurse s assistants, nurse s aides, therapists and other important providers of healthcare services. As a result, we are experiencing challenges in recruiting and retaining qualified staff due to this high demand. Our hospitals and nursing centers are particularly dependent on nurses for patient care. The difficulty we have experienced in hiring and retaining qualified personnel has increased our average wage rates and may force us to increase our use of contract nursing and therapy personnel. We may continue to experience increases in our labor costs primarily due to higher wages and benefit costs required to attract and retain qualified healthcare personnel. Our ability to control labor costs will significantly affect our future operating results.

### Professional and General Liability Insurance

Our healthcare operations are primarily insured for professional and general liability risks by our wholly owned limited purpose insurance subsidiary, Cornerstone Insurance Company ( Cornerstone ). Cornerstone insures initial losses up to specified coverage levels per occurrence and in the aggregate. On a per claim basis, coverages for losses in excess of those insured by Cornerstone are maintained through unaffiliated commercial insurance carriers. Effective January 1, 2003, Cornerstone insures all claims in all states up to a per occurrence limit without the benefit of any aggregate coverage limit through unaffiliated commercial insurance carriers, thereby increasing our financial risk.

We believe that our insurance is adequate in amount and coverage. There can be no assurance that in the future such insurance will be available at a reasonable price or that we will be able to maintain adequate levels of professional and general liability insurance coverage.

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**Where You Can Find More Information**

We file annual, quarterly and special reports, proxy statements and other information with the SEC under the Exchange Act.

You also may read or obtain copies of this information in person or by mail from the Public Reference Room of the SEC, 100 F Street, NE, Room 1580, Washington, D.C. 20549. Please call the SEC at 1-800-SEC-0330 for further information on the Public Reference Room. Our filings with the SEC also are available to the public on the SEC s website at *www.sec.gov*. You also may inspect reports, proxy statements and other information about us at the office of the NASD, Inc. at 1735 K Street, N.W., Washington, D.C. 20006.

Our filings with the SEC, including our Annual Report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and any amendments thereto, are available free of charge on our website, through a link to the SEC s website, as soon as reasonably practicable after they are electronically filed with or furnished to the SEC. In addition, our corporate governance guidelines, code of conduct, and charters for our audit, compliance and quality, executive compensation, and nominating and governance committees of our board of directors are available on our website and upon request of the Company s Corporate Secretary. Our website is *www.kindredhealthcare.com*. Information made available on our website is not a part of this document.

In addition, you may request a copy of our SEC filings (excluding exhibits) at no cost by writing or telephoning us at the following address or telephone number:

Kindred Healthcare, Inc.
680 South Fourth Street
Louisville, KY 40202
Attention: Investor Relations
(502) 596-7300

**Item 1A.** ***Risk Factors***

Certain statements made in this Annual Report on Form 10-K and the documents we incorporate by reference in this Annual Report on Form 10-K include forward-looking statements within the meaning of Section 27A of the Securities Act and Section 21E of the Exchange Act. All statements regarding our expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, plans and objectives of management and statements containing the words such as anticipate, approximate, believe, plan, estimate, expect, project, could, should, will, intend, may and other similar expre forward-looking statements.

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

- our ability to operate pursuant to the terms of our debt obligations and the Master Lease Agreements,
- our ability to meet our rental and debt service obligations,

our and AmerisourceBergen s ability to complete the Proposed Pharmacy Transaction, including the receipt of all required regulatory approvals and the satisfaction of other closing conditions to the Proposed Pharmacy Transaction,

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adverse developments with respect to our results of operations or liquidity,

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

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

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

changes in the reimbursement rates or methods of payment from third party payors, including the Medicare and Medicaid programs, changes arising from and related to LTAC PPS, including potential changes to hospital Medicare payment rules, Medicare Part D and changes in Medicare and Medicaid reimbursements for our nursing centers,

national and regional economic conditions, particularly their effect on the availability and cost of labor, materials and other services,

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

our ability to successfully pursue our development activities and successfully integrate new operations, including the realization of anticipated revenues, economies of scale, cost savings and productivity gains associated with such operations,

the increase in the costs of defending and insuring against alleged professional liability claims and our ability to predict the estimated costs related to such claims,

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

our ability to successfully dispose of unprofitable facilities, and

our ability to ensure and maintain an effective system of internal controls over financial reporting.

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

**Changes in the reimbursement rates or methods of payment from third party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a substantial reduction in our revenues and operating margins.**

We depend on reimbursement from third party payors, including the Medicare and Medicaid programs, for substantially all of our revenues. For the year ended December 31, 2006, we derived approximately 67% of our total revenues from the Medicare and Medicaid programs and approximately 33% from private third party payors, such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. The Medicare and Medicaid programs are highly regulated and subject to frequent and substantial changes. See Item 1 Business.

Private third party payors are continuing their efforts to control healthcare costs through direct contracts with healthcare providers, increased utilization review and greater enrollment in managed care programs and preferred provider organizations. These private payors increasingly are demanding discounted fee structures and the assumption by healthcare providers of all or a portion of the financial risk.

We could be affected adversely by the continuing efforts of governmental and private third party payors to contain healthcare costs. We cannot assure you that reimbursement payments under governmental and private

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third party payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Future changes in third party payor reimbursement rates or methods, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services and products could result in a substantial reduction in our net operating revenues. Our operating margins may continue to be under pressure because of deterioration in pricing flexibility, changes in payor mix and growth in operating expenses in excess of increases in payments by third party payors. In addition, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients is limited.

**Our failure to pay rent or otherwise comply with the provisions of any of our Master Lease Agreements could materially adversely affect our financial position, results of operations and liquidity.**

We currently lease 39 of our hospitals and 186 of our nursing centers from Ventas under our Master Lease Agreements. Our failure to pay the rent or otherwise comply with the provisions of any of our Master Lease Agreements with Ventas would result in an Event of Default under such Master Lease Agreement. Upon an Event of Default, remedies available to Ventas include, without limitation, terminating such Master Lease Agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such Master Lease Agreement, including the difference between the rent under such Master Lease Agreement and the rent payable as a result of reletting the leased properties, or requiring us to pay the net present value of the rent due for the balance of the term of such Master Lease Agreement. The exercise of such remedies would have a material adverse effect on our financial condition and our businesses. See Item 1 Business Master Lease Agreements.

**We have limited operational and strategic flexibility since we lease a substantial number of our facilities.**

We lease a substantial number of our facilities from Ventas and other third parties. Under our leases, we generally are required to operate continuously our leased properties as a provider of healthcare services. In addition, these leases generally limit or restrict our ability to assign the lease to another party. Our failure to comply with these lease provisions would result in an event of default under the leases and subject us to material damages, including potential defaults under our revolving credit facility. Given these restrictions, we may be forced to continue operating unprofitable facilities to avoid defaults under our leases. See Item 1 Business Master Lease Agreements.

**Significant legal actions could subject us to increased operating costs and substantial uninsured liabilities, which could materially and adversely affect our financial position, results of operations and liquidity.**

We incur significant costs for professional liability claims, particularly in our nursing center and hospital operations. We have experienced a significant number of professional liability claims in recent years. In addition to large compensatory claims, plaintiffs attorneys increasingly are seeking significant punitive damages and attorney s fees. As a result, our professional liability costs are significant and can be unpredictable.

We insure a substantial portion of our professional liability risks primarily through a wholly owned limited purpose insurance subsidiary. The limited purpose insurance subsidiary insures initial losses up to specified coverage levels per occurrence and in the aggregate. On a per claim basis, coverages for losses in excess of those insured by the limited purpose insurance subsidiary are maintained through unaffiliated commercial insurance carriers. Effective January 1, 2003, the limited purpose insurance subsidiary insures all claims in all states up to a per occurrence limit without the benefit of any aggregate coverage limit through unaffiliated commercial insurance carriers, thereby increasing our financial risk. We maintain professional and general liability insurance in amounts and coverage that management believes are sufficient for our operations. However, our insurance might not cover all claims against us or the full extent of our liability nor continue to be available at a reasonable cost. Moreover, the cost of insurance coverage maintained with unaffiliated commercial insurance carriers has

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increased significantly and may continue to increase. If we are unable to maintain adequate insurance coverage or are required to pay punitive damages that are uninsured, we may be exposed to substantial liabilities.

We also are subject to lawsuits under the federal False Claims Act and comparable state laws for submitting fraudulent bills for services to the Medicare and Medicaid programs. These lawsuits, which may be initiated by whistleblowers, can involve significant monetary damages, fines, attorney fees and the award of bounties to private plaintiffs who successfully bring these suits, as well as to the government programs.

**We could experience significant increases to our operating costs due to shortages of qualified nurses and other healthcare professionals.**

The market for qualified nurses and other healthcare professionals is highly competitive. We, like other healthcare providers, have experienced difficulties in attracting and retaining qualified personnel such as nurses, pharmacists, certified nurse s assistants, nurse s aides, therapists and other important providers of healthcare services. Our hospitals and nursing centers are particularly dependent on nurses for patient care. The difficulty we have experienced in hiring and retaining qualified personnel has increased our average wage rates and may force us to increase our use of contract personnel. We may continue to experience increases in our labor costs primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel. Salaries, wages and benefits were approximately 55% of our consolidated revenues for the year ended December 31, 2006. Our ability to control labor costs will significantly affect our future operating results.

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

**We may not be able to meet our substantial rent and debt service requirements.**

A substantial portion of our cash flows from operations is dedicated to the payment of rents related to our leased properties as well as principal and interest obligations on our outstanding indebtedness. Subject to certain restrictions, we also have the ability to incur substantial additional borrowings under our revolving credit facility. If we are unable to generate sufficient funds to meet our obligations, we may be required to refinance, restructure or otherwise amend some or all of such obligations, sell assets or raise additional cash through the sale of our equity. We cannot assure you that such restructuring activities, sales of assets or issuances of equity can be accomplished or, if accomplished, would raise sufficient funds to meet these obligations. In addition, our capital structure and our revolving credit facility:

- require us to dedicate a substantial portion of our cash flow to payments on our rent and interest obligations, thereby reducing the availability of cash flow to fund working capital, capital expenditures and other general corporate activities,
- require us to pledge as collateral substantially all of our assets, and
- require us to maintain certain financial ratios at specified levels, thereby reducing our financial flexibility.

These provisions:

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

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could affect adversely our ability to make material acquisitions, obtain future financing or take advantage of business opportunities that may arise, and

could increase our vulnerability to a downturn in general economic conditions or in our business.

**We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that reduce our revenues and profitability.**

In the ordinary course of our business, we are subject regularly to inquiries, investigations and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations.

The extensive federal, state and local regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, and the confidentiality and security of health-related information. In particular, various laws including anti-kickback, anti-fraud and abuse amendments codified under the Social Security Act prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by Medicare or other governmental programs. Sanctions for violating the anti-kickback, anti-fraud and abuse amendments under the Social Security Act include criminal penalties, civil sanctions, fines and possible exclusion from government programs such as Medicare and Medicaid. See Item 1 Business Governmental Regulation.

We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bans on Medicare and Medicaid payments for new admissions and civil monetary penalties. If we fail to comply with the extensive laws and regulations applicable to our businesses, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. Furthermore, should we lose licenses for a number of our facilities as a result of regulatory action or otherwise, we could be in default under our Master Lease Agreements and our revolving credit facility.

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

**Acquisitions that we have made or may make in the future may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.**

We intend to selectively pursue strategic acquisitions of LTAC hospitals, skilled nursing centers, pharmacies, rehabilitation operations and other related healthcare operations. Acquisitions may involve significant cash expenditures, debt incurrence, additional operating losses, amortization of certain intangible assets of acquired companies, dilutive issuances of equity securities and expenses that could have a material adverse effect on our financial position, results of operations and liquidity. Acquisitions involve numerous risks, including:

difficulties integrating acquired operations, personnel and information systems, or in realizing projected efficiencies and cost savings,

diversion of management s time from existing operations,

potential loss of key employees or customers of acquired companies, and

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inaccurate assessment of assets and liabilities and exposure to undisclosed or unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We cannot assure you that we will succeed in obtaining financing for acquisitions at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility. We also may be unable to operate acquired facilities profitably or succeed in achieving improvements in their financial performance.

**We continue to seek acquisitions and other strategic opportunities for each of our businesses that may impact our financial position, results of operations and liquidity.**

We continue to seek acquisitions and other strategic opportunities for each of our businesses. Accordingly, we are often engaged in evaluating potential transactions and other strategic alternatives. In addition, from time to time, we engage in preliminary discussions that may result in one or more transactions. Although there is uncertainty that any of these discussions will result in definitive agreements or the completion of any transactions, our short-term and long-term financial position, results of operations and liquidity may be impacted if we complete any such transactions. Moreover, although we would enter into transactions to enhance shareholder value, our ability to achieve this objective would be subject to integration risks, the ability to retain and attract key personnel, the ability to realize synergies and other risks.

**If we fail to attract patients and residents and compete effectively with other healthcare providers, our revenues and profitability may decline.**

The long-term healthcare services industry is highly competitive. Our hospitals face competition from healthcare providers that provide services comparable to those offered by our hospitals. Many competing hospitals are larger and more established than our hospitals. We may experience increased competition from existing hospitals as well as hospitals converted, in whole or in part, to specialized care facilities. Our nursing centers compete on a local and regional basis with other nursing centers and other long-term healthcare providers. Some of our competitors operate newer facilities and may offer services not provided by us or are operated by entities having greater financial and other resources than us. Our rehabilitation division competes with national, regional and local rehabilitation service providers within our markets. Several of these competitors may have greater financial and other resources than us and may be more established in the markets in which we compete. Our institutional pharmacies generally compete on price and quality of the services provided. Several of the competitors to our pharmacy operations are larger and more established service providers in the markets in which we compete. We cannot assure you that increased competition in the future will not adversely affect our financial position, results of operations and liquidity.

**The inability or failure of management in the future to conclude that we maintain effective internal controls over financial reporting, or the inability of our independent auditor to issue a report attesting to management s assessment of our internal controls over financial reporting, could have a material adverse effect on our financial position, results of operations and liquidity.**

Under the Sarbanes-Oxley Act of 2002, our management is required to report in our Annual Report on Form 10-K on the effectiveness of our internal controls over financial reporting, and our independent auditor is required to attest to management s assessment of our internal controls over financial reporting. Significant resources are required to establish that we are in full compliance with the financial reporting controls and procedures. If we fail to have, or management or our independent auditor is unable to conclude that we maintain, effective internal controls and procedures for financial reporting, we could be unable to provide timely and reliable financial information which could have a material adverse effect on our financial position, results of operations and liquidity.

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**Our results of operations may suffer as a result of our Proposed Pharmacy Transaction.**

The Proposed Pharmacy Transaction is conditioned, among other things, on a favorable determination by the Internal Revenue Service (the IRS ), receipt of necessary regulatory approvals, implementation of financing arrangements and registration of the common stock of Newco with the SEC. There are numerous uncertainties associated with the satisfaction of each of these conditions, as well as others, in the Proposed Pharmacy Transaction. Even if all of these conditions are satisfied, the Proposed Pharmacy Transaction is not expected to be completed until the second calendar quarter of 2007. Until that time, if the business focus of KPS personnel is diverted as a result of activities related to the Proposed Pharmacy Transaction or if KPS loses any customers as a result of the Proposed Pharmacy Transaction, our operating results may suffer. For the same reasons, if we are unable to successfully complete the Proposed Pharmacy Transaction, the ongoing performance and prospects of KPS may be adversely affected.

**Our earnings will decrease if we divest KPS.**

For the year ended December 31, 2006, KPS s operating income was $49 million. KPS represented 14% of our 2006 revenues and approximately 28% of our 2006 pretax income (before allocation of corporate overhead). If we divest KPS as we anticipate as part of the Proposed Pharmacy Transaction, we will no longer have the benefit of the earnings associated with that business. Our earnings will decrease since it is likely that we will be unable to replace the earnings of KPS upon the divestiture of that business in the near term, if at all.

**Following the Proposed Pharmacy Transaction, we will be more highly leveraged and as a result, our ability to borrow and to invest our cash flows may be limited.**

If the Proposed Pharmacy Transaction is completed and KPS is divested, we will be a more highly leveraged business and we will have fewer financial resources as a result of the loss of the earnings associated with the KPS business. Our ability to satisfy our obligations and maintain profitability will be solely dependent upon the performance of our three remaining businesses since we will not be able to rely upon the financial resources of KPS.

**If the Proposed Pharmacy Transaction does not qualify as a tax-free transaction, tax could be imposed on us and our shareholders.**

It is a condition to closing the Proposed Pharmacy Transaction that we receive a private letter ruling from the IRS that the spin-off of KPS and the subsequent merger of KPS and distribution of Newco common stock will qualify for tax-free treatment to holders of our common stock (except with respect to cash received in lieu of a fractional share) and, generally, to us.

Though the IRS ruling has been received, the ruling does not address all of the issues that are relevant to determining whether the Proposed Pharmacy Transaction will qualify for tax-free treatment because the IRS will not rule on certain issues. As a condition to closing, we will receive an opinion of counsel that the Proposed Pharmacy Transaction will generally qualify for tax-free treatment to us and our shareholders. The opinion of counsel is intended to address certain of those matters that the ruling does not. The IRS ruling and opinion of counsel will not address, however, state, local or foreign tax consequences of the spin-off, merger and distribution of Newco common stock.

The IRS ruling relied, and the opinion of counsel will rely, on representations, assumptions and undertakings made by us and Newco (and its subsidiaries), including representations and undertakings from Newco regarding the conduct of its business and other matters after the closing of the Proposed Pharmacy Transaction. If such representations, assumptions or undertakings are incorrect, neither the IRS ruling nor the opinion of counsel would be valid. In addition, current law generally creates a presumption that the spin-off of KPS in the Proposed Pharmacy Transaction would be taxable to us, but not to our shareholders, if Newco or its shareholders were to engage in

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certain transactions that result in a change in ownership of its stock during the four-year period beginning two years before the spin-off, unless it is established that the spin-off and such transactions are not part of a plan or series of related transactions to effect a change in ownership of the stock of Newco.

Furthermore, notwithstanding the IRS private letter ruling and the opinion of counsel, the IRS could determine that the Proposed Pharmacy Transaction should be treated as a taxable transaction to us and our shareholders if it determines that any of the representations, assumptions or undertakings that were included in the request for the private letter ruling are false or have been violated or if it disagrees with the conclusions in the opinion of counsel that are not covered by the IRS ruling. If the spin-off of KPS in the Proposed Pharmacy Transaction fails to qualify for tax-free treatment, the deemed receipt of shares of KPS will be treated as a taxable distribution to our shareholders. In addition, events occurring after the distribution of common stock of Newco could cause us to recognize a gain on the spin-off of KPS.

**We may be required to satisfy certain indemnification obligations to Newco or may not be able to collect on indemnification rights from Newco.**

Under the terms of the Proposed Pharmacy Transaction, we will indemnify Newco, and Newco will indemnify us, for certain damages, liabilities and expenses resulting from a breach by the other of certain covenants contained in a master transaction agreement entered into as part of the Proposed Pharmacy Transaction. We will indemnify Newco for damages, liabilities and expenses, subject in certain circumstances to such damages, liabilities and expenses exceeding a threshold amount, incurred by Newco relating to the entities, assets and liabilities we retain, and Newco will indemnify us for all damages, liabilities and expenses incurred by us relating to Newco s entities, assets and liabilities. We will indemnify Newco against certain damages, liabilities and expenses resulting from a breach of our representations and warranties in the master transaction agreement. The representations and warranties in the master transaction agreement will survive for a period of 15 months after the consummation of the Proposed Pharmacy Transaction.

In addition, we will indemnify Newco, and Newco will indemnify us, for certain damages, liabilities and expenses resulting from a breach by the other of any of the representations, warranties or covenants contained in a tax matters agreement entered into as part of the Proposed Pharmacy Transaction. Newco also will indemnify us for certain damages, liabilities and expenses arising out of any tax imposed with respect to the spin-off of KPS if such tax is attributable to any act, any failure to act or any omission by Newco or any of its subsidiaries. We will indemnify Newco for all damages, liabilities and expenses relating to pre-closing taxes or taxes imposed on Newco or its subsidiaries because KPS was part of our consolidated return, and Newco will indemnify us for all damages, liabilities and expenses relating to post-closing taxes of Newco or its subsidiaries.

The indemnification obligations described above could be significant and we cannot presently determine the amount, if any, of indemnification obligations for which we might be liable or for which we might seek payment. Our ability to satisfy these obligations will depend upon our future financial performance and other factors. Similarly, the ability of Newco to satisfy any such obligations to us will depend on its future financial performance and other factors. We cannot assure you that we will have the ability to satisfy any obligations to Newco or that Newco will have the ability to satisfy any obligations to us.

**After the closing of the Proposed Pharmacy Transaction, our management will own Newco common stock and there will continue to be agreements and other relationships between Newco and us.**

As a result of their ownership of our common stock, most of our management and certain members of our board of directors will own Newco stock following the Proposed Pharmacy Transaction. In addition, our Executive Chairman and our President and Chief Executive Officer will serve on the board of directors of Newco. The service of these individuals on the Newco board of directors and their continued service as our officers and directors as well as the ownership of Newco common stock by our management and directors, could

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create, or appear to create, potential conflicts of interest for these officers and directors when faced with decisions that could have implications for Newco and us.

In addition, we expect to enter into an information services agreement with Newco to provide all of Newco s information services. We expect that Newco also will be the sole supplier of institutional pharmacy products and services to our skilled nursing facilities and pharmacy management services to our hospitals pursuant to multi-year agreements. Though we believe the terms and conditions of these agreements will be at fair market value, there can be no assurance that we could not have obtained superior terms in the market.

**Newco will be our primary supplier of institutional pharmacy products and services to our skilled nursing facilities and pharmacy management services to our hospitals and we will be subject to Newco s risks in connection with the Proposed Pharmacy Transaction and its operation as a stand-alone entity.**

We will be dependent upon Newco as the primary supplier of institutional pharmacy products and services to our skilled nursing facilities and pharmacy management services to our hospitals. After, and as a result of the Proposed Pharmacy Transaction, Newco will operate for the first time as an independent public entity. Newco is exposed to many risks, including, without limitation, initial operation without the support of the corporate infrastructure of Newco s former parent companies. If Newco fails to operate successfully as an independent company, or if Newco fails to devote sufficient time and resources to its agreement with us or if its performance is substandard, our businesses may be harmed. Any delays, errors, inefficiencies or interruptions in the products and services provided by Newco could adversely affect our business.

