Kindred

Delivering Post-Acute Care Solutions Through Innovations and Partnerships

2017 Quality, Innovation and Social Responsibility Report

The right care in the right place at the right time.

Delivering Post-Acute Care Solutions Through Innovation and Transformed Capabilities

For more than a decade Kindred has highlighted the accomplishments of our 100,000 caregivers and teammates in providing high-quality care to the more than 1,000,000 patients and families we serve annually. As I reflect on this past year, I am proud that, once again, our clinical outcomes continued to improve and outpace national benchmarks. More importantly, our programs enable patients to move seamlessly from hospital to home and our focus on wellness and rehabilitation improves the lives of thousands of people across the country.

Yet there is more to Kindred than our excellent clinical capabilities. We have recognized that as America ages and the delivery system remains fragmented, consumers of healthcare are confused and demand a broader set of services. In addition to quality care for their immediate medical needs, our customers have basic questions about how to pay for care, where to seek care in the highest quality setting, and how to obtain services to remain independent at home.

Our partner hospital systems and managed care organizations are also seeking solutions. They need answers on how to best care for a growing chronically ill population, how readmissions can be reduced or eliminated, how to reduce the cost of care, and most importantly how patients can be transitioned home safely and quickly.

In this year's report, we are excited to demonstrate how Kindred is providing answers to patients, families, health systems and payors through our expanded capabilities. Simply put, Kindred has become both a ***provider*** of quality post-acute care and a ***manager*** of post-acute care by deploying a variety of products and services designed to improve quality, outcomes and the customer experience while lowering the total cost of care.

We will share how our growing Contact Center, staffed by a team of more than 100 Registered Nurses available 24 hours a day, 7 days a week, answers questions, provides medical and social guidance, and serves as patient/family care managers for more than 400,000 patients as they move throughout the healthcare system all the way into the home.

We will also detail how in-home visits by our Physician House Calls practitioners enable chronically ill people to remain at home and avoid expensive hospital admissions.

Additionally, in order to create a seamless system of care from hospital to home, and to create virtual networks of quality providers, we have forged partnerships with hospital systems and others in the post-acute continuum to deliver care to patients in the right place, at the right time, for the right cost.

You will also see how we are leveraging our data analytic and technology capabilities to transform the way care is delivered so that patients, caregivers and provider partners have the information in real time to improve the quality and efficiency of care.

Improving the lives of patients is what we do. On behalf of our talented teammates, I thank you for letting us share the story of just how we do it.

Benjamin A. Breier
President and Chief Executive Officer
Kindred Healthcare

Kindred Is

As the nation's largest provider of post-acute care, Kindred delivers integrated solutions to support patients and manage their care across the continuum, resulting in high-quality outcomes. Over the past several years, Kindred has transformed its capabilities to meet the health and wellness needs of Americans from hospital to home.

100,100
dedicated employees taking care of over

1,000,000
people in their own homes and in

2,654 locations in

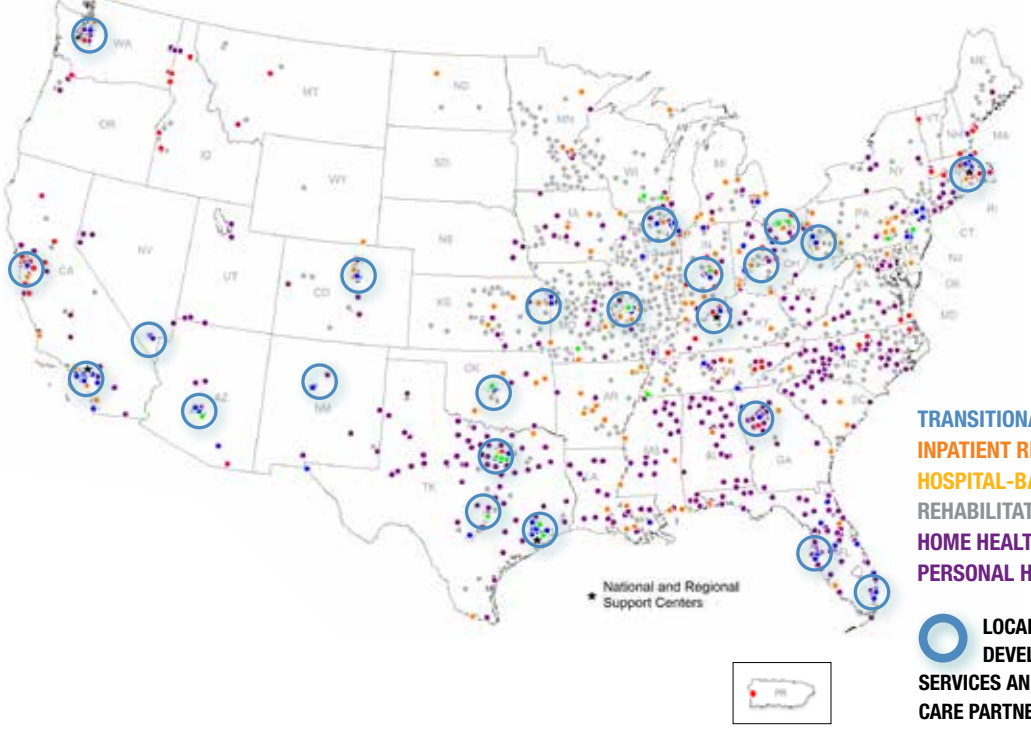
46 states.

OUR MISSION

Kindred'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

At Kindred, we believe that if we focus on our people, on quality and customer service, our business results will follow.



TRANSITIONAL CARE HOSPITALS (82)
INPATIENT REHABILITATION HOSPITALS (19)
HOSPITAL-BASED ACUTE REHAB UNITS (102)
REHABILITATION EXTERNAL SITES OF SERVICE (1,708)
HOME HEALTH, HOSPICE AND PERSONAL HOME CARE (635)

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

As the nation's **85th** largest non-government employer, Kindred helps drive economic activity in states and support local communities nationwide. In 2016, Kindred invested **$3.98 billion** in salaries and labor costs, **$218 million** in company-paid health and benefit programs, **$99 million** in provider, property and income taxes, **$1.36 billion** in products and services from vendors, and more than **$700,000** for the Alzheimer's, Heart, and Lung associations in order to help find solutions for the diseases and conditions that most affect our patients and residents.

