



CONTINUE THE CARE

2011 Quality and Social Responsibility Report

Driving Integrated,
Cost-Effective Care Across
the Post-Acute Continuum



YEAR IN REVIEW:

Delivering on
Quality, Value
and Innovation
in Patient Care
Delivery

498,000

patients and residents were cared for by Kindred in settings across the post-acute continuum.

Kindred Long-Term Acute Care and Rehabilitation Hospitals, Skilled Nursing and Rehabilitation Centers and PeopleFirst Homecare and Hospice continued to **improve in key quality indicators** and

OUTPERFORM NATIONAL QUALITY BENCHMARKS

throughout 2011.

In 2011, Kindred's Long-Term Acute Care Hospitals treated the sickest, most medically complex patients, discharging nearly

70%

of patients home or to a lower level of care after an average length of stay of 28 days.

Customer **satisfaction** high with

92%

of our patients, residents and families indicating they would recommend Kindred again.

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Kindred's **RehabCare** Division is the **LARGEST PROVIDER OF REHABILITATION SERVICES** in the United States with 2,139 sites of service.

Since 2008, Kindred Nursing and Rehabilitation Centers discharged **16% MORE PATIENTS HOME** - with 52% of patients discharged home in 2011 after an **AVERAGE STAY OF 32 DAYS.**

RehabCare therapists helped 471,000 patients and residents achieve an average of **MORE THAN 76% IMPROVED FUNCTION** and independence from what they were able to do prior to illness or injury.

From 2008 to 2011, we have **REDUCED THE TOTAL AVERAGE LENGTH OF STAY** in our hospitals by 12% and in our nursing and rehabilitation centers by 27%.

Kindred Long-Term Acute Care Hospitals and Nursing and Rehabilitation Centers **REDUCED REHOSPITALIZATION RATES BY OVER 8%** from 2008 to 2011.

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A healthcare worker, likely a nurse, is shown in a clinical setting. She is wearing blue scrubs and has a red stethoscope around her neck. She is looking down at a patient who is lying in a hospital bed. The patient's head is visible, and they appear to be resting. The background is a light-colored wall with some medical equipment. The overall tone of the image is professional and focused.

EACH YEAR, NEARLY

9 MILLION

PEOPLE – 24,000 A DAY –
ARE DISCHARGED FROM
SHORT-TERM ACUTE
CARE HOSPITALS AND
REQUIRE SOME FORM
OF POST-ACUTE CARE.

ADVANCING INTEGRATED POST-ACUTE CARE

Kindred is developing the capacity to deliver the full continuum of post-acute care in local healthcare markets



LTAC HOSPITALS (121)

INPATIENT REHABILITATION HOSPITALS (5)

HOSPITAL-BASED ACUTE REHAB UNITS (102)

NURSING AND REHABILITATION CENTERS (224)

REHABCARE SITES OF SERVICES (2,139)

HEMOCARE AND HOSPICE LOCATIONS (51)

LOCAL KINDRED MARKETS WITH A DEVELOPING CONTINUUM OF POST-ACUTE SERVICES AND ACTIVE INTEGRATED CARE PARTNERSHIPS

Kindred Healthcare is

77,800

dedicated employees taking care of

53,500

patients and residents every day in over

2,200

locations in

46

states.

OUR MISSION

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

OUR MANAGEMENT PHILOSOPHY

Kindred Healthcare's management philosophy is to focus on our people, on quality and customer service, and our business results will follow.

In local healthcare delivery systems throughout the country, Kindred is
AN ACTIVE PARTNER
in advancing integrated care and new payment models.

CONTINUE THE CARE

Transforming Post-Acute Care

Our nation's healthcare delivery system is changing to require coordination and collaboration among providers with the goal of improved quality and better patient outcomes while reducing costs. While post-acute care historically has been an afterthought in healthcare, it now plays an important role in effective integrated care strategies.

Every year, more than 34 million patients are discharged from inpatient hospital care. For many of these patients a quick recovery is impossible. They require specialized medical and rehabilitative care after a short stay in a traditional hospital – they need post-acute care – in order to recover and regain independence. The goal of post-acute care is to provide recovery, help patients regain function and ensure an independent lifestyle.

Kindred is uniquely positioned to deliver quality medical care and rehabilitative services across the entire post-acute continuum. Our team of physicians, clinicians, therapists and dedicated support staff enables us to more successfully and seamlessly transition patients and effectively manage their entire episode of care across multiple settings – this is how we *Continue the Care*. We make recovery possible at sites of service in local communities nationwide, including

long-term acute care (LTAC) hospitals, acute rehabilitation units, inpatient rehabilitation hospitals (IRHs), sub-acute units, transitional care centers, skilled nursing and rehabilitation centers, homecare, hospice and through contract rehabilitation services provided in acute and post-acute settings.

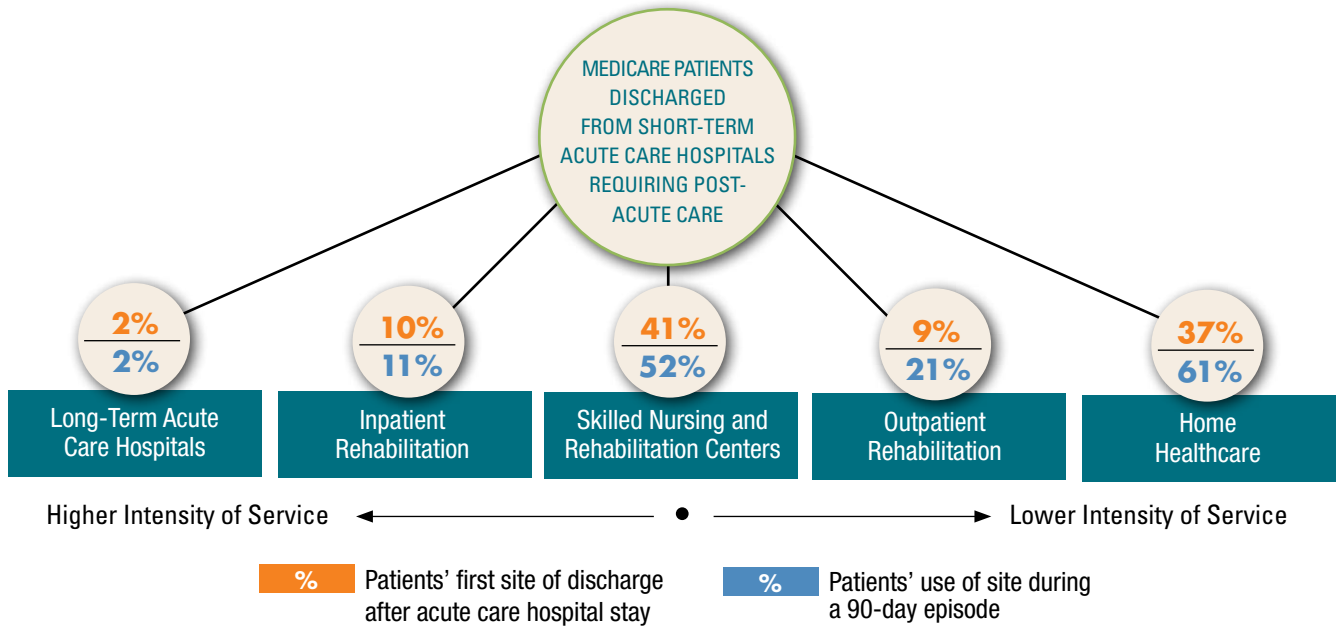
Through partnerships with physicians, health systems, managed care organizations, and acute care hospitals in local markets, Kindred is increasingly able to break down silos of care, better manage episodes of care and deliver on our promise of high-quality, person-centered healthcare.

