KINDRED HEALTHCARE, INC
Form 10-K
February 29, 2012
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2011

OR

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

Commission File Number: 001-14057

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

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

(502) 596-7300

(Registrant s telephone number, including area code)

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

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

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

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

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

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

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

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

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

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

The aggregate market value of the shares of the registrant held by non-affiliates of the registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2011, was approximately $1,091,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2012, there were 52,114,266 shares of the registrant s common stock, $0.25 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference from the registrant s 2011 definitive proxy statement, which will be filed no later than 120 days after December 31, 2011.

Table of Contents

TABLE OF CONTENTS

Table of Contents

PART I

Item 1. ***Business***

GENERAL

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates long-term acute care (LTAC) hospitals, inpatient rehabilitation hospitals (IRFs), nursing and rehabilitation centers, assisted living facilities, a contract rehabilitation services business and a home health and hospice business across the United States. At December 31, 2011, our hospital division operated 121 LTAC hospitals (8,597 licensed beds) and five IRFs (183 licensed beds) in 26 states. Our nursing center division operated 224 nursing and rehabilitation centers (27,148 licensed beds) and six assisted living facilities (413 licensed beds) in 27 states. Our rehabilitation division provided rehabilitation services primarily in hospitals and long-term care settings. Our home health and hospice business provided home health, hospice and private duty services from 51 locations in eight states. All references in this Annual Report on Form 10-K to Kindred, Company, we, us, or our mean Kindred Healthcare, and, unless the context otherwise requires, our consolidated subsidiaries.

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

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

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

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

In connection with the RehabCare Merger, we entered into a new $650 million senior secured asset-based revolving credit facility (the ABL Facility) and a new $700 million senior secured term loan facility (the Term Loan Facility) (collectively, the New Credit Facilities). We also successfully completed the private placement of $550 million of senior notes due 2019 (the Notes). We used proceeds from the New Credit Facilities and the Notes to pay the Merger Consideration, repay all amounts outstanding under our and RehabCare s previous credit facilities and to pay transaction costs. The amounts outstanding under our and RehabCare s former credit facilities that were repaid at the RehabCare Merger closing were $390 million and $345 million, respectively. The New Credit Facilities have incremental facility capacity in an aggregate amount between the two facilities of $200 million, subject to meeting certain conditions, including a specified senior secured leverage ratio. In connection with these new credit arrangements, we paid $46 million of lender fees related to debt issuance that were capitalized as deferred financing costs and paid $13 million of other financing costs that were charged to interest expense.

Table of Contents

See Part II Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity for additional information on the New Credit Facilities and the Notes.

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

Vista Acquisition. On November 1, 2010, we completed the acquisition of five LTAC hospitals from Vista Healthcare, LLC (Vista) for a purchase price of $179 million in cash (the Vista Acquisition). The Vista Acquisition was financed through operating cash flows and proceeds from our former revolving credit facility.

The Vista Acquisition included four freestanding hospitals and one hospital-in-hospital with a total of 250 beds, all of which are located in southern California. We did not acquire the working capital of Vista or assume any of its liabilities. All of the Vista hospitals are leased.

Spin-Off Transaction. On July 31, 2007, we completed the spin-off of our former institutional pharmacy business, Kindred Pharmacy Services, Inc. (KPS), and the immediate subsequent combination of KPS with the former institutional pharmacy business of AmerisourceBergen Corporation (AmerisourceBergen) to form a new, independent, publicly traded company named PharMerica Corporation (PharMerica) (the Spin-off Transaction). Immediately prior to the Spin-off Transaction, KPS incurred $125 million of bank debt, the proceeds of which were distributed to us. Immediately after the Spin-off Transaction, our stockholders and the stockholders of AmerisourceBergen each held approximately 50% of the outstanding common stock of PharMerica.

For accounting purposes, the assets and liabilities of KPS were eliminated from our balance sheet effective at the close of business on July 31, 2007, and since August 1, 2007, the future operating results of KPS are no longer included in our operating results. In accordance with the authoritative guidance for accounting for the impairment or disposal of long-lived assets, the historical operating results of KPS are not reported as a discontinued operation of us because of the significance of the expected continuing cash flows between PharMerica and us under pharmacy services contracts for services to be provided by PharMerica to our hospitals and nursing and rehabilitation centers. Accordingly, for periods prior to August 1, 2007, the historical operating results of KPS are included in our historical continuing operations.

In addition to the pharmacy services contracts noted above, we also entered into new agreements with PharMerica for information systems services, transition services and certain tax matters.

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

Discontinued Operations

In recent years, we completed several transactions related to the divestiture of unprofitable hospitals and nursing and rehabilitation centers.