**Item 1B.** ***Unresolved Staff Comments***

Not applicable.

**Item 2.** ***Properties***

For information concerning the hospitals, nursing centers, and institutional pharmacies operated by us, see Item 1 Business Hospital Division Hospital Facilities, Item 1 Business Health Services Division Nursing Center Facilities, Item 1 Business Pharmacy Division Pharmacy Locations, and Item 1 Business Master Lease Agreements. We believe that our facilities are adequate for our future needs in such locations.

Our corporate headquarters is located in a 287,000 square foot building in Louisville, Kentucky.

We are subject to various federal, state and local laws and regulations governing the use, discharge and disposal of hazardous materials, including medical waste products. Compliance with these laws and regulations is not expected to have a material adverse effect on us. It is possible, however, that environmental issues may arise in the future which we cannot now predict.

**Item 3.** ***Legal Proceedings***

We are a party to various legal actions (some of which are not insured), and regulatory and other government investigations and sanctions arising in the ordinary course of our business. We cannot predict the ultimate outcome of pending litigation and regulatory and other government investigations. The U.S. Department of Justice, CMS or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future which may, either individually or in the aggregate, have a material adverse effect on our financial position, operating results and liquidity. See note 19 of the notes to consolidated financial statements.

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

Not applicable.

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**EXECUTIVE OFFICERS OF THE REGISTRANT**

Set forth below are the names, ages (as of January 1, 2007) and present and past positions of our current executive officers:

| Name | Age | Position |
|---|---|---|
| Edward L. Kuntz | 61 | Executive Chairman of the Board |
| Paul J. Diaz | 45 | President and Chief Executive Officer |
| Richard A. Lechleiter | 48 | Executive Vice President and Chief Financial Officer |
| Frank J. Battafarano | 56 | Executive Vice President and President, Hospital Division |
| Lane M. Bowen | 56 | Executive Vice President and President, Health Services Division |
| Richard E. Chapman | 58 | Executive Vice President and Chief Administrative and Information Officer |
| William M. Altman | 47 | Senior Vice President, Compliance and Government Programs |
| Benjamin A. Breier | 36 | President, People*first* Rehabilitation Division |
| Joseph L. Landenwich | 42 | Senior Vice President of Corporate Legal Affairs and Corporate Secretary |
| Mark A. McCullough | 45 | President, Pharmacy Division |
| Gregory C. Miller | 37 | Senior Vice President, Corporate Development and Financial Planning |
| M. Suzanne Riedman | 55 | Senior Vice President and General Counsel |

**Edward L. Kuntz** has served as our Executive Chairman of the Board since January 1, 2004. Mr. Kuntz served as our Chairman of the Board and Chief Executive Officer from January 1999 to December 31, 2003. He also served as our President from November 1998 to January 2002. He served as our Chief Operating Officer and a director from November 1998 to January 1999.

**Paul J. Diaz** has served as one of our directors since May 2002, as our Chief Executive Officer since January 1, 2004 and as our President since January 2002. Mr. Diaz served as our Chief Operating Officer from January 2002 to December 31, 2003. From 1996 to July 1998, he served in various executive capacities with Mariner Health Group, Inc. ( Mariner Health ), a long-term healthcare provider, most recently as Executive Vice President and Chief Operating Officer. After leaving Mariner Health and prior to joining us, he served as the managing member of Falcon Capital Partners, LLC, a private investment and consulting firm specializing in healthcare restructurings, and as Chairman and Chief Executive Officer of Capella Senior Living, LLC, a start-up venture to provide long-term healthcare services.

**Richard A. Lechleiter**, a certified public accountant, has served as our Executive Vice President and Chief Financial Officer since February 2005. He served as Senior Vice President and Chief Financial Officer from February 2002 to February 2005. He served as Treasurer from July 1998 to December 2003 and also served as Vice President, Finance and Corporate Controller from April 1998 to February 2002. Mr. Lechleiter served as Vice President, Finance and Corporate Controller of our predecessor from November 1995 to April 1998. From June 1995 to November 1995, he was Director of Finance for our predecessor.

**Frank J. Battafarano** has served as our Executive Vice President since February 2005 and as President, Hospital Division since November 1998. He served as our Vice President of Operations from April 1998 to November 1998. He held the same position with our predecessor from February 1998 to April 1998. From May 1996 to January 1998, Mr. Battafarano served as Senior Vice President of the central regional office of our predecessor. From January 1992 to April 1996, he served as an executive director and hospital administrator for our predecessor.

**Lane M. Bowen** has served as our Executive Vice President since February 2005 and as President, Health Services Division since October 2002. He served as the Senior Vice President, Pacific Region of the Health Services Division from September 2001 to October 2002. From January 2001 to September 2001, Mr. Bowen served as Senior Vice President, South Region of the Health Services Division.

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**Richard E. Chapman** has served as our Executive Vice President and Chief Administrative and Information Officer since February 2005. He served as Chief Administrative and Information Officer and Senior Vice President from January 2001 to February 2005. From April 1998 to January 2001, he served as our Senior Vice President and Chief Information Officer. Mr. Chapman served as Senior Vice President and Chief Information Officer of our predecessor from October 1997 to April 1998.

**William M. Altman**, an attorney, has served as our Senior Vice President, Compliance and Government Programs since April 2002 and previously served as Vice President of Compliance and Government Programs since October 1999. He served as Operations Counsel in our law department from April 1998 to September 1999. He held the same position with our predecessor from June 1996 through April 1998.

**Benjamin A. Breier** has served as our President, People*first* Rehabilitation division since August 2005. Prior to joining us, Mr. Breier served as Senior Vice President, Operations for Concentra, Inc., a leading provider of workers compensation and occupational health services, from December 2003 to August 2005. Mr. Breier served as Director, Operations for Premier Practice Management, Inc., a group purchasing and quality improvement alliance of healthcare operators, from January 2000 to May 2001.

**Joseph L. Landenwich**, an attorney and certified public accountant, has served as our Senior Vice President of Corporate Legal Affairs and Corporate Secretary since December 2003. Mr. Landenwich served as Vice President of Corporate Legal Affairs and Corporate Secretary from November 1999 to December 2003. He served as Corporate Counsel from April 1998 to November 1999 and as Assistant Secretary from February 1999 to November 1999. Mr. Landenwich also was Corporate Counsel with our predecessor from September 1996 to April 1998.

**Mark A. McCullough**, a certified public accountant, has served as our President, Pharmacy Division since February 2003. From March 2001 to February 2003, he served as Vice President of Pharmacy and prior to that as Vice President of Finance for our pharmacy operations from April 2000 to March 2001. Mr. McCullough was the Director of Financial Reporting for Catholic Health Initiatives, a healthcare provider, from December 1998 to March 2000.

**Gregory C. Miller** has served as our Senior Vice President, Corporate Development and Financial Planning since January 2005. He served as our Vice President, Corporate Development and Financial Planning from January 2004 to January 2005. Prior to joining us, Mr. Miller served in various positions, most recently as Senior Vice President, for Houlihan Lokey Howard & Zukin, an investment bank, from March 1998 to January 2004.

**M. Suzanne Riedman**, an attorney, has served as our Senior Vice President and General Counsel since August 1999. She served as our Vice President and Associate General Counsel from April 1998 to August 1999. Ms. Riedman held the same positions with our predecessor from January 1997 to April 1998. She joined our predecessor as counsel in September 1995 and became Associate General Counsel in January 1996.

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## PART II

**Item 5.** ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

### MARKET PRICE FOR COMMON STOCK

### AND DIVIDEND HISTORY

Our common stock is quoted on the New York Stock Exchange (the NYSE ) under the ticker symbol KND. The prices in the table below, for the calendar quarters indicated, represent the high and low sale prices for our common stock as reported on the NYSE.

| | Sales price of common stock | |
|---|---|---|
| **2006** | **High** | **Low** |
| First quarter | $ 29.50 | $ 19.70 |
| Second quarter | $ 27.40 | $ 22.76 |
| Third quarter | $ 32.07 | $ 24.91 |
| Fourth quarter | $ 29.99 | $ 24.95 |

| **2005** | **High** | **Low** |
|---|---|---|
| First quarter | $ 35.32 | $ 26.75 |
| Second quarter | $ 42.02 | $ 30.15 |
| Third quarter | $ 42.11 | $ 28.56 |
| Fourth quarter | $ 33.26 | $ 24.74 |

Our revolving credit facility contains covenants that limit, among other things, our ability to pay dividends. Any determination to pay dividends in the future will be dependent upon our results of operations, financial position, contractual restrictions, restrictions imposed by applicable laws and other factors deemed relevant by our Board of Directors. We have not paid any cash dividends on our common stock.

As of January 31, 2007, there were 501 holders of record of our common stock.

See Part III Item 12 Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, for disclosures regarding our equity compensation plans.

As required by Section 303A.12 of the NYSE listing standards, on May 30, 2006, Paul J. Diaz, our President and Chief Executive Officer, certified that he was not aware of any violation by us of NYSE corporate governance listing standards. The certifications required by Section 302 of the Sarbanes-Oxley Act of 2002 are included as exhibits to this Annual Report on Form 10-K.

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**PERFORMANCE GRAPH**

The following graph summarizes the cumulative total return to shareholders of the Company s common stock from December 31, 2001 to December 31, 2006, compared to the cumulative total return on the Standard & Poor s 500 Stock Index (the S&P 500 Index ) and the Standard & Poor s 1500 Health Care Index (the S&P 1500 Health Care Index ). The graph assumes an investment of $100 in each of the Company s common stock, the S&P 500 Index, and the S&P 1500 Health Care Index on December 31, 2001, and also assumes the reinvestment of all dividends.

| | 12/31/01 | 12/31/02 | 12/31/03 | 12/31/04 | 12/31/05 | 12/31/06 |
|---|---|---|---|---|---|---|
| Kindred Healthcare, Inc. | $ 100.00 | $ 34.91 | $ 99.96 | $ 115.19 | $ 99.08 | $ 97.12 |
| S&P 500 Index | 100.00 | 81.04 | 95.33 | 98.51 | 105.89 | 113.27 |
| S&P 1500 Health Care Index | 100.00 | 77.90 | 100.25 | 111.15 | 116.61 | 135.03 |

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**Item 6.** ***Selected Financial Data***

**KINDRED HEALTHCARE, INC.**

**SELECTED FINANCIAL DATA**

**(In thousands, except per share amounts)**

| | Year ended December 31, | | | | |
|---|---|---|---|---|---|
| | **2006** | **2005** | **2004** | **2003** | **2002** |
| **Statement of Operations Data:** | | | | | |
| Revenues | $ 4,266,661 | $ 3,852,975 | $ 3,421,411 | $ 3,115,830 | $ 2,953,301 |
| Salaries, wages and benefits | 2,329,382 | 2,071,320 | 1,897,406 | 1,762,085 | 1,674,081 |
| Supplies | 685,884 | 570,179 | 471,628 | 416,682 | 387,934 |
| Rent | 310,404 | 264,633 | 249,141 | 240,311 | 233,654 |
| Other operating expenses | 701,566 | 631,195 | 562,754 | 525,965 | 458,102 |
| Depreciation and amortization | 122,196 | 100,982 | 87,229 | 76,464 | 64,606 |
| Interest expense | 13,921 | 8,098 | 12,814 | 10,312 | 12,018 |
| Investment income | (14,500) | (11,059) | (6,425) | (6,119) | (9,604) |
| | 4,148,853 | 3,635,348 | 3,274,547 | 3,025,700 | 2,820,791 |
| Income from continuing operations before reorganization items and income taxes | 117,808 | 217,627 | 146,864 | 90,130 | 132,510 |
| Reorganization items | | (1,639) | (304) | (1,010) | (5,520) |
| Income from continuing operations before income taxes | 117,808 | 219,266 | 147,168 | 91,140 | 138,030 |
| Provision for income taxes | 46,569 | 87,875 | 60,149 | 37,977 | 57,770 |
| Income from continuing operations | 71,239 | 131,391 | 87,019 | 53,163 | 80,260 |
| Discontinued operations, net of income taxes: | | | | | |
| Income (loss) from operations | 7,504 | 14,899 | (617) | (49,086) | (45,507) |
| Loss on divestiture of operations | (32) | (1,381) | (15,822) | (79,413) | |
| Net income (loss) | $ 78,711 | $ 144,909 | $ 70,580 | $ (75,336) | $ 34,753 |
| Earnings (loss) per common share: | | | | | |
| Basic: | | | | | |
| Income from continuing operations | $ 1.82 | $ 3.52 | $ 2.43 | $ 1.53 | $ 2.31 |
| Discontinued operations: | | | | | |
| Income (loss) from operations | 0.19 | 0.40 | (0.02) | (1.41) | (1.31) |
| Loss on divestiture of operations | | (0.04) | (0.44) | (2.28) | |
| Net income (loss) | $ 2.01 | $ 3.88 | $ 1.97 | $ (2.16) | $ 1.00 |
| Diluted: | | | | | |
| Income from continuing operations | $ 1.74 | $ 2.90 | $ 2.05 | $ 1.52 | $ 2.23 |
| Discontinued operations: | | | | | |
| Income (loss) from operations | 0.18 | 0.33 | (0.01) | (1.40) | (1.26) |
| Loss on divestiture of operations | | (0.03) | (0.37) | (2.27) | |

| | | | | | |
|---|---|---|---|---|---|
| Net income (loss) | $ 1.92 | $ 3.20 | $ 1.67 | $ (2.15) | $ 0.97 |
| Shares used in computing earnings (loss) per common share: | | | | | |
| Basic | 39,108 | 37,328 | 35,774 | 34,880 | 34,723 |
| Diluted | 40,923 | 45,239 | 42,403 | 35,047 | 36,001 |
| **Financial Position:** | | | | | |
| Working capital | $ 395,563 | $ 324,337 | $ 296,577 | $ 265,207 | $ 338,160 |
| Assets | 2,016,127 | 1,760,561 | 1,593,293 | 1,585,414 | 1,644,178 |
| Long-term debt | 130,090 | 26,323 | 32,544 | 139,397 | 162,008 |
| Stockholders equity | 995,578 | 870,536 | 719,785 | 597,565 | 631,628 |

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**Item 7.** ***Management s Discussion and Analysis of Financial Condition and Results of Operation***

You should read the following discussion together with the selected financial data in Item 6 and our consolidated financial statements and the notes thereto included in this Annual Report on Form 10-K. All financial and operating data presented in Items 6 and 7 reflects the continuing operations of our business for all periods presented unless otherwise indicated.

**Overview**

We are a healthcare services company that through our subsidiaries operates hospitals, nursing centers, institutional pharmacies and a contract rehabilitation services business across the United States. At December 31, 2006, our hospital division operated 81 LTAC hospitals with 6,419 licensed beds in 24 states. Our health services division operated 242 nursing centers with 30,664 licensed beds in 28 states. We also operated a contract rehabilitation services business that provides rehabilitative services primarily in long-term care settings. Our pharmacy division operated an institutional pharmacy business with 46 pharmacies in 26 states and a pharmacy management business servicing substantially all of our hospitals.

On October 25, 2006, we signed a definitive agreement with AmerisourceBergen to combine our respective institutional pharmacy businesses, KPS and PharMerica LTC, into a new, independent, publicly traded company. See note 2 of the notes to consolidated financial statements.

**Basis of Presentation**

In recent years, we have completed certain strategic divestitures to improve our future operating results. For accounting purposes, the operating results of these businesses and the losses associated with these transactions have been classified as discontinued operations in our accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2006 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 accompanying consolidated balance sheet. See notes 3 and 4 of the notes to consolidated financial statements.

On January 1, 2004, we completed 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.

In April 2004, the Board of Directors declared a 2-for-1 stock split in the form of a 100% stock dividend that was distributed in May 2004. Share and per share data for all periods presented in the accompanying consolidated financial statements have been adjusted retroactively to reflect the stock split.

The operating results of acquired businesses are included in the accompanying consolidated statement of operations since the respective acquisition dates.

**Critical Accounting Policies**

Our discussion and analysis of financial condition and results of operations are based upon our consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires the use of estimates and judgments that affect the reported amounts and related disclosures of commitments and contingencies. We rely on historical experience and on various other assumptions that we believe to be reasonable under the circumstances to make judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ materially from these estimates.

We believe the following critical accounting policies, among others, affect the more significant judgments and estimates used in the preparation of our consolidated financial statements.

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*Revenue recognition*

We have agreements with third party payors that provide for payments to each of our operating divisions. These payment arrangements may be based upon prospective rates, reimbursable costs, established charges, discounted charges or per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from Medicare, Medicaid, other third party payors and individual patients for services rendered. Retroactive adjustments that are likely to result from future examinations by third party payors are accrued on an estimated basis in the period the related services are rendered and adjusted as necessary in future periods based upon new information or final settlements.

Favorable settlements of prior year hospital Medicare cost reports aggregated $8 million in 2006, $65 million in 2005 and $8 million in 2004. In addition, we recorded approximately $14 million of income in 2005 and $3 million of income in 2004 related to prior year retroactive nursing center Medicaid rate increases in Indiana and North Carolina, respectively.

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

| | Year ended December 31, | | |
|---|---|---|---|
| | 2006 | 2005 | 2004 |
| Medicare | $ 1,973,323 | $ 1,668,820 | $ 1,468,662 |
| Medicaid | 1,138,955 | 1,209,732 | 1,091,295 |
| Private and other | 1,524,424 | 1,294,575 | 1,104,554 |
| | 4,636,702 | 4,173,127 | 3,664,511 |
| Eliminations: | | | |
| Rehabilitation | (225,936) | (195,325) | (156,203) |
| Pharmacy | (144,105) | (124,827) | (86,897) |
| | (370,041) | (320,152) | (243,100) |
| | $ 4,266,661 | $ 3,852,975 | $ 3,421,411 |

*Collectibility of accounts receivable*

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies and individual patients. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

In evaluating the collectibility of accounts receivable, we consider a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third party payors and general industry conditions. Actual collections of accounts receivable in subsequent periods may require changes in the estimated provision for loss. Changes in these estimates are charged or credited to the results of operations in the period of the change.

The provision for doubtful accounts totaled $34 million for 2006, $14 million for 2005 and $20 million for 2004. In the fourth quarter of 2005, we recorded a $3 million favorable change in estimate related to the provision for doubtful accounts in our pharmacy division.

*Allowances for insurance risks*

We insure a substantial portion of our professional liability risks and workers compensation risks through a wholly owned limited purpose insurance subsidiary. Provisions for loss for these risks are based upon independent actuarially determined estimates.

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The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of or less than the amounts recorded. To the extent that subsequent expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited.

Provisions for loss for professional liability risks retained by our limited purpose insurance subsidiary have been discounted based upon independent actuarial estimates of claim payment patterns using a discount rate of 5% in each of the last three years. Amounts equal to the discounted loss provision are funded annually. We do not fund the portion of professional liability risks related to estimated claims that have been incurred but not reported. Accordingly, these liabilities are not discounted. The allowance for professional liability risks aggregated $250 million at December 31, 2006 and $252 million at December 31, 2005. If we did not discount any of the allowances for professional liability risks, these balances would have approximated $263 million at December 31, 2006 and $266 million at December 31, 2005.

As a result of improved professional liability underwriting results of our limited purpose insurance subsidiary, we received a return of capital of $34 million in 2006 and $30 million in 2005 from our limited purpose insurance subsidiary. Prior to 2004, we recorded substantial cost increases related to professional liability risks. A portion of these costs were not funded into our limited purpose insurance subsidiary until the following fiscal year. Based upon actuarially determined estimates, we funded approximately $15 million into our limited purpose insurance subsidiary in 2004 to satisfy fiscal 2003 funding requirements.

Changes in the number of professional liability claims and the cost to settle these claims significantly impact the allowance for professional liability risks. A relatively small variance between our estimated and ultimate actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the allowance for professional liability risks. For example, a 1% variance in the allowance for professional liability risks at December 31, 2006 would impact our operating income by approximately $3 million.

The provision for professional liability risks (continuing operations), including the cost of coverage maintained with unaffiliated commercial insurance carriers, aggregated $59 million for 2006, $71 million for 2005 and $69 million for 2004. Changes in estimates for prior year professional liability costs reduced professional liability costs by approximately $27 million, $11 million and $13 million in 2006, 2005 and 2004, respectively. While we expect that professional liability costs for 2007 may be higher than the costs recorded over the last three years, we believe that the annual growth rates for professional liability costs appear to be moderating.

We recorded favorable changes in estimate aggregating $19 million, $42 million and $18 million for 2006, 2005 and 2004, respectively, for professional liability reserves related primarily to our former Florida and Texas nursing centers (included in discontinued operations).

Provisions for loss for workers compensation risks retained by our limited purpose insurance subsidiary are not discounted and amounts equal to the loss provision are funded annually. The allowance for workers compensation risks aggregated $85 million at December 31, 2006 and $78 million at December 31, 2005. The provision for workers compensation risks, including the cost of coverage maintained with unaffiliated commercial insurance carriers, aggregated $38 million for 2006, $47 million for 2005 and $46 million for 2004.

See notes 4 and 10 of the notes to consolidated financial statements.

*Accounting for income taxes*

The provision for income taxes is based upon our estimate of taxable income or loss for each respective accounting period. We recognize an asset or liability for the deferred tax consequences of temporary differences

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between the tax bases of assets and liabilities and their reported amounts in the financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets are recovered or liabilities are settled. We also recognize as deferred tax assets the future tax benefits from net operating and capital loss carryforwards. A valuation allowance is provided for these deferred tax assets if it is more likely than not that some portion or all of the net deferred tax assets will not be realized.