Kindred's committed approach has led to a proven track record of success with superior clinical outcomes, high customer satisfaction and quality care.



CURRENTLY THERE ARE 47.6 MILLION MEDICARE BENEFICIARIES WITH AN ESTIMATED 7,000 INDIVIDUALS ADDED TO THE PROGRAM EACH DAY.*

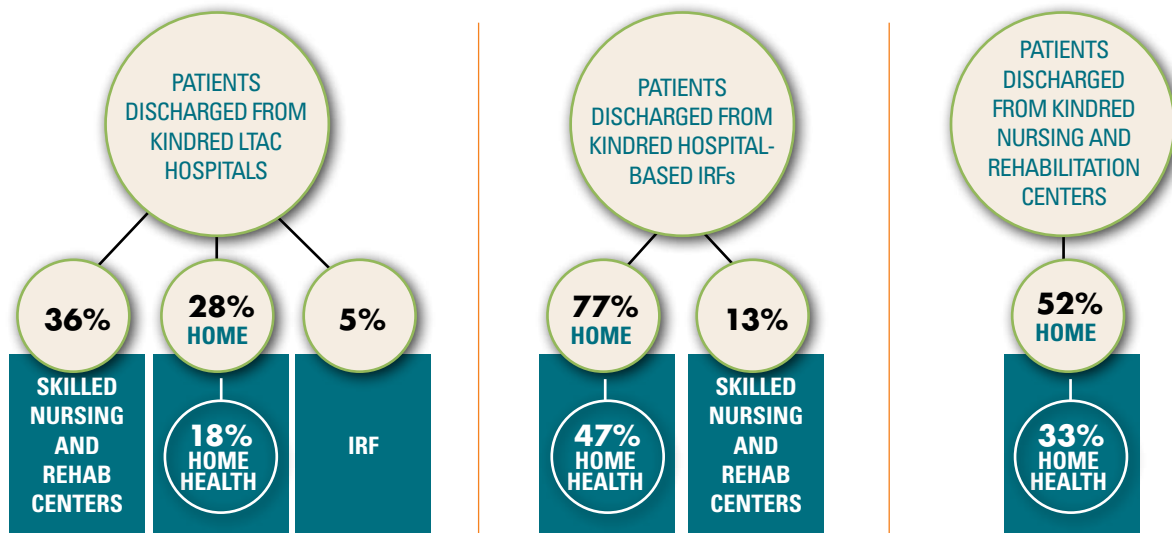
35% OF MEDICARE BENEFICIARIES ARE DISCHARGED FROM ACUTE HOSPITALS TO POST-ACUTE CARE.⁽¹⁾



(1) RTI, 2009: Examining Post-Acute Care Relationships in an Integrated Hospital System

Following an acute hospital stay, a growing number of Medicare patients need post-acute care – often in multiple care settings. Kindred is expanding its capacity to deliver a full continuum of post-acute care in local markets nationwide, in response to this need.

In order to best provide care from hospital to home, our integrated and interdisciplinary care management teams focus on a patient's individual needs. Transitioning patients home more quickly provides superior clinical outcomes and lowers costs by reducing lengths of stay – while reducing unnecessary rehospitalizations.



SOURCE: Kindred Internal Data

*Kaiser Family Foundation, 2011 statehealthfacts.org, and AARP 2011 projections.

“Effective coordination of care between acute and post-acute settings has benefits for patients and providers. Such coordination can reduce hospital readmissions – thereby reducing spending and **IMPROVING PATIENT EXPERIENCES.**”

Medicare Payment Advisory Commission (MedPAC) June 2007 Report

Driving Innovations in Care Coordination

Our nation’s healthcare system is undergoing a transformation that emphasizes Accountable Care Organizations, bundled payment systems and private sector initiatives; all of which share the goal of better care coordination across settings, improved quality outcomes and lower costs. In local healthcare delivery systems throughout the country, Kindred is an active partner in advancing new integrated care and payment models.

Throughout 2011, Kindred built upon its significant and ongoing efforts to improve care coordination and management throughout an entire patient episode of care by increasing partnerships with physicians, care networks, managed care organizations, acute care hospitals and payors. Developing these relationships has led to active communication, enabling a better understanding of patient needs, better care transitions, improved care outcomes and more patients discharged home.

Kindred is proud to be participating in a number of innovative integrated care projects, including participating in bundling demonstrations, applying for Innovation Grants, and partnering with recently announced **Accountable Care Organization (ACO) Pioneers**.

Representing our network of diverse post-acute services in local healthcare delivery markets in hospital **Joint Operating Committees (JOCs)**, and utilizing our internal interdisciplinary team approach has resulted in improved patient care and streamlined transitions between care settings. In addition to JOCs, our partnerships benefit all involved – patients, payors and providers alike – through IT linkages, mechanisms to track and share key data, integrated physician leadership across settings and alignment of financial and clinical goals.