In June 2009, we purchased for resale six under-performing nursing and rehabilitation centers (the Nursing Centers) previously leased from Ventas for $55.7 million. In addition, we paid Ventas a lease termination fee of

Table of Contents

$2.3 million. The Nursing Centers were included in our Master Lease Agreements (as defined below under Master Lease Agreements) with Ventas and we do not have the ability to terminate a lease of an individual facility under the Master Lease Agreements. We recorded a pretax gain of $2.1 million ($1.3 million net of income taxes) during 2010 and a pretax loss of $39.5 million ($24.3 million net of income taxes) during 2009 related to these divestitures. We disposed of the Nursing Centers during 2009 and 2010 for $27.2 million.

For accounting purposes, the operating results of these businesses and the losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented. Assets not sold at December 31, 2011 have been measured at the lower of carrying value or estimated fair value less costs of disposal and have been classified as held for sale in the accompanying consolidated balance sheet. See notes 4 and 5 of the notes to consolidated financial statements.

HEALTHCARE OPERATIONS

We are organized into four operating divisions: the hospital division, the nursing center division, the rehabilitation division and the home health and hospice division. The expansion of our home health and hospice operations and changes to our organizational structure have led us to segregate our home health and hospice business into a separate division. Our home health and hospice business was previously included in the rehabilitation division. For more information about our operating divisions, as well as financial information, see Part II Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations and note 7 of the notes to consolidated financial statements.

The hospital division operates LTAC hospitals and IRFs. The nursing center division operates nursing and rehabilitation centers and assisted living facilities. The rehabilitation division provides rehabilitation services primarily in hospitals and long-term care settings. The home health and hospice division provides home health, hospice and private duty services to patients in a variety of settings, including homes, skilled nursing facilities and other residential settings. We believe that the independent focus of each division on the unique aspects of its business enhances its ability to attract patients, residents and non-affiliated customers, improve the quality of its operations and achieve operating efficiencies.

Based upon the authoritative guidance for business segments and after giving consideration to our business segments after the RehabCare Merger, our operating divisions represent five reportable operating segments, including (i) hospitals, (ii) skilled nursing and rehabilitation centers, (iii) skilled nursing-based rehabilitation contract therapy services (SRS), (iv) hospital-based rehabilitation contract therapy services (HRS) and (v) home health and hospice services. The SRS and HRS operating segments are both contained within the rehabilitation division.

Prior period business segment information has been restated to conform with the current period presentation. See note 7 of the notes to consolidated financial statements.

COMPETITIVE STRENGTHS

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

Well-diversified service offerings across the post-acute continuum. Through our organic development and acquisitions, we have created a well-diversified portfolio of service offerings. The RehabCare Merger added IRFs to our existing service offerings as well as significantly increased the scale of our contract rehabilitation services business and LTAC hospital business. Following the RehabCare Merger, Kindred operates the largest network of LTAC hospitals and IRFs and is the largest operator of skilled nursing contract rehabilitation therapy services in the United States based upon revenues. We also are the fourth largest operator of skilled nursing and rehabilitation centers in the United States. This array of services creates multiple earnings streams and multiple avenues for growth and further development.

Table of Contents

Uniquely positioned for bundled or episodic payment environment. As healthcare reform is implemented, we believe that healthcare providers that can operate with scale across the continuum of care will have a competitive advantage in an episodic payment environment. Our diversified service offerings enable us both to do this effectively and to participate with other healthcare providers in determining the most appropriate setting for patients as they continue their care throughout a post-acute episode. With the completion of the RehabCare Merger, we are a leader in four critical segments of the post-acute continuum, well-positioned to enhance our cluster market strategy of delivering the right care at the right site of service. We also are positioned to become a valuable partner to short-term acute care hospitals and managed care organizations, which are seeking to increase care coordination and more effectively manage healthcare costs.

Strong asset base including owned real estate. We have been focused on adding high quality assets to our balance sheet through opportunistic acquisitions and development of state-of-the-art LTAC hospitals and transitional care centers in our skilled nursing and rehabilitation centers. We own the real estate of 19 LTAC hospitals, one IRF, 25 nursing and rehabilitation centers and two assisted living facilities, a significant increase from the 16 facilities we owned in 2006.

Strong cash flow generation. We have demonstrated the ability to generate strong operating cash flows in a highly regulated environment. Our operating cash flows offer opportunities to fund our acquisition and development strategies as well as reduce our leverage over time.

Proven and experienced management team. We have an industry leading management team with strong executive leadership and experience in executing and integrating strategic acquisitions. Paul J. Diaz, President and Chief Executive Officer, has over 20 years experience in the healthcare industry. With the inclusion of key operating officers from RehabCare, we believe our management team has demonstrated the ability to adapt and respond to an ever changing healthcare environment.

OUR STRATEGY

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

The key elements of our operating strategy include:

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

Improve operating efficiency. We are continually focused on improving operating efficiency and controlling costs, while maintaining quality patient care, by standardizing key operating procedures and optimizing the skill mix of our staff based upon the clinical needs of each patient or resident. We have implemented specialized programs and technology enhancements to improve our quality and to make our caregivers more efficient.