Quality Care: The Foundation That Supports Innovative Solutions for an Aging America

Outperforming Quality Benchmarks...

More than 91% of Kindred at Home home health locations had ***3 or more stars*** in CMS's 5-Star Rating System (quality of patient care).

In 2016, our ***Transitional Care Hospitals improved on ventilator wean rates to nearly 50%.***

In 2016, our ***Personal Home Care Assistance locations significantly outperformed national benchmarks*** in client satisfaction.

In 2016, ***Kindred Hospice's services outperformed national benchmarks in nearly all quality measures.***

... Sending More People Home...

In 2016, ***Kindred Transitional Care Hospitals*** treated the most seriously ill and medically complex patients, discharging more than ***74% of patients home or to a lower acuity setting***.

Kindred's ***acute rehabilitation units and Inpatient Rehabilitation Hospitals outperformed national benchmarks*** in successfully discharging more patients to home/community.

In 2016, ***Kindred Rehabilitation Services*** delivered therapy to more than ***501,000 patients***, aiding in their recovery and return home.

...With Better Outcomes

At discharge from ***RehabCare*** services, ***patients regained 83.1% of the function*** that they had prior to injury or illness that necessitated the therapy services.

Kindred's freestanding ***Inpatient Rehabilitation Hospitals and hospital-based acute rehabilitation units outperformed peers*** in key clinical metrics including functional improvement measures.

In 2016, ***RehabCare therapists significantly improved patients' functional outcome measures*** in Kindred and unaffiliated nursing centers.

The Post-Acute Imperative

Demand for Post-Acute Care Is High and Growing

The nation's healthcare system is complex, with a rapidly growing aging demographic. More than 11,000 people reach Medicare eligibility each day and this older population is increasingly chronically ill with multiple medical conditions. As a result, the demand for acute and post-acute care interventions continues to rise.

This growing need comes at a time when care between hospitals and post-acute settings is often disjointed, resulting in higher hospital readmission and mortality rates for many patients discharged to post-acute care facilities.

Evolving Models Require New Solutions

The growing demand for care that reduces readmission and mortality rates underscores the need for an effective post-acute solution. Policy and payment models are evolving to meet that need. Research highlights that post-acute care, as a whole, is key to addressing the total cost of care, and hospitals and health systems have ample incentives to address variations in care quality, costs and expertise. Among them are larger fines for rehospitalizations and alternative payment models that increasingly hold hospitals responsible for managing the costs of all hospital-related care and post-acute services included for a 90-day episode after discharge from the hospital.

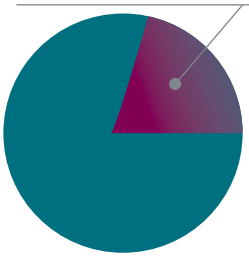
This environment demands quality, cost-effective services following a hospital stay. Post-acute care offers this essential ongoing medical and rehabilitative care, and plays a valuable role in assisting patients in regaining or maintaining cognitive or physical function. Yet simply providing care isn't enough.

[1] *Burke, et al, Hospital Readmission From Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes, March 2016*

A disjointed system responsible for a much larger, older and more chronically-ill population with wide variations in care outcomes demands new solutions.

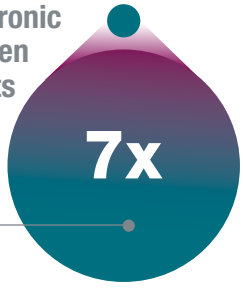
By 2029, Medicare beneficiaries will account for more than 20% of the nation's population.

Source: 2015 U.S. Census Bureau



Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.

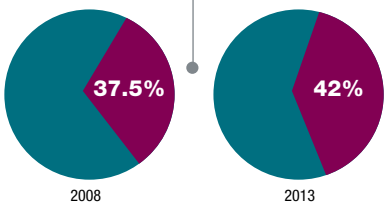
AHRQ, 2006



"Medicare can cut 5% to 10% of its total spending if it focuses on chronic disease prevention and coordinated care for those with chronic conditions."

Ken Thorpe, PhD, health policy professor at Emory University in Atlanta, 2012

Between 2008 and 2013, the percentage of Medicare beneficiaries discharged from a hospital to a post-acute setting increased from 37.5% to nearly 42%.



MedPAC 2015 March Report to Congress

14% of Medicare beneficiaries have

chronic conditions

Centers for Disease Control (CDC)

The Kindred Solution

Care, Care Management and Data

The dynamics of a rapidly aging population and changing payment models require innovative solutions beyond delivering quality care within settings across the continuum. Kindred's solution is to marry our post-acute clinical expertise with new customer-friendly resources and innovative care management. It's a solution that puts the patient at the center of everything we do while helping to solve the problems of our partners and payors.

Kindred has a strategic vision to lead the way as the nation's healthcare landscape evolves to a value-based system. We are focused on providing care coordination across an entire episode of care, in order to improve key quality outcomes including lower hospital readmissions, shorter lengths of stay, smoother transitions of care between settings and sustained independence at home.