Transitional Care and Homecare Pilot

Our approach to integration and coordination is to break down the silos of care and focus on the unique needs of

each patient. One pilot that illustrates this approach is in our Columbus, Ohio, market. Upon admission to our skilled nursing and rehabilitation centers in the area, patients are assessed as to whether they may require homecare after discharge for a full recovery and independence. A Clinical Integration Specialist (CIS) from Kindred’s homecare agency attends all care conferences and understands all aspects of the patient’s care, improvement and progression toward discharge. During this time, the CIS is an advocate for the patient and a trusted advisor to the patient and family who works to ensure everyone is prepared for the transition to homecare.

The goal is to ensure a seamless transition to the home, a more rapid return to the community and reduce rates of post-discharge rehospitalization.

Innovations in Technology

Kindred has recognized and invested in the development of information technologies including electronic health records (EHRs) in order to improve clinical delivery, capture real-time documentation, track patient outcomes, and better serve our business partners.

We are committed to invest in and enhance our internally developed ProTouch system that is used in all our LTAC hospitals. Recent upgrades to this system establish alerts to a patient’s change in condition or medication management; enable clearer communication between physicians, nurses and case managers; and provide improved data analytics.



It is important to

RECOGNIZE THE ROLE THAT LTACs PLAY

in breaking the cycle of countless rehospitalizations. Oftentimes we care for patients with severe COPD... After several cycles of being treated in a short-term hospital, discharged home and readmitted very shortly thereafter, they are admitted to our LTAC, where we provide more aggressive respiratory therapy and rehabilitation and prevent an immediate rehospitalization.



Dr. Amy Patel – Hospitalist in Kindred Hospital Northeast – Stoughton



Additionally, in the Cleveland, Ohio, market we have established an electronic linkage with our acute care partner's health record, EPIC, within our local LTAC hospital.

In 2011, we began the process of implementing the Point Click Care web-based EHR in our Nursing Center Division, beginning with our Transitional Care Centers. This tool will improve the accuracy of documentation, streamline processes and increase operating efficiencies – all contributing to improved quality care.

Throughout our **RehabCare Division**, our therapists in the field rely on handheld technologies and applications that provide the highest levels of productivity and efficiency. Enhanced technology initiatives drive improved clinical and operational results throughout the division. In 2011, we added the ability to track and trend treatment data, which provides the ability to identify and implement best practices, target clinical advancements and provide improved patient outcomes.

Innovations in Reduced Rehospitalizations

Kindred continues its focus on innovative strategies to reduce rehospitalizations from post-acute care settings through a collaborative project with Dr. Andrew Kramer, a noted expert in this area. 2011 witnessed the development

and first pilot test of an application that identifies patients at highest risk of hospitalization in a single cluster market so that clinicians can most appropriately tailor care interventions and reduce the risk of rehospitalization.

The pilot test demonstrated the potential of the web application to identify patient risk, and to identify sites with elevated readmission rates for Kindred LTAC hospitals and nursing and rehabilitation centers. Equally important, the tool identifies the specific factors that increase the risk of hospitalization so that colleagues can take action to reduce the risk.

Innovations in Physician Engagement

At Kindred we recognize that physicians are a key element of integrated and coordinated care. Throughout 2011, we engaged in several initiatives to foster improved physician alignment which resulted in physicians increasingly following patients from the acute hospital to a variety of Kindred post-acute settings. Additionally, physicians are an integral part of the medical leadership team at our facilities. To promote training of physicians in post-acute care, Kindred facilities are used as academic sites for residents, medical students and allied health clinicians.

Kindred LTAC hospitals
**REDUCED
 REHOSPITALIZATION**
 rates by 8.4% from 2008 to 2011.

Long-Term Acute Care Hospitals

Research indicates that only five percent of our nation's population accounts for nearly half of overall healthcare spending.* As healthcare struggles to deliver quality care at a lower cost for the sickest patients, LTAC hospitals play a vital role in caring for and stabilizing the most medically complex patients, and improving function so that they may go to a lower, less costly setting of care without being rehospitalized.

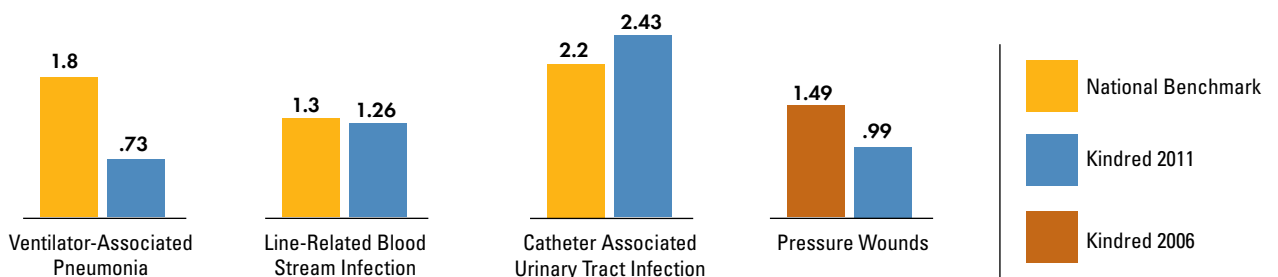
Our patients are critically ill with few care options left. They come to our hospitals because they require aggressive and specialized care with an extended recovery time that conventional short-term acute care hospitals are not equipped to provide. Kindred LTAC Hospitals offer expert interdisciplinary care and services tailored to the medically complex patient including 24-hour physician support, special care units, telemetry units with on-site laboratory and radiology services and operating rooms.

Kindred LTAC Hospitals are accredited by the Joint Commission, meet all conditions of participation for the Medicare program as overseen by the national Centers for Medicare and Medicaid Services and are licensed and inspected by state regulatory authorities.

Who Are Our Patients

The physicians and clinical teams in Kindred LTAC Hospitals treat the very sickest patients who require the most intense and life-saving medical interventions. Our LTAC patients have three to six concurrent active diagnoses and have suffered an acute episode on top of several chronic illnesses. We use patient screening criteria to evaluate the appropriateness of patients admitted to our hospitals to ensure that those patients requiring less-intense services receive care and rehabilitation in alternate settings best suited for their needs. The criteria dictate that our long-term acute care is comparable to a traditional acute hospital level of care and address the patient's needs for high intensity of service because of an intense severity of illness.

