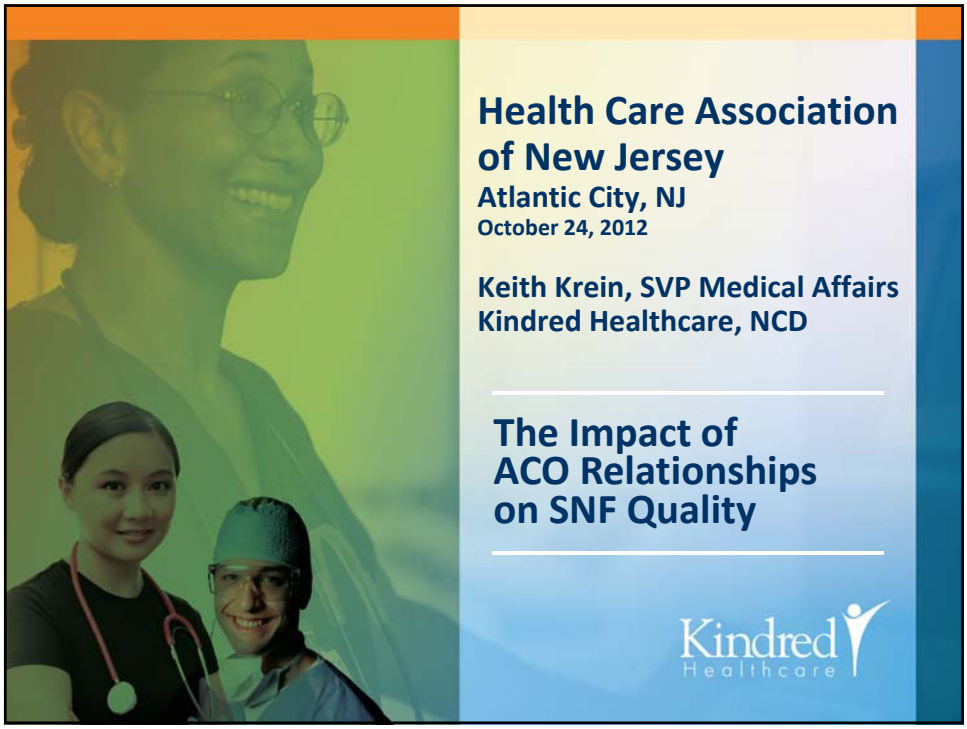


Health Care Association of New Jersey

Atlantic City, NJ
October 24, 2012

Keith Krein, SVP Medical Affairs
Kindred Healthcare, NCD

The Impact of ACO Relationships on SNF Quality

Kindred Healthcare

Accountable Care Organizations

"Voluntary groups of physicians, hospitals, and other health care providers that are willing to assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to them on the basis of patients' use of primary care services.

If an ACO succeeds in **both delivering high-quality care or improving care and reducing the cost** of that care below what would otherwise have been expected, it will share in the savings it achieves for Medicare."

The New England Journal of Medicine (NEJM), October 20, 2011
Making Good on ACOs' Promise – The Final Rule for the Medicare Shared Savings Program
Donald M. Berwick MD, Administrator, CMS

Perspective – Final Rule for Medicare Shared Savings Program

The New England Journal of Medicine

"We believe that today's ACO rule is the next step in our shared commitment to a better, more lasting health care system. We look forward to being a trusted partner in our nation's journey toward **patient-centered, coordinated care."**

Donald M. Berwick MD, Administrator, CMS

The New England Journal of Medicine (NEJM), October 20, 2011

Making Good on ACOs' Promise – The Final Rule for the Medicare Shared Savings Program

Key Principles of Accountable Care

The Brookings Institution

Underlying Causes of Poor Performance	Principles of Accountable Care
Lack of clarity about aims, and about whose perspectives are most relevant.	Clear aims: better overall health through higher-quality care and lower costs with a focus on patients.
Providers are fragmented and unable to coordinate care well; providers accept responsibility only for what they directly control.	Establish provider organizations accountable for achieving better results for all of their patients at a lower cost.
Payment system drives fragmentation, rewards unnecessary care, and penalizes care coordination and overall efficiency.	Align financial, regulatory, and professional incentives with the aims of better health through higher-quality care, lower costs.
Inadequate information to support provider and patient confidence about the value of reforms.	Valid, meaningful performance measures that support provider accountability for aims and support informed and confident patient care choices.

Kaiser Health News

ACOs Multiply As Medicare Announces 27 New Ones *APR 10, 2012*

Despite uncertainty over how the Supreme Court will rule on the health law, a key provision intended to help transform the delivery of care is moving ahead.

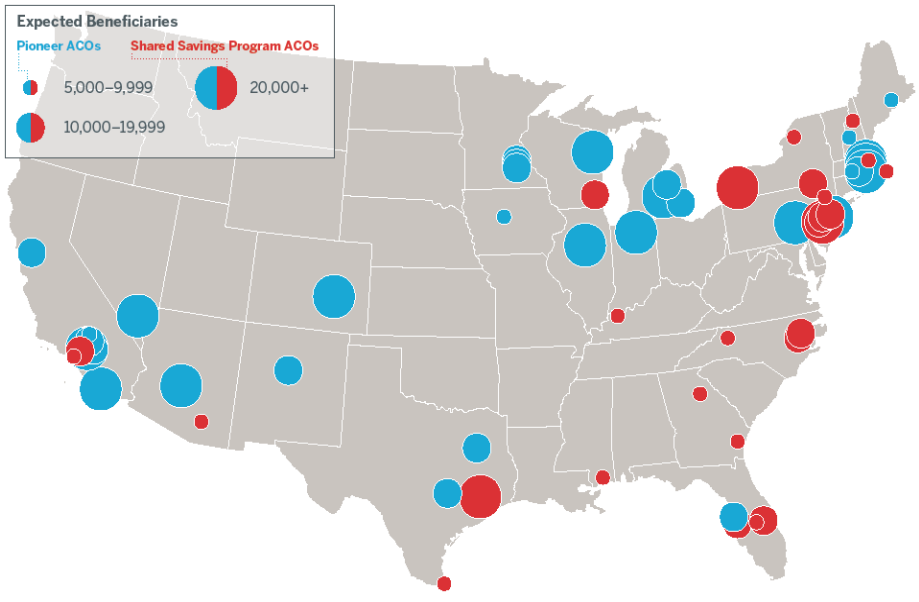
…27 health systems have been selected to participate in Medicare's Shared Savings Program, which offers financial incentives for physicians, hospitals and other health care providers to team up in "accountable care organizations."