In November 2004, the IRS proposed certain adjustments to our 2000 and 2001 federal income tax returns which we were contesting. The principal proposed adjustment related to the manner of reduction of our tax attributes, primarily our net operating loss carryforwards, in connection with the emergence of our subsidiaries and us from proceedings under the bankruptcy code. In 2006, we reached a settlement with the IRS, pending final documentation, related to all disputed federal tax issues for fiscal 2000 and 2001. In connection with the settlement, we agreed to pay approximately $3 million to the IRS in 2007. In the fourth quarter of 2006, we reflected the impact of the settlement in our consolidated balance sheet by increasing certain net deferred tax assets by approximately $16 million, reducing currently payable income taxes by approximately $70 million and increasing stockholders equity by approximately $86 million. Because of fresh-start accounting rules related to our reorganization in 2001, the settlement of these pre-reorganization income tax matters had no impact on earnings in 2006.

Our effective income tax rate was 39.5% in 2006, 40.1% in 2005 and 40.9% in 2004. We recorded favorable income tax adjustments in 2006 related to the resolution of certain income tax contingencies that reduced the provision for income taxes by approximately $3 million.

There are significant uncertainties with respect to capital loss and net operating loss carryforwards which could affect materially the realization of certain deferred tax assets. Accordingly, we have recognized deferred tax assets to the extent it is more likely than not they will be realized and a valuation allowance is provided for deferred tax assets to the extent the realizability of the deferred tax assets is uncertain. We recognized net deferred tax assets totaling $159 million at December 31, 2006 and $135 million at December 31, 2005.

After our emergence from bankruptcy, the realization of pre-reorganization deferred tax assets and the resolution of certain income tax contingencies eliminated in full the goodwill recorded in connection with fresh-start accounting. After the fresh-start accounting goodwill was eliminated in full, the excess of approximately $80 million in 2006, $18 million in 2005 and $32 million in 2004 was treated as an increase to capital in excess of par value and a reduction in the deferred tax valuation allowance.

We are subject to various income tax audits at the federal and state levels in the ordinary course of business. Such audits could result in increased tax payments, interest and penalties. While we believe our tax positions are appropriate, we cannot assure you that the various authorities engaged in the examination of our income tax returns will not challenge our positions.

*Valuation of long-lived assets and goodwill*

We regularly review the carrying value of certain long-lived assets and the related identifiable intangible assets with respect to any events or circumstances that may indicate whether an impairment or an adjustment to the carrying value or amortization period is necessary. If circumstances suggest the recorded amounts cannot be recovered based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

In assessing the carrying values of long-lived assets, we estimate future cash flows at the lowest level for which there are independent, identifiable cash flows. For this purpose, these cash flows are aggregated based upon the contractual agreements underlying the operation of the facility or group of facilities. Generally, an individual facility is considered the lowest level for which there are independent, identifiable cash flows. However, to the extent that groups of facilities are leased under a master lease agreement in which the operations

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of a facility and compliance with the lease terms are interdependent upon other facilities in the agreement (including our ability to renew the lease or divest a particular property), we define the group of facilities under a master lease agreement as the lowest level for which there are independent, identifiable cash flows. Accordingly, the estimated cash flows of all facilities within a master lease are aggregated for purposes of evaluating the carrying values of long-lived assets.

In accordance with Statement of Financial Accounting Standards ( SFAS ) No. 142 ( SFAS 142 ), Goodwill and Other Intangible Assets, we are required to perform an impairment test for goodwill at least annually or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. We perform our annual impairment test at the end of each year. No impairment charge was recorded in each of the last three years in connection with our annual impairment test.

Our other intangible assets with finite lives are amortized under SFAS 142 using the straight-line method over their estimated useful lives, ranging from one to 13 years.

**Recently Issued Accounting Pronouncements**

On September 29, 2006, the Financial Accounting Standards Board (the FASB ) issued SFAS No. 158 ( SFAS 158 ), Employers Accounting for Defined Benefit Pension and Other Postretirement Plans. SFAS 158 requires an employer to recognize the overfunded or underfunded status of a defined benefit postretirement plan (other than a multiemployer plan) as an asset or liability in its statement of financial position, and to recognize changes in that funded status in the year in which the changes occur through comprehensive income. SFAS 158 also requires an employer to measure the funded status of a plan as of the date of its year-end statement of financial position and revises certain disclosure requirements. The benefit obligation is defined as the projected benefit obligation for pension plans and as the accumulated postretirement benefit obligation for any other postretirement benefit plan, such as a retiree healthcare plan. We adopted SFAS 158 at the end of 2006. The adoption of SFAS 158 did not have a material impact on our financial position, results of operations or liquidity.

On September 15, 2006, the FASB issued SFAS No. 157 ( SFAS 157 ), Fair Value Measurements, which addresses how companies should measure fair value when they are required to use a fair value measure for recognition or disclosure purposes under generally accepted accounting principles. SFAS 157 is effective for fiscal years beginning after November 15, 2007. The adoption of SFAS 157 is not expected to have a material impact on our financial position, results of operations or liquidity.

On September 13, 2006, the SEC staff issued Staff Accounting Bulletin No. 108 ( SAB 108 ), Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements. SAB 108 was issued to eliminate the diversity of practice surrounding how public companies quantify financial statement misstatements. SAB 108 is effective for fiscal years ending after November 15, 2006. The adoption of SAB 108 did not have a material impact on our financial position, results of operations or liquidity.

On July 13, 2006, the FASB issued FASB Interpretation No. 48 ( FIN 48 ), Accounting for Uncertainty in Income Taxes. The interpretation clarifies the accounting for uncertain income tax issues recognized in an entity s financial statements in accordance with FASB Statement No. 109, Accounting for Income Taxes. FIN 48 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. FIN 48 is effective for fiscal years beginning after December 15, 2006. We have completed our analysis of FIN 48 and the adoption of FIN 48 will not have a material impact on our financial position, results of operations or liquidity.

In May 2005, the FASB issued SFAS No. 154 ( SFAS 154 ), Accounting Changes and Error Corrections A replacement of APB Opinion No. 20 and FASB Statement No. 3. SFAS 154 changes the requirement for the accounting for, and reporting of, a change in accounting principle. SFAS 154 applies to all voluntary changes in accounting principles and changes required by accounting pronouncements without specific transition provisions.

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The provisions of SFAS 154 are effective for accounting changes and correction of errors made in fiscal years beginning after December 15, 2005. The adoption of SFAS 154 is not expected to have a material impact on our financial position, results of operations or liquidity.

In December 2004, the FASB issued SFAS No. 123 (revised 2004) ( SFAS 123R ), Share-Based Payment, which requires companies to expense the fair value of employee stock options and other forms of stock-based compensation for interim periods that begin after June 15, 2005. This requirement represents a significant change because stock option awards have not been recognized as compensation expense in our historical consolidated financial statements under Accounting Principles Board Opinion No. 25 ( APB 25 ), Accounting for Stock Issued to Employees. SFAS 123R requires the cost of an award, based upon fair value on the date of grant, to be recognized over the period during which an employee is required to provide service in exchange for the award (usually the vesting period). The fair value of the award on the date of grant will be estimated using option pricing models. In April 2005, the SEC approved a new rule that delayed the effective date of SFAS 123R for public companies until the first annual period, rather than the first interim period, that begins after June 15, 2005. We adopted SFAS 123R on January 1, 2006 and began to recognize compensation expense prospectively in our consolidated financial statements for non-vested stock options outstanding at December 31, 2005 and for all future stock option grants. The adoption of SFAS 123R reduced net income by approximately $6 million for the year ended December 31, 2006.

In December 2005, we accelerated the vesting of approximately 944,000 unvested stock options awarded to employees and officers which had exercise prices greater than the closing price at December 14, 2005 of $26.48 per share. The acceleration of the vesting of these stock options increased the pro forma stock-based employee compensation expense in 2005 by $13 million ($8 million net of income taxes or $0.18 per diluted share). The decision to accelerate the vesting of the outstanding underwater stock options was made primarily to reduce compensation expense that otherwise would be recorded in future periods following the adoption of SFAS 123R, to enhance management s focus on increasing shareholder returns and to improve employee morale and retention.

**Impact of Medicare and Medicaid Reimbursement**

We depend on reimbursement from third party payors, including the Medicare and Medicaid programs, for substantially all of our revenues. For the year ended December 31, 2006, we derived approximately 67% of our total revenues from the Medicare and Medicaid programs and approximately 33% from private third party payors, such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers.

The Medicare and Medicaid programs are highly regulated and subject to frequent and substantial changes. See Part I Item 1 Business Governmental Regulation for an overview of the reimbursement systems impacting our businesses and Part I Item 1A Risk Factors.

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**Results of Operations Continuing Operations**

***For the years ended December 31, 2006, 2005 and 2004***

A summary of our operating data follows (dollars in thousands, except statistics):

| | Year ended December 31, | | |
|---|---|---|---|
| | **2006** | **2005** | **2004** |
| **Revenues:** | | | |
| Hospital division | $ 1,726,816 | $ 1,608,120 | $ 1,398,658 |
| Health services division | 1,957,172 | 1,780,009 | 1,677,392 |
| Rehabilitation division | 300,106 | 262,773 | 228,426 |
| Pharmacy division | 652,608 | 522,225 | 360,035 |
| | 4,636,702 | 4,173,127 | 3,664,511 |
| Eliminations: | | | |
| Rehabilitation | (225,936) | (195,325) | (156,203) |
| Pharmacy | (144,105) | (124,827) | (86,897) |
| | (370,041) | (320,152) | (243,100) |
| | $ 4,266,661 | $ 3,852,975 | $ 3,421,411 |
| **Operating income (loss):** | | | |
| Hospital division | $ 388,422 | $ 419,546 | $ 328,950 |
| Health services division | 246,866 | 216,515 | 222,971 |
| Rehabilitation division | 30,362 | 32,052 | 31,431 |
| Pharmacy division | 48,461 | 56,837 | 37,062 |
| Corporate: | | | |
| Overhead | (157,157) | (134,514) | (123,749) |
| Insurance subsidiary | (7,125) | (10,155) | (7,042) |
| | (164,282) | (144,669) | (130,791) |
| Reorganization items | | 1,639 | 304 |
| | $ 549,829 | $ 581,920 | $ 489,927 |

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**Operating data (Continued):**

| | Year ended December 31, | | |
|---|---|---|---|
| | 2006 | 2005 | 2004 |
| **Hospital data:** | | | |
| End of period data: | | | |
| Number of hospitals | 81 | 74 | 72 |
| Number of licensed beds | 6,419 | 5,694 | 5,569 |
| Revenue mix %: | | | |
| Medicare | 61 | 67 | 65 |
| Medicaid | 10 | 6 | 7 |
| Private and other | 29 | 27 | 28 |
| Admissions: | | | |
| Medicare | 29,575 | 28,870 | 26,723 |
| Medicaid | 3,985 | 3,222 | 2,975 |
| Private and other | 7,761 | 6,090 | 5,508 |
| | 41,321 | 38,182 | 35,206 |
| Admissions mix %: | | | |
| Medicare | 71 | 76 | 76 |
| Medicaid | 10 | 8 | 8 |
| Private and other | 19 | 16 | 16 |
| Patient days: | | | |
| Medicare | 837,928 | 814,922 | 788,122 |
| Medicaid | 193,277 | 115,377 | 117,533 |
| Private and other | 285,427 | 227,842 | 214,227 |
| | 1,316,632 | 1,158,141 | 1,119,882 |
| Average length of stay: | | | |
| Medicare | 28.3 | 28.2 | 29.5 |
| Medicaid | 48.5 | 35.8 | 39.5 |
| Private and other | 36.8 | 37.4 | 38.9 |
| Weighted average | 31.9 | 30.3 | 31.8 |
| Revenues per admission: | | | |
| Medicare | $ 35,599 | $ 37,298 | $ 33,762 |
| Medicaid | 42,508 | 30,665 | 34,462 |
| Private and other | 65,015 | 71,023 | 71,517 |
| Weighted average | 41,790 | 42,117 | 39,728 |
| Revenues per patient day: | | | |
| Medicare | $ 1,256 | $ 1,321 | $ 1,145 |
| Medicaid | 876 | 856 | 872 |
| Private and other | 1,768 | 1,898 | 1,839 |
| Weighted average | 1,312 | 1,388 | 1,249 |
| Medicare case mix index (discharged patients only) | 1.10 | 1.19 | 1.23 |
| Average daily census | 3,607 | 3,173 | 3,060 |
| Occupancy % | 63.7 | 59.1 | 59.2 |

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**Operating data (Continued):**

| | Year ended December 31, | | |
|---|---|---|---|
| | 2006 | 2005 | 2004 |
| **Nursing center data:** | | | |
| End of period data: | | | |
| Number of nursing centers: | | | |
| Owned or leased | 237 | 226 | 225 |
| Managed | 5 | 5 | 7 |
| | 242 | 231 | 232 |
| Number of licensed beds: | | | |
| Owned or leased | 30,059 | 28,510 | 28,407 |
| Managed | 605 | 605 | 803 |
| | 30,664 | 29,115 | 29,210 |
| Revenue mix %: | | | |
| Medicare | 34 | 33 | 34 |
| Medicaid | 47 | 49 | 48 |
| Private and other | 19 | 18 | 18 |
| Patient days (a): | | | |
| Medicare | 1,593,743 | 1,496,372 | 1,478,775 |
| Medicaid | 6,196,011 | 5,955,973 | 6,087,465 |
| Private and other | 1,732,808 | 1,515,549 | 1,508,999 |
| | 9,522,562 | 8,967,894 | 9,075,239 |
| Patient day mix %: | | | |
| Medicare | 17 | 17 | 16 |
| Medicaid | 65 | 66 | 67 |
| Private and other | 18 | 17 | 17 |
| Revenues per patient day: | | | |
| Medicare Part A | $ 383 | $ 353 | $ 337 |
| Total Medicare (including Part B) | 419 | 395 | 383 |
| Medicaid | 147 | 146 | 133 |
| Private and other | 219 | 210 | 200 |
| Weighted average | 206 | 198 | 185 |
| Average daily census | 26,089 | 24,570 | 24,796 |
| Occupancy % | 87.8 | 86.2 | 86.9 |
| **Rehabilitation data:** | | | |
| Revenue mix %: | | | |
| Company-operated | 75 | 76 | 73 |
| Non-affiliated | 25 | 24 | 27 |
| **Pharmacy data:** | | | |
| Number of customer licensed beds at end of period: | | | |
| Company-operated | 30,232 | 28,657 | 28,634 |
| Non-affiliated | 72,339 | 64,625 | 37,561 |

| | | | |
|---|---|---|---|
| | 102,571 | 93,282 | 66,195 |

(a) Excludes managed facilities.

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*The Year in Review*

During 2006, we successfully managed through a number of significant challenges and established a strong foundation for future growth. Our most significant accomplishments in 2006 include the following:

- our operators managed through unprecedented regulatory changes in each of our operating divisions while improving our level of quality and customer service;
- we successfully resolved the last remaining issues associated with our 2001 reorganization, including the Ventas rent reset and the expiration of our warrants;
- we announced the Proposed Pharmacy Transaction, which we believe will create a stronger competitor in the institutional pharmacy industry and unlock substantial value for our shareholders on a tax-free basis; and
- we continued to grow through acquisitions and organic development while also disposing of underperforming facilities to reposition our portfolio for future growth.

Our hospital division, which has provided substantial growth over the years, faced significant regulatory challenges in 2006. During the second half of 2006, Medicare reimbursement rates were reduced, negatively impacting Medicare revenues by approximately $34 million, and Medicare patient volumes declined on a same-store basis during the same period. After a difficult third quarter, our hospital division reported strong fourth quarter results driven primarily by strength in our non-government business and operating efficiencies within certain administrative functions. Despite Medicare reimbursement difficulties, our hospitals reported growth in revenues and admissions for the full year. Excluding the effect of significant favorable prior year Medicare cost report settlements in 2005, our hospital operating income increased in 2006. In 2007 and beyond, we will continue to explore ways to better utilize our existing hospital capacity by further developing our relationships with managed care providers and expanding our services.

In our health services division, fiscal 2006 was a year in which our continued investments in quality and customer service began to result in significant improvements in our operating results. These investments over the past several years have included, among other things, improved staffing and clinical resource development, reduced contract labor utilization, investments in physical plant and equipment and expansion of services to effectively care for higher acuity Medicare and managed care patients. We also have continued to execute on our risk management initiatives, which have provided a more stable environment to improve our clinical processes and resolve quality issues when they arise. In addition, these quality investments enabled our nursing centers to successfully transition to the expanded Medicare RUGs categories that became effective on January 1, 2006. Our 2006 operating results in this division were encouraging, with solid growth in revenues, overall occupancy, Medicare and managed care mix and operating income compared to 2005. We believe that there are additional opportunities to improve our nursing center results in the future by continuing to execute our strategy of providing cost-effective care to higher acuity patients and residents.

In People*first* Rehabilitation, we made progress in 2006 to position this business to grow beyond the Kindred hospital and nursing center portfolio that currently comprises most of its revenues. After operating for less than three years as a separate division, People*first* has one of the most effective therapist recruitment and retention programs in the industry and its name recognition and reputation for clinical excellence is expanding in the marketplace. As the labor market for therapists becomes more competitive, People*first* is well positioned to grow through a program of external contract development and higher levels of productivity. Over the longer term, we believe that this division has opportunities to grow in a regulatory environment that is generally favorable to providing more rehabilitation therapy services in lower cost settings, particularly nursing centers.

The most significant regulatory changes in 2006 occurred in our KPS institutional pharmacy business. On January 1, 2006, the Medicare Part D program became effective. As a result, a substantial portion of our revenues shifted from a state-sponsored Medicaid payor source to a federally funded program. Like most providers in the

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industry, the Medicare Part D transition for KPS was challenging and required a number of operational changes as well as an extensive communications and implementation plan for each of our nursing center customers. While 2006 was a transition year from a regulatory and operational perspective, significant efforts also were required to integrate acquisitions and prepare for the Proposed Pharmacy Transaction.

Fiscal 2006 also marked the conclusion of all remaining issues related to our 2001 reorganization. The Ventas rent reset issue was successfully concluded through an independent appraisal process. This was a significant event for Kindred, providing clarity around our capital costs and a financial framework that will accommodate our future growth and expansion plans.

In addition to the rent reset issue, all of our outstanding warrants issued in connection with our 2001 reorganization expired in April 2006, resulting in the issuance of a significant number of shares of common stock. We expended all of the $142 million of warrant proceeds to repurchase shares and expended another $52 million to complete our previously announced share repurchase program. These transactions have simplified our equity structure and reduced our diluted share count by approximately 10% compared to 2005.

In October 2006, we entered into a definitive agreement related to the Proposed Pharmacy Transaction. We believe that the business prospects underlying the Proposed Pharmacy Transaction, including the operational synergies and economies of scale that can be realized over the long term, provide a compelling opportunity to enhance Kindred shareholder value. We expect to complete the Proposed Pharmacy Transaction in the second quarter of 2007.

With respect to future growth opportunities, we continued our program of organic development and selective acquisitions. In 2006, we acquired six hospitals (646 licensed beds), 11 nursing centers (1,579 licensed beds), four assisted living facilities (228 licensed beds) and three institutional pharmacies (4,593 customer beds). In addition, we opened two hospitals containing 98 licensed beds and opened five pharmacies in new markets. In 2007, we will continue to seek further organic development and strategic acquisitions that enhance shareholder value and that reflect a more concentrated market-by-market strategy. We have already entered into an agreement to lease eight additional nursing centers, and we expect to open four hospitals in 2007 that are currently under development.

*Hospital Division*

Revenues increased 7% in 2006 to $1.7 billion and 15% in 2005 to $1.6 billion, primarily as a result of growth in admissions, new hospital development, the Commonwealth Transaction and, in 2005, favorable reimbursement rates. Revenues associated with the Commonwealth Transaction approximated $95 million for 2006. Revenues related to favorable prior year Medicare cost report settlements aggregated $8 million in 2006, $65 million in 2005 and $8 million in 2004. On a same-store basis, revenues increased 5% in 2006 and 8% in 2005. The 2006 Hospital Medicare Rule reduced our hospital Medicare revenues by approximately $26 million in 2006.

Admissions rose 8% in both 2006 and 2005 compared to each respective prior year. Average length of stay increased to 32 days in 2006 compared to 30 days in 2005 and 32 days in 2004. On a same-store basis, admissions rose 1% in 2006 and 5% in 2005. Medicare same-store admissions declined 4% in 2006 and increased 5% in 2005, while non-government same-store admissions increased 17% in 2006 and 7% in 2005.

Hospital wage and benefit costs increased 11% to $762 million in 2006 and increased 5% to $685 million in 2005 compared to $651 million in 2004. Average hourly wage rates grew 2% in 2006 and 4% in 2005, while employee benefit costs increased 9% in 2006 and 5% in 2005. The Hospital Services Reorganization had the effect of reducing hospital wage and benefit costs and increasing other operating expenses in all periods after July 1, 2004.

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Professional liability costs were $19 million in 2006, $21 million in 2005 and $20 million in 2004.

Hospital operating income declined 7% in 2006 to $388 million and increased 28% in 2005 to $420 million. As discussed in the quarterly consolidated financial information included in the consolidated financial statements, hospital operating income for the last three years included certain adjustments. Excluding these items, hospital operating income grew 5% in 2006 and 12% in 2005. Growth in hospital operating income in both periods was primarily attributable to growth in admissions (particularly non-government admissions) and operating efficiencies associated with growth in volumes. Operating income in 2006, 2005 and 2004 was reduced by approximately $27 million, $18 million and $8 million, respectively, in connection with the Hospital Services Reorganization. Aggregate operating costs per admission, including costs associated with the Hospital Services Reorganization, increased 4% in 2006 and 2% in 2005. Operating income associated with the Commonwealth Transaction approximated $6 million for 2006.

*Health Services Division*

Revenues increased 10% in 2006 to $2.0 billion and 6% in 2005 to $1.8 billion. Revenues increased in both periods primarily as a result of generally favorable reimbursement rates and, in 2006, an increase in patient days and the Commonwealth Transaction. Revenues associated with the Commonwealth Transaction approximated $104 million for 2006.