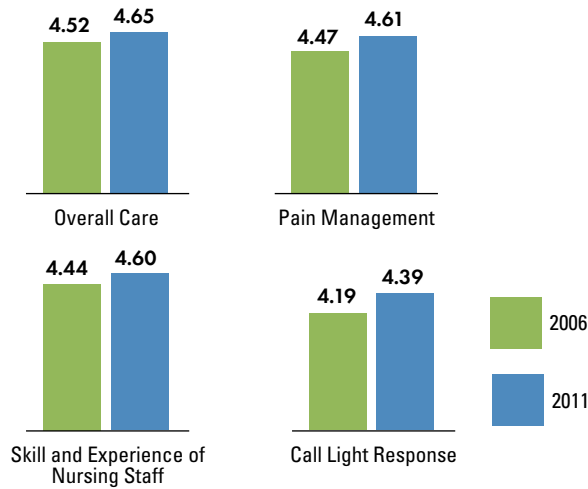
KINDRED'S QUALITY EXCEEDS NATIONAL BENCHMARKS ON MANY KEY INDICATORS



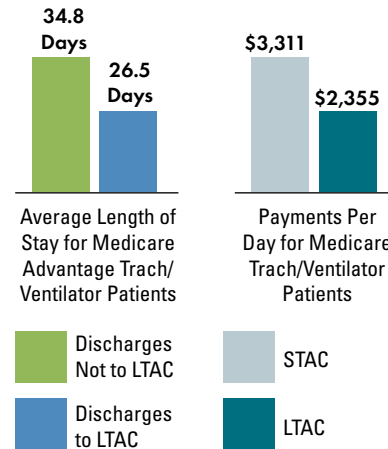
Source: National Healthcare Safety Network (2010) and Kindred Internal Data (2011)

Rates per 1,000 Patient Days

PATIENT/FAMILY SATISFACTION SCORES
(1 = Poor, 5 = Excellent)



LOWERING THE COST OF CARING AND THE AVERAGE LENGTH OF STAY FOR THE MOST MEDICALLY COMPLEX MEDICARE AND MEDICARE ADVANTAGE PATIENTS



Source: MedPar (2010)

Interdisciplinary Care Coordination

In each LTAC hospital we use Interdisciplinary Care Coordination Teams to best treat the patient by planning for his or her unique clinical needs, focusing on any barriers to discharging the individual to the next level of care. The expertise of every team member is critical in the collaborative process in order to achieve Kindred’s standard of quality patient care. Many disciplines contribute to the team including nursing, physicians, respiratory care, case management, pharmacy, nutrition, infection control, Chief Clinical Officers and wound care specialists.

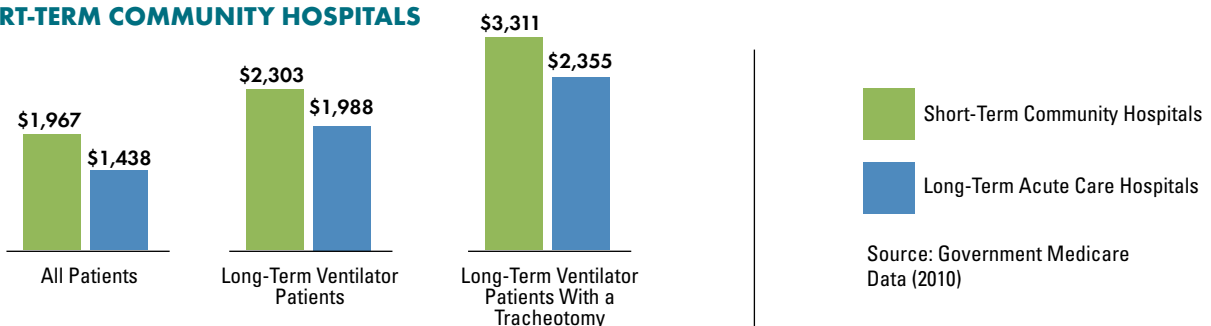
Subacute Units

Situated within our LTAC hospitals, our subacute units – licensed as skilled nursing facilities – provide medical care and rehabilitation for those patients who no longer require the very intense and aggressive medical care provided in a long-term acute care hospital. Being co-located enables care and treatment by the same physicians, therapists and care professionals ensuring a coordinated transition and improved outcomes.

“ For patients with tracheostomies, Medicare spending for the episode of care was **LOWER** for those who used a [long-term acute care hospital] than for those who did not. ”

MedPAC, March 2011 Report to Congress

LONG-TERM ACUTE CARE HOSPITALS COST SIGNIFICANTLY LESS PER DAY THAN SHORT-TERM COMMUNITY HOSPITALS



Source: Government Medicare Data (2010)

There has been an **8.2%**
IMPROVEMENT
in Kindred Nursing and Rehabilitation
Centers' Rehospitalization rate in the
first 30 days from 2008 to 2011.

Nursing and Rehabilitation Centers

Skilled nursing and rehabilitation centers have emerged as essential components of an effective integrated care delivery system providing intensive nursing care and rehabilitation therapies in a very cost-efficient setting. Acute providers and managed care payors increasingly recognize the value of today's nursing and rehabilitation centers to manage episodes of care, reduce rehospitalizations and transition patients home sooner.

In 2011, the patients served in our nursing and rehabilitation centers continued to be more medically and clinically complex with growing nursing and therapy needs. Despite challenging reimbursement and regulatory pressures, Kindred invested additional clinical resources, including an 11% increase in nursing hours per patient day since 2004, to meet the growing patient needs. This investment has resulted in an increase in patients discharged home, a decrease in the average length of stay and a reduction of hospital readmissions.

Outcomes Excellence

We demonstrate our dedication to quality care and performance improvement through the outcomes data that we measure and report. Kindred is leading the industry in outcomes tracking, providing robust reports which include rehospitalization rates, length of stay, discharge disposition, functional outcome measures and customer satisfaction. We use this data to improve our quality and build post-acute care relationships that establish appropriate patient goals and create plans of care for a successful return to home.