Instead of getting paid for each service ACOs **reward providers that are able to manage chronic disease and meet certain quality measures, including reducing hospital admissions and emergency room visits.** If they improve care while restraining costs, the systems can share in the savings.

WHERE THE ACOs ARE

32 Pioneer and 27 Shared Savings Program ACOs as of April 2012

Medicare Accountable Care Organizations have emerged at a rapid pace—and more may be on the way. As of April 15, CMS said it's reviewing approximately 150 applications to join the second Shared Savings Program cohort, slated to launch in July 2012.



ACOs Potential Impact on SNF Quality

1 **Transparency**
- Might as well adjust to the fact that entities, other than surveyors, will be more interested in what we are doing

2 **ACO or Market Level Outcomes**
- Coordinated, efficient, error free "transitions of care"
- Length of Stay
- Functional rehabilitation progress
- Re-hospitalization rates
- Patient and Family Satisfaction

3 **Regulatory Level Outcomes**
- Clinical QMs (falls, pressure sores, infection, restraints, pain, psychotropic meds, etc)
- Pharmacy error rates and Safety
- Annual and Complaint Survey compliance

ACOs Potential Impact on SNF Quality

- Transparency
  - Entities (other than surveyors) will be more interested in what we are doing and generally "in our business"
  - ACO clinicians and physicians will likely have greater involvement in what happens to "their" patients when they enter our facilities
  - ACOs will have a vested interest in our ability to improve quality and reduce cost and they will insist on ways to measure both
  - We (read OUR CLINICIANS) will need to be conversant with the status of our patients/residents in terms of clinical complexity, rehab potential, discharge potential and hospitalization risk and we (read OUR CLINICIANS) will need to dialogue with external clinicians in regard to case specific situations and aggregate outcome data
    - **Will we have the in-house physician and nursing talent to dialogue with their ACO peers?**
    - **Will the ACO insist on placing their physicians in our SNFs?**

Existing MCO relationships may be a "window" to an ACO future?

Kaiser and *Health Care Partners* examples:

- Guidelines and Pathways for such things as transfer readiness, clinical treatment and rehab goals, length of stay and discharge preparation
- Daily Medical Management - Physician presence mandatory – they place their docs in our SNFs
- Weekly Clinical Meetings and Case Management
- Quarterly Joint Operating Committees (JOC)
- Robust Performance Improvement (PI) process on Quality Measures including Re-hospitalization reviews
- Make suggestions about décor, food, room assignments, staffing, etc.

Who are our SNF Patients?

And why is this important

Tremendous Opportunities Exist to Better Manage Patients Discharged from Acute Care Hospitals

Medicare Patients' Use of Post-Acute Services Throughout an "Episode of Care" [1]

Intensity of Service

	SHORT-TERM ACUTE CARE HOSPITALS	LONG-TERM ACUTE CARE HOSPITALS	INPATIENT REHAB	SKILLED NURSING FACILITIES	OUTPATIENT REHAB	HOME HEALTH CARE
Patients' ***first*** site of discharge after acute care hospital stay		2%	10%	41%	9%	37%
Patients' use of site during ***90 day*** episode		2%	11%	52%	21%	61%

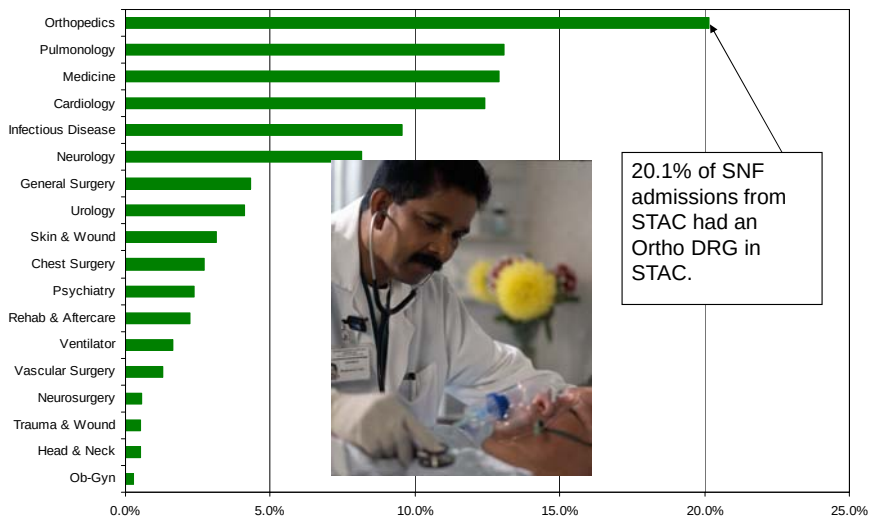
35% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

*** 52% of the 35% are admitted to SNFs within 90 days ***

[1] Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System

SNF Patients

Percent of Total Medicare Discharges to SNFs from Short-Term Acute Care Hospitals FY 2006



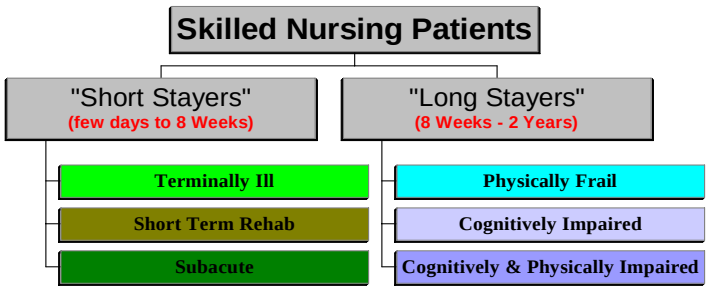
STACH Severity of Illness (SOI) Scores by PAC Discharge Setting

Increasing Severity

Severity of Illness Level	All Post-Acute Care	Long Term Acute Care Hospital	Inpatient Rehab Facility	Nursing and Rehab Facility	Home Health
SOI 4	5.9%	33.2%	5.4%	6.9%	4.0%
SOI 3	29.3%	36.6%	25.7%	33.3%	27.3%
SOI 2	46.5%	24.1%	48.5%	45.7%	47.6%
SOI 1	16.0%	3.6%	19.4%	11.7%	18.7%

The APR-DRG system classifies patients by severity of illness, physiologic decompensation or organ system loss of function The four SOI levels1 to 4 indicate, minor, moderate, major, or extreme severity of illness. Source: RTI International, March 2008

Basic Profile of Skilled Nursing & Rehabilitation Center Patients / Residents



Different subgroups have differing priorities, needs and discharge potential. Anticipate growth in the Short Stay or Transitional Care population and shrinkage in Long Stay or Chronic Care Resident population. However, **this trend is not occurring at the same rate across geographic regions nor among facilities in the same markets.**

Tale of Two Nursing Centers

Nursing Center	# of Beds	DC Expire	DC Hospital	DC Home	Total Nursing & Therapy PPD	Annual Surveys
A	126	64%	8%	13%	3.72	Def FREE
B	120	9%	16%	67%	4.97	State Avg

Two Skilled Nursing Centers of similar size, but with very different metrics… Why?

