KINDRED HEALTHCARE, INC
Form 10-K
February 26, 2010
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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, 2009

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	**40202-2412**

Louisville, Kentucky
(Address of principal executive offices) **(Zip Code)**

(502) 596-7300

(Registrant s telephone number, including area code)

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ¨ 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 ¨ Accelerated filer þ 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, 2009, was approximately $471,000,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2010, there were 39,111,208 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 18, 2010 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 and rehabilitation centers and a contract rehabilitation services business across the United States. At December 31, 2009, our hospital division operated 83 long-term acute care (LTAC) hospitals (6,580 licensed beds) in 24 states. Our health services division operated 222 nursing and rehabilitation centers (27,523 licensed beds) in 27 states. We also operated a contract rehabilitation services business that provides rehabilitative services primarily in long-term care settings. 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.

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 beginning August 1, 2007, the future operating results of KPS were 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 the Company because of the significance of the expected continuing cash flows between PharMerica and the Company under pharmacy services contracts for services to be provided by PharMerica to the Company s hospitals and nursing 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.

Commonwealth Transaction. In February 2006, we acquired the operations of the LTAC hospitals, nursing centers and assisted living facilities operated by Commonwealth Communities Holdings LLC and certain of its affiliates for a total purchase price of $124 million in cash (the Commonwealth Transaction).

The Commonwealth Transaction included five freestanding LTAC hospitals and one hospital-in-hospital with a total of 421 licensed hospital beds. Three of these hospitals also operate co-located sub-acute units and skilled nursing units with a total of 168 licensed beds. In addition, we acquired the operations of nine nursing and rehabilitation centers containing 1,316 licensed beds and four assisted living facilities with a total of 215 licensed beds. In the transaction, we also acquired the right to develop 95 additional licensed hospital beds in Massachusetts. In September 2008, we closed one of the freestanding LTAC hospitals acquired in the Commonwealth Transaction and relinquished the related licensed beds to the Commonwealth of Massachusetts. See Discontinued Operations.

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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.

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 several transactions related to the divestiture of unprofitable hospitals and nursing centers.

In June 2009, we purchased for resale six under-performing nursing centers (the Nursing Centers) previously leased from Ventas for $55.7 million (the 2009 Facility Acquisitions). In addition, we paid Ventas a lease termination fee of $2.3 million. The Nursing Centers were included in our Master Lease Agreements (as defined) with Ventas and we do not have the ability to terminate a lease of an individual facility under the Master Lease Agreements. The aggregate annual rent for the Nursing Centers was approximately $6 million for the year ended December 31, 2008. The Nursing Centers, which contained 777 licensed beds, generated pretax losses of $0.5 million, $2.5 million and $5.5 million for 2009, 2008 and 2007, respectively. We recorded a pretax loss of $39.5 million ($24.3 million net of income taxes) during 2009 related to these divestitures. We disposed of five of the Nursing Centers in 2009 for $26.2 million and intend to dispose of the remaining Nursing Center as soon as practicable.

In September 2008, we purchased for resale a LTAC hospital for $22.3 million that was previously leased. We recorded a pretax loss of $36.9 million ($22.7 million net of income taxes) in 2008 resulting from the losses related to the purchase, closure and planned divestiture of the hospital, including the impairment of a certificate of need intangible asset ($15.2 million), the impairment of property and equipment ($17.3 million) and other costs ($4.4 million).

In September 2008, we also announced our intention to dispose of another LTAC hospital and its related operations. We recorded a pretax loss of $7.4 million ($4.6 million net of income taxes) during 2008 related to the impairment of the hospital s building and equipment.

These two hospitals generated pretax losses of $3.3 million in 2009 and $8.0 million in each of 2008 and 2007.

We also discontinued the operations of a hospital in 2008 after terminating the hospital operating lease and ceasing operations.

In June 2007, we purchased for resale 21 nursing centers and one LTAC hospital (collectively, the Ventas Facilities) previously leased from Ventas for $171.5 million (the 2007 Facility Acquisitions). In addition, we paid Ventas a lease termination fee of $3.5 million.

The Ventas Facilities, which contained 2,634 licensed nursing center beds and 220 licensed hospital beds, generated pretax income of approximately $3 million in 2008 and a pretax loss of approximately $4 million in 2007. During 2008 and 2007, we sold the Ventas Facilities for approximately $95 million. We recorded a pretax gain of $10.5 million ($6.5 million net of income taxes) during 2008 and a pretax loss of $112.7 million ($69.3 million net of income taxes) during 2007 related to the sale of the Ventas Facilities.