Increase patient and resident volumes, particularly commercial patients**.** We continue to expand our sales and marketing functions in our hospital and nursing center divisions to grow same-facility admissions and to take advantage of available capacity. Given the relatively higher reimbursement rates from commercial insurers as a group, as compared to Medicare and Medicaid, we continue to focus on expanding our relationships

Table of Contents

with insurers and enhancing their understanding of our services in order to increase commercial patient volume. Since 2009, we have grown our annual non-government admissions in our hospitals by approximately 31% and increased our non-government patient days in our nursing and rehabilitation centers by approximately 8%. We believe that our expanded service offerings and scope of operations will be attractive to commercial payors.

Improve and expand relationships with referring providers. Substantially all of the patients and residents admitted to our hospitals and nursing and rehabilitation centers are referred to us by other healthcare providers such as general short-term acute care hospitals, intensive care units, managed care programs, physicians, and other healthcare providers. Accordingly, we are focused on maintaining strong relationships with these providers as well as developing more comprehensive relationships with physician groups.

Expand presence in home health and hospice business. We continue to expand our presence in the home health and hospice business, and now provide services in eight states through 51 locations. In September 2011, we completed the Professional Acquisition which significantly expanded our scope of operations. In April 2011, we acquired a home health company that operates five locations in Southern California and the San Jose, California markets. In 2010, we acquired a home health company that operates in 11 locations. We intend to expand our home health and hospice operations through additional acquisitions or de novo sites, particularly in cluster markets where we have other healthcare operations.

Grow through development in cluster markets. Our hospitals and nursing center divisions are increasingly focused on the opportunities available in markets where we operate multiple hospitals or have affiliated hospitals or nursing and rehabilitation centers. These cluster markets present opportunities for our hospitals and nursing and rehabilitation centers to share centralized business office operations and collaborate on their sales and marketing and managed care strategies. Our expanded rehabilitation business and home health and hospice operations furthers the continuum of care we can provide in these cluster markets. These cluster markets also allow us to better coordinate and manage the continuum of care for our patients, implement physician services strategies and reduce re-hospitalizations.

Re-deploy assets and management time to higher margin growth businesses. We intend to concentrate our efforts on higher margin businesses such as home health and hospice and contract rehabilitation. In addition, we continue to allocate capital to the development of LTAC hospitals, IRFs and transitional care centers, particularly in cluster markets where we have other healthcare operations. We also continue to review our hospital and nursing and rehabilitation center operations to divest or eliminate under-performing facilities.

Grow through selective acquisitions. We seek growth opportunities through strategic acquisitions in selected target markets, particularly where an acquisition, such as the RehabCare Merger and the Professional Acquisition, may assist us in scaling our operations more rapidly and efficiently than internal growth. In 2011, our acquisition of RehabCare significantly expanded the scope of our hospital and rehabilitation operations as well as added IRFs to our post-acute continuum. We also completed the Professional Acquisition which significantly expanded our home health and hospice operations. In 2010, we acquired four freestanding LTAC hospitals and one LTAC hospital within a host hospital (HIH) with a total of 250 hospital beds, four nursing and rehabilitation centers with a total of 510 nursing and rehabilitation center beds and one assisted living facility with 136 assisted living beds.

Grow our hospital division through business development. Our hospital growth strategy is also focused on the development and expansion of our services:

Freestanding hospitals and IRFs. At December 31, 2011, we operated 92 freestanding hospitals (7,449 licensed beds) and five IRFs (183 licensed beds). During 2011, we opened one freestanding hospital which added a total of 50 licensed beds. During 2010, we opened one freestanding hospital and two replacement hospitals which added a total of 46 licensed beds. At December 31, 2011, we have under development two replacement hospitals which will add 126 licensed beds and one new IRF and one replacement IRF which will add 76 licensed beds to our capacity.

Table of Contents

Sub-acute units. We are well-positioned to develop sub-acute units in several of our hospitals to broaden our scope of services, promote higher quality care and take advantage of unused capacity. At December 31, 2011, we operated nine sub-acute units with 475 licensed beds, have three hospital-based sub-acute units with 102 licensed beds under development, and plan to expand one existing sub-acute unit by 30 licensed beds.

Hospital-in-hospital units. We have contracts with non-Kindred short-term acute care and other hospitals to operate HIHs. 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 HIHs also receive patients from other general short-term acute care hospitals. During 2010, we acquired one HIH with 30 licensed beds. At December 31, 2011, we operated 29 HIHs with 1,148 licensed beds.

Expand program development of our hospital division. We are a leading provider of long-term acute care to patients with pulmonary dysfunction. In addition, we have developed and continue to expand other inpatient and outpatient service areas such as wound care, post-surgical care, acute rehabilitation, pain management, as well as new intensive care units, where we believe opportunities exist to position our hospitals as centers of excellence in certain markets. We also continue to expand our sub-acute programs in selected markets where we believe there is a need for our services and where we have unused capacity.