A Tale of Two Nursing Centers
The Rest of the Story

Center Name	DC Home	DC Hospital	DC Other	DC Nur Cen	DC Expire	DC Total	Nrsg & Ther PPD
A	16 13%	10 8%	18	1	80 64%	126	3.72

Center A – Boston suburb:

- Alzheimer's Care Center caring exclusively for Long Stay Residents
- Consumer Reports Recommend List
- Last three annual surveys were Deficiency Free (10 of last 12 Deficiency Free)
- AHCA Bronze and Silver Quality Award recipient
- Robust restorative nursing program
- Very Strong Social Services and nutrition services
- Moderate size therapy staff, no Respiratory Therapy
- This is where you want to be for long stay Alzheimer's Care

A Tale of Two Nursing Centers
The Rest of the Story

Center Name	DC Home	DC Hospital	DC Other	DC Nur Cen	DC Expire	DC Total	Nrsg & Ther PPD
B	1222 67%	296 16%	82	60	159 9%	1819	4.97

Center B – Greater Los Angeles area:

- Located on hospital campus
- Heavy Managed Care volume of higher acuity short stay patients
- Doctors & NPs round in Center daily
- Robust therapy services including Respiratory therapy
- Center discharges about 100 patients to HOME per month
- Very Good care, but surveys are challenging due to patient volume and clinical complexity issues
- This is where you want to be for short stay, medical recovery and rehabilitation

Hospital Readmissions

- 20% of Medicare beneficiaries discharged from the hospital are readmitted within 30 days
- 90% are unplanned readmissions
  - $12 billion annually
- Patient Protection and Affordable Care Act
  - Starting October 1, 2012, reduce Medicare DRG payments to hospitals with higher than expected readmissions for specified conditions
  - Hospitals could have as much as $3 billion at risk annually under the ACA readmissions reduction program

ACOs and SNF RE-HOSPITALIZATIONS

"With the rising rate of hospital discharges to SNFs and the increasing complexity of SNF admissions, readmissions to hospital from nursing homes is a major issue for hospitals. The result is that preventing hospital readmissions is becoming a major focus of nursing home performance efforts…

Nursing homes that choose to compete for higher reimbursed Medicare patients and participate in Accountable Care Organizations (ACOs) **will be compelled to demonstrate their performance** in this regard."

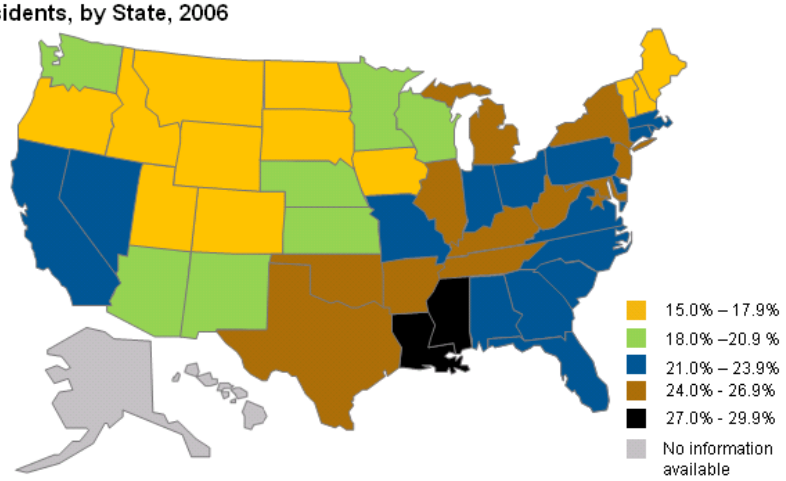
AHCA / Alliance
2011 Annual Quality Report

ACOs may increasingly depend on Rehospitalization rates as a "proxy" for Clinical Quality of Care

- **Complex discussion in the SNF setting**
  - Patient Population (comorbidities and complications)
  - Physician involvement and availability
  - Diagnostic testing availability (lab, x-ray, etc)
  - Pharmacy availability & medication management (meds, IVs)
  - Nursing assessment skills
  - Programmatic Clinical competencies of SNF
  - Nurse / physician communication and understanding
  - Advance Directives, Surrogate Decision making, End-of-Life planning
  - Family expectations
  - Transition issues – accurate transfer data and medical info, continuity of care

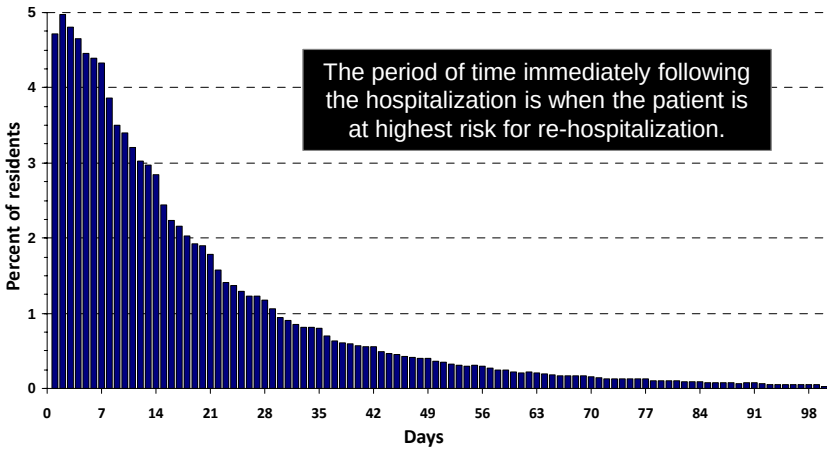
Re-hospitalization Rates for Short-stay Nursing Facility Patients, by State

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006



Source: Vincent Mor, et al. (2010) Medicare SNF Rehospitalizations: Implications for Medicare Payment Reform. Health Affairs.