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In January 2007, we acquired from HCP, Inc., formerly known as Health Care Property Investors, Inc. (HCP), the real estate related to 11 unprofitable leased nursing centers operated by us for resale in exchange for the real estate related to three hospitals previously owned by us (the HCP Transaction). As part of the HCP Transaction, we continue to operate these 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 $9.9 million on the 11 nursing centers, (2) add the three hospitals to the master lease with a current annual rent of $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. The 11 unprofitable nursing centers, which contained 1,754 licensed beds, were sold in 2007 and generated a pretax loss of approximately $4 million for 2007. In addition, we terminated a nursing center lease with another landlord during 2007. We recorded a pretax loss related to these divestitures of $13.4 million ($8.3 million net of income taxes) in 2007.

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, 2009 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 3 and 4 of the notes to consolidated financial statements.

HEALTHCARE OPERATIONS

We are organized into three operating divisions: the hospital division, the health services division and the rehabilitation division. The hospital division operates LTAC hospitals. The health services division operates nursing and rehabilitation centers. The rehabilitation division primarily provides rehabilitation services primarily in long-term care 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.

Congress and the White House Administration are currently considering healthcare reform bills, which would initiate significant reforms to the United States healthcare system, including potential material changes to the delivery of healthcare services and the reimbursement paid for such services by the government or other third party payors. The House of Representatives has passed a healthcare reform bill entitled The Affordable Healthcare for America Act and the Senate has passed a healthcare reform bill entitled The Patient Protection and Affordable Care Act. At this time, we cannot predict if or when one of these bills or similar legislation may be passed and submitted to the President.

The healthcare reforms contained in these bills would impact each of our businesses in some manner. Due to the unsettled nature of the current healthcare reform bills, the substantial regulatory changes that would need to be implemented by the Centers for Medicare and Medicaid Services (CMS) and others, and the numerous processes required to implement these reforms, we cannot predict which healthcare reforms will be implemented at the federal or state level, the timing of any such reforms, or the effect such reforms or any other future legislation or regulation will have on our business.

Several of the proposed reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. The proposed reforms could include modifications to the conditions of qualification for payment, bundling payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. In addition, a primary goal of healthcare reform is to reduce costs which could include reductions in the reimbursement paid to us and other healthcare providers. Moreover, healthcare reform could negatively impact insurance companies, other third party payors, our customers, as well as other healthcare providers, which may in turn negatively impact our

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business. As such, these healthcare reforms or other similar healthcare reforms, if adopted, could have a material adverse effect on our business, financial position, results of operations and liquidity.

HOSPITAL DIVISION

Our hospital division provides long-term acute care services to medically complex patients through the operation of a national network of 83 hospitals with 6,580 licensed beds located in 24 states as of December 31, 2009. We operate the largest network of LTAC hospitals in the United States based upon fiscal 2009 revenues of approximately $1.9 billion (before eliminations). As a result of our commitment to the LTAC 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 the hospital division s 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 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, 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 2009, the average length of stay for patients in our hospitals was approximately 31 days.

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. 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 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.

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

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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,
- promoting best practices through our hospitals and standardizing products and services to promote better care,
- expanding our service excellence programs to further embed a culture of caring in each of our hospitals,
- maintaining clinical outcomes programs, which include concurrent reviews 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, a national commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals (the Joint Commission),
- engaging quality councils at the divisional, regional, district 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 patient census,
- increasing the standardization of operating processes, procedures and equipment,
- 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,

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.

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

Freestanding Hospitals At December 31, 2009, we operated 67 freestanding hospitals (5,888 licensed beds). During 2009, we opened one hospital with 60 licensed hospital beds. During 2008 and 2007, we opened five new freestanding hospitals and one replacement hospital which added a total of 331 licensed hospital beds and 39 licensed sub-acute beds. The maturation of these hospitals is a key component of our growth strategy. We have two new freestanding hospitals under development which will add 100 licensed hospital beds to our capacity. Pursuant to the Medicare, Medicaid and SCHIP Extension Act of 2007 (the SCHIP Extension Act), a three-year moratorium, beginning December 29, 2007, has been imposed on the establishment of a LTAC hospital or satellite facility, subject to exceptions for facilities under development. We believe both of the freestanding hospitals under development are exempt from the three-year moratorium established by the SCHIP Extension Act. We also have two replacement hospitals under development.

Sub-Acute Development 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. We operate seven sub-acute units with 409 licensed beds and we have five hospital-based sub-acute units with approximately 150 licensed beds currently under development.