Specialized Clinical Programs

To meet the needs of the communities we serve, our centers have developed additional expertise in the clinical areas of cardiac, pulmonary, renal, orthopedic, stroke recovery and wound care. Through 2011, nearly 200 programs have been implemented in Kindred centers nationwide. Through these programs, patients benefit from specialty physician involvement, an interdisciplinary team with advanced training for the conditions they treat and specific protocols

and equipment to best meet their needs. While all Kindred centers care for a variety of conditions, these programs offer additional and advanced capabilities to care for patients with more complex therapy needs.

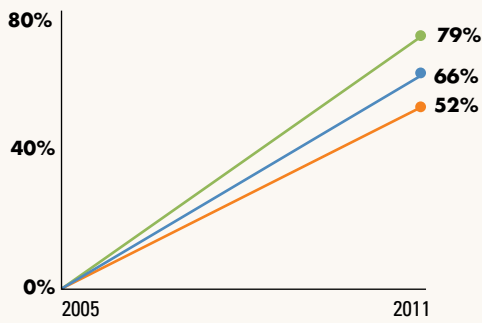
Transitional Care – Short-Term Rehabilitation

As patients have become more medically and clinically complex, we specialize in providing services to meet their unique and changing needs. Our transitional care centers are shaping the future of our nursing and rehabilitation centers. These centers focus on patients who require aggressive short-term rehabilitative and medically complex care. Generally they are recuperating from joint surgery, strokes or other procedures and need an intensive, supervised rehabilitation regimen. Rehabilitation services include physical, occupational and speech-language therapies. These services are dedicated to restoring patients and residents to 75 – 100% of their prior level of function.

Alzheimer's and Dementia Care

Many of our patients go home within a few weeks, and for those residents who are unable to return home, we provide safe, compassionate care in an environment that fosters independence and dignity. We care for a great number of residents with some sort of dementia, including Alzheimer's disease. Many of our nursing and rehabilitation centers specialize in providing interventions to best manage the unique challenges facing these residents and offer a supportive and safe environment for the resident, and peace of mind for their families.

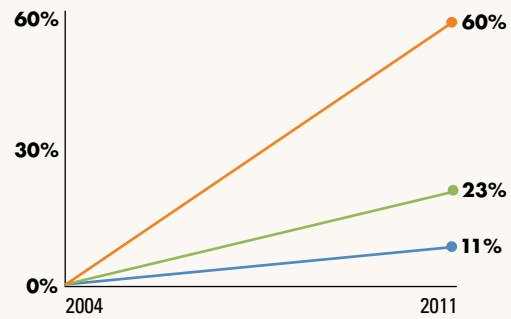
KINDRED IS CARING FOR MORE AND SICKER PATIENTS...



- % Increase in Patients Receiving Dialysis
- % Increase in Admissions from Hospital
- % Increase in Patients with IV Therapy

Source: Kindred Internal Data

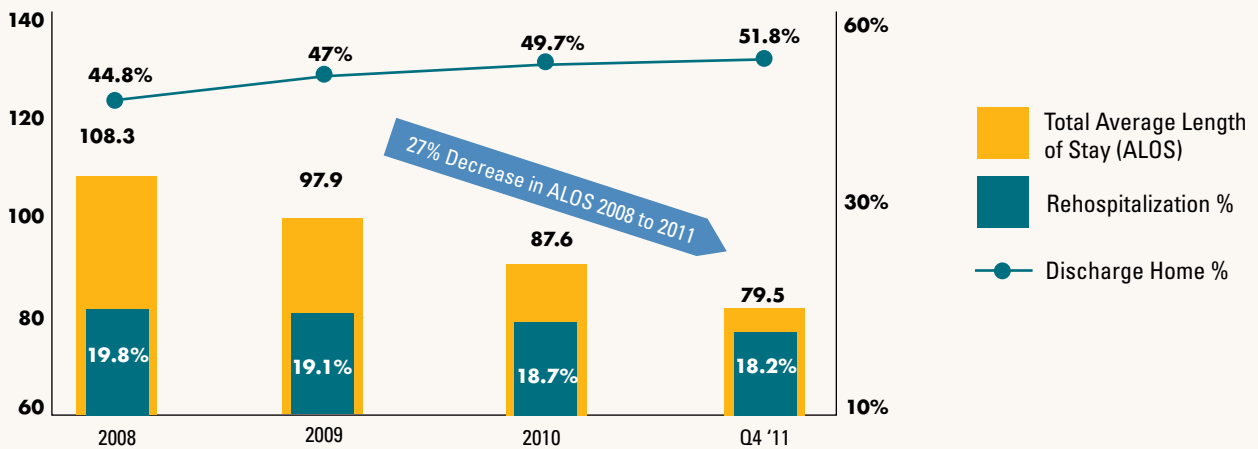
AND IN TURN HAS INVESTED IN ADDITIONAL CLINICAL RESOURCES...



- % Increase in Rehabilitation Hours Per Patient Day
- % Increase in Pharmacy Costs
- % Increase in Nursing Hours Per Patient Day

Source: Kindred Internal Data

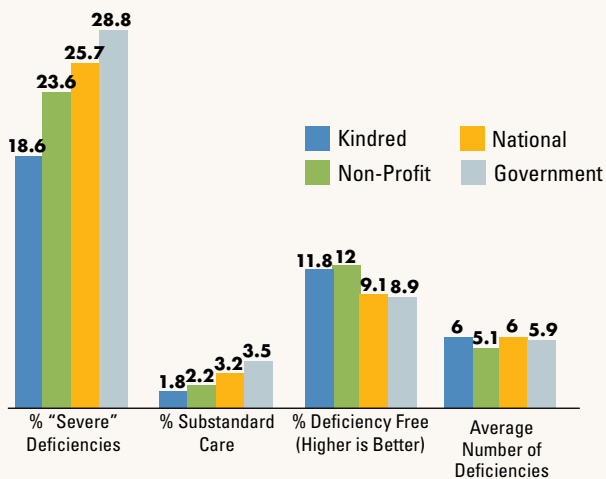
RESULTING IN FEWER REHOSPITALIZATIONS AND MORE PATIENTS GOING HOME SOONER...