A Post-Acute Care Solution for Hospital Systems

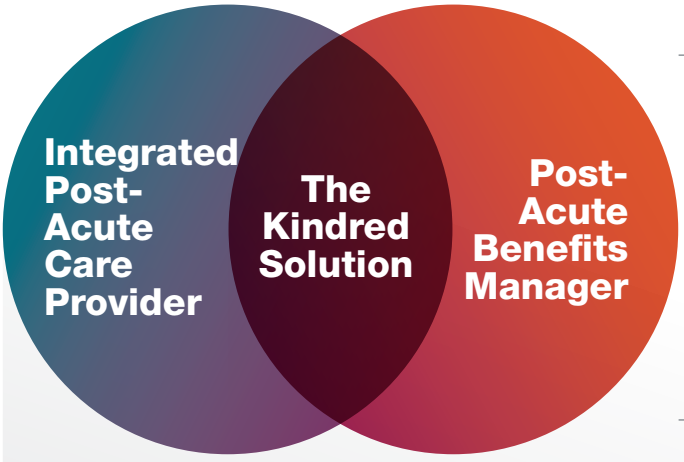
Kindred's post-acute presence in local markets nationwide – complemented by its key capabilities of care coordination, data analytics to predict the optimal patient discharge setting and tools that follow and support a patient on an ongoing basis – helps hospital systems develop high-performing post-acute networks, efficiently manage patients and appropriately navigate any associated risk. Positive partnerships between hospital systems and Kindred can advance integrated care and expand the reach of the hospital far beyond its four walls.

Solving the Post-Acute Care Puzzle for Payors

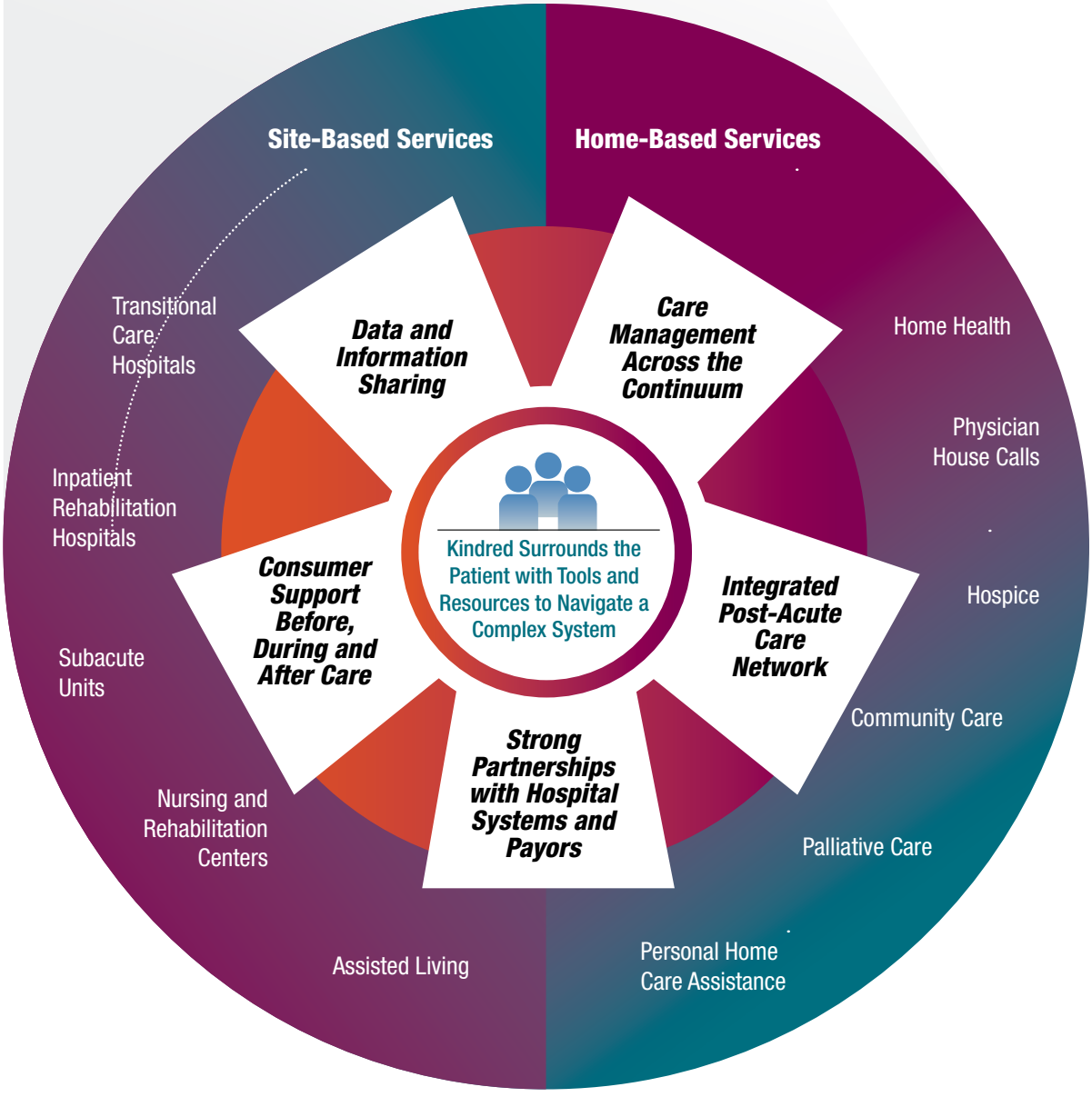
At the same time that health providers are experiencing new risk-based payment models, payors are demanding high-quality clinical outcomes, shorter lengths of stay and lower rates of rehospitalizations. Kindred has developed the post-acute solution for these payors.

Kindred has the platform in place to effectively manage costly, chronically-ill populations. By applying data analytics for risk stratification and patient placement we can drive patients to the lowest-cost, most clinically appropriate setting. Providing the right care in the right place allows us to create care models that support wellness and prevent the need for a hospital admission. In-home physician services and post-discharge patient support further enable Kindred to deliver population health and integrated care management.

Kindred has developed care management capabilities to wrap around our sites of service and our high-performing post-acute networks to manage patient health from hospital to home – and to keep them safe at home.



Clinical excellence, national reach and the innovative use of technology allow us to better coordinate post-acute care benefits management and be the business solution that payors and partners require.



Making Post-Acute Benefits Management Real

The Power of Partnerships in Improving Population Health

As part of Kindred's response to the evolving healthcare environment, we are building robust alliances to support effective care coordination across an entire patient episode. Strong partnerships, joint venture agreements and clinical collaborations position Kindred to deliver the comprehensive post-acute care solution that hospitals, health systems and payors are demanding.