Improve portfolio of nursing and rehabilitation centers. Our nursing center division continually seeks to improve its existing portfolio. We have:

opened a newly constructed transitional care center with 120 nursing and rehabilitation center beds during 2011,

acquired four nursing and rehabilitation centers with a total of 510 nursing and rehabilitation center beds and one assisted living facility with 136 assisted living beds during 2010,

expanded our transitional care centers and transitional care units to address the needs of more Medicare and managed care short-term patients,

announced our intention to allow the leases for 54 nursing and rehabilitation centers with 6,140 licensed beds to expire in 2013, and

divested or did not renew leases for nine underperforming nursing and rehabilitation centers with approximately 1,100 licensed beds in the last three years.

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

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

Table of Contents

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 121 LTAC hospitals with 8,597 licensed beds and five IRFs with 183 licensed beds in 26 states as of December 31, 2011. We operate the largest network of LTAC hospitals and IRFs in the United States based upon fiscal 2011 revenues.

As a result of our commitment to the hospital business, we have developed a comprehensive program of care for medically complex patients that allows us to deliver high quality care in a cost-effective manner. A number of our hospitals also provide skilled nursing, sub-acute and outpatient services. Outpatient services may include diagnostic services, rehabilitation therapy, CT scanning, one-day surgery and laboratory.

In our LTAC hospitals, we treat medically complex patients, including the critically ill, suffering from multiple organ system failures, most commonly of the cardiovascular, pulmonary, kidney, gastro-intestinal and cutaneous (skin) systems. In particular, we have a core competency in treating patients with cardio-pulmonary disorders, skin and wound conditions, and life-threatening infections. Prior to being admitted to one of our LTAC hospitals, many of our patients have undergone a major surgical procedure or developed a neurological disorder following head and spinal cord injury, cerebrovascular incident or metabolic instability. Our expertise lies in the ability to simultaneously deliver comprehensive and coordinated medical interventions directed at all affected organ systems, while maintaining a patient-centered, integrated care plan. Medically complex patients are characteristically dependent on technology for continued life support, including mechanical ventilation, total parenteral nutrition, respiratory or cardiac monitors and kidney dialysis machines. During 2011, the average length of stay for patients in our hospitals was approximately 28 days.

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

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

Our IRFs provide services to patients who require intensive inpatient rehabilitative care. Our IRF patients typically experience significant physical disabilities due to various medical conditions, such as head injury, spinal cord injury, stroke, hip fractures, certain orthopedic problems, and neuromuscular disease, and require rehabilitative healthcare services in an inpatient setting. Our nurses and physical, occupational, and speech therapists work with physicians with the goal of returning patients to home and work. Patient care is provided by nursing and therapy staff as directed by physician orders. Our IRFs provide an interdisciplinary approach to treatment that leads to a higher level of care and superior outcomes. The medical, nursing, therapy, and ancillary services provided by our IRFs comply with local, state, and federal regulations, as well as other accreditation standards.

Table of Contents

Selected Hospital Division Operating Data

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

	Year ended December 31,		
	2011	2010	2009
Revenues	$ 2,549,992	$ 1,973,321	$ 1,932,892
Operating income	$ 487,442	$ 360,357	$ 363,811
Hospitals in operation at end of period	126	89	83
Licensed beds at end of period	8,780	6,887	6,580
Admissions	60,520	45,559	45,019
Patient days	1,688,376	1,385,669	1,381,350
Average length of stay	27.9	30.4	30.7
Revenues per admission	$ 42,135	$ 43,313	$ 42,935
Revenues per patient day	$ 1,510	$ 1,424	$ 1,399
Medicare case mix index (discharged patients only)	1.18	1.19	1.21
Average daily census	4,626	3,796	3,785
Occupancy %	64.8	65.1	64.7
Annualized employee turnover %	20.3	22.0	22.1
Assets at end of period	$ 2,056,103	$ 1,100,138	$ 867,332
Capital expenditures:			
Routine	$ 46,393	$ 36,967	$ 26,716
Development	67,321	41,140	42,371

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

Table of Contents

Sources of Hospital Revenues

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

Year ended December 31,	Medicare			Medicaid			Medicare Advantage			Commercial insurance and other		
	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues
2011	66%	60%	60%	8%	11%	8%	9%	10%	10%	17%	19%	22%
2010	64	56	56	9	13	9	9	10	10	18	21	25
2009	64	56	55	9	15	10	9	10	10	18	19	25

For the year ended December 31, 2011, revenues of the hospital division totaled approximately $2.5 billion or 44% of our total revenues (before eliminations). For more information regarding the reimbursement for our hospital services, see Governmental Regulation Hospital Division Overview of Hospital Division Reimbursement.