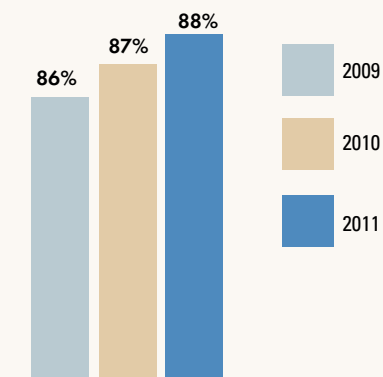
- Total Average Length of Stay (ALOS)
- Rehospitalization %
- Discharge Home %

KINDRED'S SURVEY QUALITY PERFORMANCE EXCEEDS NATIONAL AND PEER BENCHMARKS

Source: CMS-Maintained OSCAR Database, November 2011



CUSTOMER SATISFACTION IMPROVING – % PATIENTS AND RESIDENTS WHO WOULD RECOMMEND OUR NURSING AND REHABILITATION CENTERS FOR CARE



Research indicates that higher-intensity therapy leads to
SHORTER LENGTHS OF STAY.



The provision of rehabilitative therapies – including physical, occupational and speech-language – across all settings of post-acute care is integral to the goal of improving the functional ability of patients, shortening lengths of stay and driving down costs. RehabCare therapists treat patients across the Kindred continuum, enabling effective care coordination and management of patient episodes.

Throughout the entire post-acute care delivery system, a primary goal is to improve the well-being and physical abilities of each patient so that he or she may enjoy the highest quality of life possible. Regardless of the setting in which care is delivered, rehabilitative therapies are an essential component in delivering improved patient outcomes. As well as serving Kindred facilities, our RehabCare therapists provide contract rehabilitation services in unaffiliated hospitals, inpatient rehabilitation facilities, skilled nursing facilities and through home health agencies nationwide.

RehabCare therapists provided intense physical, occupational and speech-language therapies in **2,139 sites of service in 2011, helping 471,000 patients and residents** achieve improved function and independence.

There is a growing body of research that illustrates that higher-intensity therapy interventions result in shorter lengths of stay in post-acute care settings and improved recovery. Additionally, evidence suggests that rehabilitative therapies are also critical in reducing rehospitalization rates.

Recovery Through Rehabilitation

In 2011, the rehabilitation provided by our RehabCare physical and occupational therapists enabled patients and residents to **regain 76.5% of their function** as compared to what they were able to do prior to illness or injury. As well, our rehabilitation interventions in Kindred

and unaffiliated skilled nursing facilities led to the ability of **39.8% of treated patients and residents to return to home or community.**

Clinical Training for Outstanding Rehabilitation

RehabCare focuses on the clinical development of our therapists. Our rehabilitation teams are educated and trained on the latest technology, surgical approaches, protocols and precautions and will develop, follow and modify a rehabilitation plan that is unique to each patient’s needs, goals and progress toward the goal of functional independence for a safe return home.

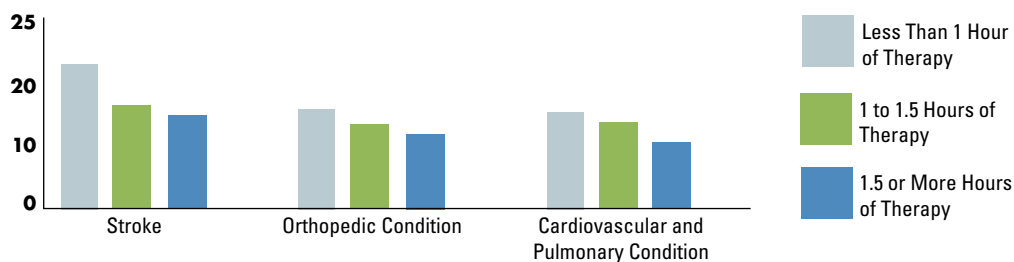
We provide ongoing clinical training related to falls management, cognitive retraining, pain management, seating and positioning, low vision and bariatric care, among many others.

Inpatient Rehabilitation Hospitals and Hospital-Based Acute Rehabilitation Units

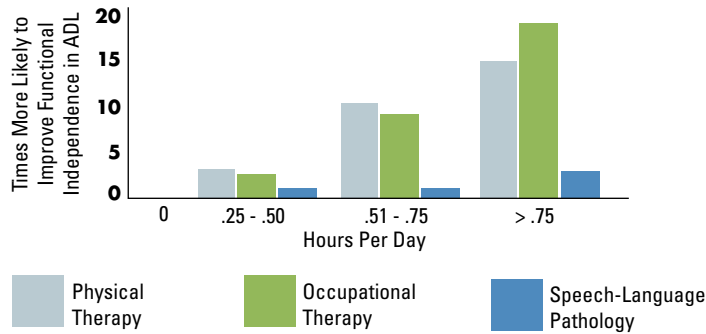
Through expert, intense and aggressive interdisciplinary therapy care our Inpatient Rehabilitation Hospitals (certified by Medicare as inpatient rehabilitation facilities (IRFs)) provide rapid recovery and improved function for patients who can tolerate at least three hours of rehabilitation therapy each day.

In 2011, we cared for approximately 42,400 patients in 102 hospital-based acute rehabilitation units. More than 76% were discharged to home or community after an average length of stay of just over 12 days.

LENGTH OF STAY (DAYS) BY NUMBER OF HOURS OF THERAPY RECEIVED PER DAY



STROKE PATIENTS' ODDS OF IMPROVING ADL FUNCTIONAL INDEPENDENCE OVER NO THERAPY INTERVENTION, BY PATIENT THERAPY HOURS PER DAY, 2002



Source: DU Jette, et al. "The Relation Between Therapy Intensity and Outcomes of Rehabilitation in Skilled Nursing Facilities." Archives of Physical Medicine and Rehabilitation

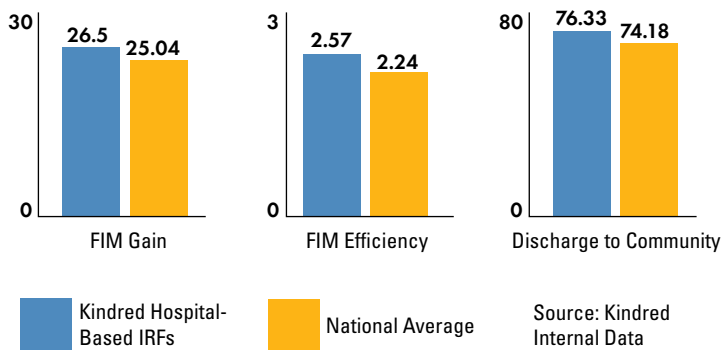
Earlier rehabilitation admission, higher-level activities early in the rehabilitation process, tube feeding and newer medications are associated with

BETTER
stroke rehabilitation
OUTCOMES.