Networks to Support Care Management

Kindred is developing high-performance, post-acute care networks through partnerships with health systems and other top-performing health providers to align patient care across the continuum. These limited networks offer objective site placement, patient-centric care management solutions and clinical expertise to improve care delivery and outcomes while meeting new payment requirements.

Joint Ventures

Kindred continues to engage in joint venture arrangements with some of the nation's leading health systems in order to drive efficiencies and clinical integration. We've partnered with inpatient rehabilitation hospitals, home health, transitional care hospitals, hospice and care management. These partnerships continue to produce strong quality performance with optimal clinical outcomes.

Collaborations to Enhance Post-Acute Coverage

Kindred has recently engaged in a strategic clinical collaboration with Genesis HealthCare. This collaboration complements our existing platform of post-acute services with unaffiliated nursing centers to better Continue the Care in local communities. Within this new relationship, Genesis and Kindred will collaborate to develop and implement initiatives across the healthcare continuum with the specific goals of improving quality care, patient safety, efficiency and availability of healthcare services in the community. The collaboration will utilize the clinical expertise of both entities to align patient care across the continuum.

Accountable Care Organizations (ACOs)

In August 2016, the Centers for Medicare and Medicaid Services (CMS) announced that

the Silver State ACO, of which Kindred is a strategic owner and partner, was among only 22% of the nation's Medicare Shared Savings ACOs that generated savings for the 2015 performance year. Kindred has also developed strategic partnerships to deliver integrated post-acute care with numerous other ACOs throughout the nation, including Next Generation ACOs.

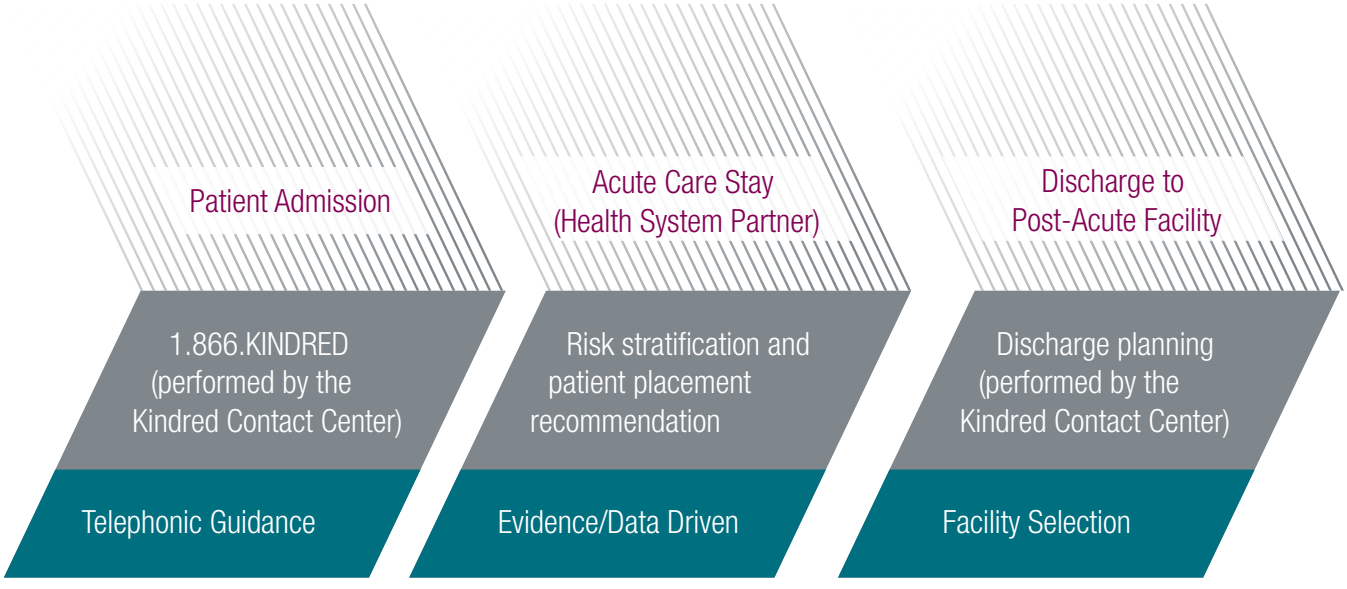
Coordinating Care Through Information Connectivity

Kindred has broken down the care delivery silos by establishing a Health Information Exchange to securely share data between Kindred locations and our healthcare partners. Clinicians' immediate access to complete and accurate patient data – regardless of where they are on the care continuum – enables improved quality and safety outcomes, as well as new efficiencies and better transitions between settings. Kindred has partnered with the leading Information Technology company, Inovalon, to create a market leading tool to enable evidence-based post-acute care site placement decision-making, to reduce rehospitalizations and lower total cost of care.

Kindred is partnering with health systems around the country to improve care and reduce costs.

Ardent Health Services · Baptist Memorial Health Care · Community Health Network · Craig Hospital · Dignity Health · Floyd · Lancaster General Health · Mercy · Methodist · Seton Healthcare Family · Shepherd Center · Texas Health Resources · St. Luke's Hospital · St. Mary Medical Center · University Hospitals · UW Health · Valley Baptist · Wake Forest Baptist Health · Inovalon

Tools to Manage Care Across the Patient Journey



Care Management Capabilities Across a Patient's Journey

A positive patient experience relies on a full complement of interrelated solutions. We surround each patient with the right resources at the appropriate time to ensure smooth transitions and quality outcomes and to support ongoing wellness after returning home. Our care management capabilities allow us to directly support patients and their families before, during and after their healthcare episode.