Hospital Facilities

The following table lists by state the number of hospitals and IRFs and related licensed beds we operated as of December 31, 2011:

State	Licensed beds	Number of facilities			
		Owned by us	Leased from Ventas (2)	Leased from other parties	Total
Arizona	217		3	1	4
California	1,097	4	5	6	15
Colorado	105		1	1	2
Florida (1)	745	2	6	2	10
Georgia (1)	117			2	2
Illinois (1)	632	1	4	2	7
Indiana	221	1	1	2	4
Kentucky (1)	414		1	1	2
Louisiana	292		1	3	4
Massachusetts (1)	676	3	2	2	7
Michigan (1)	77			1	1
Missouri (1)	335	1	2	2	5
Nevada	222	1	1	1	3
New Jersey (1)	117			3	3
New Mexico	61		1		1
North Carolina (1)	124		1		1
North Dakota	72			2	2
Ohio	309			5	5
Oklahoma	153		1	2	3
Pennsylvania	482	2	2	5	9
South Carolina (1)	59			1	1
Tennessee (1)	109		1	1	2
Texas	1,912	2	6	21	29
Virginia (1)	60	1			1
Washington (1)	110	2			2
Wisconsin	62			1	1

Totals	8,780	20	39	67	126

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

Table of Contents

Quality Assessment and Improvement

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

The hospital division has implemented a program whereby its LTAC hospitals and IRFs are reviewed by internal quality auditors for compliance with standards of the Joint Commission or the American Osteopathic Association (the AOA). The purposes of this internal review process are to (1) ensure ongoing compliance with industry recognized standards for hospitals, (2) assist management in analyzing each hospital s operations and (3) provide consulting and educational programs for each hospital to identify opportunities to improve patient care.

Hospital Division Management and Operations

Each of our LTAC hospitals has a fully credentialed, multi-specialty medical staff to meet the needs of the medically complex, long-term acute patient. Our LTAC hospitals offer a broad range of physician services including pulmonology, internal medicine, infectious diseases, neurology, nephrology, cardiology, radiology and pathology. In addition, our LTAC 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 LTAC 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 LTAC hospital s interdisciplinary team to determine a care plan. Typically, and where appropriate, the care plan involves the services of several disciplines, such as pulmonary medicine, infectious disease and physical medicine.

A hospital chief executive officer or administrator supervises and is responsible for the day-to-day operations at each of our hospitals. Each hospital (or network of hospitals) also employs a chief financial officer who monitors the financial matters of such 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, promotes the standardization of certain processes and allows staff in our hospitals to focus more attention on patient care.

A division president and a chief financial officer manage the hospital division. The operations of the hospital division are divided into a central region, a southeast region and a west region, each headed by a senior officer of the division who reports to the division president. The clinical issues and quality concerns of the hospital division are managed by the division s chief medical officer and senior vice president of clinical operations.

Table of Contents

Hospital Division Competition

In each geographic market that we serve, there are generally several competitors that provide similar services to those provided by our hospital division. In addition, several of the markets in which the hospital division operates have other LTAC hospitals and IRFs that provide services comparable to those offered by our hospitals. Certain competing hospitals are operated by not-for-profit, non-taxpaying or governmental agencies, which can finance capital expenditures on a tax-exempt basis and receive funds and charitable contributions unavailable to our hospital division.

Competition for patients covered by non-government reimbursement sources is intense. The primary competitive factors in the LTAC hospital and IRF business include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies have entered the LTAC hospital and IRF business with licensed hospitals that compete with our hospitals. The competitive position of any LTAC hospital and IRF also is affected by the ability of its management to negotiate contracts with purchasers of, and to receive referrals from, group healthcare services, including managed care companies, preferred provider organizations and health maintenance organizations. Such organizations attempt to obtain discounts from established charges, as well as to limit their overall expenditures by compressing average lengths of stay. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations and other organizations that finance healthcare varies from market to market, depending on the number and market strength of such organizations.

NURSING CENTER DIVISION

Our nursing center division provides quality, cost-effective care through the operation of a national network of 224 nursing and rehabilitation centers (27,148 licensed beds) and six assisted living facilities (413 licensed beds) located in 27 states as of December 31, 2011. We are the largest publicly held operator of nursing and rehabilitation centers in the United States based upon our fiscal 2011 revenues of approximately $2.3 billion. Through our nursing and rehabilitation centers, we provide short stay patients and long stay residents with a full range of medical, nursing, rehabilitative, pharmacy and routine services, including daily dietary, social and recreational services.

Consistent with industry trends, patients and residents admitted to our nursing and rehabilitation centers arrive with greater medical complexity and require a more extensive and costly level of care. This is particularly true with our Medicare population for whom the average length of stay in 2011 was 33 days. To appropriately care for a higher acuity short stay patient population and a more frail and unstable long stay resident 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, assisting physician oversight through the selective use of nurse practitioners, enhancing nursing skills via ongoing education and competency evaluations and improving clinical case management through the employment of clinical case managers.