SNF Days until Re-hospitalization



Andrew Kramer, MD, CEO, Providigm LLC

We (the SNF Industry) should care greatly about Risk Adjustment

- Not all patients/residents have the same risk for a potentially avoidable hospitalization
- To compare rates across SNFs (or other PAC settings) risk adjustment is essential
- To track or monitor trends over time in a SNF (or other PAC settings) risk adjustment is essential
- Risk adjustment models can identify residents at highest risk for potentially avoidable hospitalizations

CMS developing a "Risk Adjusted" Rehospitalization Quality Measure for SNFs - "Potentially avoidable"

Overall Readmission Pattern by PAC Site

Site	Total PAC Episodes with within 30 days of Anchor STACH	Total # of Re-hospitalizations	% Re-hospitalizations
LTACH	121,892	10,989	9.0%
IRF	305,329	30,381	10.0%
Home Health	1,725,155	187,898	10.9%
SNF	1,977,864	333,678	16.9%
Community	5,325,852	938,919	17.6%
Hospice	396,343	6308	1.6%

The Moran Group

Source: CMS LDS Standard Analytical Files, 2009 Date Files – Hospitalizations with admission dates after 1-5-2009 and discharge dates on or before 11-1-2011

Heart Failure Readmission Pattern by PAC Site

Site	Total PAC Episodes with within 30 days of Anchor STACH	Total # of Re-hospitalizations	% Re-hospitalizations
LTACH	4298	305	7.1%
IRF	6256	807	12.9%
Home Health	90,639	14,641	16.2%
SNF	100,748	21,208	21.1%
Community	248,337	68,623	27.6%
Hospice	29,836	563	1.9%

The Moran Group

Source: CMS LDS Standard Analytical Files, 2009 Date Files – Hospitalizations with admission dates after 1-5-2009 and discharge dates on or before 11-1-2011

MCO Re-hospitalization Story

- The Kaiser network in Southern California
- JOC Meeting in Kindred SNF - 2009
- Kaiser doc proudly shares internal Re-hospitalization report:
  - Six months of data on rates of re-hospitalization from SNF to STACH for Kaiser members only
  - Captured Re-hospitalization rates at 3 days, 7 days, and 30 days
  - In that six month period, 110 SNFs sent 7000 patients back to the hospital
  - Re-hospitalization rates varied from 8% to 60%
  - Do the math !!!!

What is a Quality Admission from ACO point of view?

- Communication with referral Center to coordinate patient's medication, treatment, equipment needs and treatment goals
- RN and physicians available to "catch" the patient (assessment, condition, prognosis, meds, treatments, advance directives, family expectations, etc)
- Therapy availability seven days a week
- Discharge planning begins early with focus on reduced length of stay
- RNs and physicians identify and respond quickly to "changes in condition" to reduce morbidity and re-hospitalization rates
- Smooth transition to home or next site of care
- Patient and family satisfaction

Pioneer ACO: Provider Minimum Expectations Example

- MDs and APCs will either be employed by a group participating in the ACO or will be identified as a "preferred" attending clinician. Both groups will be asked to comply with a set of minimum expectations:
  - Legible discharge summary will be completed within 24 Hours of discharge and sent to ACO Medical Records for scanning into EMR
  - The Discharge summary will follow a predetermined template
    - Complete discharge med list (including pertinent changes and reasons), physical exam changes, pending labs, code status, advance directive status and follow-up plan
  - 24/7 coverage by clinicians who have experience managing patients in the SNF setting who will respond in a timely manner
  - Timely (same day) communication to PCP if unexpected change in patient status occurs
  - Newly admitted patients seen with in 48 hours by physician
  - Use of ACO preferred vendors
  - Will participate in team meetings and family meetings as necessary
  - Will participate in quality and INTERACT or other related readmission reviews
  - Comply with all payer minimum requirements
  - Will review the patients discharge/follow up needs and ensure that follow up care is appropriate and returned to ACO PCP.

Pioneer ACO: Facility Minimum Expectations Example

- Stable staff turnover; minimal use of agency; nursing supervisor on evening and night shifts
- High Quality Mental Health coverage available 7 days per week by phone and see patients within 2 – 3 days for consultation
- Provider credentialing needs to be timely and well communicated
- Same day admission screens and able to accept patient until 9 PM 7 days a week
- Able to accept direct admits from home/ER/clinician office
- Suitable work space for MD and APCs with computer access; internet access; facility PCs permit download of Citrix to enable remote access to Epic
- Facility meets patient expectations regarding food, cleanliness and environment
- DME is in the patients room prior to arrival when appropriate
- INTERACT (or comparable tool) is utilized and quarterly reports sent to ACO
- Established day/time for team meetings for ACO patients
- Therapies are provided as ordered at least six days/wk. If patient arrives before 2PM, assessment and initial evaluation must be completed and documented on the day of admission
- STAT Radiology, Labs obtained and resulted within 5 hours and prescriptions delivered within 6 hours
- Patients are surveyed regarding their satisfaction and results shared with ACO and have target > 90th percentile
- Patients receive typed list of medications upon discharge, med changes are highlighted and explained
- Adherence to discharge planning checklist

AHCA Quality Initiative The Goals

- Safely Reduce Hospital Readmissions
- Increase Staff Stability
- Increase Customer Satisfaction
- Safely Reduce the Off-Label Use of Antipsychotics

Kindred Healthcare

$6 billion[2] consolidated revenues

2,200[3] sites of service, **452** facilities in **46** states

53,500[3] patients and residents per day

77,800[3] dedicated employees, making Kindred a top-150 private employer in the U.S.[4]

(1) Ranking based on revenues.
(2) Pro forma revenues for the year ended December 31, 2011 (before intercompany eliminations).
(3) As of December 31, 2011.
(4) Ranking provided by TMP, Inc.

Kindred's Service Lines

HOSPITAL
Long-term Acute Care Hospitals
Inpatient Rehabilitation Hospitals

$2.5 billion revenues[1]

- Largest operator in U.S.[2]
- 121 LTAC hospitals 8,597 licensed beds[3]
- 5 IRFs 183 licensed beds[3]

NURSING CENTER
Nursing and Rehabilitation Centers

$2.3 billion revenues[1]

- Fourth largest nursing center operator in U.S.[2]
- 224 nursing centers 27,148 licensed beds[3]
- 6 assisted living facilities 413 licensed beds[3]

REHABILITATION SERVICES
RehabCare

$1.0 billion revenues[1]

- Largest contract therapy company in U.S.[2]
- 2,139 sites of service served through 8,750 therapists[3]
- 102 hospital-based acute rehabilitation units[3]

HOMECARE & HOSPICE
PeopleFirst

$106 million annualized revenues[4]

- 51 sites of service[3]
- 2,100 employees serving 4,800 patients on a daily basis[3]

(1) Revenues for the year ended December 31, 2011 (divisional revenues before intercompany eliminations).
(2) Ranking based on number of facilities.
(3) As of December 31, 2011.
(4) Annualized based on revenues for the three months ended December 31, 2011 (divisional revenues before intercompany eliminations) plus annualized revenues for the Synergy acquisition.