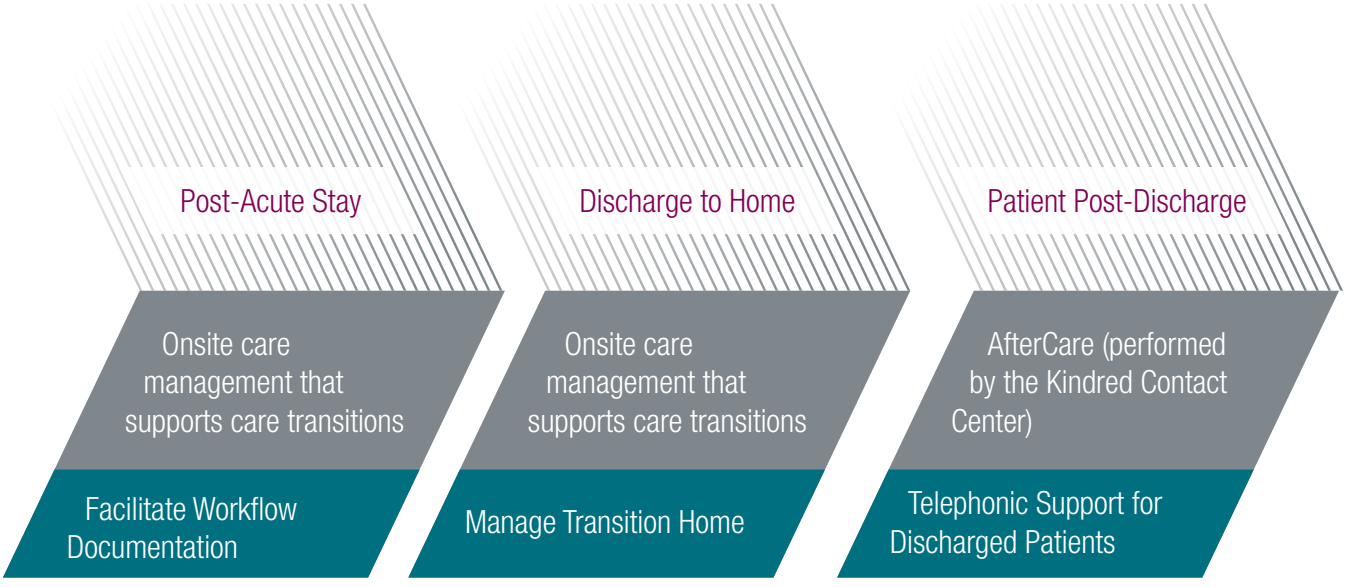
Physician House Calls

Kindred House Calls brings high-quality, physician-based house call services to homebound patients who are at high risk for hospitalization and cannot easily access traditional outpatient services. Through our tailored medical care, we are delivering improved clinical outcomes, preventing emergency room visits and hospital stays, and creating positive patient experiences. Recognizing that patients prefer to age at home or in their senior living communities, Kindred House Calls also supports earlier access to hospice care as patients near the end of life. Kindred House Calls is one of the largest home-based primary care practices in the nation, with approximately 100 practitioners providing care to more than 10,000 patients annually in 12 markets in five states.

In 2017, Kindred House Calls was selected by CMS to participate in its Comprehensive Primary Care Plus (CPC+) program, a public-private partnership to provide improved access to quality healthcare at lower costs. Kindred House Calls will participate in its Colorado and Ohio markets, benefiting approximately 5,000 patients while further building our expertise in value-based care.

1.866.KINDRED

Kindred understands the difficulties that patients, families and loved ones face in navigating the complex and confusing healthcare system when dealing with tough medical decisions. That's why we offer our toll-free resource, 1.866.KINDRED. Calls are answered 24/7 by Registered Nurses who can help identify the best and most convenient care options to meet a patient's needs after a hospital stay – even if it's not with Kindred. Our goal is to be a trusted consumer resource as our nurses answer questions about



insurance or Medicare coverage, discuss medical conditions and detail the care options available to consumers in their local community.

AfterCare

Kindred's AfterCare Program is designed to maintain personal, consistent and compassionate communication with patients after they are discharged from any line of Kindred services. Trained nurses call patients at regular intervals – 14, 30, 60 and 90 days – after discharge to track patient progress, answer ongoing questions, identify any new care needs and ensure a positive patient experience. This personal, individual touch is valuable in preventing a decline in patient condition and helping prevent costly rehospitalizations. For patients with multiple chronic conditions, the follow-up calls with trained clinical professionals familiar with their personal situation are invaluable to their ongoing condition management and well-being.

An AfterCare Story of Success

Ralph and Sammie had been married for 72 years when Ralph broke his left hip and also required back surgery. During his recovery, Ralph's priority was to get home to be with his wife. That's when our Kindred at Home nurses and therapists helped Ralph recover, be pain free and regain his independence once he was discharged home.

During a routine AfterCare follow-up, our nurse found out that while Ralph was still doing well, Sammie was currently in an inpatient rehabilitation hospital receiving care, but she wanted to get home to be with Ralph.

Kindred's AfterCare nurses were then able to help refer Sammie to home health services with physical therapy and nursing, and she was able to come home and fully regain her independence.

This is how Kindred's AfterCare program allows clinicians to remain in touch with patients – providing them with the feeling that they have a support system to help with their ongoing health management and well-being.

Partnership Success

Inpatient Rehabilitation Joint Venture – Lancaster General Hospital

Lancaster General, a 533-bed hospital in Lancaster, Pennsylvania, opened a 50-bed inpatient rehabilitation hospital (IRF) in 2007 as a joint venture partnership with Kindred Healthcare with the goal of operating profitably while meeting the Institute for Health Improvement's "Triple Aim" goals of reducing costs, improving the patient experience and producing better outcomes. Lancaster General provides the clinical services, and Kindred handles the administration and management.

Since opening the IRF, the Lancaster Rehabilitation Hospital has outperformed the national average on nearly every major clinical quality and outcome metric. Additionally, the joint venture operation has enhanced the hospital's financial performance and improved patient satisfaction scores from 90% to 98%.

Home Health Solutions for ACOs

In the Phoenix market, Kindred at Home established a strategic relationship with a Pioneer ACO serving more than 400,000 individuals across Arizona. Kindred participated in a preferred home health network, assuming financial risk based on well-defined patient satisfaction and quality measures. Participating Kindred at Home branches consistently achieved targets for overall patient satisfaction, likelihood to recommend, and percent reduction in the hospital readmission rate, resulting in maximum upside performance benefit.