Aggregate patient days increased 6% in 2006 and declined 1% in 2005. On a same-store basis, aggregate patient days increased 1% in 2006 and declined 1% in 2005 compared to prior periods.

Nursing center wage and benefit costs increased 10% to $1.0 billion in 2006 and increased 6% to $945 million in 2005 compared to $895 million in 2004. In connection with the Rehabilitation Services Reorganization, we transferred approximately 4,000 employees from our nursing centers to the new rehabilitation division. Average hourly wage rates increased 4% in both 2006 and 2005, while employee benefit costs increased 6% in 2006 and 2% in 2005.

Professional liability costs totaled $39 million in 2006 and $49 million in both 2005 and 2004.

Nursing center operating income increased 14% in 2006 to $247 million and declined 3% in 2005 to $216 million. Operating income in 2006 increased primarily due to improved reimbursement rates and increases in patient days (particularly Medicare and non-government patient days). Operating income associated with the Commonwealth Transaction approximated $10 million for 2006. Despite generally favorable reimbursement rates, nursing center operating income in 2005 declined primarily due to a decline in patient days and increased wage and contract labor costs in connection with our efforts to enhance the quality of services provided to our patients and residents. Aggregate operating costs per patient day increased 3% in 2006 and 9% in 2005.

*Rehabilitation Division*

Revenues increased 14% to $300 million in 2006 and 15% to $263 million in 2005. The increase in revenues in 2006 and 2005 was primarily attributable to growth in both new customers and volume of services provided to existing customers, and in 2005, the full year impact of the Hospital Services Reorganization. Revenues derived from unaffiliated customers aggregated $74 million in 2006, $63 million in 2005 and $62 million in 2004.

Operating income declined to $30 million in 2006 compared to $32 million in both 2005 and 2004. Operating income for 2006 included a pretax charge of approximately $3 million related primarily to revisions to prior estimates for accrued contract labor costs. Operating income also was negatively impacted in 2006 and 2005 by increased costs associated with wage pressures resulting from an increasingly competitive marketplace for therapists.

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*Pharmacy Division*

Revenues increased 25% in 2006 to $653 million and 45% in 2005 to $522 million. The increase in revenues in both periods resulted primarily from acquisitions, price increases, higher drug utilization, same-store growth in non-affiliated customers, and in 2005, the full year impact of the Hospital Services Reorganization. Revenues associated with pharmacy acquisitions approximated $153 million in 2006 and $86 million in 2005. At December 31, 2006, we provided pharmacy services primarily to nursing centers containing 102,600 licensed beds, including 30,200 licensed beds that we operate. The aggregate number of customer licensed beds that we serviced at December 31, 2005 totaled 93,300 compared to 66,200 at December 31, 2004.

On January 1, 2006, Medicare Part D became effective. Under this program, Medicare beneficiaries who 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. Most of our nursing center residents whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for the Medicare Part D drug benefit. Accordingly, since January 1, 2006, Medicaid is no longer a primary payor for the pharmacy services provided to these residents. In fiscal 2006, our pharmacy division derived approximately 9% of its revenues from the state Medicaid programs compared to 45% in fiscal 2005.

Our pharmacy operating income declined 15% to $49 million in 2006 and increased 53% to $57 million in 2005. The decline in pharmacy operating income in 2006 was attributable to transition issues associated with the conversion to Medicare Part D, costs associated with the Proposed Pharmacy Transaction and weak results from acquired pharmacies. Operating income for 2006 included costs of approximately $3 million incurred in connection with the Proposed Pharmacy Transaction. Operating income associated with acquisitions totaled $5 million in 2006 compared to $9 million in 2005. The cost of goods sold as a percentage of institutional pharmacy revenues were 66.6% in 2006 compared to 65.5% in 2005 and 65.1% in 2004. Pharmacy operating income increased in 2005 primarily due to volume growth and the favorable impact of the Hospital Services Reorganization.

*Corporate Overhead*

Operating income for our operating divisions excludes allocations of corporate overhead. These costs aggregated $157 million in 2006, $135 million in 2005 and $124 million in 2004. As a percentage of consolidated revenues, corporate overhead totaled 3.7% in 2006, 3.5% in 2005 and 3.6% in 2004. Excluding the items discussed in the quarterly consolidated financial information, corporate overhead totaled $147 million in 2006, $127 million in 2005 and $118 million in 2004. The increase in corporate overhead in 2006 and 2005 was primarily attributable to increases in stock-based compensation and certain incentive compensation costs.

Corporate expenses included the operating losses of our limited purpose insurance subsidiary of $7 million in 2006, $10 million in 2005 and $7 million in 2004.

*Capital Costs*

Rent expense increased 17% to $311 million in 2006 and 6% to $265 million in 2005. A substantial portion of the increase in both periods resulted from contractual inflation and contingent rent increases, including those associated with the Master Lease Agreements, growth in the number of leased facilities, development and acquisition activities, and in 2006, the Ventas rent reset. For 2006, the rent reset increased rent expense by approximately $14 million.

Depreciation and amortization expense increased to $122 million in 2006 from $101 million in 2005 and $87 million in 2004. The increase was primarily a result of our ongoing capital expenditure program, and development and acquisition activities. We expect that annual growth rates in depreciation costs will moderate in 2007.

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Interest expense aggregated $14 million in 2006 compared to $8 million in 2005 and $13 million in 2004. The increase in 2006 was primarily attributable to increased borrowings under our revolving credit facility as a result of the Commonwealth Transaction. The decline in interest expense in 2005 was primarily a result of the repayment of our long-term debt in 2004. Interest expense in 2004 included a pretax charge of approximately $1 million resulting from the refinancing of our credit agreements.

Investment income related primarily to our insurance subsidiary investments totaled $14 million in 2006 compared to $11 million in 2005 and $6 million in 2004.

*Income Taxes*

The provision for income taxes is based upon our estimate of taxable income or loss for each respective accounting period and includes the effect of certain non-taxable and non-deductible items. Our effective income tax rate was 39.5% in 2006, 40.1% in 2005 and 40.9% in 2004. We recorded favorable income tax adjustments in 2006 related to the resolution of certain income tax contingencies that reduced the provision for income taxes by approximately $3 million.

We have reduced our net deferred tax assets by a valuation allowance to the extent we do not believe it is more likely than not that the asset ultimately will be realizable.

In 2006, we reached a settlement with the IRS, pending final documentation, related to all disputed federal tax issues for fiscal 2000 and 2001. In connection with the settlement, we agreed to pay approximately $3 million to the IRS in 2007. In the fourth quarter of 2006, we reflected the impact of the settlement in our consolidated balance sheet by increasing certain net deferred tax assets by approximately $16 million, reducing currently payable income taxes by approximately $70 million and increasing stockholders equity by approximately $86 million. Because of fresh-start accounting rules related to our reorganization in 2001, the settlement of these pre-reorganization income tax matters had no impact on earnings in 2006.

Our aggregate net operating loss carryforwards aggregated $9 million and $187 million at December 31, 2006 and 2005, respectively. These carryforwards expire in various amounts through 2025.

*Consolidated Results*

Income from continuing operations before income taxes declined 46% to $117 million in 2006 from $219 million in 2005 and increased 49% in 2005 from $147 million in 2004. Net income from continuing operations declined 46% to $71 million in 2006 and increased 51% in 2005 to $132 million.

***Fourth Quarter Operating Results Continuing Operations***

Operating results for the fourth quarter of 2006 included pretax income of $7 million related to a favorable actuarial adjustment of professional liability costs, pretax income of $2 million related to favorable settlements of prior year hospital Medicare cost reports and pretax income of $1 million from insurance recoveries related to hurricane costs. These items also included a pretax charge of $4 million to adjust certain estimated institutional pharmacy Medicare Part D revenues recorded in the first nine months of 2006, a pretax charge of $3 million to adjust the accounts receivable of an acquired institutional pharmacy, and a pretax charge of $5 million for professional fees and other costs incurred in connection with the Proposed Pharmacy Transaction and the rent reset issue with Ventas. We also recorded favorable income tax adjustments in the fourth quarter of 2006 that increased net income by $3 million.

Operating results for the fourth quarter of 2005 included pretax income of $3 million related to a favorable bad debt adjustment in our pharmacy business, pretax income of $2 million related to favorable settlements of prior year hospital Medicare cost reports, pretax income of $0.5 million from the dissolution of a pharmacy partnership interest, pretax income of $0.5 million from insurance recoveries related to hurricane losses, a pretax

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charge of $3 million for investment banking services and consulting fees, and a $0.2 million favorable pretax adjustment related to accrued reorganization costs.

**Discontinued Operations**

Net income from discontinued operations aggregated $8 million in 2006 compared to $15 million in 2005 and net losses of $1 million in 2004. Discontinued operations included a favorable pretax adjustment of approximately $19 million ($12 million net of income taxes) in 2006, $42 million ($26 million net of income taxes) in 2005 and $18 million ($11 million net of income taxes) in 2004 resulting from a change in estimate for professional liability reserves related primarily to our former nursing centers in Florida and Texas.

During 2006, we entered into the HCP Transaction and classified 11 nursing centers as discontinued operations. The HCP Transaction was completed in January 2007. In February 2007, we sold nine of the nursing centers and expect to close on the sale of the other two remaining nursing centers in 2007. We expect to record a pretax loss of approximately $11 million to $14 million in the first quarter of 2007 related to the divestitures.

During 2005, we disposed of three unprofitable leased nursing centers, designated two owned nursing centers as held for sale and closed one nursing center. The pretax loss associated with these transactions totaled $7 million ($4 million net of income taxes).

In December 2004, we purchased for resale two hospitals formerly leased from Ventas. We paid $21 million to purchase the facilities and $0.5 million in lease termination fees. Based upon the expected net realizable value of the two properties, we recorded a pretax loss of $13 million ($8 million net of income taxes). During 2004, we also allowed leases on three other nursing centers to expire. No gain or loss resulted from these transactions.

In July 2004, we purchased for resale three leased nursing centers in exchange for total consideration of $19 million. Based upon the expected net realizable value of these properties, we recorded a pretax loss of $12 million ($8 million net of income taxes).

See notes 4 and 10 of the notes to consolidated financial statements.

**Liquidity**

Cash flows provided by operations (including discontinued operations) aggregated $130 million for 2006, $263 million for 2005 and $268 million for 2004. During each year we maintained sufficient liquidity to fund our ongoing capital expenditure program and finance our acquisitions and strategic divestiture activities.

Prior to 2006, our federal income tax payments have been significantly reduced primarily as a result of certain income tax benefits arising in connection with our reorganization, including the utilization of net operating loss carryforwards. Beginning in 2006, cash payments of federal income taxes more closely reflected our provision for income taxes. Accordingly, our operating cash flows in 2006 declined from the levels reported in 2005. Operating cash flows for 2006 included $55 million of federal income tax payments compared to $5 million in 2005 and none in 2004.

Operating cash flows in 2005 included $48 million related to favorable settlements of prior year hospital Medicare cost reports.

Cash and cash equivalents totaled $21 million at December 31, 2006 compared to $83 million at December 31, 2005. Long-term debt at December 31, 2006 aggregated $130 million (including $129 million of borrowings under our revolving credit facility). Based upon our existing cash levels, expected operating cash flows and capital spending (including planned acquisitions), and the availability of borrowings under our

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revolving credit facility, we believe that we have the necessary financial resources to satisfy our expected short-term and long-term liquidity needs. There were no outstanding borrowings under the revolving credit facility at December 31, 2005.

In October 2006, Ventas exercised a one-time right to reset rent under each of the Master Lease Agreements. These new aggregate annual rents of approximately $239 million became effective retroactively to July 19, 2006 and were determined as fair market rentals by the final independent appraisers engaged in connection with the rent reset process under the Master Lease Agreements. Aggregate annual Ventas rents prior to the rent reset approximated $206 million. As required, Ventas paid us a reset fee of approximately $5 million that will be amortized as a reduction of rent expense over the remaining original terms of the Master Lease Agreements. In connection with the exercise of the rent reset, the new annual rents were allocated among the facilities subject to the Master Lease Agreements in accordance with the determinations made by the final appraisers during the rent reset process. The new contingent annual rent escalator is 2.7% for Master Lease Agreements Nos. 1, 3 and 4. The new contingent annual rent escalator for Master Lease Agreement No. 2 is based upon the CPI with a floor of 2.25% and a ceiling of 4%. Prior to the rent reset, the contingent annual Ventas rent escalator under each of the Master Lease Agreements was 3.5%.

In 2003, we had agreed to pay Ventas additional rents in varying amounts generally over seven years in consideration for the divestiture of our former Florida and Texas nursing centers. For accounting purposes, these additional rent payments were classified as long-term debt. As a result of the rent reset, the remaining obligations under the 2003 agreement were extinguished. For accounting purposes, our remaining debt obligation to Ventas of $28 million as of July 18, 2006 has been reclassified as a deferred credit in the accompanying consolidated balance sheet and will be amortized as a reduction of rent expense over the remaining original terms of the Master Lease Agreements.

The leases for 56 nursing centers and eight hospitals expire in April 2008 under the Master Lease Agreements. These facilities are held in seven renewal bundles. At our option, all, but not less than all, of the leased properties in each bundle may be extended for one five-year renewal term beyond the initial term at the then existing rental rate plus the then existing escalator amount per annum. The rental rate will escalate each year during the renewal term at the applicable escalation rate. The renewal notices for these bundles of leased properties must be delivered to Ventas on or before April 29, 2007.

In August 2006, we entered into definitive agreements related to the HCP Transaction. Under the HCP Transaction, we acquired the real estate related to 11 unprofitable nursing centers operated by us for resale in exchange for three hospitals previously owned by us. The HCP Transaction was completed in January 2007. As part of the HCP Transaction, we will continue to operate the hospitals under a long-term lease arrangement with HCP. In addition, we paid HCP a one-time cash payment of approximately $36 million. We also amended our existing master lease with HCP to (1) terminate the current annual rent of approximately $10 million on the 11 nursing centers, (2) add the three hospitals to the master lease with a current annual rent of approximately $6 million and (3) extend the initial expiration date of the master lease until January 31, 2017 except for one hospital which has an expiration date of January 31, 2022.

In November 2006, we entered into a definitive agreement to sell the real estate and related operations of these 11 nursing centers for $78 million. In February 2007, we sold nine of the nursing centers for approximately $74 million and we expect to close on the sale of the other two nursing centers for approximately $4 million during 2007.

In August 2005, our Board of Directors authorized us to execute up to $100 million in common stock and warrant repurchases. During 2005, we repurchased approximately 1.8 million shares of our common stock at an aggregate cost of approximately $48 million. During 2006, we repurchased approximately 2.0 million shares of our common stock in the open market at an aggregate cost of approximately $52 million, thereby completing the

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share repurchase program. We financed the repurchases from both operating cash flows and borrowings under our revolving credit facility.

Our Series A warrants and Series B warrants expired on April 20, 2006. In connection with the exercise of these warrants, we issued approximately 10.1 million shares of common stock and received net proceeds of approximately $142 million. These proceeds were used to repurchase approximately 5.8 million shares of our common stock in the open market in 2006.

In December 2005, we completed certain amendments to our revolving credit facility. These amendments, among other things, allowed us to increase the credit capacity from $300 million to $400 million and increased the amount permitted for acquisitions and certain investments from $400 million to $500 million. We obtained lender commitments for the increased credit capacity in February 2006. At December 31, 2006, our remaining permitted acquisition amount aggregated $218 million.

In August 2005, we completed certain amendments to our revolving credit facility. These amendments (a) increased the amount permitted for acquisitions and certain investments by us from $150 million to $400 million, (b) provided us with the additional flexibility to repurchase up to $150 million of our common stock and warrants, and (c) increased the permitted capital expenditures in each fiscal year. These amendments also expanded the borrowing base of the revolving credit facility to include certain additional real estate holdings. In addition, these amendments clarified certain regulatory issues and expanded certain representations and covenants by us, none of which are expected to impact our financial flexibility.

Amounts borrowed under the revolving credit facility bear interest, at our option, at (a) the London Interbank Offered Rate plus an applicable margin ranging from 2.00% to 2.75% or (b) prime plus an applicable margin ranging from 1.00% to 1.75%. The applicable margin is based upon our adjusted leverage ratio as defined in the revolving credit facility. The revolving credit facility is collateralized by substantially all of our assets including certain owned real property and is guaranteed by substantially all of our subsidiaries. The revolving credit facility constitutes a working capital facility for general corporate purposes and permitted acquisitions and investments in healthcare facilities and companies up to certain limits. The revolving credit facility also allows us, to a limited extent, to pay cash dividends and to repurchase our common stock. The terms of our revolving credit facility include certain financial covenants and covenants which limit acquisitions and annual capital expenditures. At December 31, 2006, we were in compliance with the terms of our revolving credit facility.

Future payments of principal and interest due under long-term debt agreements, lease obligations and certain other contractual commitments as of December 31, 2006 follows (in thousands):

| | Payments due by period | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Non-cancelable operating leases | | | | |
| Year | Credit facility (a) | Other long-term debt | Ventas (b) | Other | Total | Letters of credit and guarantees of indebtedness | Total |
| 2007 | $ 11,004 | $ 127 | $ 238,971 | $ 73,344 | $ 312,315 | $ | $ 323,446 |
| 2008 | 11,034 | 127 | 195,750 | 66,246 | 261,996 | | 273,157 |
| 2009 | 134,566 | 127 | 174,139 | 58,933 | 233,072 | 400 | 368,165 |
| 2010 | | 128 | 93,144 | 51,927 | 145,071 | | 145,199 |
| 2011 | | 128 | 52,646 | 44,138 | 96,784 | | 96,912 |
| Thereafter | | 647 | 70,194 | 247,359 | 317,553 | | 318,200 |
| | $ 156,604 | $ 1,284 | $ 824,844 | $ 541,947 | $ 1,366,791 | $ 400 | $ 1,525,079 |

(a) Credit facility interest is based upon the weighted average interest rate of 8.4% as of December 31, 2006.
(b) See Part I Business Master Lease Agreements Rental Amounts and Escalators.

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As a result of improved professional liability underwriting results of our limited purpose insurance subsidiary, we received a return of capital of $34 million in 2006 and $30 million in 2005 from our limited purpose insurance subsidiary. These proceeds were used primarily to repay borrowings under our revolving credit facility. We funded approximately $15 million into our limited purpose insurance subsidiary in 2004 to satisfy fiscal 2003 funding requirements.

**Capital Resources**

Excluding acquisitions, capital expenditures totaled $151 million in 2006, $126 million in 2005 and $92 million in 2004. Excluding acquisitions, capital expenditures (including new hospital development) could approximate $175 million to $225 million in 2007. We believe that our capital expenditure program is adequate to improve and equip existing facilities. Capital expenditures in each of the last three years were financed through internally generated funds. At December 31, 2006, the estimated cost to complete and equip construction in progress approximated $104 million.

In February 2006, we completed the Commonwealth Transaction for a total purchase price of $124 million in cash and the assumption of certain operating lease obligations. The acquisition was primarily financed with borrowings under our revolving credit facility.

We expended $11 million and $115 million during 2006 and 2005, respectively, for pharmacy acquisitions. We financed these acquisitions primarily through the use of operating cash flows. Acquisitions during 2004 related primarily to certain hospital acquisitions and our strategic divestiture activities in which we acquired previously leased facilities for resale.

At December 31, 2006, the remaining permitted acquisition amount under our revolving credit facility aggregated $218 million.

**Other Information**

*Effects of Inflation and Changing Prices*

We derive a substantial portion of our revenues from the Medicare and Medicaid programs. Congress and certain state legislatures have enacted or may enact additional significant cost containment measures limiting our ability to recover our cost increases through increased pricing of our healthcare services. Medicare revenues in LTAC hospitals and nursing centers are subject to fixed payments under the Medicare prospective payment systems. Medicaid reimbursement rates in many states in which we operate nursing centers also are based upon fixed payment systems. Generally, these rates are adjusted annually for inflation. However, these adjustments may not reflect the actual increase in the costs of providing healthcare services.

On January 25, 2007, CMS issued the 2007 Proposed Rule. The 2007 Proposed Rule would be effective for discharges occurring on or after July 1, 2007 through June 30, 2008. The 2007 Proposed Rule is subject to a 60-day public comment period.

CMS projects an overall decrease in payments to all Medicare certified LTAC hospitals of 2.9% from the 2007 Proposed Rule. Included in this proposed decrease are (1) an increase to the standard federal payment rate of .71%; (2) revisions to payment methodologies impacting short-stay outliers which reduce payments by .9%; (3) adjustments to the wage index component of the federal payment resulting in projected reductions in payment of .5%; and (4) an extension of the policy known as the 25 Percent Rule to all LTAC hospitals, which CMS projects will reduce payments by 2.2%. We believe that the 2007 Proposed Rule, if adopted, could reduce Medicare reimbursement to our hospitals by approximately $20 million in the second half of 2007.

The proposed short-stay outlier revisions would create a new category for cases having lengths of stay less than a threshold which is based upon the average of a patient in a short-term hospital with the same diagnosis.

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Payment for such cases would be based upon the payment that the short-term acute care hospital would have received.

Currently, CMS has regulations governing payment to LTAC hospitals that are co-located with another hospital, such as a HIH. Most co-located hospitals can admit up to 25% of its patients from its host hospital and be paid according to LTAC PPS. Admissions that exceed this 25 Percent Rule are paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. CMS is currently phasing-in this policy which will become fully effective on September 1, 2008.

CMS is now proposing to expand this policy to all LTAC hospitals, regardless of whether they are co-located with another hospital. Under this proposal, all LTAC hospitals will be paid LTAC PPS rates for admissions from a single referral source up to 25%. Admissions beyond 25% would be paid using the short-term hospital payment system. Patients reaching high cost outlier status in the short-term hospital are not counted when computing the 25% limit. Under the proposal, the 25% threshold would not apply immediately to certain LTAC hospitals. Hospitals having fiscal years beginning on or after July 1, 2007 and before October 1, 2007, including most of our hospitals, will have their admission cap initially set at 50%. For most of our hospitals, this 50% cap would apply until September 1, 2008, after which the cap would be reduced to 25%.