We operate transitional care units at 95 of our nursing and rehabilitation centers. These units within our nursing and rehabilitation centers typically consist of 20 to 50 beds offering skilled nursing services and a range of rehabilitation services including physical, occupational and speech therapy to patients recovering from a variety of surgical procedures such as joint replacements, amputations, bariatric procedures, wound closure/repair procedures as well as medical conditions such as stroke, and cardiac and respiratory ailments. Our transitional care units enhance our ability to care for the higher acuity short-term patients typically associated with Medicare, Medicare Advantage and commercial insurance payors. Several of our nursing and rehabilitation centers have clinical programs focused primarily upon the patient population arriving for recovery, recuperation and rehabilitation. We refer to this patient population as transitional care patients and the nursing and rehabilitation centers providing these higher level clinical services as transitional care centers. We currently classify 37 of our nursing and rehabilitation centers as transitional care centers.

Table of Contents

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

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

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

Selected Nursing Center Division Operating Data

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

	Year ended December 31,		
	2011	**2010**	**2009**
Revenues	$ 2,254,099	$ 2,187,885	$ 2,150,342
Operating income	$ 338,265	$ 303,418	$ 305,590
Facilities in operation at end of period:			
Nursing and rehabilitation centers:			
Owned or leased	220	222	218
Managed	4	4	4
Assisted living facilities	6	7	6
Licensed beds at end of period:			
Nursing and rehabilitation centers:			
Owned or leased	26,663	26,957	26,711
Managed	485	485	485
Assisted living facilities	413	463	327
Patient days (a)	8,496,611	8,675,214	8,810,288
Revenues per patient day (a)	$ 265	$ 252	$ 244
Average daily census (a)	23,278	23,768	24,138
Admissions (a)	80,794	76,451	72,801
Occupancy % (a)	85.9	87.4	89.0
Medicare average length of stay (a,b)	32.8	34.0	35.4
Annualized employee turnover %	39.2	39.6	38.9
Assets at end of period	$ 638,078	$ 647,355	$ 566,592
Capital expenditures:			
Routine	$ 34,304	$ 37,024	$ 39,663
Development	19,167	26,701	5,687

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

Table of Contents

Sources of Nursing and Rehabilitation Center Revenues

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

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

	Medicare		Medicaid		Medicare Advantage		Private and other	
Year ended December 31,	Patient days	Revenues	Patient days	Revenues	Patient days	Revenues	Patient days	Revenues
2011	17%	36%	58%	38%	5%	7%	20%	19%
2010	16	35	60	40	4	7	20	18
2009	17	34	61	42	4	6	18	18

For the year ended December 31, 2011, revenues of the nursing center division totaled approximately $2.3 billion or 38% of our total revenues (before eliminations). For more information regarding the reimbursement for our nursing and rehabilitation center services, see Governmental Regulation Nursing Center Division Overview of Nursing Center Division Reimbursement.

Table of Contents

Nursing and Rehabilitation Center Facilities

The following table lists by state the number of nursing and rehabilitation centers and assisted living facilities and related licensed beds we operated as of December 31, 2011:

		Number of facilities				
State	Licensed beds	Owned by us	Leased from Ventas (2)	Leased from other parties	Managed	Total
Alabama (1)	464		2	1		3
Arizona	562		3	1		4
California	2,435	4	6	11		21
Colorado	460		4			4
Connecticut (1)	522		5			5
Georgia (1)	520		4			4
Idaho	695	1	7			8
Indiana	3,662	10	13	2		25
Kentucky (1)	1,556	2	10	1		13
Maine (1)	756		8	2		10
Massachusetts (1)	4,765	2	26	12	3	43
Montana (1)	276		2			2
Nevada	174		2			2
New Hampshire (1)	502		3			3
North Carolina (1)	1,939		16	2		18
Ohio (1)	2,053	5	9	2		16
Oregon (1)	205		2			2
Pennsylvania	103		1			1
Rhode Island (1)	187		2			2
Tennessee (1)	1,065		3	5		8
Texas	405	3				3
Utah	411		4			4
Vermont (1)	294		1		1	2
Virginia (1)	601		4			4
Washington (1)	656		7			7
Wisconsin (1)	1,922		11	1		12
Wyoming	371		4			4
Totals	27,561	27	159	40	4	230

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

Nursing Center Division Management and Operations

Each of our nursing and rehabilitation centers is managed by a state-licensed executive director who is supported by other professional personnel, including a director of nursing, nursing assistants, licensed practical nurses, staff development coordinator, activities director, social services director, clinical liaisons, admissions coordinator and business office manager. The directors of nursing are state-licensed nurses who supervise our nursing staffs that include registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing and rehabilitation center, the types of services provided and the acuity level of the patients and residents. The nursing and rehabilitation centers contract with physicians who provide medical director services and serve on performance improvement committees. We provide our nursing and rehabilitation centers with centralized information systems, federal and

16

Table of Contents

state reimbursement expertise, state licensing and Medicare and Medicaid certification and maintenance support, as well as legal, finance, accounting, purchasing and facilities management support. The centralization of these services improves operating efficiencies, promotes the standardization of certain processes and permits our healthcare staff to focus on the delivery of quality care.