Diana's Journey to Recovery

In 2016, Diana contracted pneumonia and was admitted to a local hospital. Doctors told her husband of 20 years, Jayson, that Diana had only days left to live. But Jayson kept the faith, even as Diana underwent surgery to remove a quarter of her right lung.

During her hospital stay after surgery, she was on a ventilator, relied on a feeding tube, was unable to speak and could barely move. But she would need specialized care and rehabilitation over an extended period of time in order to regain her independence and return home – this is why she came to a Kindred Transitional Care Hospital. George Armylagos, Director of Respiratory Therapy, recalled, "She came to us from a short-term facility; she was on the vent, trached and, as a matter of fact, she had been on a vent for two months."

The weaning was a difficult process. Diana said, "It was so hard at first to be without the ventilator to try to breathe on my own. And then he gave me two hours the next time and more hours and then finally I did without it. I felt free when they took all the tubes out."

As a respiratory therapist, George was pleased, "Within two weeks we were able to wean her off the vent completely."

While her interdisciplinary team of doctors, respiratory and nursing were able to stabilize and improve Diana's condition, a rehabilitation team of physical, occupational and speech therapists were able to go in and help her gain strength.

Diana commented, "They were taking me to the gym every morning and they were teaching me how to walk. And when I was able to stand for the first time, they all clapped with me. When you see that you had the encouragement and the support telling you that you can make it and you will make it, you don't want to give up. You won't give up."

The rehabilitation team was able to work with Diana to get her walking on her own, swallowing on her own and speaking on her own. With the help of the Kindred team, she was able to fully recover, and return home to her husband with complete independence.

"I want to thank the staff members at Kindred that were there for me and that encouraged me in telling me, 'Yes, you can do it,'" commented Diana. "I can go dancing now. People see me now, and it's like it never even happened."

Quality Across the Post-Acute Spectrum

Transitional Care Hospitals, certified by Medicare as long-term acute care (LTAC) hospitals, deliver quality patient outcomes for the most difficult to treat, the chronically and critically ill and medically complex patients who require specialized and aggressive interventions over an extended recovery period.

Inpatient Rehabilitation Hospitals offer full-time rehabilitation, interdisciplinary care management and 24-hour physician-supported medical care. Rehabilitation teams are driven to help each patient get stronger and more independent, recover more rapidly and return home.

Rehabilitation therapists provide medically necessary rehabilitation care across a full range of healthcare settings to bring about recovery and improved function while supporting the highest quality of life possible.

Skilled Nursing Facilities (SNFs) deliver clinical and rehabilitative services in a cost-effective setting to make recovery possible and help patients return home. For long-term residents, nursing centers provide safe, compassionate care in a comfortable environment.

In order to most efficiently meet this need in greater communities nationwide, Kindred is developing relationships with unaffiliated nursing centers to establish local comprehensive post-acute networks for patients.

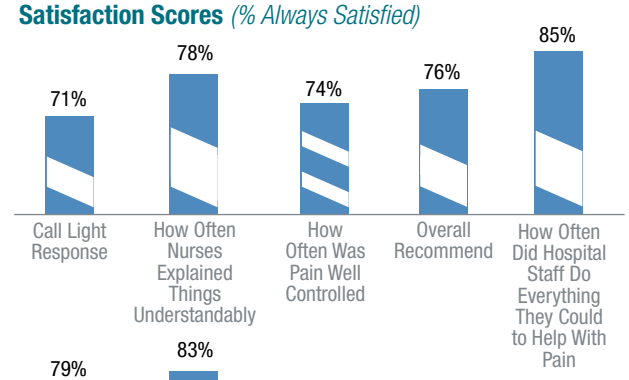
Home Care professionals deliver cost-effective care and support in the setting most desired by patients, with the goal of enabling wellness, independence and quality of life at home.

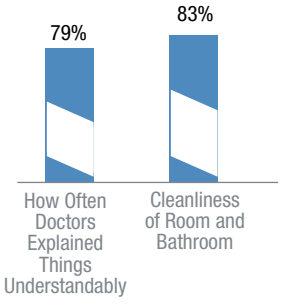
Hospice physicians and caregivers work together to create and support a familiar and comfortable environment while delivering expert medical care, pain management and extensive educational, spiritual and grief support throughout the dying process.

Community Care professionals deliver needed assistance with activities of daily living for veterans and families who want support to care for a loved one as well as for Medicaid beneficiaries and low-income individuals. Eligible individuals receive medical support services in their own home or in a community-based setting without being required to move to a facility.

Transitional Care Hospital Quality Results

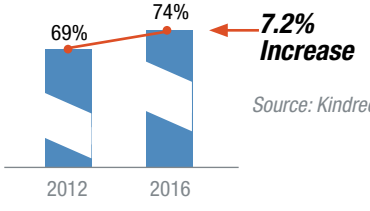
Kindred 2016 Transitional Care Hospital Patient/Family Satisfaction Scores *(% Always Satisfied)*





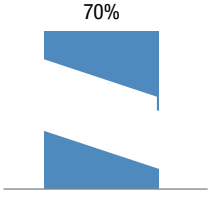
Source: CMS Hospital Consumer Assessment of Healthcare Providers and Systems

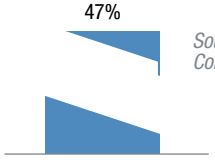
Kindred Transitional Care Hospital Increasing Discharge to Home or Other



Source: Kindred Internal Discharge Data

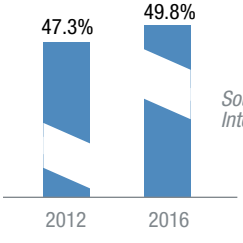
Kindred 2016 Transitional Care Hospital Quality Indicators