What is the optimal PAC setting for patient placement - Figuring it all out

- Care PRD demonstration project (Uniform Patient Assessment) is working its way through CMS
- At Kindred, we needed a common language and set of definitions to manage referrals and transitions of care
- Began crafting internal language in 2007 via work of Clinical Excellence and Service Line Strategic Planning Committee
- Not an easy task

Kindred Healthcare:
Service Line Offerings - Patient Characteristics

SERVICE LINE SETTING *KINDRED NAME*	LONG TERM ACUTE CARE Hospital	TRANSITIONAL / SUBACUTE CARE Hospital and Nursing & Rehab Center	LONG TERM CHRONIC CARE Nursing & Rehab Center	DEMENTIA CARE Secured Units in Nursing & Rehab Center *REFLECTIONS*	HOSPICE & PALLIATIVE CARE Hospital, Nursing & Rehab Center, and Community *PASSAGES*	OUTPATIENT SERVICES Hospital or Nursing & Rehab Center	HOME HEALTH SERVICES Community
Patient Type	Multiple concurrent, acute and/or unstable illnesses OR overall medical complexity requiring daily physician management and intensive nursing services; (e.g. Vent Patients; Complex Wound Care; Post surgical complications, etc.) Patients generally require 2 to 6 weeks of care	Clinically complex, but generally stable OR Rehabilitation and recovery from an acute illness or exacerbation of a chronic illness requiring enhanced skilled nursing competencies, therapy interventions and clinical management (e.g. Recovery from acute Cardiac or Respiratory events or exacerbations, Status post surgery, stroke, fracture, wound, etc) Patients generally require between 1 to 12 weeks of care	Primarily support and supervision of individuals with stable functional, cognitive, or behavioral impairments and/or chronic illness and dysfunction. Emphasis on dignity, socialization and preserving function Residents generally require months or years of care	Specialized Dementia care, programs and activities offered in a secure, structured environment to emphasize remaining abilities and quality of life; plus routine ADL care Residents generally require months or years of care	Palliative and end of life Hospice care with appropriate Psychosocial, Spiritual, ADL support and Pain management; (e.g. Cancer, late stage congestive heart failure and respiratory failure, end stage Alzheimers, etc.) Patients/residents generally require several weeks, up to six months of care	Primarily rehab provided to patients no longer needing inpatient care for chronic illness or acute event (CVA, fracture, wound, etc.) Patients generally require two to six weeks of care	Primarily nursing or therapy oversight of individuals able to remain at home or other unsupervised congregate living arrangement, but requiring nursing or therapy interventions and/or supervision. Patients generally require up to three months of care

* *Transitional / Subacute Care CENTERS* and *Transitional /Subacute Care UNITS* are differentiated primarily by "short stay" census in the Center and certain clinical criteria. TCCs will have a minimum short stay ADC of 50 or greater. Short stay = Medicare and Managed Care ADC.

Kindred Healthcare:
Service Line Offerings - Parameters

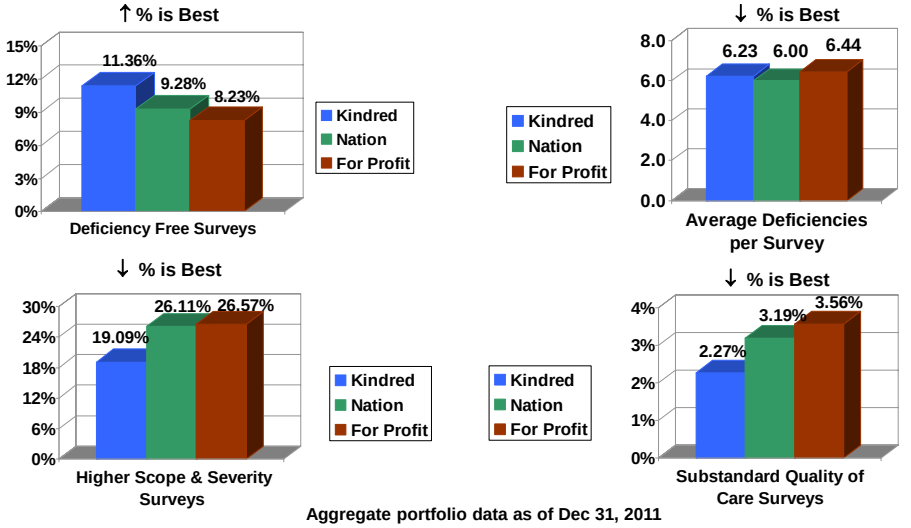
SERVICE LINE SETTING *KINDRED NAME*	LONG TERM ACUTE CARE Hospital	TRANSITIONAL / SUBACUTE CARE Hospital and Nursing & Rehab Center	LONG TERM CHRONIC CARE Nursing & Rehab Center	DEMENTIA CARE Secure Unit in Nursing & Rehab Center *REFLECTIONS*	HOSPICE & PALLIATIVE CARE Hospital, Nursing & Rehab Center, and Community *PASSAGES*	OUTPATIENT SERVICES Hospital or Nursing & Rehab Center	HOME HEALTH SERVICES Community
Physician / Practitioner	DAILY Specialty Medical Consults routine	WEEKLY TO BI-WEEKLY OR As Medically Necessary, Some Consults available	MONTHLY AND as Medically Necessary	MONTHLY AND as Medically Necessary	As Medically Necessary	As Medically Necessary	As Medically Necessary
Staffing	Nurse Hours 7.0 – 9.0 PPD Resp Hours 1 – 2 PPD	Nurse Hours 3.4 – 5.5 PPD Resp Hours as applicable Up to 1 PPD	Nurse Hours 2.9 - 3.4 PPD "Activities" Offered 3 to 4 hours/day	Nurse Hours 2.9 - 3.4 PPD "Activities" Offered 4 to 5 hours/day	Nurse Hours 2.9 - 3.4 PPD	N/A	N/A
Rehab Services	Up to 2 hours/day	Up to 3 hours/day	Up to 2 hours/day	Up to 1 hour/day	Up to 1 hour/day (Symptom mgmt.)	Up to 5 X/week	Up to 7 X/week
Ancillary Services	On Site x-ray and RX On / Off Site Lab	On or Off Site Lab, x-ray and RX	Off Site Lab, RX Mobile x-ray	Off Site Lab, RX Mobile x-ray	Spiritual, Bereavement Counseling	N/A	N/A
Admission Hours	24/7	24/7	As scheduled	As scheduled	As scheduled	9 AM to 5 PM	As scheduled
Reimburse PPD**	$800 - $2200	$250 - $1000	$150 - $250	$150 - $250	$150 - $250	Physician Fee Schedule Payment	Physician Fee Schedule Payment

** Transitional / Subacute Care CENTERS* and *Transitional / Subacute Care UNITS* are differentiated primarily by "short stay" census in the Center and certain clinical criteria. *Transitional Care CENTERS* will have a minimum short stay ADC of 50 or greater. Short stay = Medicare and Managed Care ADC.