Our nursing center division is managed by a division president and a chief financial officer. Our nursing center operations are divided into two geographic regions, each of which is headed by an operational executive vice president. These two operational executive vice presidents report to the division president. The clinical issues and quality concerns of the nursing center division are overseen by the division s chief medical officer as well as a senior vice president of clinical and residential services 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. Divisional, regional and/or district staff also support the nursing center 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 our clinical operations personnel as well as our performance improvement committees and family satisfaction surveys. Our performance improvement committees oversee resident healthcare needs and resident and staff safety. Additionally, physician medical directors serve on these committees and advise on healthcare policies and procedures. Regional and district nursing professionals visit our nursing and rehabilitation centers periodically to review practices and recommend improvements where necessary in the level of care provided and to ensure compliance with requirements under applicable Medicare and Medicaid regulations. Surveys of residents families are conducted on a regular basis and provide an opportunity for families to rate various aspects of our service and the physical condition of our nursing and rehabilitation centers. These surveys are reviewed by performance improvement committees at each nursing and rehabilitation center to promote and improve resident care.

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

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

Nursing Center Division Competition

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

Table of Contents

REHABILITATION DIVISION

Our rehabilitation division provides rehabilitation services, including physical and occupational therapies and speech pathology services, to residents and patients of nursing centers, acute and LTAC hospitals, outpatient clinics, home health agencies, assisted living facilities, school districts and hospice providers under the name RehabCare. We are organized into two operating segments: skilled nursing rehabilitation services (SRS) and hospital rehabilitation services (HRS). Our SRS operations provide contract therapy services primarily to freestanding skilled nursing centers. As of December 31, 2011, our SRS segment provided rehabilitative services to 1,774 nursing centers in 44 states. Our HRS operations provide program management and therapy services on an inpatient basis in hospital-based inpatient rehabilitation units, LTAC hospitals, sub-acute (or skilled nursing) units, as well as on an outpatient basis to hospital-based and other satellite programs. As of December 31, 2011, our HRS segment operated 102 hospital-based inpatient rehabilitation units and provided rehabilitation services in 115 LTAC hospitals, 25 sub-acute (or skilled nursing) units, and 115 outpatient clinics.

SRS Operations

Our SRS operations involve therapy management services provided primarily to freestanding skilled nursing centers allowing our customers to fulfill their continuing need for therapists on a full-time or part-time basis without the need to hire and retain full-time staff. As of December 31, 2011, SRS managed 1,774 contract therapy programs. We are the largest contract therapy company in the United States based upon fiscal 2011 revenues of approximately $775 million.

SRS provides specialized rehabilitation programs designed to meet the individual needs of the residents and patients we serve. Our specialized care programs address complex medical needs, such as wound care, pain management, and cognitive retraining, in addition to programs for neurologic, orthopedic, cardiac and pulmonary conditions such as stroke, fractures and other orthopedic conditions. We also provide clinical education and programming which is developed and supported by our clinical experts. These programs are implemented in an effort to ensure clinical practices that support the provision of quality rehabilitation services in accordance with applicable standards of care.

SRS recruits and retains qualified professionals with the clinical expertise to provide quality patient care and measurable rehabilitation outcomes. Our rehabilitation division also provides regulatory guidance and compliance support that benefits our clients and their residents and patients.

HRS Operations

Our HRS operations provide program management and therapy services on an inpatient basis in hospital-based inpatient rehabilitation units, LTAC hospitals, sub-acute (or skilled nursing) units, as well as on an outpatient basis to hospital-based and other satellite programs.

Hospital-based inpatient rehabilitation units. We are a leading operator of hospital-based inpatient rehabilitation units on a contract basis. As of December 31, 2011, we managed 102 hospital-based inpatient rehabilitation units. The hospital-based inpatient rehabilitation units we operate provide high acuity rehabilitation for patients recovering from strokes, orthopedic conditions and head injuries. We establish hospital-based inpatient rehabilitation units in acute care hospitals that have vacant space and unmet rehabilitation needs in their markets. We also work with acute care hospitals that currently operate hospital-based inpatient rehabilitation units to improve the delivery of clinical services to patients by implementing our scheduling, clinical protocol and outcome systems, as well as through time management training for existing staff. In the case of acute care hospitals that do not operate hospital-based inpatient rehabilitation units, we review their historical and existing hospital population, as well as the demographics of the geographic region, to determine the optimal size of the proposed hospital-based inpatient rehabilitation units and the potential of the new facility under our management to attract patients and generate revenues sufficient to cover anticipated expenses. Our relationships with these hospitals are customarily in the form of contracts for management services which are typically three to five years in duration.

Table of Contents

A hospital-based acute rehabilitation unit within a hospital affords the hospital the ability to offer rehabilitation services to patients who might otherwise be discharged to a setting outside the acute care hospital, thus improving the ability to provide a full continuum of care and consistency in clinical services and outcomes. A hospital-based acute rehabilitation unit within a hospital typically consists of 20 beds and is staffed with a program director, a rehabilitation physician or medical director, and clinical staff, which may include a psychologist, physical and occupational therapists, a speech/language pathologist, a social worker, a case manager and other appropriate support personnel.