CMS is also proposing that the annual update to the DRG classifications and relative weights would be made in a budget neutral manner, effective October 1, 2007. As such, the estimated aggregate industry LTAC PPS payments would be unaffected by the annual recalibration of DRG payment weights.

On August 1, 2006, CMS issued rules to reweight LTAC hospital DRGs, among other things, beginning October 1, 2006. CMS estimated that the effect of this rule would decrease Medicare reimbursements to LTAC hospitals by an additional 1.3%. The revised DRG reweighting reduced our hospital Medicare revenues by approximately $1 million in the fourth quarter of 2006. Based upon our historical Medicare patient volumes, we expect the revised DRG reweighting will reduce Medicare revenues to our hospitals by approximately $3 million to $5 million on an annual basis.

On May 2, 2006, CMS issued the 2006 Hospital Medicare Rule. The 2006 Hospital Medicare Rule became effective for discharges occurring after June 30, 2006. The 2006 Hospital Medicare Rule reduced our hospital Medicare revenues by approximately $26 million in 2006. Based upon our historical Medicare patient volumes, we expect the 2006 Hospital Medicare Rule will reduce Medicare revenues to our hospitals associated with short-stay outliers and high cost outliers by approximately $42 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 2006 Hospital Medicare Rule. The annual market basket adjustment has typically ranged between 3% and 4%, or approximately $25 million to $30 million annually. The 2006 Hospital Medicare Rule also extends until July 1, 2008 CMS s authority to impose a one-time prospective budget neutrality adjustment to LTAC hospital rates. This authority was previously scheduled to expire on October 1, 2006.

Most of our hospitals have been operating under LTAC PPS since September 1, 2003. Operating results under this system are subject to changes in patient acuity and expense levels in our hospitals. These factors, among others, are subject to significant change. Slight variations in patient acuity could significantly change Medicare revenues generated under LTAC PPS. In addition, our hospitals may not be able to appropriately adjust their operating costs as patient acuity levels change. Under this system, Medicare reimbursements to our hospitals are based upon a fixed payment system. Operating margins in the hospital division could be negatively impacted if we are unable to control the operating costs of the division. As a result of these uncertainties, we cannot predict the ultimate long-term impact of LTAC PPS on our hospital operating results and we can provide no assurances that such regulations or operational changes resulting from these regulations will not have a material adverse impact on our financial position, results of operations or liquidity. In addition, we can provide

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no assurances that LTAC PPS will not have a material adverse effect on revenues from private and commercial third party payors. Various factors, including a reduction in average length of stay, have had a negative impact on revenues from private and commercial third party payors.

LTAC PPS maintains LTAC hospitals as a distinct provider type, separate from short-term acute care hospitals. Only providers certified as LTAC hospitals may be paid under this system. To maintain certification under LTAC PPS, the average length of stay of Medicare patients must be at least 25 days. Under the previous system, compliance with the 25-day average length of stay threshold was based upon all patient discharges.

CMS is currently evaluating various certification criteria for designating a hospital as a LTAC hospital. If such certification criteria were developed and enacted into legislation, our hospitals may not be able to maintain their status as LTAC hospitals or may need to adjust their operations.

On August 1, 2005, CMS published the final rules related to the DRG weights and the geometric length-of-stay thresholds that took effect for hospital Medicare discharges occurring on or after October 1, 2005. In connection with the final rules, CMS estimated that these changes could result in an aggregate reduction in payments to LTAC hospitals of approximately 4.2%. These changes reduced our hospital Medicare revenues by approximately $9 million in the fourth quarter of 2005 and $34 million for 2006.

Medicare payments to our nursing centers are based upon certain RUGs payment rates developed by CMS that provide various levels of reimbursement based upon patient acuity. On July 28, 2005, CMS published the final rules related to revised RUG payment rates to nursing centers. Among other things, the final rules provide for a 3.1% inflation update to all RUGs categories effective October 1, 2005. In addition, the final rules increase the indexing of RUG categories, expand the total RUG categories from 44 to 53 and eliminate the 20% payment add-on for the care of higher acuity patients that had been in effect since 2000 under the BBRA.

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. This legislation allows, among other things, an annual $1,740 Medicare Part B outpatient therapy cap, effective January 1, 2006. The legislation also requires CMS to implement a broad process for reviewing medically necessary therapy claims, creating an exception to the cap. This exception process, which was set to expire on January 1, 2007, was included in the Tax Relief and Health Care Act of 2006 and will continue to function as an exception to the Medicare Part B outpatient therapy cap until January 1, 2008.

On January 1, 2006, Medicare Part D implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit. Medicare beneficiaries who also are entitled to benefits under a state Medicaid program (so-called dual eligibles ) will have their outpatient prescription drug costs covered by the new Medicare drug benefit, subject to certain limitations. Most of the nursing center residents that we serve whose drug costs are currently covered by state Medicaid programs are dual eligibles who will qualify for the new Medicare drug benefit. Accordingly, Medicaid will no longer be a primary payor for the pharmacy services provided to these residents.

The first year of Medicare Part D resulted in significant challenges to our institutional pharmacy business as well as the institutional pharmacy industry. These challenges included, but were not limited to, the inability of the Medicare Part D program to accurately reflect dual eligible residents, inaccurate reimbursement associated with Medicare co-payments and extensive prior authorization and other processes mandated by the PDPs. We cannot assure you that the challenges presented by Medicare Part D and the regulations promulgated under Medicare Part D will not have a material adverse effect on our institutional pharmacy business.

We believe that our operating margins may continue to be under pressure as the growth in operating expenses, particularly professional liability, labor and employee benefits costs, exceeds payment increases from third party payors. In addition, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients is limited.

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**Item 7A.** ***Quantitative and Qualitative Disclosures About Market Risk***

The following discussion of our exposure to market risk contains forward-looking statements that involve risks and uncertainties. The information presented has been prepared utilizing certain assumptions considered reasonable in light of information currently available to us. Given the unpredictability of interest rates as well as other factors, actual results could differ materially from those projected in such forward-looking information.

Our exposure to market risk relates to changes in the prime rate, federal funds rate and the London Interbank Offered Rate which affect the interest paid on certain borrowings.

The following table provides information about our financial instruments that are sensitive to changes in interest rates. The table presents principal cash flows and related weighted average interest rates by expected maturity date.

**Interest Rate Sensitivity**

**Principal (Notional) Amount by Expected Maturity**

**Average Interest Rate**

**(Dollars in thousands)**

| | Expected maturities | | | | | | | Fair value |
|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 | 2011 | Thereafter | Total | 12/31/06 |
| **Liabilities:** | | | | | | | | |
| Long-term debt, including amounts due within one year: | | | | | | | | |
| Fixed rate: | $ 71 | $ 76 | $ 81 | $ 86 | $ 91 | $ 556 | $ 961 | $ 948 |
| Average interest rate | 6.0% | 6.0% | 6.0% | 6.0% | 6.0% | 6.0% | | |
| Variable rate (a) | $ | $ | $ 129,200 | $ | $ | $ | $ 129,200 | $ 129,200 |

(a) Interest on borrowings under our revolving credit facility is payable, at our option, at (1) the London Interbank Offered Rate plus an applicable margin ranging from 2.00% to 2.75% or (2) prime plus an applicable margin ranging from 1.00% to 1.75%. The applicable margin is based upon our adjusted leverage ratio as defined in the revolving credit facility.

**Item 8.** ***Financial Statements and Supplementary Data***

The information required by this Item 8 is included in appendix pages F-2 through F-38 of this Annual Report on Form 10-K.

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

Not applicable.

**Item 9A.** ***Controls and Procedures***

**Evaluation of Disclosure Controls and Procedures and Changes in Internal Control Over Financial Reporting**

We have carried out an evaluation under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility of human error and the

circumvention or overriding of the controls and procedures. Accordingly, even effective disclosure controls and procedures can

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only provide reasonable assurance of achieving their control objectives. Based upon our evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that, as of December 31, 2006, the disclosure controls and procedures are effective to provide reasonable assurance that information required to be disclosed in the reports we file and submit under the Exchange Act is recorded, processed, summarized and reported as and when required.

There has been no change in our internal control over financial reporting during the quarter ended December 31, 2006, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**Management s Annual Report on Internal Control Over Financial Reporting**

Our management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. Our internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Our internal control over financial reporting includes those policies and procedures that:

(i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company;

(ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and

(iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our management assessed the effectiveness of the Company s internal control over financial reporting as of December 31, 2006. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework*.

Based upon our assessment and those criteria, management has concluded that the Company maintained effective internal control over financial reporting as of December 31, 2006.

Our management s assessment of the effectiveness of the Company s internal control over financial reporting as of December 31, 2006 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears in our consolidated financial statements.

**Item 9B.** ***Other Information***

Not applicable.

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## PART III

**Item 10.** ***Directors, Executive Officers and Corporate Governance***

The information required by this Item, other than the information set forth above under Part I Executive Officers of the Registrant, is omitted because we are filing a definitive proxy statement, which includes the required information, pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K. The required information contained in our proxy statement is incorporated herein by reference.

**Item 11.** ***Executive Compensation***

The information required by this Item is omitted because we are filing a definitive proxy statement, which includes the required information, pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K. The required information contained in our proxy statement is incorporated herein by reference.

**Item 12.** ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this Item is omitted because we are filing a definitive proxy statement, which includes the required information, pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K. The required information contained in our proxy statement is incorporated herein by reference.

**Item 13.** ***Certain Relationships and Related Transactions, and Director Independence***

The information required by this Item is omitted because we are filing a definitive proxy statement, which includes the required information, pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K. The required information contained in our proxy statement is incorporated herein by reference.

**Item 14.** ***Principal Accounting Fees and Services***

The information required by this Item is omitted because we are filing a definitive proxy statement, which includes the required information, pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K. The required information contained in our proxy statement is incorporated herein by reference.

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**PART IV**

**Item 15.** ***Exhibits and Financial Statement Schedules***

**(a)(1) and (a)(2) Index to Consolidated Financial Statements and Financial Statement Schedules:**



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

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**(a)(3) Index to Exhibits:**

| Exhibit number | Description of document |
|---|---|
| 2.1 | Fourth Amended Joint Plan of Reorganization of Vencor, Inc. and Affiliated Debtors under Chapter 11 of the Bankruptcy Code. Exhibit 2.1 to the Current Report on Form 8-K of the Company dated March 19, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 2.2 | Order Confirming the Fourth Amended Joint Plan of Reorganization of Vencor, Inc. and Affiliated Debtors under Chapter 11 of the Bankruptcy Code, as entered by the United States Bankruptcy Court for the District of Delaware on March 16, 2001. Exhibit 2.2 to the Current Report on Form 8-K of the Company dated March 19, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 2.3 | Purchase and Sale Agreement by and among those entities listed on Schedule P thereto as buying entities (individually and collectively, Buyer ), those entities listed on Schedule P thereto as selling entities ( Sellers ) and Jeffrey A. Goldshine, Douglas B. Noble, and Mary Catherine Rumsey ( Signatory Owners ), and solely for purposes of Article III thereof and the Guaranty, Kindred Healthcare Operating, Inc. ( Buyer Guarantor ), dated as of October 24, 2005. Exhibit 2.1 to the Company s Current Report on Form 8-K dated October 24, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 2.4 | Agreement of Sale between HCRI Massachusetts Properties Trust and HCRI Massachusetts Properties Trust II, as Seller, and Kindred Healthcare Operating, Inc., as Purchaser, dated December 27, 2005. Exhibit 2.5 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 2.5 | Mutual Termination of Purchase and Sale Agreement made on February 28, 2006 between HCRI Massachusetts Properties Trust, a Massachusetts business trust, HCRI Massachusetts Properties Trust II, a Massachusetts business trust, and Kindred Healthcare Operating, Inc., a Delaware corporation. Exhibit 2.6 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 2.6 | Master Transaction Agreement, dated as of October 25, 2006, by and among AmerisourceBergen Corporation, PharMerica, Inc., Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc., Kindred Pharmacy Services, Inc., Safari Holding Corporation, Hippo Merger Corporation and Rhino Merger Corporation. Exhibit 10.1 to the Company s Current Report on Form 8-K dated October 25, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 3.1 | Amended and Restated Certificate of Incorporation of the Company. Exhibit 4.1 to the Company s Registration Statement on Form S-3 filed August 31, 2001 (Comm. File No. 333-68838) is hereby incorporated by reference. |
| 3.2 | Certificate of Amendment of Amended and Restated Certificate of Incorporation. Exhibit 3.1 to the Company s Form 10-Q for the quarterly period ended March 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 3.3 | Amended and Restated Bylaws of the Company. Exhibit 3.1 to the Company s Current Report on Form 8-K dated November 6, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 4.1 | Articles IV, IX, X and XII of the Restated Certificate of Incorporation of the Company is included in Exhibit 3.1. |
| 10.1 | $300,000,000 Amended and Restated Credit Agreement dated as of June 28, 2004 among Kindred Healthcare, Inc., the Lenders Party Hereto, and JPMorgan Chase Bank, as Administrative Agent and Collateral Agent, J.P. Morgan Securities, Inc. as Sole Bookrunner and Sole Lead Arranger, Citicorp USA, Inc., as Syndication Agent, General Electric Capital Corporation, The CIT Group/Business Credit, Inc. and Wells Fargo Foothill, as Co-Documentation Agents. Exhibit 10.1 to the Company s Form 10-Q for the quarterly period ended June 30, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.2 | Amendment No. 1 and Consent dated as of August 2, 2005, under the $300,000,000 Amended and Restated Credit Agreement dated as of June 28, 2004 among the Company, the Lenders party thereto, and JPMorgan Chase Bank, N.A. (formerly known as JPMorgan Chase Bank), as Administrative Agent and Collateral Agent. Exhibit 99.1 to the Company s Current Report on Form 8-K dated August 2, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.3 | Amendment No. 2 to Credit Agreement and Security Agreement dated as of December 22, 2005, to the $300,000,000 Amended and Restated Credit Agreement dated as of June 28, 2004 among Kindred Healthcare, Inc., the Lenders party thereto, and JPMorgan Chase Bank, N.A. (formerly known as JPMorgan Chase Bank), as Administrative Agent and Collateral Agent, as supplemented with additional lender commitments. Exhibit 10.1 to the Company s Current Report on Form 8-K dated February 6, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.4 | Amendment No. 3 to Credit Agreement dated as of October 19, 2006, to the $400,000,000 Amended and Restated Credit Agreement dated as of June 28, 2004 among Kindred Healthcare, Inc., the Lenders party thereto, and JPMorgan Chase Bank, N.A. (formerly known as JPMorgan Chase Bank), as Administrative Agent and Collateral Agent. Exhibit 10.1 to the Company s Current Report on Form 8-K dated October 19, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.5 | Consent No. 3 and Waiver dated as of January 19, 2007, pursuant to the $400,000,000 Amended and Restated Credit Agreement dated as of June 28, 2004 among Kindred Healthcare, Inc., the Lenders party thereto, and JPMorgan Chase Bank, N.A. (formerly known as JPMorgan Chase Bank), as Administrative Agent and Collateral Agent. Exhibit 10.1 to the Company s Current Report on Form 8-K dated January 19, 2007 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.6 | Trust Agreement between T. Rowe Price Trust Company and Kindred Healthcare, Inc. for Kindred 401(k) Plan. Exhibit 10.14 to the Company s Form 10-K for the year ended December 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.7 | Trust Agreement between T. Rowe Price Trust Company and Kindred Healthcare, Inc. for Kindred and Affiliates 401(k) Plan. Exhibit 10.15 to the Company s Form 10-K for the year ended December 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.8 | Kindred 401(k) Plan, Amended and Restated effective as of January 1, 2003 (except where otherwise indicated). Exhibit 10.20 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.9 | Amendment No. 1 to the Kindred 401(k) Plan dated July 1, 2004. Exhibit 10.1 to the Company s Form 10-Q for the quarterly period ended September 30, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.10 | Amendment No. 2 to the Kindred 401(k) Plan dated as of March 8, 2005. Exhibit 10.1 to the Company s Form 10-Q for the quarterly period ended March 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.11 | Amendment No. 3 to the Kindred 401(k) Plan effective as of January 1, 2006. |
| 10.12 | Amendment No. 4 to the Kindred 401(k) Plan effective as of January 1, 2006. |
| 10.13 | Amendment No. 5 to the Kindred 401(k) Plan effective as of December 27, 2006. |
| 10.14 | Tax Allocation Agreement dated as of April 30, 1998 by and between Vencor, Inc. and Ventas, Inc. Exhibit 10.9 to the Company s Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.15 | Agreement of Indemnity-Third Party Leases dated as of April 30, 1998 by and between Vencor, Inc. and its subsidiaries and Ventas, Inc. Exhibit 10.11 to the Company s Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.16 | Agreement of Indemnity-Third Party Contracts dated as of April 30, 1998 by and between Vencor, Inc. and its subsidiaries and Ventas, Inc. Exhibit 10.12 to the Company s Form 10-Q for the quarterly period ended June 30, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.17 | Form of Indemnification Agreement between the Company and certain of its officers and employees. Exhibit 10.31 to the Ventas, Inc. Form 10-K for the year ended December 31, 1995 (Comm. File No. 1-10989) is hereby incorporated by reference. |
| 10.18 | Form of Indemnification Agreement between the Company and each member of its Board of Directors dated October 29, 2001. Exhibit 10.21 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.19* | Kindred Deferred Compensation Plan, Second Amendment and Restatement effective as of January 1, 2005. Exhibit 10.5 to the Company s Form 10-Q for the quarterly period ended September 30, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.20 | Tax Refund Escrow Agreement and First Amendment to the Tax Allocation Agreement made and entered into as of the 20th of April 2001 by and between the Company and each of its subsidiaries and Ventas, Inc., Ventas Realty Limited Partnership and Ventas LP Realty, L.L.C. Exhibit 10.31 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.21* | Vencor, Inc. Supplemental Executive Retirement Plan dated January 1, 1998, as amended. Exhibit 10.27 to the Company s Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference. |
| 10.22* | Amendment No. Two to Supplemental Executive Retirement Plan dated as of January 15, 1999. Exhibit 10.48 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.23* | Amendment No. Three to Supplemental Executive Retirement Plan dated as of December 31, 1999. Exhibit 10.49 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.24* | Amendment No. 4 to the Vencor, Inc. Supplemental Executive Retirement Plan. Exhibit 10.3 to the Company s Form 10-Q for the quarterly period ended March 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.25* | Amendment No. 5 to Supplemental Executive Retirement Plan. Exhibit 10.6 to the Company s Form 10-Q for the quarterly period ended September 30, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.26* | Company s 2000 Long-Term Incentive Plan, dated effective as of January 1, 2001. Exhibit 10.46 to the Company s Form 10-K for the year ended December 31, 2000 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.27* | Amendment No. One to the Company s Long-Term Incentive Plan, dated effective as of June 21, 2001. Exhibit 10.12 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.28* | Amendment No. Two to the Company s Long-Term Incentive Plan, dated effective as of December 16, 2003. Exhibit 10.37 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.29* | Kindred Healthcare, Inc. Short-Term Incentive Plan. Exhibit 10.3 to the Company s Form 10-Q for the quarterly period ended March 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.30* | Form of Kindred Healthcare Operating, Inc. Change-in-Control Severance Agreement. Exhibit 10.28 to the Company s Registration Statement on Form S-4 (Reg. No. 333-57953) is hereby incorporated by reference. |
| 10.31* | Employment Agreement dated as of February 22, 2006 by and between Kindred Healthcare, Inc. and Edward L. Kuntz. Exhibit 10.1 to the Company s Current Report on Form 8-K dated February 22, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.32* | Change-in-Control Severance Agreement dated as of February 22, 2006 by and between Kindred Healthcare Operating, Inc. and Edward L. Kuntz. Exhibit 10.2 to the Company s Current Report on Form 8-K dated February 22, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.33* | Employment Agreement dated as of October 28, 2003 by and between Kindred Healthcare Operating, Inc. and Paul J. Diaz. Exhibit 10.41 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.34* | Change-in-Control Severance Agreement dated as of January 28, 2002 by and between Kindred Healthcare Operating, Inc. and Paul J. Diaz. Exhibit 10.7 to the Company s Form 10-Q for the quarterly period ended March 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.35* | Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Richard E. Chapman. Exhibit 10.58 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.36* | Amendment No. 1 to the Employment Agreement dated December 21, 2001 by and between Kindred Healthcare Operating, Inc. and Richard E. Chapman. Exhibit 10.43 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.37* | Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.63 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.38* | Amendment to Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.64 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.39* | Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and Frank J. Battafarano. Exhibit 10.65 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.40* | Amendment No. 3 to the Employment Agreement dated December 21, 2001 by and between Kindred Healthcare Operating, Inc. and Frank J. Battafarano. Exhibit 10.50 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.41* | Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.67 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.42* | Amendment to Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.68 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.43* | Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and M. Suzanne Riedman. Exhibit 10.69 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.44* | Amendment No. 3 to Employment Agreement dated December 21, 2001 by and between Kindred Healthcare Operating, Inc. and M. Suzanne Riedman. Exhibit 10.56 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.45* | Employment Agreement dated as of July 28, 1998 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.70 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.46* | Amendment to Employment Agreement dated as of September 28, 1998 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.71 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.47* | Amendment No. 2 to Employment Agreement dated as of November 5, 1999 between Vencor Operating, Inc. and Richard A. Lechleiter. Exhibit 10.72 to the Company s Form 10-K for the year ended December 31, 1999 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.48* | Amendment No. 3 to Employment Agreement dated December 21, 2001 by and between Kindred Healthcare Operating, Inc. and Richard A. Lechleiter. Exhibit 10.60 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.49* | Employment Agreement dated as of December 21, 2001 between Kindred Healthcare Operating, Inc. and William M. Altman. Exhibit 10.61 to the Company s Form 10-K for the year ended December 31, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.50* | Employment Agreement dated as of October 28, 2002 by and among Kindred Healthcare Operating, Inc. and Lane M. Bowen. Exhibit 10.74 to the Company s Form 10-K for the year ended December 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.51* | Change-in-Control Severance Agreement dated as of October 28, 2002 by and between Kindred Healthcare Operating, Inc. and Lane M. Bowen. Exhibit 10.75 to the Company s Form 10-K for the year ended December 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.52* | Employment Agreement dated as of February 25, 2003 by and among Kindred Healthcare Operating, Inc. and Mark A. McCullough. Exhibit 10.4 to the Company s Form 10-Q for the quarterly period ended March 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.53* | Change-in-Control Severance Agreement dated as of February 25, 2003 by and between Kindred Healthcare Operating, Inc. and Mark A. McCullough. Exhibit 10.5 to the Company s Form 10-Q for the quarterly period ended March 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.54* | Retention Agreement dated as of December 14, 2006 by and between Kindred Pharmacy Services, Inc. and Mark A. McCullough. |
| 10.55* | Employment Agreement dated as of February 25, 2003 by and among Kindred Healthcare Operating, Inc. and Joseph L. Landenwich. Exhibit 10.6 to the Company s Form 10-Q for the quarterly period ended March 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.56* | Change-in-Control Severance Agreement dated as of February 25, 2003 by and between Kindred Healthcare Operating, Inc. and Joseph L. Landenwich. Exhibit 10.7 to the Company s Form 10-Q for the quarterly period ended March 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.57* | Employment Agreement dated as of August 1, 2005 by and between Kindred Healthcare Operating, Inc. and Benjamin A. Breier. Exhibit 99.2 to the Company s Current Report on Form 8-K dated August 1, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.58* | Change-in-Control Severance Agreement dated as of August 1, 2005 by and between Kindred Healthcare Operating, Inc. and Benjamin A. Breier. Exhibit 99.3 to the Company s Current Report on Form 8-K dated August 1, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.59* | Employment Agreement dated as of January 1, 2006 by and between Kindred Healthcare Operating, Inc. and Gregory C. Miller. Exhibit 10.1 to the Company s Current Report on Form 8-K dated January 1, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.60* | Change-in-Control Severance Agreement dated as of January 1, 2006 by and between Kindred Healthcare Operating, Inc. and Gregory C. Miller. Exhibit 10.2 to the Company s Current Report on Form 8-K dated January 1, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.61 | Amended and Restated Master Lease Agreement No. 1 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.4 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.62 | Exhibit C to the Amended and Restated Master Lease Agreement No. 1 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.1 to the Company s Current Report on Form 8-K dated October 12, 2006 (Comm. File No. 001-14507) is hereby incorporated by reference. |
| 10.63 | Amended and Restated Master Lease Agreement No. 2 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.5 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.64 | Exhibit C to the Amended and Restated Master Lease Agreement No. 2 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.2 to the Company s Current Report on Form 8-K dated October 12, 2006 (Comm. File No. 001-14507) is hereby incorporated by reference. |
| 10.65 | Amended and Restated Master Lease Agreement No. 3 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.6 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.66 | Exhibit C to the Amended and Restated Master Lease Agreement No. 3 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.3 to the Company s Current Report on Form 8-K dated October 12, 2006 (Comm. File No. 001-14507) is hereby incorporated by reference. |
| 10.67 | Amended and Restated Master Lease Agreement No. 4 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.7 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.68 | Exhibit C to the Amended and Restated Master Lease Agreement No. 4 dated as of April 20, 2001 for Lease Executed by Ventas Realty, Limited Partnership, as Lessor and Vencor, Inc. and Vencor Operating, Inc. as Tenant. Exhibit 10.4 to the Company s Current Report on Form 8-K dated October 12, 2006 (Comm. File No. 001-14507) is hereby incorporated by reference. |
| 10.69 | Second Specific Property Lease Amendment by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership. Exhibit 10.84 to the Company s Form 10-K for the year ended December 31, 2002 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.70 | Master Lease among Health Care Property Investors, Inc. and Health Care Property Partners, collectively, as Lessors and Kindred Nursing Centers East, L.L.C., Kindred Nursing Centers West, L.L.C. and Kindred Nursing Centers Limited Partnership, collectively, as Lessee, dated May 16, 2001. Exhibit 10.11 to the Company s Form 10-Q for the quarterly period ended June 30, 2001 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.71 | Fourth Amendment to Master Lease by and among Health Care Property Investors, Inc. and Health Care Property Partners, collectively, as Lessor and Kindred Nursing Centers East, L.L.C., Kindred Nursing Centers West, L.L.C. and Kindred Nursing Centers Limited Partnership, collectively, as Lessee, dated February 28, 2006. |
| 10.72 | Fifth Amendment to Master Lease by and among Health Care Property Investors, Inc., Health Care Property Partners and Texas HCP Holding, L.P., collectively, as Lessor and Kindred Nursing Centers East, L.L.C., Kindred Nursing Centers West, L.L.C., Kindred Nursing Centers Limited Partnership and Transitional Hospitals Corporation of Wisconsin, Inc., collectively, as Lessee, dated January 31, 2007. |
| 10.73 | Master Lease Agreement dated as of February 28, 2006 by and between HCRI Massachusetts Properties Trust II, as Lessor and Kindred Nursing Centers East, L.L.C., as Tenant. Exhibit 10.6 to the Company s Form 10-Q for the quarterly period ended March 31, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.74 | Master Lease Agreement dated as of February 28, 2006 by and between HCRI Massachusetts Properties Trust and HCRI Massachusetts Properties Trust II, as Lessor and Kindred Hospitals East, L.L.C., as Tenant. Exhibit 10.7 to the Company s Form 10-Q for the quarterly period ended March 31, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.75 | Master Lease No. 1 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of June 30, 2003. Exhibit 10.4 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.76 | Master Lease No. 2 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of June 30, 2003. Exhibit 10.5 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.77 | Master Lease No. 3 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of June 30, 2003. Exhibit 10.6 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.78 | Master Lease No. 4 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of June 30, 2003. Exhibit 10.7 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.79 | Master Lease Combination Amendment and Agreement by and among Kindred Healthcare, Inc. (f/k/a Vencor, Inc.), Kindred Healthcare Operating, Inc. (f/k/a Vencor Operating, Inc.), and Ventas Realty, Limited Partnership dated as of May 10, 2006. Exhibit 10.1 to the Company s Current Report on Form 8-K dated May 10, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.80 | Master Lease No. 1 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.79 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.81 | Master Lease No. 1 Partial Lease Termination Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.80 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.82 | Master Lease No. 2 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.81 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.83 | Master Lease No. 2 Partial Lease Termination Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.82 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.84 | Master Lease No. 3 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.83 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.85 | Master Lease No. 4 Amendment Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.84 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.86 | Master Lease No. 4 Partial Lease Termination Agreement by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership dated as of December 11, 2003. Exhibit 10.85 to the Company s Form 10-K for the year ended December 31, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.87 | Master Lease No. 1 Partial Lease Termination Agreement (IN-4620), dated as of December 22, 2004, by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership. Exhibit 10.74 to the Company s Form 10-K for the year ended December 31, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.88 | Master Lease No. 1 Partial Lease Termination Agreement (CA-4693), dated as of December 22, 2004, by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership. Exhibit 10.75 to the Company s Form 10-K for the year ended December 31, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.89 | Master Lease No. 1 Amendment Agreement, dated as of December 22, 2004, by and among Kindred Healthcare, Inc., Kindred Healthcare Operating, Inc. and Ventas Realty, Limited Partnership. Exhibit 10.76 to the Company s Form 10-K for the year ended December 31, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.90 | Operations Transfer Agreement dated as of June 18, 2003 between Kindred Healthcare Operating, Inc., Kindred Nursing Centers South, L.L.C., Kindred Nursing Centers East, L.L.C., Senior Health Management, LLC, Florida Institute for Long Term Care, LLC, FI Bay Pointe, LLC, FI Boca Raton, LLC, FI Broward Nursing, LLC, FI Cape Coral, LLC, FI Carrolwood Care, LLC, FI Casa Mora, LLC, FI Evergreen Woods, LLC, FI Highland Pines, LLC, FI Highland Terrace, LLC, FI Palm Beaches, LLC, FI Pompano Rehab, LLC, FI Sanford Rehab, LLC, FI Tampa, LLC, FI The Abbey, LLC, FI The Oaks, LLC, FI Titusville, LLC, FI Waldemere, LLC, FI Windsor Woods, LLC, and FI Winkler Court, LLC. Exhibit 10.9 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |

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| Exhibit number | Description of document |
|---|---|
| 10.91 | Agreement of Sale between Kindred Healthcare Operating, Inc., Kindred Nursing Centers East, L.L.C. and Kindred Nursing Centers South, L.L.C. and WKTM Florida, LLC dated as of June 18, 2003. Exhibit 10.10 to the Company s Form 10-Q for the quarterly period ended June 30, 2003 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.92 | Agreement and Plan of Reorganization between the Company and Ventas, Inc. Exhibit 10.1 to the Company s Form 10, as amended, dated April 27, 1998 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.93* | The Company s 2000 Stock Option Plan. Exhibit 4.1 to the Company s Registration Statement on Form S-8 (Reg. No. 333-59598) is hereby incorporated by reference. |
| 10.94* | The Company s Restricted Share Plan. Exhibit 4.2 to the Company s Registration Statement on Form S-8 (Reg. No. 333-59598) is hereby incorporated by reference. |
| 10.95* | Kindred Healthcare, Inc. 2001 Stock Incentive Plan, Amended and Restated. Appendix A to the Company s Proxy Statement on Schedule 14A dated March 29, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.96* | Form of Kindred Healthcare, Inc. Non-Qualified Stock Option Grant Agreement under the 2001 Stock Incentive Plan, Amended and Restated. Exhibit 10.95 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.97* | Form of Kindred Healthcare, Inc. Incentive Stock Option Grant Agreement under the 2001 Stock Incentive Plan, Amended and Restated. Exhibit 10.96 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.98* | Form of Kindred Healthcare, Inc. Restricted Share Award Agreement under the 2001 Stock Incentive Plan, Amended and Restated. Exhibit 10.97 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.99* | Kindred Healthcare, Inc. 2001 Stock Option Plan for Non-Employee Directors, Amended and Restated. Appendix B to the Company s Proxy Statement on Schedule 14A dated March 29, 2004 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.100* | Form of Kindred Healthcare, Inc. Non-Qualified Stock Option Grant Agreement under the 2001 Stock Option Plan for Non-Employee Directors, Amended and Restated. Exhibit 10.99 to the Company s Form 10-K for the year ended December 31, 2005 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.101 | Tax Matters Agreement, by and among AmerisourceBergen Corporation, PharMerica, Inc., Kindred Healthcare, Inc., Kindred Pharmacy Services, Inc. and Safari Holding Corporation, in each case on behalf of itself and its Affiliates. Exhibit 10.2 to the Company s Current Report on Form 8-K dated October 25, 2006 (Comm. File No. 001-14057) is hereby incorporated by reference. |
| 10.102 | Other Debt Instruments Copies of debt instruments for which the related debt is less than 10% of total assets will be furnished to the SEC upon request. |
| 21 | List of Subsidiaries. |
| 23.1 | Consent of Independent Registered Public Accounting Firm. |
| 31 | Rule 13a-14(a)/15d-14(a) Certifications. |
| 32 | Section 1350 Certifications. |

* Compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of this Annual Report on Form 10-K.

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**(b) Exhibits.**

The response to this portion of Item 15 is submitted as a separate section of this Annual Report on Form 10-K.

**(c) Financial Statement Schedules.**

The response to this portion of Item 15 is included in appendix page F-38 of this Annual Report on Form 10-K.

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**SIGNATURES**

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

Date: March 1, 2007

KINDRED HEALTHCARE, INC.

By: /s/ Paul J. Diaz
**Paul J. Diaz**

**President and**

**Chief Executive Officer**

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

| Signature | Title | Date |
|---|---|---|
| /s/ Ann C. Berzin<br>**Ann C. Berzin** | Director | March 1, 2007 |
| /s/ Thomas P. Cooper, M.D.<br>**Thomas P. Cooper, M.D.** | Director | March 1, 2007 |
| /s/ Michael J. Embler<br>**Michael J. Embler** | Director | March 1, 2007 |
| /s/ Garry N. Garrison<br>**Garry N. Garrison** | Director | March 1, 2007 |
| /s/ Isaac Kaufman<br>**Isaac Kaufman** | Director | March 1, 2007 |
| /s/ John H. Klein<br>**John H. Klein** | Director | March 1, 2007 |
| /s/ Eddy J. Rogers, Jr.<br>**Eddy J. Rogers, Jr.** | Director | March 1, 2007 |
| /s/ Edward L. Kuntz<br>**Edward L. Kuntz** | Executive Chairman of the Board | March 1, 2007 |
| /s/ Paul J. Diaz | President and Chief Executive Officer<br>(Principal Executive Officer) | March 1, 2007 |

| | | |
|---|---|---|
| **Paul J. Diaz** | | |
| /s/ Richard A. Lechleiter<br>**Richard A. Lechleiter** | Executive Vice President and Chief Financial Officer (Principal Financial Officer) | March 1, 2007 |
| /s/ John J. Lucchese<br>**John J. Lucchese** | Senior Vice President and Corporate Controller (Principal Accounting Officer) | March 1, 2007 |

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**KINDRED HEALTHCARE, INC.**

**INDEX TO CONSOLIDATED FINANCIAL STATEMENTS**

**AND FINANCIAL STATEMENT SCHEDULES**



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

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**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

To the Board of Directors and Shareholders

of Kindred Healthcare, Inc.:

We have completed integrated audits of Kindred Healthcare, Inc. s consolidated financial statements and of its internal control over financial reporting as of December 31, 2006, in accordance with the standards of the Public Company Accounting Oversight Board (United States). Our opinions, based on our audits, are presented below.

*Consolidated financial statements and financial statement schedule*

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Kindred Healthcare, Inc. and its subsidiaries at December 31, 2006 and 2005, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2006 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. These financial statements and financial statement schedule are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements and financial statement schedule based on our audits. We conducted our audits of these statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1 of the Notes to Consolidated Financial Statements, the Company began recognizing compensation expense for the fair value of non-vested stock based compensation awards effective January 1, 2006.

*Internal control over financial reporting*

Also, in our opinion, management s assessment, included in Management s Annual Report on Internal Control Over Financial Reporting appearing under Item 9A, that the Company maintained effective internal control over financial reporting as of December 31, 2006 based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), is fairly stated, in all material respects, based on those criteria. Furthermore, in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2006, based on criteria established in *Internal Control Integrated Framework* issued by COSO. The Company s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express opinions on management s assessment and on the effectiveness of the Company s internal control over financial reporting based on our audit. We conducted our audit of internal control over financial reporting in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. An audit of internal control over financial reporting includes obtaining an understanding of internal control over financial reporting, evaluating management s assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we consider necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in

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accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

March 1, 2007

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**KINDRED HEALTHCARE, INC.**

**CONSOLIDATED STATEMENT OF OPERATIONS**

**(In thousands, except per share amounts)**

| | Year ended December 31, | | |
|---|---|---|---|
| | **2006** | **2005** | **2004** |
| Revenues | $ 4,266,661 | $ 3,852,975 | $ 3,421,411 |
| Salaries, wages and benefits | 2,329,382 | 2,071,320 | 1,897,406 |
| Supplies | 685,884 | 570,179 | 471,628 |
| Rent | 310,404 | 264,633 | 249,141 |
| Other operating expenses | 701,566 | 631,195 | 562,754 |
| Depreciation and amortization | 122,196 | 100,982 | 87,229 |
| Interest expense | 13,921 | 8,098 | 12,814 |
| Investment income | (14,500) | (11,059) | (6,425) |
| | 4,148,853 | 3,635,348 | 3,274,547 |
| Income from continuing operations before reorganization items and income taxes | 117,808 | 217,627 | 146,864 |
| Reorganization items | | (1,639) | (304) |
| Income from continuing operations before income taxes | 117,808 | 219,266 | 147,168 |
| Provision for income taxes | 46,569 | 87,875 | 60,149 |
| Income from continuing operations | 71,239 | 131,391 | 87,019 |
| Discontinued operations, net of income taxes: | | | |
| Income (loss) from operations | 7,504 | 14,899 | (617) |
| Loss on divestiture of operations | (32) | (1,381) | (15,822) |
| Net income | $ 78,711 | $ 144,909 | $ 70,580 |
| Earnings per common share: | | | |
| Basic: | | | |
| Income from continuing operations | $ 1.82 | $ 3.52 | $ 2.43 |
| Discontinued operations: | | | |
| Income (loss) from operations | 0.19 | 0.40 | (0.02) |
| Loss on divestiture of operations | | (0.04) | (0.44) |
| Net income | $ 2.01 | $ 3.88 | $ 1.97 |
| Diluted: | | | |
| Income from continuing operations | $ 1.74 | $ 2.90 | $ 2.05 |
| Discontinued operations: | | | |
| Income (loss) from operations | 0.18 | 0.33 | (0.01) |
| Loss on divestiture of operations | | (0.03) | (0.37) |
| Net income | $ 1.92 | $ 3.20 | $ 1.67 |

Shares used in computing earnings per common share:

| | | | |
|---|---|---|---|
| Basic | 39,108 | 37,328 | 35,774 |
| Diluted | 40,923 | 45,239 | 42,403 |

See accompanying notes.

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**KINDRED HEALTHCARE, INC.**

**CONSOLIDATED BALANCE SHEET**

**(In thousands, except per share amounts)**

| | December 31, 2006 | |
|---|---|---|
| | 216,339 | 899 |
| Discontinued operations | 700 | 2,391 |

In May 2011, a new bargaining unit contract eliminated postretirement medical coverage for affected active employees and froze defined pension benefits. The elimination of postretirement medical coverage resulted in a non-cash curtailment gain of $3,974,000 which was recognized in the 13 weeks ended June 26, 2011, reduced 2011 net periodic postretirement medical expense by $82,000 beginning in the 13 weeks ended June 26, 2011 and reduced the benefit obligation liability at June 26, 2011 by $3,371,000. The freeze of defined pension benefits reduced 2011 net periodic pension expenses by $188,000 beginning in the 13 weeks ended June 26, 2011 and reduced the benefit obligation liability at June 26, 2011 by $592,000.

In March 2011, we notified certain participants in our postretirement medical plans of changes to be made to the plans, including increases in participant premium cost-sharing and elimination of coverage for certain participants. The changes resulted in a non-cash curtailment gain of $1,991,000 which was recognized in the 13 weeks ended March 27, 2011 and reduced the benefit obligation liability at March 27, 2011 by $3,030,000.

In November 2010, we notified certain participants in our postretirement medical plans of changes to be made to the plans, including increases in participant premium cost-sharing and elimination of coverage for certain participants. The changes resulted in a non-cash curtailment gain of $10,172,000 which was recognized in the 13 weeks ended December 26, 2010, reduced 2011 net periodic postretirement medical cost by $769,000 beginning in the 13 weeks ended December 26, 2010, and reduced the benefit obligation liability at December 26, 2010 by $15,065,000.

In March 2010, members of the St. Louis Newspaper Guild voted to approve a new 5.5 year contract, effective in April
2010. The new contract eliminated postretirement medical coverage for active employees and defined pension benefits were frozen. The elimination of postretirement medical coverage resulted in non-cash curtailment gains of $11,878,000, which were recognized in the 13 weeks ended March 28, 2010 and reduced the benefit obligation liability at March 28, 2010 by $6,576,000. The freeze of defined pension benefits resulted in non-cash curtailment gains of $2,004,000, which were recognized in the 13 weeks ended March 28, 2010, reduced 2010 net periodic pension expenses by $668,000 beginning in the 13 weeks ended June 27, 2010, and reduced the benefit obligation liability at March 28, 2010 by $2,004,000.

In December 2009, we notified certain participants in our postretirement medical plans of changes to be made to the plans, including increases in participant premium cost-sharing and elimination of coverage for certain participants. The

changes resulted in non-cash curtailment gains of $31,130,000, which were recognized in the 13 weeks ended December 27, 2009, reduced 2010 net periodic postretirement medical cost by $1,460,000 beginning in the 13 weeks ended March 28, 2010, and reduced the benefit obligation liability at December 27, 2009 by $28,750,000.

Increases in participant premium cost-sharing discussed more fully above were treated as negative plan amendments. Curtailment treatment was utilized in situations in which coverage was eliminated. Curtailment gains were calculated by revaluation of plan liabilities after consideration of other plan changes.

Equity in earnings in associated companies decreased $1,595,000 in 2011.

The factors noted above resulted in an operating loss of $101,334,000 in 2011 compared to operating income of $148,997,000 in 2010.

Nonoperating Income and Expense

Financial expense, including amortization of debt financing costs, decreased $6,323,000, or 8.8%, to $65,308,000 in 2011 due to lower debt balances and lower interest rates partially offset by $5,120,000 of debt financing costs associated with the termination of a notes offering in May 2011.

Overall Results

In 2010, as a result of the Affordable Care Act we wrote off $2,012,000 of deferred income tax assets due to the loss of future tax deductions for providing retiree prescription drug benefits. We recognized income tax benefit of 12.3% of loss from continuing operations before income taxes in 2011 and income tax expense of 38.3% of income from continuing operations before income taxes in 2010. See Note 11 of the Notes to Consolidated Financial Statements, included herein, for a reconciliation of the expected federal income tax rate to the actual tax rates.

As a result of the factors noted above, loss attributable to Lee Enterprises, Incorporated (which includes discontinued operations) totaled $146,868,000 in 2011 compared to income of $46,105,000 in 2010. We recorded loss per diluted common share of $3.27 in 2011 and earnings per diluted common share of $1.03 in 2010. Excluding unusual matters, as detailed in the table below, diluted earnings per common share, as adjusted, were $0.71 in both 2011 and 2010. Per share amounts may not add due to rounding.

| (Thousands of Dollars, Except Per Share Data) | 2011 Amount | Per Share | 2010 Amount | Per Share |
|---|---|---|---|---|
| Income (loss) attributable to Lee Enterprises, Incorporated, as reported | (146,868) | (3.27) | 46,105 | 1.03 |
| Adjustments: | | | | |
| Curtailment gains | (16,137) | | (45,012) | |
| Impairment of goodwill and other assets, including TNI Partners | 216,339 | | 899 | |
| Debt financing and reorganization costs | 12,612 | | 8,514 | |
| Unusual matters related to discontinued operations | 1,011 | | 2,612 | |
| Other, net | 5,502 | | 1,739 | |
| | 219,327 | | (31,248) | |
| Income tax effect of adjustments, net, and other unusual tax matters | (40,779) | | 17,167 | |
| | 178,548 | 3.98 | (14,081) | (0.31) |
| Income attributable to Lee Enterprises, Incorporated, as adjusted | 31,680 | 0.71 | 32,024 | 0.71 |

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DISCONTINUED OPERATIONS

In October 2012, we sold the North County Times in Escondido, CA for $11,950,000, before income taxes. The transaction resulted in a gain of approximately $2,000,000, after income taxes, which was recorded in October 2012. Operating results of the North County Times have been classified as discontinued operations for all periods presented.