** Inclusive of Managed Care contract Rates and Medicare

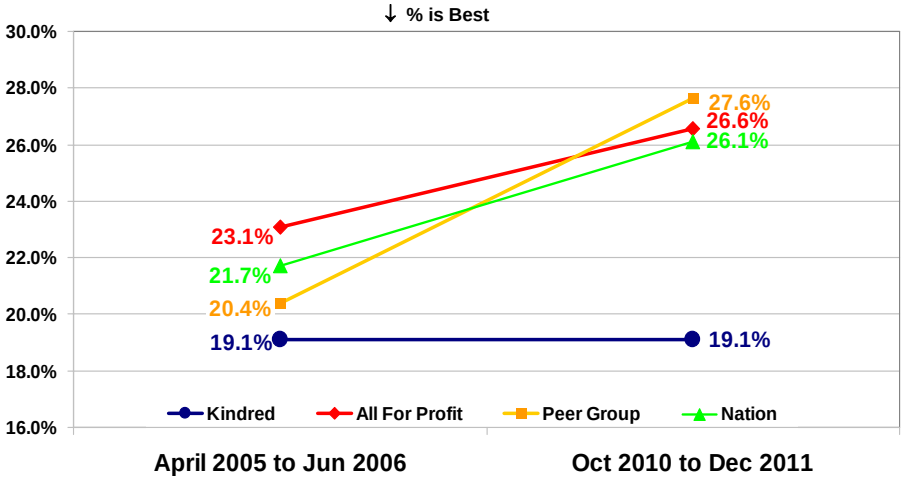
Transparency in Outcome Metrics at Kindred
Five Consecutive Years of Publicly Reported Outcomes

Nursing Center Division
Annual Survey Outcome Metrics



Aggregate portfolio data as of Dec 31, 2011

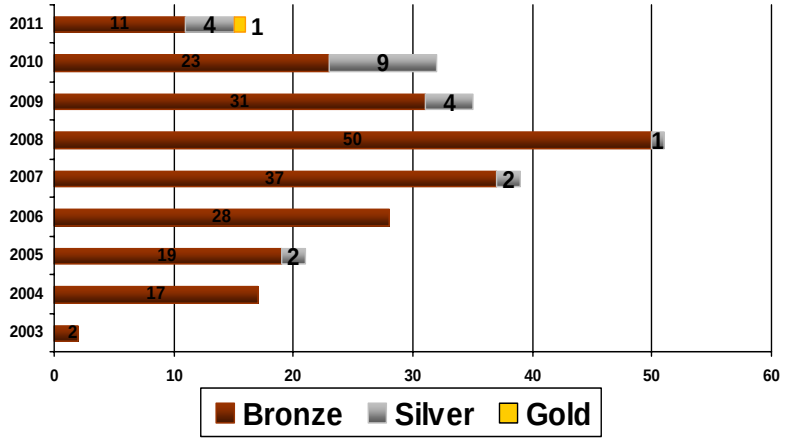
Nursing Center Division
% of Annual Surveys with Higher Scope and Severity Tags



Each data point represents the most recent Standard Survey for all Centers in Kindred (n = 220), Peer Group (n = 2084) For Profit (n = 10,846), Nation (n = 15,719) as of Dec 31, 2011; Not same store comparisons (Kindred Continuing OPS for most recent data); Higher Scope and Severity = Tag Level F, H, I, J, K, L. Data provided by TSI Healthcare Solutions from CASPER data base. There may be a 30 to 60 day lag in posting surveys to CASPER.

Nursing Center Division
AHCA Quality Awards

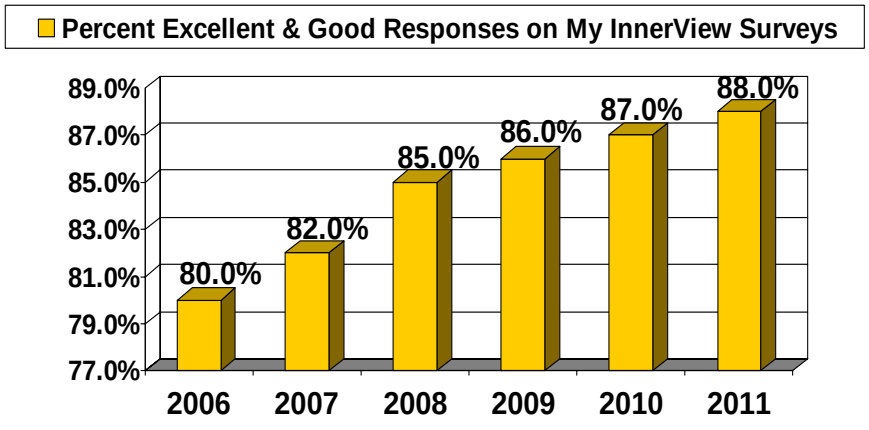
> 90% of Nursing Center Division Facilities have achieved Bronze Awards since 2003



Represents awards earned during each calendar year and does not account for divestitures

Nursing Center Division
Resident and Family Satisfaction Survey

Would you recommend this Facility?



Do you have a physician strategy?

Considerations:

- Do you view physicians as customers?
- Credentialing
- Privileging
- Open Vs Closed Medical Staff
- Organized Medical Staff
  - Bylaws and Committee structure

Expectations:

- Presence in Facility?
- Rounding with nursing staff?
- Meeting with facility leadership?
- Education and In-services?
- Time lapse until new admissions are seen?
- Family conferences?
- Feedback to Facility leadership?
- Utilization (pharmacy, ancillaries, rehab, etc.)?

Do you consider physicians to be customers?