LTAC hospitals. We also provide rehabilitation and program management services, including physical and occupational therapies and speech pathology services, to LTAC hospitals. We provide specialized care programs that support patients with complex medical needs, such as wound care, pain management and cognitive deficits, in addition to programs for neurologic, orthopedic, cardiac and pulmonary recovery. As of December 31, 2011, we managed therapy programs in 115 LTAC hospitals. We also provide LTAC hospitals with clinical education and programming supported by our clinical experts in an effort to ensure that clinical practices support the provision of quality rehabilitation services in accordance with applicable standards of care.

Sub-acute units. As of December 31, 2011, we managed 25 sub-acute (or skilled nursing) units. These units provide lower intensity rehabilitation for medically complex patients. Patients diagnoses typically require long-term care and cover approximately 60 clinical conditions, including stroke, post-surgical conditions, pulmonary disease, cancer, congestive heart failure, burns and wounds. The hospital-based sub-acute unit enables patients to remain in a hospital setting where emergency needs can be met quickly as opposed to being sent to a freestanding skilled nursing facility. These types of units are typically located within the acute care hospital and are separately licensed or under the hospital s license as permitted by applicable laws. The hospital benefits by retaining patients who otherwise would be discharged to another setting, capturing additional revenue and utilizing idle space.

Outpatient. We also manage outpatient therapy programs that provide therapy services to patients with a variety of orthopedic and neurological conditions that may be related to work or sports injuries. As of December 31, 2011, we managed 115 hospital-based and satellite outpatient therapy programs. An outpatient therapy program complements the hospital s occupational medicine initiatives and allows therapy to be continued for patients discharged from inpatient rehabilitation facilities and medical/surgical beds. An outpatient therapy program also attracts patients into the hospital and is operated either on the hospital s campus or in satellite locations controlled by the hospital.

We believe our management of outpatient therapy programs enables the efficient delivery of therapy services through our scheduling, clinical protocol and outcome systems, as well as through time management training for our therapy personnel. We also provide our customers with guidance on compliance and quality assurance objectives. We typically are paid by outpatient therapy customers on the basis of a negotiated fee per unit of service.

Table of Contents

Selected Rehabilitation Division Operating Data

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

	Year ended December 31,		
	2011	2010	2009
SRS:			
Revenues	$ 775,158	$ 403,755	$ 389,875
Operating income	$ 65,916	$ 33,703	$ 32,951
Revenue mix %:			
Company-operated	30	56	54
Non-affiliated	70	44	46
Sites of service (at end of period)	1,774	635	554
Revenue per site	$ 592,848	$ 686,480	$ 703,745
Therapist productivity %	80.4	82.0	84.2
Assets at end of period	$ 425,499	$ 55,781	$ 37,750
Routine capital expenditures	$ 1,700	$ 2,356	$ 919

	Year ended December 31,		
	2011	2010	2009
HRS:			
Revenues	$ 200,824	$ 83,678	$ 77,908
Operating income	$ 43,731	$ 18,969	$ 18,374
Revenue mix %:			
Company-operated	42	95	98
Non-affiliated	58	5	2
Sites of service (at end of period):			
Inpatient rehabilitation units	102	1	
LTAC hospitals	115	91	85
Sub-acute units	25	7	7
Outpatient units	115	12	8
Other	8	4	2
	365	115	102
Revenue per site	$ 783,412	$ 777,690	$ 763,805
Assets at end of period	$ 347,491	$ 798	$ 291
Routine capital expenditures	$ 238	$ 293	$ 124
Annualized employee turnover % (SRS and HRS combined)	16.5	14.4	12.8

Therapist productivity % is computed by dividing labor minutes related to patient care by total labor minutes for the period.

Sources of Rehabilitation Division Revenues

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

Table of Contents

typically pay on the basis of a negotiated fee per unit of service. For the year ended December 31, 2011, revenues of the SRS segment of our rehabilitation division totaled approximately $775 million or 13% of our total revenues (before eliminations). For the year ended December 31, 2011, revenues of the HRS segment of our rehabilitation division totaled approximately $201 million or 4% of our total revenues (before eliminations). Approximately 32% of our rehabilitation division revenues in 2011 were generated from services provided to hospitals and nursing and rehabilitation centers operated by us.

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

Geographic Coverage

The following table lists by state the number of SRS contracts we serviced as of December 31, 2011:

State	Company-operated	Non-affiliated	Total
Alabama	3	5	8
Arizona	4	3	7
Arkansas		6	6
California	21	36	57
Colorado	4	37	41
Connecticut	5	10	15
Delaware		1	1
Florida		50	50
Georgia	4	21	25
Idaho	8	6	14
Illinois		210	210
Indiana	25	35	60
Iowa		27	27
Kansas		58	58
Kentucky	13	35	48
Maine	8	23	31
Maryland		41	41
Massachusetts	42	31	73
Michigan		30	30
Minnesota		66	66
Missouri			