Results of discontinued operations consist of the following:

| (Thousands of Dollars) | 2011 | 2010 |
|---|---|---|
| Operating revenue | 28,785 | 32,203 |
| Loss from discontinued operations, before income taxes | (2,011) | (1,805) |
| Income tax benefit | (765) | (686) |
| Net loss | (1,246) | (1,119) |

LIQUIDITY AND CAPITAL RESOURCES

Operating Activities

Cash provided by operating activities of continuing operations was $80,520,000 in 2012, $101,542,000 in 2011 and $104,100,000 in 2010. We recorded a net loss of $16,299,000 in 2012 and $146,681,000 in 2011 and net income of $46,178,000 in 2010. Increased financial expense accounts for the decline in cash provided by operating activities of continuing operations in 2012. Depreciation and amortization decreased as discussed more fully under "Results of Operations". We also recognized non-cash curtailment gains totaling $16,137,000 and $45,012,000 in 2011 and 2010, respectively. Operating losses in 2011 were caused primarily by non-cash charges for impairment of goodwill and other assets and reduction of our investment in TNI, net of the related deferred income tax benefit. Changes in deferred income taxes, operating assets and liabilities and the timing of income tax payments accounted for the bulk of the remainder of the changes in cash provided by operating activities of continuing operations in all years.

Investing Activities

Cash required for investing activities of continuing operations totaled $981,000 in 2012 and $7,638,000 in 2010 and cash provided by investing activities totaled $905,000 in 2011. Capital spending totaled $8,040,000 in 2012, $7,479,000 in 2011 and $8,835,000 in 2010. Restricted cash was reduced $4,972,000 in 2012 and $4,651,000 in 2011 and increased $862,000 in 2010.

We anticipate that funds necessary for capital expenditures, which are expected to total approximately $12,000,000 in 2013, and other requirements, will be available from internally generated funds, or availability under our revolving credit facility.

Financing Activities

Cash required for financing activities totaled $93,068,000 in 2012, $99,136,000 in 2011 and $87,364,000 in 2010. We paid $32,408,000, $11,601,000 and $453,000 of debt financing and reorganization costs in 2012, 2011 and 2010, respectively. The increase in 2012 is due to the Chapter 11 Proceedings. Debt reduction accounted for the majority of the remaining usage of funds in all years.

The Plan requires us to suspend stockholder dividends and share repurchases through December 2015.

As discussed more fully below (and certain capitalized terms used below defined), in January 2012, in conjunction with the effectiveness of the Plan, we refinanced all of our debt. The Plan refinanced our then-existing credit agreement and extended the April 2012 maturity in a structure of first and second lien debt with the existing lenders. We also amended the Pulitzer Notes, and extended the April 2012 maturity with the existing Noteholders.

1st Lien Agreement

In January 2012, we entered into a credit agreement (the "1st Lien Agreement") with a syndicate of lenders (the "1st

Lien Lenders"). The 1st Lien Agreement consists of a term loan of $689,510,000, and a new $40,000,000 revolving credit facility. The revolving credit facility also supports issuance of letters of credit.

Interest Payments

Debt under the 1st Lien Agreement bears interest, at our option, at either a base rate or an adjusted Eurodollar rate ("LIBOR"), plus an applicable margin. The base rate for the facility is the greater of (a) the prime lending rate of Deutsche Bank Trust Company Americas at such time; (b) 0.5% in excess of the overnight federal funds rate at such time; or (c) 30 day LIBOR plus 1.0%. LIBOR loans are subject to a minimum rate of 1.25%. The applicable margin for term loan base rate loans is 5.25%, and 6.25% for LIBOR loans. The applicable margin for revolving credit facility base rate loans is 4.5%, and is 5.5% for LIBOR loans. At September 30, 2012, all borrowing under the 1st Lien Agreement is based on LIBOR at a total rate of 7.5%.

Principal Payments

At September 30, 2012, the balance outstanding under the term loan is $661,850,000. We may voluntarily prepay principal amounts outstanding or reduce commitments under the 1st Lien Agreement at any time, in whole or in part, without premium or penalty, upon proper notice and subject to certain limitations as to minimum amounts of prepayments.

We are required to repay principal amounts, on a quarterly basis until maturity, under the 1st Lien Agreement. Principal payments are required quarterly beginning in June 2012, and total $11,000,000 in 2013, $12,750,000 in 2014, $13,500,000 in 2015 and $3,375,000 in 2016, prior to the final maturity.

In addition to the scheduled payments, we are required to make mandatory prepayments under the 1st Lien Agreement under certain other conditions, such as from the net proceeds from asset sales. The 1st Lien Agreement also requires us to accelerate future payments in the amount of our quarterly excess cash flow, as defined. The acceleration of such payments due to future asset sales or excess cash flow does not change the due dates of other 1st Lien Agreement payments prior to the December 2015 maturity.

2012 payments made under the 1st Lien Agreement are summarized as follows:

| (Thousands of Dollars) | 2012 |
|---|---|
| Mandatory | 5,000 |
| Voluntary | 19,450 |
| Asset sales | 3,210 |
| Excess cash flow | — |
| | 27,660 |

There were no net principal payments made in 2012 under the previous credit agreement. Since September 30, 2012, principal payments under the 1st Lien Agreement total $17,750,000.

Security

The 1st Lien Agreement is fully and unconditionally guaranteed on a joint and several basis by all of our existing and future, direct and indirect subsidiaries in which we hold a direct or indirect interest of more than 50% (the "Credit Parties"); provided however, that our wholly-owned subsidiary Pulitzer Inc. ("Pulitzer") and its subsidiaries are not Credit Parties. The 1st Lien Agreement is secured by first priority security interests in the stock and other equity interests owned by the Credit Parties in their respective subsidiaries.

The Credit Parties have also granted a first priority security interest on substantially all of their tangible and intangible assets, and granted mortgages covering certain real estate, as collateral for the payment and performance of their obligations under the 1st Lien Agreement. Assets of Pulitzer and its subsidiaries, TNI, our ownership interest in, and assets of, MNI and certain employee benefit plan assets are excluded. However, assets of Pulitzer and its subsidiaries, excluding TNI, become subject to a first priority security interest of the Credit Parties upon repayment in full of the Pulitzer Notes, as discussed more fully below.

The revolving credit facility has a super-priority security interest over all of the collateral securing the term loan under

the 1st Lien Agreement, superior to that of the term loan lenders.

Covenants and Other Matters

The 1st Lien Agreement contains customary affirmative and negative covenants for financing of its type. These financial covenants include a maximum total leverage ratio, as defined. The total leverage ratio is designed to assess the leverage of the Company, excluding Pulitzer, and does not reflect our overall leverage position due to the lower leverage of Pulitzer. It is based primarily on the sum of the principal amount of debt under the 1st Lien Agreement, plus debt under the 2nd Lien Agreement, as discussed more fully below, which totals $836,850,000 at September 30, 2012, plus letters of credit and certain other factors, divided by a measure of trailing 12 month operating results, which includes distributions from MNI and other elements, but excludes the operating results of Pulitzer.

Our actual total leverage ratio at September 30, 2012 under the 1st Lien Agreement was 6.7:1. Our maximum total leverage ratio covenant will decrease, in stages, from 10.0:1 at September 30, 2012 to 9.1:1 in December 2015. On a consolidated basis, using the definitions in the 1st Lien Agreement, our leverage ratio is 5.7:1 at September 30, 2012. This consolidated measure is not the subject of a covenant in any of our debt agreements.

The 1st Lien Agreement also includes a minimum interest expense coverage ratio, as defined, which is based on the sum of interest expense, as defined, incurred under the 1st Lien Agreement and 2nd Lien Agreement, divided by the same measure of trailing 12 month operating results discussed above. The interest expense coverage ratio is similarly designed to assess the interest coverage of the Company, excluding Pulitzer, and does not reflect our overall interest coverage position. Our actual interest expense coverage ratio at September 30 2012 was 1.93:1. Our minimum interest expense coverage ratio covenant will decrease, in stages, from 1.25:1 at September 30, 2012 to 1.1:1 in December 2015.

The 1st Lien Agreement requires us to suspend stockholder dividends and share repurchases through December 2015. The 1st Lien Agreement also limits capital expenditures to $20,000,000 per year, with a provision for carryover of unused amounts from the prior year. Further, the 1st Lien Agreement restricts our ability to make additional investments, acquisitions, dispositions and mergers without the consent of the 1st Lien Lenders and limits our ability to incur additional debt. Such covenants require that substantially all of our future cash flows are required to be directed toward debt reduction or accumulation of cash collateral and that the cash flows of the Credit Parties are largely segregated from those of Pulitzer.

2nd Lien Agreement

In January 2012, we entered into a second lien term loan (the "2nd Lien Agreement") with a syndicate of lenders (the "2nd Lien Lenders"). The 2nd Lien Agreement consists of a term loan of $175,000,000.

The 2nd Lien Agreement bears interest at 15.0%, payable quarterly.

Principal Payments and Redemption

The 2nd Lien Agreement requires no principal amortization, except in March 2017 if required for income tax purposes.

The 2nd Lien Agreement may not be redeemed prior to January 30, 2013. From that date until January 30, 2014, the 2nd Lien Agreement may be redeemed at 102% of the principal amount, at 101% thereafter until January 30, 2015 and at 100% thereafter until the April 2017 final maturity. Terms of the 1st Lien Agreement also restrict principal payments under the 2nd Lien Agreement.

Security

The 2nd Lien Agreement is fully and unconditionally guaranteed on a joint and several basis by the Credit Parties and by Pulitzer and its subsidiaries, other than TNI (collectively, the "2nd Lien Credit Parties). The 2nd Lien Agreement is secured by second priority security interests in the stock and other equity interests owned by the 2nd Lien Credit Parties.

The 2nd Lien Credit Parties have also granted a second priority security interest on substantially all of their tangible and intangible assets, and granted second lien mortgages or deeds of trust covering certain real estate, as collateral for the payment and performance of their obligations under the 2nd Lien Agreement. Assets of TNI, our ownership interest in, and assets of, MNI and certain employee benefit plan assets are excluded.

Covenants and Other Matters

The 2nd Lien Agreement has no affirmative financial covenants. Restrictions on capital expenditures, permitted investments, indebtedness and other provisions are similar to, but generally less restrictive than, those provisions under the 1st Lien Agreement.

2nd Lien Lenders shared in the issuance of 6,743,640 shares of our Common Stock valued at $9,576,000, an amount equal to 13% of outstanding shares on a pro forma basis as of January 30, 2012. 2nd Lien Lenders also received $8,750,000 in the form of non-cash fees, which were added to and included in the principal amount of the second lien term loan.

Pulitzer Notes

In conjunction with its formation in 2000, St. Louis Post-Dispatch LLC ("PD LLC") borrowed $306,000,000 (the “Pulitzer Notes”) from a group of institutional lenders (the “Noteholders”). The Pulitzer Notes were guaranteed by Pulitzer pursuant to a Guaranty Agreement with the Noteholders. The aggregate principal amount of the Pulitzer Notes was payable in April 2009.

In February 2009, the Pulitzer Notes and the Guaranty Agreement described below were amended (the “Notes Amendment”). Under the Notes Amendment, PD LLC repaid $120,000,000 of the principal amount of the debt obligation. The remaining debt balance of $186,000,000 was refinanced by the Noteholders until April 2012.

In January 2012, in connection with the Plan, we entered into an amended Note Agreement and Guaranty Agreement which amended the Pulitzer Notes and extended the maturity with the Noteholders. After consideration of unscheduled principal payments totaling $15,145,000 ($10,145,000 in December 2011 and $5,000,000 in January 2012), offset by $3,500,000 of non-cash fees paid to the Noteholders in the form of additional Pulitzer Notes debt, the amended Pulitzer Notes had a balance of $126,355,000 in January 2012.

The Pulitzer Notes bear interest at 10.55%, increasing 0.75% in January 2013 and January of each year thereafter. Due to the increasing interest rate, interest on the Pulitzer Notes is charged to expense using a calculated effective interest rate during the period. This method increased 2012 financial expense $871,000 from the amount actually payable to the Noteholders during this period.

Principal Payments

At September 30, 2012, the balance of the Pulitzer Notes is $109,000,000. We may voluntarily prepay principal amounts outstanding under the Pulitzer Notes at any time, in whole or in part, without premium or penalty, upon proper notice, and subject to certain limitations as to minimum amounts of prepayments. The Pulitzer Notes provide for mandatory scheduled annual prepayments totaling $1,400,000 in 2012 and $6,400,000 annually thereafter.

In addition to the scheduled payments, we are required to make mandatory prepayments under the Pulitzer Notes under certain other conditions, such as from the net proceeds from asset sales. The Pulitzer Notes also require us to accelerate future payments in the amount of our quarterly excess cash flow, as defined. The acceleration of such payments due to future asset sales or excess cash flow does not change the due dates of other Pulitzer Notes payments prior to the final maturity in December 2015.

2012 payments made under the Pulitzer Notes are summarized as follows:

| (Thousands of Dollars) | 2012 |
|---|---|

| | |
|---|---|
| Prior to refinancing | 500 |
| Pursuant to the Plan, net | 11,645 |
| Mandatory | 1,400 |
| Voluntary | 15,955 |
| Asset sales | — |
| Excess cash flow | — |
| | 29,500 |

Since September 30, 2012, principal payments under the Pulitzer Notes total $9,000,000.

Security

The Guaranty Agreement provides that obligations under the Pulitzer Notes are fully and unconditionally guaranteed on a joint and several basis by Pulitzer's existing and future subsidiaries other than TNI. The Pulitzer Notes are also secured by the first priority security interests in the stock and other equity interests owned by Pulitzer in its subsidiaries other than TNI. Also, Pulitzer and each of its subsidiaries granted a first priority security interest on substantially all of its tangible and intangible assets, and granted first lien mortgages or deeds of trust covering certain real estate, as collateral for the payment and performance of their obligations under the Pulitzer Notes. Our ownership interest in TNI and certain employee benefit plan assets are excluded. However, assets of Pulitzer and its subsidiaries, excluding TNI, become subject to a first priority security interest of the Credit Parties upon repayment in full of the Pulitzer Notes, as discussed more fully below.

Covenants and Other Matters

The Pulitzer Notes contain certain covenants and conditions including the maintenance, by Pulitzer, of minimum trailing 12 month EBITDA (minimum of $25,600,000 at September 30, 2012), as defined in the Guaranty Agreement, and limitations on capital expenditures and the incurrence of other debt.

Further, the Pulitzer Notes have limitations or restrictions on distributions, loans, advances, investments, acquisitions, dispositions and mergers. Such covenants require that substantially all future cash flows of Pulitzer are required to be directed first toward repayment of the Pulitzer Notes or accumulation of cash collateral and that cash flows of Pulitzer are largely segregated from those of the Credit Parties.

Intercreditor Agreements

The 1st Lien Agreement, 2nd Lien Agreement and Pulitzer Notes contain cross-default provisions tied to each of the various agreements. Intercreditor agreements and an intercompany subordination agreement are in effect.

Other

Cash payments to the Lenders, Noteholders and legal and professional fees related to the Plan totaled $38,628,000, of which $6,273,000 was paid in 2011, and the remainder of which was paid in 2012. $721,000 of such costs were charged to expense in 2011. In addition, previously capitalized financing costs of $4,514,000 at September 25, 2011 were charged to expense in 2012 as debt financing costs prior to consummation of the Plan, with the remainder classified as reorganization costs in the Consolidated Statements of Operations and Comprehensive Income (Loss) upon consummation of the Plan.

Debt under the Plan was considered compromised. As a result, the 1st Lien Agreement, 2nd Lien Agreement and Pulitzer Notes were recorded at their respective present values, which resulted in a discount to the stated principal amount totaling $23,709,000. This amount is being amortized as a non-cash component of financial expense over the terms of the related debt. Such amounts totaled $4,085,000 in 2012 and are estimated to total $5,418,000 in 2013, $5,359,000 in 2014, $5,293,000 in 2015, $2,429,000 in 2016 and $1,125,000 in 2017.

Debt is summarized as follows:

| (Thousands of Dollars) | Amount | | Interest Rates (%) |
|---|---|---|---|
| | September 30 2012 | September 25 2011 | September 30 2012 |
| 1st Lien Agreement | 661,850 | — | 7.50 |
| 2nd Lien Agreement | 175,000 | — | 15.00 |
| Credit Agreement: | | | |
| A Term Loan | — | 569,335 | |
| Revolving credit facility | — | 286,425 | |
| Pulitzer Notes | 109,000 | 138,500 | 10.55 |
| Unaccreted (unamortized) present value adjustment | (19,624) | 290 | |
| | 926,226 | 994,550 | |
| Less current maturities of debt | 17,400 | 994,550 | |
| Current amount of present value adjustment | (5,418) | — | |
| Total long term debt | 914,244 | — | |

At September 30, 2012, our weighted average cost of debt is 9.2%.

Aggregate maturities of debt total $17,400,000 in 2013, $19,150,000 in 2014, $19,900,000 in 2015, $714,400,000 in 2016 and $175,000,000 in 2017.

Liquidity

At September 30, 2012, after consideration of letters of credit, we have approximately $29,942,000 available for future use under our revolving credit facility. Including cash, our liquidity at September 30, 2012 totals $43,862,000. This liquidity amount excludes any future cash flows. We expect all interest and principal payments due in the next twelve months will be satisfied by our continuing cash flows, which will allow us to maintain an adequate level of liquidity.

There are numerous potential consequences under the 1st Lien Agreement, 2nd Lien Agreement, and the Note and Guaranty Agreements related to the Pulitzer Notes, if an event of default, as defined, occurs and is not remedied. Many of those consequences are beyond our control. The occurrence of one or more events of default would give rise to the right of the 1st Lien Lenders, 2nd Lien Lenders and/or the Noteholders, to exercise their remedies under the 1st Lien Agreement, 2nd Lien Agreement, and the Note and Guaranty Agreements, respectively, including, without limitation, the right to accelerate all outstanding debt and take actions authorized in such circumstances under applicable collateral security documents.

Our ability to operate as a going concern is dependent on our ability to remain in compliance with debt covenants and to refinance or amend our debt agreements as they become due, or earlier if available liquidity is consumed. We are in compliance with our debt covenants at September 30, 2012.

At December 14, 2012, the principal amount of our outstanding debt totals $919,100,000. This amount is already less than the $938,700,000 amount projected in the Plan in September 2013. Lower cash balances and asset sales have contributed to the improvement in debt repayment compared to the Plan.

In 2010, we filed a Form S-3 shelf registration statement ("Shelf") with the SEC, which has been declared effective. The Shelf gives us the flexibility to issue and publicly distribute various types of securities, including preferred stock, common stock, secured or unsecured debt securities, purchase contracts and units consisting of any combination of such securities, from time to time, in one or more offerings, up to an aggregate amount of $750,000,000. In July 2011,

the SEC announced changes to the issuer eligibility rules which will require us to have a public float of at least $75,000,000 in order to use the Shelf. Subject to maintenance of the minimum level of equity market float and the conditions of our existing debt agreements, the Shelf may enable us to sell securities quickly and efficiently when market conditions are favorable or financing needs arise. Net proceeds from the sale of any securities must be used generally to reduce debt.

Other Matters

Cash and cash equivalents decreased $9,635,000 in 2012 and increased $4,133,000 in 2011 and $11,517,000 in 2010.

SEASONALITY

Our largest source of publishing revenue, retail advertising, is seasonal and tends to fluctuate with retail sales in markets served. Historically, retail advertising is higher in the December and June quarters. Advertising revenue is lowest in the March quarter.

Quarterly results of operations are summarized in Note 17 of the Notes to Consolidated Financial Statements, included herein.

INFLATION

Price increases (or decreases) for our products are implemented when deemed appropriate by us. We continuously evaluate price increases, productivity improvements, sourcing efficiencies and other cost reductions to mitigate the impact of inflation.

CHANGES IN LAWS AND REGULATIONS

Energy Costs

Energy costs have become more volatile, and may increase in the future as a result of carbon emissions and other regulations being developed by the United States Environmental Protection Agency.

Health Care Costs

The Affordable Care Act was enacted into law in 2010. As a result, in 2010 we wrote off $2,012,000 of deferred income tax assets due to the loss of future tax deductions for providing retiree prescription drug benefits.

The Affordable Care Act will be supported by a substantial number of underlying regulations, some of which have not been issued. Accordingly, a complete determination of the impact of the Affordable Care Act cannot be made at this time. However, we expect our future health care costs to increase more rapidly based on analysis published by the United States Department of Health and Human Services, input from independent advisors and our understanding of various provisions of the Affordable Care Act that differ from our current medical plans, such as:

•Cost of a transitional reinsurance program to fund state level programs;
•Certain preventive services provided at no cost to employees;
•Higher maximum age for dependent coverage;
•Elimination of annual and lifetime benefit caps; and,
•Free choice vouchers for certain lower income employees.

Administrative costs are also likely to increase as a result of new compliance reporting. New costs being imposed on other medical care businesses, such as health insurers, pharmaceutical companies and medical device manufacturers, may be passed on to us in the form of higher costs. We may be able to mitigate certain of these future cost increases through changes in plan design.

We do not expect the Affordable Care Act will have a significant impact on our postretirement medical benefit obligation liability.