Source: CMS LTAC Compare 2016

Kindred Transitional Care Hospital Ventilator Wean Rates

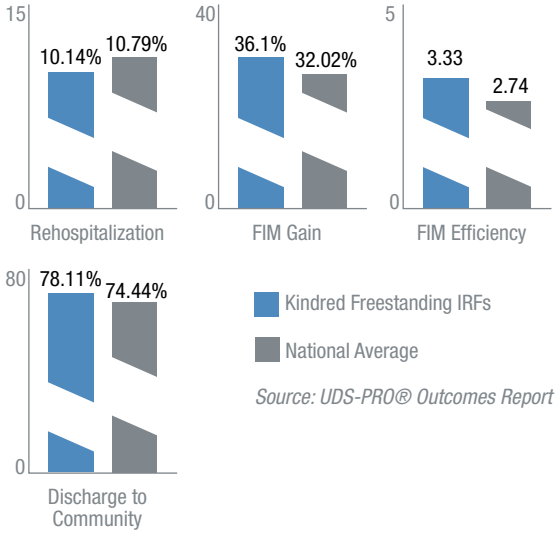


Source: Kindred Internal Data

Kindred Hospitals have an average length of stay of **29** days and have a readmission rate of just **8.33%**

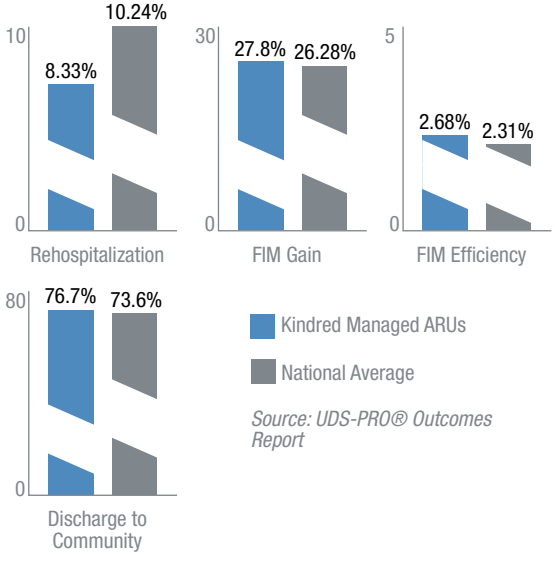
IRF and ARU Quality Results

Kindred Freestanding IRFs Performance in 2016 Key Quality Measures



Source: UDS-PRO® Outcomes Report

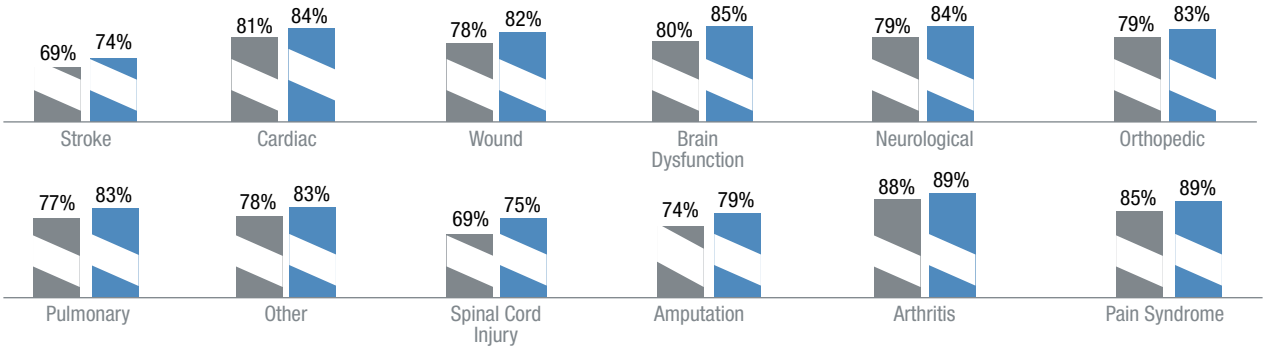
Kindred Managed ARUs Performance in 2016 Key Quality Measures



Source: UDS-PRO® Outcomes Report

RehabCare Quality Results

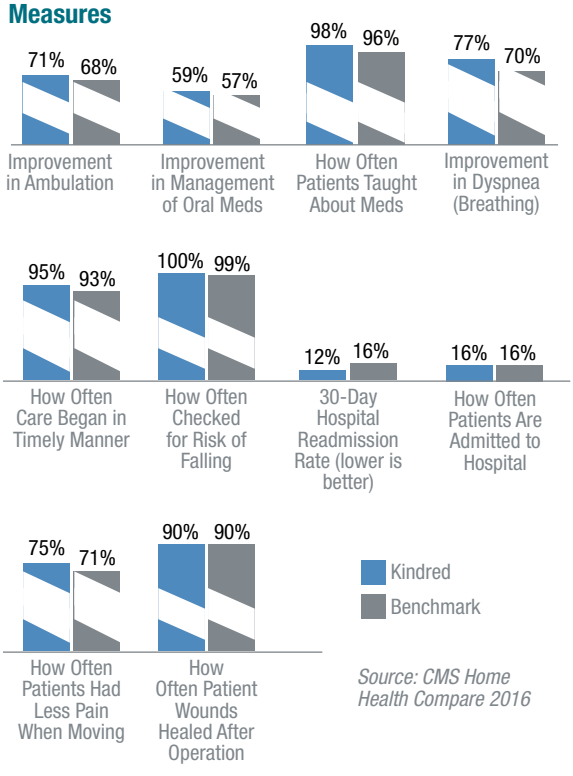
RehabCare's Increase in Functional Outcome Measurement Scores from Admission to Discharge



Source: Kindred Internal RehabCare Division Data, Using Modified "Functional Outcomes Measures" (FOMS)