Cluster Market Development We are increasingly focused on the opportunities available to us in markets where we operate multiple hospitals or in which we have affiliated 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. These cluster markets also allow us to better coordinate and manage the continuum of care for each of our patients as well as implement physician services strategies. We believe a more market focused approach will increase admissions over time, better educate the marketplace on our ability to care for post-acute patients and enhance our capabilities to care for patients across various post-acute settings.

Growing Through Selective Acquisitions We seek growth opportunities through strategic acquisitions in selected target markets, particularly where an acquisition may assist us in scaling our operations more rapidly and efficiently than internal growth.

Hospital-in-Hospital We have contracts with non-Kindred short-term acute care and other hospitals to operate LTAC hospitals with a host hospital (HIH). 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 general short-term acute care hospitals in addition to the host hospital. At December 31, 2009, we operated 16 HIHs with 692 licensed beds. We currently have a 50-bed HIH under development which we believe is exempt from the three-year moratorium established by the SCHIP Extension Act.

Expanding Program Development. 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 given markets. We continue 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 continue to expand our sub-acute programs in selected markets.

Increasing Patient Volume, Particularly Commercial Patients. We continue to expand our sales and marketing function to grow same-store admissions and to take advantage of available capacity. We generally receive higher reimbursement rates from commercial insurers as a group than from the Medicare and Medicaid

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programs. As a result, we work to expand relationships with insurers and to enhance their understanding of our services in order to increase commercial patient volume. Each of our hospitals employs specialized staff to focus on patient admissions and the patient referral process. We have enhanced our sales and marketing function and implemented new technologies to increase the speed of referrals and admissions.

Improving Relationships with Referring Providers. Substantially all of the acute and medically complex patients admitted to our hospitals are transferred to us by other healthcare providers such as general short-term acute care hospitals, intensive care units, managed care programs, physicians, nursing centers and home care settings. Accordingly, we are focused on maintaining strong relationships with these providers as well as developing more comprehensive relationships with physician groups. 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,		
	2009	**2008**	**2007**
Revenues	$ 1,932,892	$ 1,837,322	$ 1,727,419
Operating income	$ 363,811	$ 345,367	$ 365,068
Hospitals in operation at end of period	83	82	81
Licensed beds at end of period	6,580	6,482	6,358
Admissions	45,019	43,936	41,330
Patient days	1,381,350	1,395,049	1,328,050
Average length of stay	30.7	31.8	32.1
Revenues per admission	$ 42,935	$ 41,818	$ 41,796
Revenues per patient day	$ 1,399	$ 1,317	$ 1,301
Medicare case mix index (discharged patients only)	1.21	1.15	1.11
Average daily census	3,785	3,812	3,638
Occupancy %	64.7	64.8	64.6
Annualized employee turnover %	22.1	25.2	26.1
Assets at end of period	$ 867,332	$ 847,394	$ 846,429
Capital expenditures:			
Routine	$ 26,716	$ 35,932	$ 35,646
Development	42,371	33,285	59,438

The term operating income is defined as earnings before interest, income taxes, depreciation, amortization, rent and corporate overhead. 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

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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 at existing facilities.

Sources of Hospital Revenues

The hospital division receives payment for its services from third party payors, including government reimbursement programs such as Medicare and Medicaid and 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 admissions, patient days and revenues derived from the payor sources indicated:

ear ended ecember 31,	Medicare			Medicaid			Medicare Advantage (a)			Commercial insurance and other		
	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues	Admissions	Patient days	Revenues
009	64%	56%	55%	9%	15%	10%	9%	10%	10%	18%	19%	25%
008	66	58	55	10	15	10	8	8	9	16	19	26
007	68	60	58	10	15	10	4	4	4	18	21	28

(a) Data not available prior to April 1, 2007.

For the year ended December 31, 2009, revenues of the hospital division totaled approximately $1.9 billion or 42% 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.

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Hospital Facilities

The following table lists by state the number of hospitals and related licensed beds we operated as of December 31, 2009:

		Number of facilities			
State	Licensed beds	Owned by us	Leased from Ventas (2)	Leased from other parties	Total
Arizona	217		2	2	4
California	823	4	5	1	10
Colorado	68		1		1
Florida (1)	745	2	6	2	10
Georgia (1)	72			1	1
Illinois (1)	545		4	1	5
Indiana	119	1	1		2
Kentucky (1)	414		1	1	2
Louisiana	168		1		1
Massachusetts (1)	676	1	2	4	7
Missouri (1)	265		2	1	3
Nevada	238	1	1	1	3
New Jersey (1)	117			3	3
New Mexico	61		1		1
North Carolina (1)	124		1		1
Ohio	250			3	3
Oklahoma	93		1	1	2
Pennsylvania	393	2	2	3	7
South Carolina (1)	59			1	1