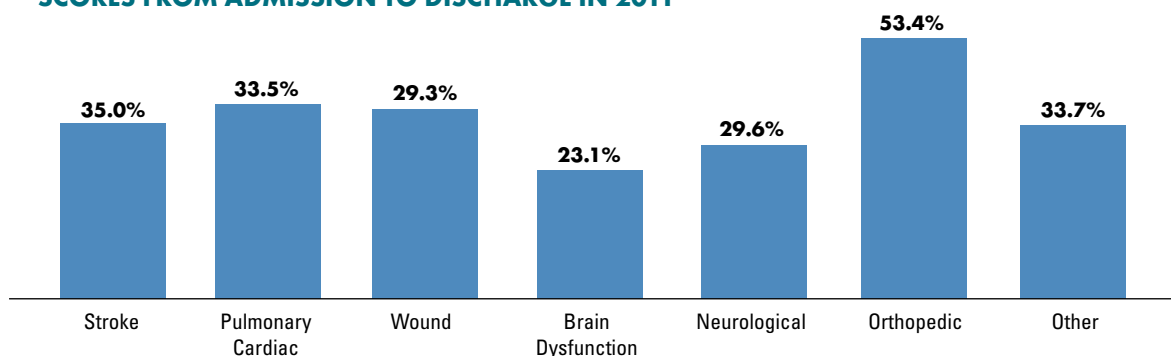
Horn et al, Archives of Physical Medicine and Rehabilitation Vol 86, December 2005



KINDRED IRFS OUTPERFORM NATIONAL IRF PERFORMANCE IN KEY QUALITY MEASURES



REHABCARE'S INCREASE (%) IN FUNCTIONAL OUTCOME MEASUREMENT SCORES FROM ADMISSION TO DISCHARGE IN 2011



Source: Kindred Internal Data, Using Modified "Functional Outcome Measures" (FOMS)

Homecare is a
COST-EFFECTIVE
 service for individuals
 recuperating from a hospital stay.



As the lowest cost post-acute provider, homecare enables patients to return home sooner. Through the effective uses of rehabilitation and clinical care, patients gain the abilities and improved health to live independently and prevent new hospital admissions.

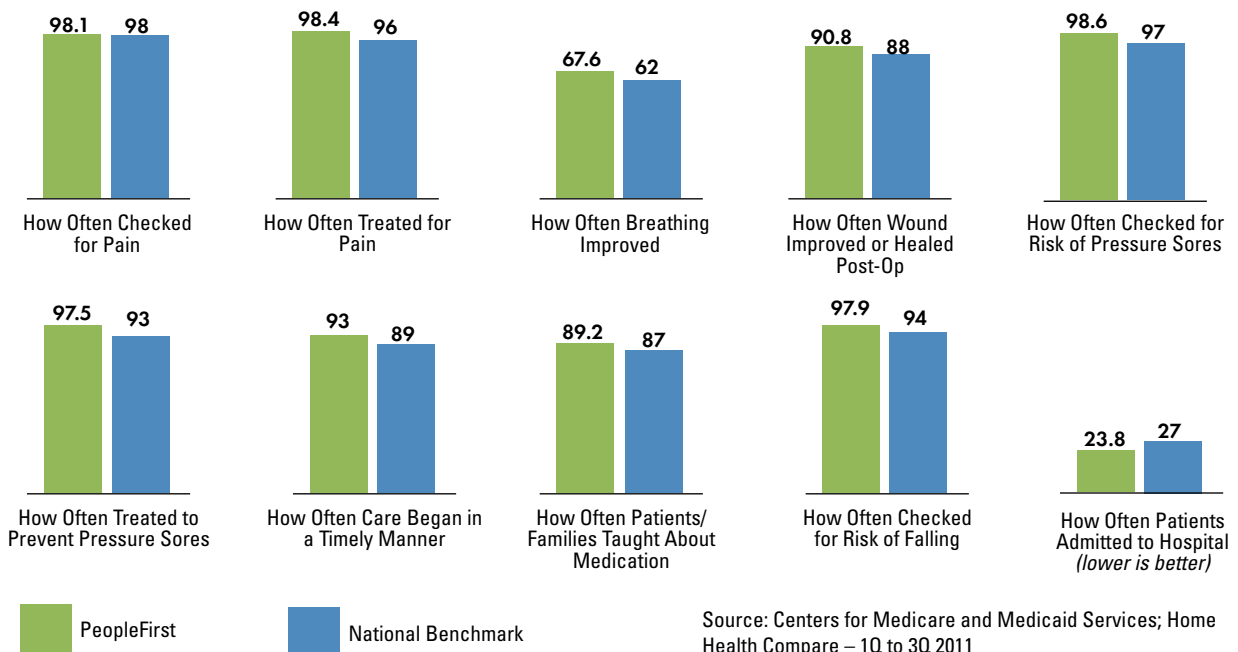
Kindred's homecare and hospice division, **PeopleFirst**, includes 2,300 caring employees serving 4,800 individuals on a daily basis – providing home-based medical and rehabilitative care as well as a comfortable and supportive environment for end of life care.

2011 saw significant growth and development for PeopleFirst Homecare and Hospice. This additional expertise and expanded capability ensures our ability to continue the care for patients, residents and clients across the entire post-acute spectrum. These capabilities allow us to provide care and services in an individual's most-preferred

location – their home or place of residence. Our homecare professionals are able to provide the most cost-effective critical nursing and rehabilitative services that alleviate the need for a hospital admission or emergency room visit in the least expensive setting.

The ability to discharge patients from LTAC hospitals, IRFs or skilled nursing and rehabilitation centers to our home health services ensures a greater coordination of care, with quicker transfers home and fewer post-discharge rehospitalizations – all at significant savings to the healthcare system.

PEOPLEFIRST HOMECARE EXCEEDS NATIONAL PERFORMANCE ON THESE KEY QUALITY MEASURES



Source: Centers for Medicare and Medicaid Services; Home Health Compare – 1Q to 3Q 2011

In 2011, all PeopleFirst Hospice locations completed implementation of the National Hospice & Palliative Care Organization's Family Evaluation of Hospice Care Survey, which will provide the ability for each location to benchmark against State and National data moving forward.