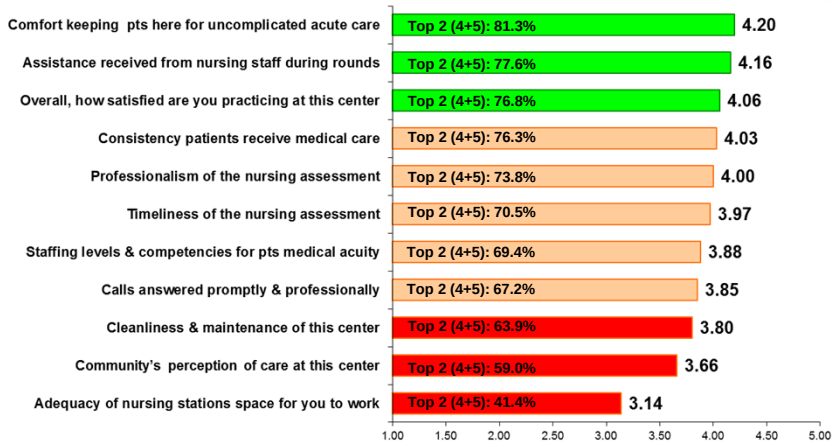
- **Improve physicians ability to be efficient and productive in your facility**
  - Work space, phone and computer access, privacy
  - Nursing assistance with patients and charts
  - Consistency of care and communication
  - Productive, interesting & efficient PI meetings
- **Offer accurate, complete & concise reporting**
  - "Nursing 101" - V/S, CC or SS, appropriate history, Meds and allergies, chart available, call back protocol
- **Monthly formal meeting with ED & DNS**
  - Voice in hiring of key personnel, equipment needs
  - Consider informal contacts/activities with medical director e.g. fund raising, holiday activities

Do you KNOW what your physicians are thinking?

Physician Satisfaction - SNF - 2011

Deyta SATISFACTION EXPERTS™

Based on 5 POINT SCALE, where 1 is Poor, 2 is Fair, 3 is Good, 4 is Very Good and 5 is Excellent



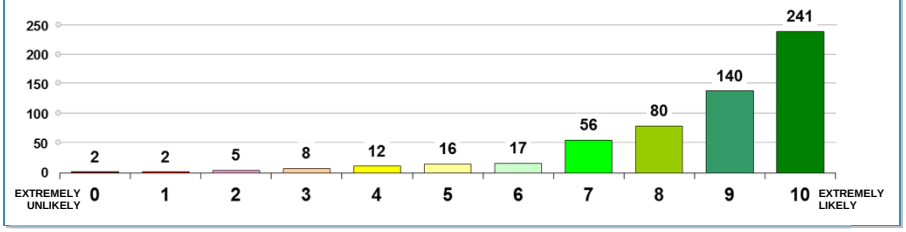
- **The overall evaluation of practicing at Kindred Nursing Centers is 4.06 with 76.8% favorable; among the higher rated items – highly correlated with nursing assistance and consistency of medical care.**

Physician Satisfaction - SNF - 2011

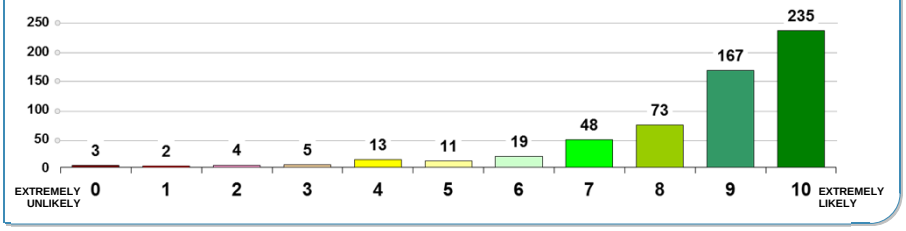
Deyta SATISFACTION EXPERTS™

On a scale of 0 to 10, where 0 is "extremely unlikely" and 10 is "extremely likely".

"Would you recommend this Kindred facility to your peers for PAC?"



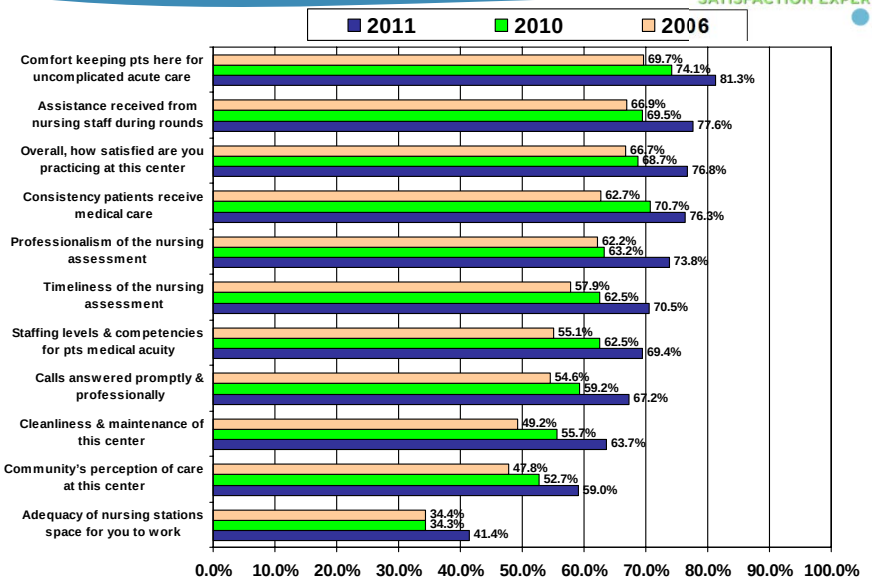
"Would you recommend this Kindred facility to other patients for PAC?"