Pension Plans

In July 2012, the Surface Transportation Extension Act of 2012 (“STEA”) was signed into law. STEA provides for changes in the determination of discount rates that result in a near-term reduction in minimum funding requirements for our defined benefit pension plans. STEA will also increase future premiums to be paid to the Pension Benefit Guarantee Corporation.

Income Taxes

Certain states in which we operate are considering changes to their corporate income tax rates. At this time, the impact of such changes cannot be determined.

CONTRACTUAL OBLIGATIONS

The following table summarizes our significant contractual obligations at September 30, 2012:

| (Thousands of Dollars) | Payments (or Commitments) Due (Years) | | | | |
|---|---|---|---|---|---|
| Nature of Obligation | Total | Less Than 1 | 1-3 | 3-5 | More Than 5 |
| Debt (Principal Amount) [1] | 945,850 | 17,400 | 39,050 | 889,400 | — |
| Financial expense [2][3] | 327,486 | 87,233 | 171,708 | 68,545 | — |
| Operating lease obligations | 14,183 | 3,534 | 3,544 | 2,803 | 4,302 |
| Capital expenditure commitments | 900 | 900 | — | — | — |
| | 1,288,419 | 109,067 | 214,302 | 960,748 | 4,302 |

(1) Maturities of long-term debt are limited to mandatory payments and, accordingly, exclude excess cash flow, asset sale and other payments required under the 1st Lien Agreement and the Pulitzer Notes as such amounts cannot be determined. See Note 5 of the Notes to Consolidated Financial Statements, included herein.

(2) Financial expense includes an estimate of interest expense for the 1st Lien Agreement, 2nd Lien Agreement and Pulitzer Notes until their maturities in December 2015, April 2017 and December 2015, respectively. Financial expense under the 1st Lien Agreement is estimated based on the 30 day minimum LIBOR level of 1.25% as increased by our applicable margin of 6.25% applied to the outstanding balance, as reduced by future contractual maturities of such debt. Financial expense under the 2nd Lien Agreement is estimated using the 15% contractual rate applied to the outstanding balance during each period, as reduced by future contractual maturities of such debt. Financial expense under the Pulitzer Notes is estimated based on the contractual interest rates applied to the outstanding balance (10.55% at September 30, 2012), as reduced by future contractual maturities of such debt. Changes in interest rates in excess of the minimum LIBOR level, use of borrowing rates not based on LIBOR, use of interest rate hedging instruments, and/or principal payments in excess of contractual maturities or based on other requirements of the 1st Lien Agreement, 2nd Lien Agreement or Pulitzer Notes could significantly change this estimate. See Note 5 of the Notes to Consolidated Financial Statements, included herein.

(3) Financial expense excludes non-cash present value adjustments and amortization of debt financing costs previously paid. Additionally, interest expense based on the effective interest rate of the Pulitzer Notes is also excluded. See Note 5 of the Notes to Consolidated Financial Statements, included herein.

The table above excludes future cash requirements for pension, postretirement and postemployment obligations. The periods in which these obligations will be settled in cash are not readily determinable and are subject to numerous future events and assumptions. We estimate cash requirements for these obligations in 2013 will total approximately $2,733,000. See Notes 6 and 7 of the Notes to Consolidated Financial Statements, included herein.

The table above also excludes future cash requirements, if any, for the payment of the Herald Value to be settled between April 2013 and April 2015. The estimated value of the Herald Value at September 30, 2012 is $300,000. See Note 16 of the Notes to Consolidated Financial Statements, included herein.

Commitments exclude unrecognized tax benefits to be recorded in accordance with FASB ASC Topic 740, Income Taxes. We are unable to reasonably estimate the ultimate amount or timing of cash settlements with the respective taxing authorities for such matters. A substantial amount of our deferred income tax liabilities is related to acquisitions and will not result in future cash payments. See Note 11 of the Notes to Consolidated Financial Statements, included herein.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk stemming from changes in interest rates and commodity prices. Changes in these factors could cause fluctuations in earnings and cash flows. In the normal course of business, exposure to certain of these market risks is managed as described below.

INTEREST RATES ON DEBT

Our debt structure and interest rate risk are managed through the use of fixed and floating rate debt. Our primary exposure is to LIBOR. A 100 basis point increase or decrease to LIBOR would, if in excess of LIBOR minimums discussed more fully below, decrease or increase, respectively, income before income taxes on an annualized basis by approximately $6,619,000, based on $661,850,000 of floating rate debt outstanding at September 30, 2012.

Our debt under the 1st Lien Agreement is subject to minimum interest rate levels of 1.25%. Based on the difference between interest rates in December 2012 and our 1.25% minimum rate, LIBOR would need to increase approximately 70 basis points for six month borrowing up to approximately 105 basis points for one month borrowing before our borrowing cost would begin to be impacted by an increase in interest rates.

At September 30, 2012, approximately 70.0% of the principal amount of our debt is subject to floating interest rates. We regularly evaluate alternatives to hedge the related interest rate risk.

Certain of our interest-earning assets, including those in employee benefit plans, also function as a natural hedge against fluctuations in interest rates on debt.

COMMODITIES

Certain materials used by us are exposed to commodity price changes. We manage this risk through instruments such as purchase orders and non-cancelable supply contracts. We participate in a buying cooperative with other publishing companies, primarily for the acquisition of newsprint. We are also involved in continuing programs to mitigate the impact of cost increases through identification of sourcing and operating efficiencies. Primary commodity price exposures are newsprint and, to a lesser extent, ink and energy costs.

North American newsprint producers continue to deleverage under difficult market conditions as they continue to face significant declines in domestic demand as well as weakening export demand. Three of these companies exited U.S. and/or Canadian financial reorganization protection in September and October 2012. Other producers have also reacted with extended production downtime or permanent closure of facilities as well as converting paper machines to other paper grades. The high cost of attaining recycled fibers has led to significant reductions in the availability of newsprint with recycled content.

Newsprint pricing has remained relatively stable since mid-2010. Selected West coast producers have announced a $30 per metric tonne increase on 30 pound newsprint, effective throughout the December 2012 calendar quarter. The increase was precipitated primarily by a mill closure and the tightening of supply on the West coast. This increase, as well as future price changes, if any, will be influenced primarily by the balance between supply capacity and demand, domestic and export, in addition to the producers' ability to mitigate input cost pressures. The final extent of future price change announcements, if any, is subject to negotiations with each newsprint producer.

A $10 per tonne price increase for 30 pound newsprint would result in an annualized reduction in income before income taxes of approximately $775,000 based on anticipated consumption in 2013, excluding consumption of TNI and MNI and the impact of LIFO accounting. Such prices may also decrease. We manage significant newsprint inventories, which may help to mitigate the impact of future price increases.

SENSITIVITY TO CHANGES IN VALUE

Our fixed rate debt consists of the 2nd Lien Agreement and Pulitzer Notes, which are not traded on an active market and are held by small groups of investors. We are unable, as of September 30, 2012, to measure the maximum potential impact on fair value of fixed rate debt from adverse changes in market interest rates under normal market

conditions. The change in value, if determined, could be significant.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Information with respect to this Item is included herein under the caption “Consolidated Financial Statements”.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Information with respect to this Item is included in our Proxy Statement to be filed in January 2013, which is incorporated herein by reference, under the caption “Relationship with Independent Registered Public Accounting Firm”.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

Under the supervision and with the participation of our senior management, including our chief executive officer and chief financial officer, we conducted an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures, as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, as of the end of the period covered by this annual report (the “Evaluation Date”). Based on this evaluation, our chief executive officer and chief financial officer concluded as of the Evaluation Date that our disclosure controls and procedures were effective such that the information relating to the Company, including our consolidated subsidiaries, required to be disclosed in our SEC reports (i) is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms, and (ii) is accumulated and communicated to our management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rule 13a-15(f) of the Exchange Act. Under the supervision and with the participation of our senior management, including our chief executive officer and chief financial officer, we assessed the effectiveness of our internal control over financial reporting as of September 30, 2012, using the criteria set forth in the Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this assessment, management has concluded that our internal control over financial reporting is effective as of September 30, 2012. Our independent registered public accounting firm, KPMG LLP, has issued a report on the Company's internal control over financial reporting. The report on the audit of internal control over financial reporting appears in this Annual Report.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting that occurred during the 14 weeks ended September 30, 2012 that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

MANAGEMENT REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The management of Lee Enterprises, Incorporated (the "Company") is responsible for establishing and maintaining adequate internal control over financial reporting. The Company's internal control system is designed to provide reasonable assurance regarding the preparation and fair presentation of the Company's Consolidated Financial Statements in accordance with generally accepted accounting principles in the United States of America.

Any internal control system, no matter how well designed, has inherent limitations and may not prevent or detect misstatements. Accordingly, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management of the Company assessed the effectiveness of the Company's internal control over financial reporting as of September 30, 2012. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in Internal Control - Integrated Framework. Based on the assessment and those criteria, we believe that the Company maintained effective internal control over financial reporting as of September 30, 2012.

KPMG LLP, the Company's independent registered public accounting firm, issued a report on the effectiveness of the Company's internal control over financial reporting. Their report appears on the following page.

| | |
|---|---|
| /s/ Mary E. Junck | /s/ Carl G. Schmidt |
| Mary E. Junck | Carl G. Schmidt |
| Chairman, President and Chief Executive Officer | Vice President, Chief Financial Officer |
| (Principal Executive Officer) | and Treasurer |
| | (Principal Financial and Accounting Officer) |
| December 14, 2012 | December 14, 2012 |

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Lee Enterprises, Incorporated:
We have audited Lee Enterprises, Incorporated and subsidiaries (the Company) internal control over financial reporting as of September 30, 2012, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Lee Enterprises, Incorporated and subsidiaries maintained, in all material respects, effective internal control over financial reporting as of September 30, 2012, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Lee Enterprises, Incorporated and subsidiaries as of September 30, 2012 and September 25, 2011, and the related consolidated statements of operations and comprehensive income (loss), stockholders' equity (deficit), and cash flows for the 53-week period ended September 30, 2012 and each of the 52-week periods ended September 25, 2011 and September 26, 2010, and our report dated December 14, 2012 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Chicago, Illinois
December 14, 2012

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Information with respect to this Item, except for certain information related to our executive officers included under the caption “Executive Team” in Part I of this Annual Report, is included in our Proxy Statement to be filed in January 2013, which is incorporated herein by reference, under the captions “Proposal 1 - Election of Directors” and “Section 16(a) Beneficial Ownership Reporting Compliance”. Our executive officers are those elected officers whose names and certain information are set forth under the caption “Executive Team” in Part 1 of this Annual Report.

We have a Code of Business Conduct and Ethics ("Code") that applies to all of our employees, including our principal executive officer, and principal financial and accounting officer. The Code is monitored by the Audit Committee of our Board of Directors and is annually affirmed by our directors and executive officers. We maintain a corporate governance page on our website which includes the Code. The corporate governance page can be found at www.lee.net by clicking on “Governance”. A copy of the Code will also be provided without charge to any stockholder who requests it. Any future amendment to, or waiver granted by us from, a provision of the Code will be posted on our website.

ITEM 11. EXECUTIVE COMPENSATION

Information with respect to this Item is included in our Proxy Statement to be filed in January 2013 which is incorporated herein by reference, under the captions, “Compensation of Directors”, “Executive Compensation” and “Compensation Discussion and Analysis”; provided, however, that the subsection entitled “Executive Compensation - Report of the Executive Compensation Committee of the Board of Directors on Executive Compensation” shall not be deemed to be incorporated by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Information with respect to this Item is included in our Proxy Statement to be filed in January 2013, which is incorporated herein by reference, under the caption “Voting Securities and Principal Holders Thereof” and “Equity Compensation Plan Information”.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information with respect to this Item is included in our Proxy Statement to be filed in January 2013, which is incorporated herein by reference, under the caption “Directors' Meetings and Committees of the Board of Directors”.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

Information with respect to this Item is included in our Proxy Statement to be filed in January 2013, which is incorporated herein by reference, under the caption “Relationship with Independent Registered Public Accounting Firm”.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

The following documents are filed as part of this Annual Report:

FINANCIAL STATEMENTS

Consolidated Statements of Operations and Comprehensive Income (Loss) - Years ended September 30, 2012, September 25, 2011 and September 26, 2010
Consolidated Balance Sheets - September 30, 2012 and September 25, 2011
Consolidated Statements of Stockholders' Equity (Deficit) - Years ended September 30, 2012, September 25, 2011 and September 26, 2010
Consolidated Statements of Cash Flows - Years ended September 30, 2012, September 25, 2011 and September 26, 2010
Notes to Consolidated Financial Statements
Report of Independent Registered Public Accounting Firm

FINANCIAL STATEMENT SCHEDULES

All schedules have been omitted as not required, not applicable, not deemed material or because the information is included in the Notes to Consolidated Financial Statements, included herein.

EXHIBITS

See Exhibit Index, included herein.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized on the 14th day of December 2012.

LEE ENTERPRISES, INCORPORATED

| | |
|---|---|
| /s/ Mary E. Junck | /s/ Carl G. Schmidt |
| Mary E. Junck | Carl G. Schmidt |
| Chairman, President and Chief Executive Officer (Principal Executive Officer) | Vice President, Chief Financial Officer and Treasurer (Principal Financial and Accounting Officer) |

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in their respective capacities on the 14th day of December 2012.

| Signature | |
|---|---|
| /s/ Richard R. Cole<br>Richard R. Cole | Director |
| /s/ Nancy S. Donovan<br>Nancy S. Donovan | Director |
| /s/ Leonard J. Elmore<br>Leonard J. Elmore | Director |
| /s/ Mary E. Junck<br>Mary E. Junck | Chairman, President and Chief Executive Officer, and Director |
| /s/ Brent Magid<br>Brent Magid | Director |
| /s/ William E. Mayer<br>William E. Mayer | Director |
| /s/ Herbert W. Moloney III<br>Herbert W. Moloney III | Director |
| /s/ Andrew E. Newman<br>Andrew E. Newman | Director |
| /s/ Gordon D. Prichett<br>Gordon D. Prichett | Director |
| /s/ Gregory P. Schermer<br>Gregory P. Schermer | Vice President - Strategy, and Director |
| /s/ Carl G. Schmidt<br>Carl G. Schmidt | Vice President, Chief Financial Officer and Treasurer |

| | |
|---|---|
| /s/ Mark B. Vittert<br>Mark B. Vittert | Director |

CONSOLIDATED STATEMENTS OF OPERATIONS AND COMPREHENSIVE INCOME (LOSS)

| (Thousands of Dollars, Except Per Common Share Data) | 2012 | 2011 | 2010 |
|---|---|---|---|
| Operating revenue: | | | |
| Advertising | 495,872 | 517,348 | 537,223 |
| Circulation | 174,747 | 172,245 | 171,155 |
| Other | 39,867 | 37,726 | 40,066 |
| Total operating revenue | 710,486 | 727,319 | 748,444 |
| Operating expenses: | | | |
| Compensation | 276,379 | 283,527 | 298,873 |
| Newsprint and ink | 52,003 | 56,191 | 51,707 |
| Other operating expenses | 214,570 | 220,656 | 227,603 |
| Depreciation | 23,620 | 25,833 | 26,716 |
| Amortization of intangible assets | 42,297 | 44,473 | 45,208 |
| Impairment of goodwill and other assets | 1,388 | 204,439 | 899 |
| Workforce adjustments | 4,640 | 3,922 | 1,199 |
| Total operating expenses | 614,897 | 839,041 | 652,205 |
| Curtailment gains | — | 16,137 | 45,012 |
| Equity in earnings of associated companies | 7,231 | 6,151 | 7,746 |
| Reduction in investment in TNI | — | 11,900 | — |
| Operating income (loss) | 102,820 | (101,334) | 148,997 |
| Non-operating income (expense): | | | |
| Financial income | 236 | 296 | 411 |
| Financial expense | (83,078) | (52,696) | (63,117) |
| Debt financing costs | (2,823) | (12,612) | (8,514) |
| Other, net | (2,533) | 595 | (1,172) |
| Total non-operating expense, net | (88,198) | (64,417) | (72,392) |
| Income (loss) before reorganization costs and income taxes | 14,622 | (165,751) | 76,605 |
| Reorganization costs | 37,765 | — | — |
| Income (loss) before income taxes | (23,143) | (165,751) | 76,605 |
| Income tax expense (benefit) | (9,371) | (20,316) | 29,308 |
| Net income (loss) from continuing operations | (13,772) | (145,435) | 47,297 |
| Discontinued operations, net of income taxes | (2,527) | (1,246) | (1,119) |
| Net income (loss) | (16,299) | (146,681) | 46,178 |
| Net income attributable to non-controlling interests | (399) | (187) | (73) |
| Income (loss) attributable to Lee Enterprises, Incorporated | (16,698) | (146,868) | 46,105 |
| Other comprehensive loss, net | (7,348) | (12,737) | (14,704) |
| Comprehensive income (loss) | (24,046) | (159,605) | 31,401 |
| Income (loss) from continuing operations attributable to Lee Enterprises, Incorporated | (14,171) | (145,622) | 47,224 |
| Earnings (loss) per common share: | | | |
| Basic: | | | |
| Continuing operations | (0.29) | (3.25) | 1.06 |
| Discontinued operations | (0.05) | (0.03) | (0.03) |
| | (0.34) | (3.27) | 1.03 |
| Diluted: | | | |
| Continuing operations | (0.29) | (3.25) | 1.05 |

| | | | |
|---|---|---|---|
| Discontinued operations | (0.05) | (0.03) | (0.02) |
| | (0.34) | (3.27) | 1.03 |

The accompanying Notes are an integral part of the Consolidated Financial Statements.

CONSOLIDATED BALANCE SHEETS

| (Thousands of Dollars) | September 30 2012 | September 25 2011 |
|---|---|---|
| ASSETS | | |
| Current assets: | | |
| Cash and cash equivalents | 13,920 | 23,555 |
| Accounts receivable, less allowance for doubtful accounts: | | |
| 2012 $4,890; 2011 $5,387 | 68,190 | 69,307 |
| Income taxes receivable | 7,887 | 1,335 |
| Inventories | 7,454 | 7,060 |
| Deferred income taxes | 789 | 967 |
| Other | 6,261 | 16,102 |
| Assets of discontinued operations | 9,171 | 17,415 |
| Total current assets | 113,672 | 135,741 |
| Investments: | | |
| Associated companies | 42,201 | 44,057 |
| Restricted cash and investments | — | 4,972 |
| Other | 10,033 | 9,199 |
| Total investments | 52,234 | 58,228 |
| Property and equipment: | | |
| Land and improvements | 24,535 | 24,547 |
| Buildings and improvements | 188,743 | 187,039 |
| Equipment | 299,905 | 301,281 |
| Construction in process | 2,567 | 2,852 |
| | 515,750 | 515,719 |
| Less accumulated depreciation | 330,531 | 313,678 |
| Property and equipment, net | 185,219 | 202,041 |
| Goodwill | 247,271 | 247,271 |
| Other intangible assets, net | 451,292 | 493,589 |
| Postretirement assets, net | 7,551 | 14,934 |
| Other | 3,897 | 6,444 |
| Total assets | 1,061,136 | 1,158,248 |

The accompanying Notes are an integral part of the Consolidated Financial Statements.

| (Thousands of Dollars and Shares, Except Per Share Data) | September 30 2012 | September 25 2011 |
|---|---|---|
| LIABILITIES AND STOCKHOLDERS' EQUITY | | |
| Current liabilities: | | |
| Current maturities of long-term debt | 11,982 | 994,550 |
| Accounts payable | 22,978 | 26,796 |
| Compensation and other accrued liabilities | 38,559 | 33,991 |
| Unearned revenue | 35,078 | 35,365 |
| Liabilities of discontinued operations | 1,714 | 3,537 |
| Total current liabilities | 110,311 | 1,094,239 |
| Long-term debt, net of current maturities | 914,244 | — |
| Pension obligations | 68,636 | 73,518 |
| Postretirement and postemployment benefit obligations | 7,160 | 6,104 |
| Deferred income taxes | 60,140 | 66,204 |
| Income taxes payable | 6,062 | 8,588 |
| Other | 8,639 | 10,489 |
| Total liabilities | 1,175,192 | 1,259,142 |
| Equity (deficit): | | |
| Stockholders' equity (deficit): | | |
| Serial convertible preferred stock, no par value; authorized 500 shares; none issued | — | — |
| Common Stock, authorized 120,000 shares; issued and outstanding: | 523 | 89,915 |
| September 30, 2012; 52,291 shares; $0.01 par value | | |
| September 25, 2011; 44,958 shares; $2 par value | | |
| Class B Common Stock, $2 par value; authorized 30,000 shares; none issued | — | — |
| Additional paid-in capital | 241,039 | 140,887 |
| Accumulated deficit | (342,760) | (326,062) |
| Accumulated other comprehensive loss | (13,435) | (6,086) |
| Total stockholders' deficit | (114,633) | (101,346) |
| Non-controlling interests | 577 | 452 |
| Total deficit | (114,056) | (100,894) |
| Total liabilities and deficit | 1,061,136 | 1,158,248 |

The accompanying Notes are an integral part of the Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)

| | Amount | | | Shares | | |
|---|---|---|---|---|---|---|
| (Thousands of Dollars and Shares) | 2012 | 2011 | 2010 | 2012 | 2011 | 2010 |
| Common Stock: | | | | | | |
| Balance, beginning of year | 89,915 | 78,554 | 78,278 | 44,958 | 39,277 | 39,139 |
| Change in par value | (89,466) | — | — | — | — | — |
| Conversion from Class B Common Stock | — | 11,352 | 200 | — | 5,676 | 100 |
| Shares issued | 74 | 209 | 190 | 7,333 | 105 | 95 |
| Shares reacquired | — | (200) | (114) | — | (100) | (57) |
| Balance, end of year | 523 | 89,915 | 78,554 | 52,291 | 44,958 | 39,277 |
| Class B Common Stock: | | | | | | |
| Balance, beginning of year | — | 11,352 | 11,552 | — | 5,676 | 5,776 |
| Conversion to Common Stock | — | (11,352) | (200) | — | (5,676) | (100) |
| Balance, end of year | — | — | 11,352 | — | — | 5,676 |
| Additional paid-in capital: | | | | | | |