“ [Home health] patients often need help adjusting to or recovering from a recent acute health condition, and in-home nursing visits permits beneficiaries to

SHORTEN OR AVOID POST-ACUTE STAYS

at skilled nursing facilities and other higher cost post-acute care providers.”

MedPAC, March 2011 Report to Congress



“Studies indicate that hospice **IMPROVES THE QUALITY** of remaining life for patients who elect it and is associated with greater family satisfaction with patients' end-of-life care.”

MedPAC, March 2011 Report to Congress

Investing in Our People, Communities and Economy

Investment in Employees

Kindred recognizes that our greatest strength is the nearly **78,000 dedicated and compassionate employees** who create our dynamic culture of caring. Every day they deliver on our mission of hope, healing and recovery. In order to equip our employees to provide high-quality medical care and rehabilitation across the continuum, we invest in ongoing education, leadership training, the proper tools and resources, as well as a commitment to their health and well-being.

Our goal is to attract, develop and retain outstanding talent and to provide the opportunities to ensure clinical excellence and expertise and to grow professionally.

Leadership and Professional Development

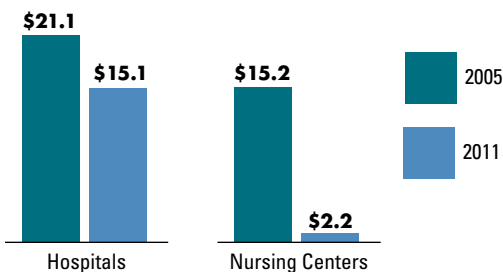
Kindred offers a series of leadership development programs designed to bring out the best among our colleagues including our Executive Fellowship, Nurse Leadership and Rehab Manager-in-Training programs. These are designed to provide hands-on field experience, practical tools and resources to help prepare employees for challenges they may face. As well, our Rising Stars program mentors and assists individuals for officer leadership positions.

In late 2011, Kindred held its third annual Clinical Impact Symposium – Cardio-Pulmonary Rehabilitation Across the Continuum. By bringing together 350 professionals from many different disciplines throughout Kindred, we furthered our commitment to provide the best in interdisciplinary care for our patients and customers, and to expand our clinical expertise.

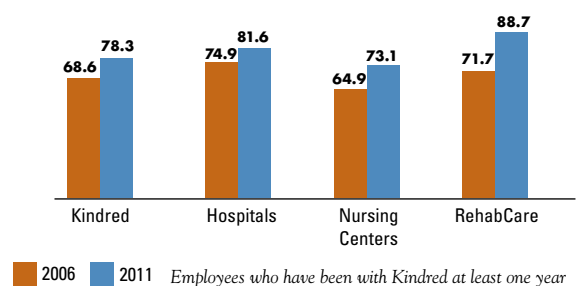
Providing HOPE

The HOPE fund (Helping Others Persevere through Emergencies) provides much needed assistance. **Since 2005, almost \$4.4 million has been donated to provide hope and financial assistance to 2,800 employees.** In 2011, employees donated the equivalent of \$254,000 to fellow employees encountering emergency situations.

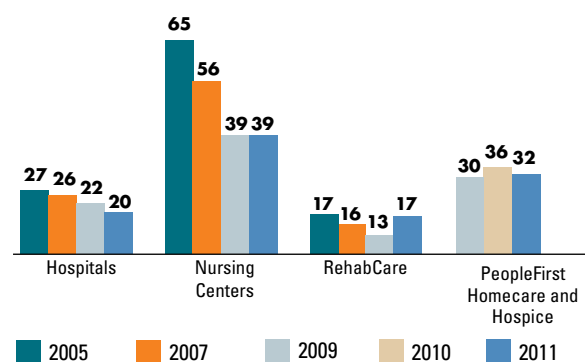
REDUCTION IN CONTRACT LABOR (\$ in millions) – IMPROVING THE CONSISTENCY OF THE PATIENT/CAREGIVER RELATIONSHIP



EMPLOYEE RETENTION (%)



TURNOVER RATES (%)



OUR PEOPLE

OVER 61,000

employees and dependents were covered under Kindred's medical plan in 2011 – an increase of 46% from 2004.

In 2011,

OVER 28,000

employees and dependents completed a Health Risk Assessment for 2012. This is approximately a 28% increase over 2010. Employees who engage in wellness programs have the opportunity to reduce their contributions for medical insurance.

The Kindred workforce is a team of **DIVERSE INDIVIDUALS**

who share the common goal of providing the highest quality care for our patients and residents. In 2011, Kindred's compassionate workforce was composed of more than **81%** women and approximately **39%** minorities.

ALMOST \$450 MILLION

was invested in our employees in 2011 including: **\$34.7 million** in employee training • approximately **\$152 million** to our employee healthcare plan • **\$2.4 million** to employees in tuition reimbursement • over **\$30 million** invested in employee recognition and bonus programs for non-management employees throughout the year.

THE COMMUNITY

On behalf of those patients and residents we serve each day we raise awareness and critical funding for the diseases and conditions that most affect them and their loved ones. We are proud to provide increased local community support by providing matching donations to the funds raised by employees.

Through ongoing support by the Kindred Foundation, we have created strong national and regional partnerships with the Alzheimer's Association, the American Heart Association and the American Lung Association.



THE ECONOMY

In 2011, at a time when unemployment and job losses remain a national concern, **KINDRED INCREASED THE NUMBER OF NET CLINICAL EMPLOYEES BY OVER 3,000**, including 900 new RNs, 330 LPNs, 1,115 CNAs and 675 physical, occupational and speech-language therapists.

Kindred is the

102nd

LARGEST NON-GOVERNMENT EMPLOYER IN THE UNITED STATES AND IN 2011 PAID OVER \$2.7 BILLION IN SALARIES AND LABOR COSTS • ALMOST \$105 MILLION IN EMPLOYEE STATE INCOME TAXES • APPROXIMATELY \$152 MILLION IN COMPANY-PAID HEALTH INSURANCE • OVER \$157 MILLION IN PROVIDER, PROPERTY AND INCOME TAXES • OVER \$644 MILLION IN PRODUCTS AND SERVICES FROM VENDORS.





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Learn more about patient and employee experiences with Kindred by following us on Facebook and Twitter.