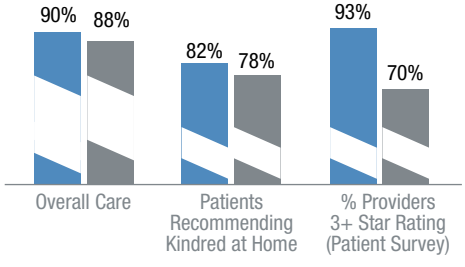
Kindred at Home Quality Results

Kindred at Home – 2016 Home Health Key Quality Measures



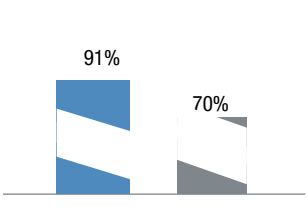
Source: CMS Home Health Compare 2016

Kindred at Home – 2016 Home Health Patient Satisfaction



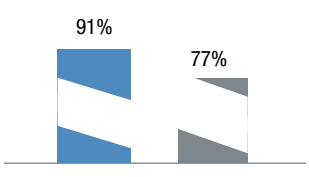
Source: CMS Home Health Compare 2016

Kindred at Home – 2016 Home Health Patient Care Star Rating of 3 Stars or Higher



Source: 2016 CMS Home Health 5-Star Rating Program

Kindred at Home – 2016 Personal Home Care Client Satisfaction

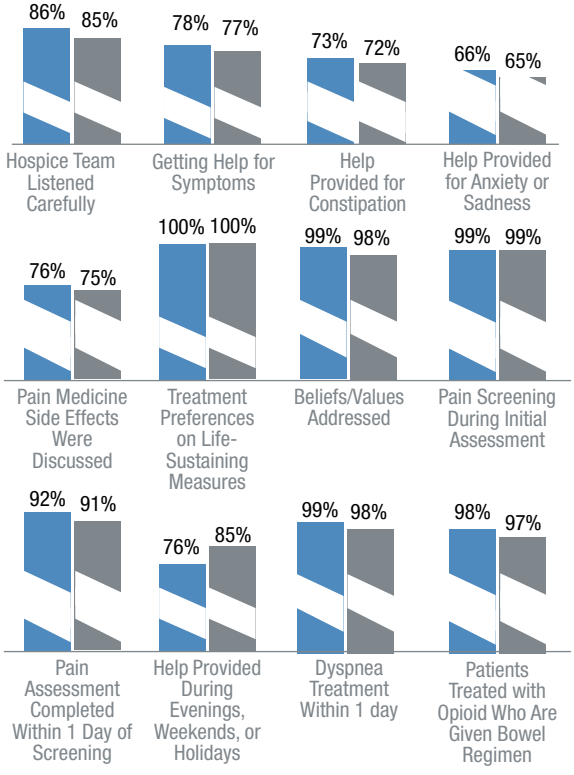


Source: 2016 Kindred Internal Client Surveys and National Survey

139 Kindred at Home Locations Named to HomeCare Elite®

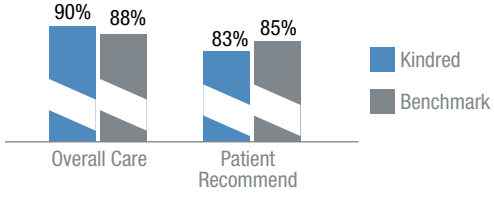
Kindred Hospice Quality Results

Kindred Hospice – 2016 Key Quality Measures



Source: 2016 SHP CAHPS Hospice Scores and Benchmarks

Kindred Hospice – 2016 Patient Satisfaction



Source: 2016 SHP CAHPS Hospice Scores and Benchmarks

Social Responsibility

Investment in our People

At Kindred's core, we value the important work that our well-trained teammates do each day to care for those in need. In order to assure the clinical competencies and adoption of best practices by our teams in the field, we are proud to invest in their training, continuing medical education and leadership skills so they may always provide the highest quality care to our patients. We also believe in maximizing the potential of our employees and offer opportunities to grow by promoting from within.

Supporting Teammates in Need

Since 2005, the HOPE (Helping Others Persevere through Emergencies) Fund has provided financial assistance to Kindred employees experiencing challenging and emergency life events. Critical assistance of more than $8.6 million was provided to 5,009 dedicated employees. In 2016, our compassionate teammates donated 4,565 hours of paid time off to support the needs of their fellow employees.

Investing in a Healthier Future for All

Every day we care for patients with debilitating and chronic illnesses that could have been prevented. We believe that we have a social responsibility to raise awareness and critical funds to find solutions for the diseases and conditions that most affect our patients and residents. We are proud of our longstanding and strong partnerships with the American Lung Association, the American Heart Association and the Alzheimer's Association.

Camp I Believe

Camp I Believe is a children's bereavement camp that provides support to grieving children and families across the country, with an emphasis placed on strong clinical programming and community engagement. With generous funding from the Kindred-Gentiva Hospice Foundation, and support from our local hospice programs, Camp I Believe is offered at no cost in 17 communities across the country to campers age 7 to 17 who have experienced the death of a parent, sibling, grandparent, aunt/uncle, cousin or friend.

As the nation's **85th** largest non-government employer, Kindred helps drive economic activity in states and support local communities nationwide. In 2016, Kindred invested **$3.98 billion** in salaries and labor costs, **$218 million** in company-paid health and benefit programs, **$99 million** in provider, property and income taxes, **$1.36 billion** in products and services from vendors, and more than **$700,000** for the Alzheimer's, Heart, and Lung associations in order to help find solutions for the diseases and conditions that most affect our patients and residents.

Kindred

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Dedicated to Hope, Healing and Recovery

HHA#: 20084096, 202600961, 20419096, 204320954, 206340963, 20682096, 208130961, 208220964, 20826096, 208270962, 20830096, 208620963, 208680963, 208730961, 209080962, 21263096, 21293096, 213070962, 213290962, 214630963, 21830096, 219160962, 21981096, 299991086, 299991238, 299991489, 299991525, 299991562, 299991566, 299991630, 299991738, 299991869, 299992259, 299992355

Hospice #: 5001096 (2011), 50370963 (2016), 50370970 (2006)

We accept patients for care regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified disabled veteran of the Vietnam era, or any other category protected by law, or decisions regarding advance directives.