PAC = Post Acute Care

Physician Satisfaction Trend

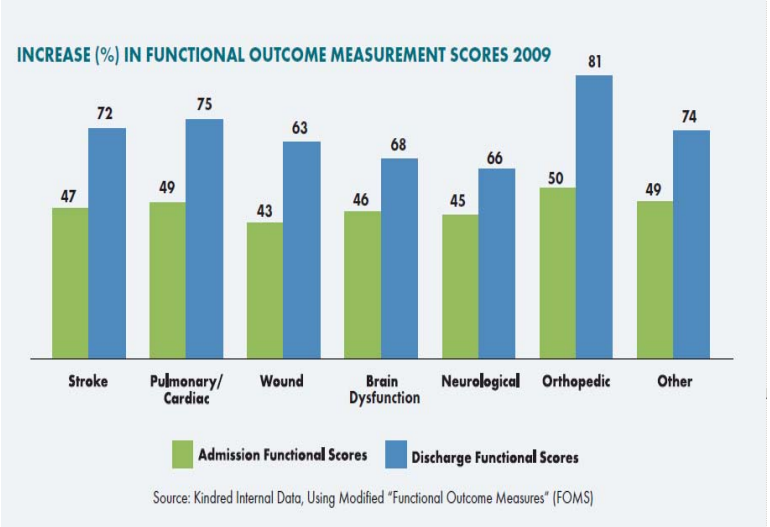
Deyta SATISFACTION EXPERTS™



Percent of top 2 responses: 4 (Very good) + 5 (Excellent)

Rehabilitation Therapy

Outcome Metrics by Diagnosis



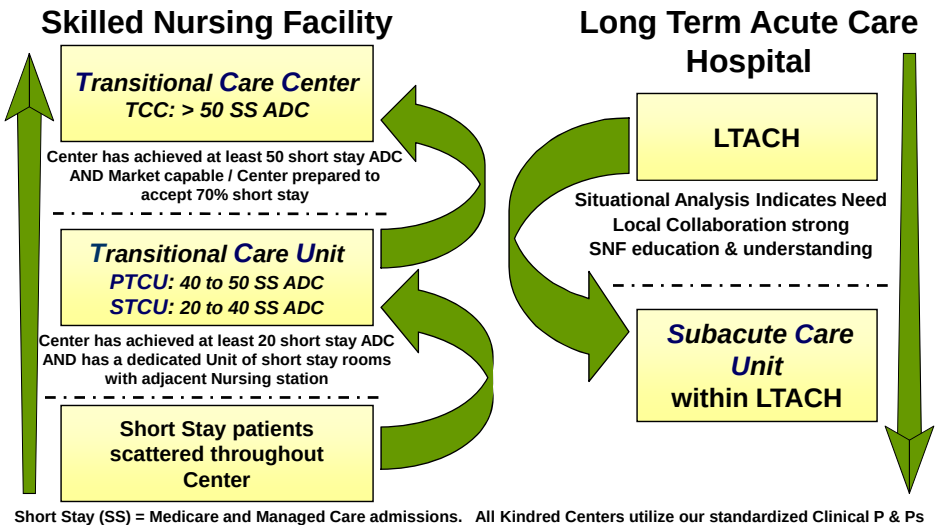
Source: Kindred Internal Data, Using Modified "Functional Outcome Measures" (FOMS)

Transitional Care Strategy

- Attention to Nurse Staffing and nurse ratios
- Focus on enhanced physician coverage and specialty Medical Directors where applicable
- Development of enhanced Clinical Programs
- EMR Linkages to hospital systems, labs, pharmacy, physicians
- Review of clinical equipment needs
- Focus on therapy services, including respiratory therapy where appropriate
- Review of physical plant and amenities
- Tracking of outcomes

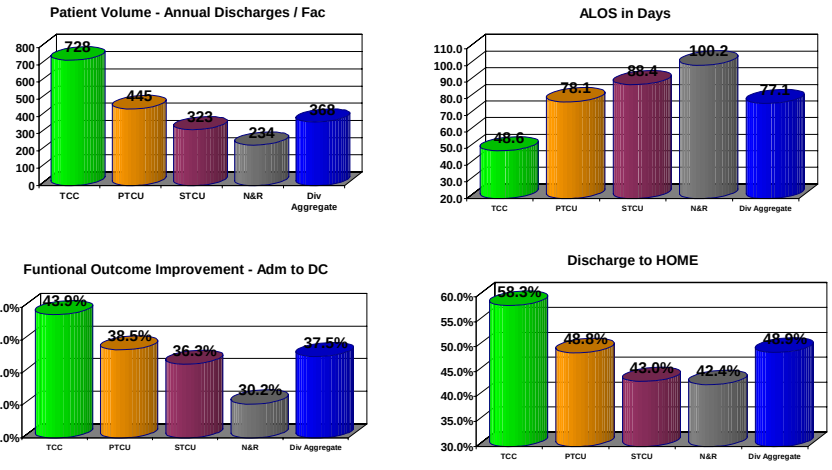
Transitional / Subacute Care

Kindred Strategy & Roadmap

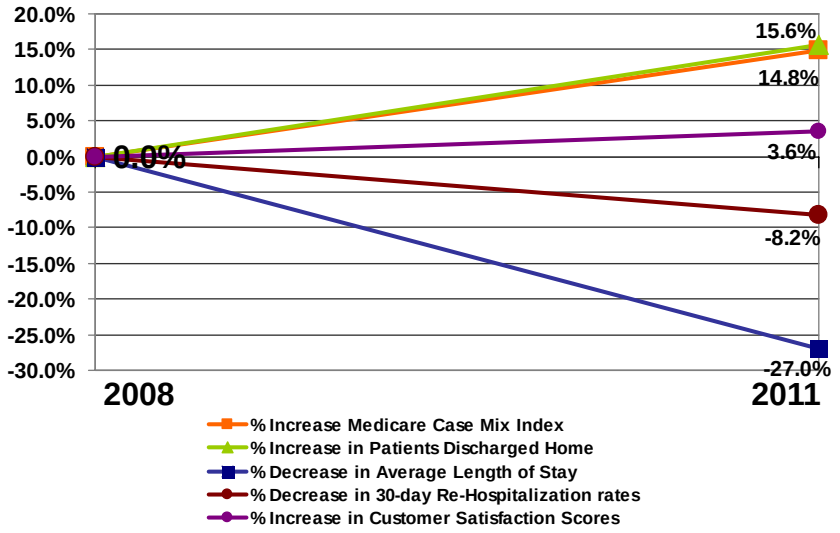


Short Stay (SS) = Medicare and Managed Care admissions. All Kindred Centers utilize our standardized Clinical P & Ps

Strategy Success
Critical Outcomes by Facility Category
All Payors - Full Year 2011



ACO - Future SNF Value Proposition



ACO Conclusion

- More transparency will be the norm and tracking Quality Outcome metrics will be imperative
- More external interest and involvement in our Centers
  - Admission and Discharge Volume will increase and the process must become more efficient, seamless and error-free
  - Length of Stay will be expected to decrease
  - Patient access to RNs and Physicians will be expected to increase
  - Patient access to Rehab will be expected to increase
  - Re-hospitalizations will be expected to decrease
  - EMR linkages will become the expectation
  - ACO Clinicians will expect to meet and dialogue with SNF Clinicians in regard to the achievement of defined outcome metrics and mutual goals
  - Solid regulatory compliance will be the expectation