State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed)
Kindred Transitional Care & Rehabilitation - Windsor
Address (No & Street, City, State, Zip Code)
581 Pocquonnock Avenue Windsor CT 06095
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
10/01/14	09/30/15

License Numbers	CCNH	RHNS	Other (specify)	Medicare Provider No
	2214-C			07-5011

Medicaid Provider Numbers	CCNH	RHNS	ICF-MR
	0000003589		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

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Kindred Transitional Care & Rehabilitation - Windsor	2214-C	09/30/15	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Kindred Transitional Care & Rehabilitation - W, for the cost for the cost report period beginning 10/01/14 and ending 09/30/15, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related

year ended as specified above

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator)			Printed Name (Owner) Richard Algood	
Subscribed and Sworn to before me	State of	Date	Signed (Notary Public)	Comm Expires / /
Address of Notary Public				

(Notary Seal)

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Kindred Transitional Care & Rehabilitation - Windsor	Period Covered:		From 10/01/14	To 09/30/15
Address of Facility 581 Pocquonock Avenue Windsor , CT 06095				
Report Prepared By Mike Grancison	Phone Number (302) 596-7529		Date 02/08/16	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of repor $				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No of Facility	Report for Year Ended	Page	of
	(860) 688-7211	09/30/15	2	37

Name of Facility (as shown on license)	Address (*No & Street, City, State, Zip*)
Kindred Transitional Care & Rehabilitation - Windsor	581 Pocquonock Avenue Windsor , CT 06095

	CCNH	RHNS	(Specify)	Medicare Provider No
License Numbers	2214-C			07-5011

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ Specify

Type of Ownership (Check appropriate box

☐ PROPRIETORSHIP ☐ LLC ☐ PARTNERSHIP ☑ PROFIT CORP ☐ NON-PROFIT CORP ☐ GOVERNMENT ☐ TRUST

If this facility opened or closed during report year provide	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ☐ Yes ☑ No If "Yes," explain fully

Administrator

Name of Administrator	Nursing Home Administrator's License No
Joy Gendron	1816

Other Operators/Owners who are assistant administrators (full or part time) of this facility

Name	License No

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab LLC	2214-C	09/30/15	3	37

Legal Name of Partnership / LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No	Report for Year Ended	Page	of
[illegible]	2214-C	09/30/15	3A	37

If this facility is owned or operated as a corporation, provide the following information

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
[illegible]	680 South 4th Street Louisville, KY 40202	[illegible]

Name of Directors, Officers	Business Address	Title	No Shares Held by Each
See Attached Pages 3 A-1			
Names of Stockholders Owning at Least 10% of Shares			
See Attached Pages 3 A-2 & 3 A-3 & 3 A-4			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Rehab LLC	2214-C	09/30/15	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control ownership, family or business association? ☐ Yes ☑ No — If "Yes", provide the Name/Address and complete the information on Page 11 of the report

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ☑ Yes ☐ No — If "Yes," provide the following information

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Cornerstone Insurance Co	680 South 4th St Louisville, KY 40202	☐	☑		Liability Insurance	P27 I n 14 c 3	8,656	8,656
Cornerstone Insurance Co	680 South 4th St Louisville, KY 40202	☐	☑		Workers Compensation	P15 Ln 1 a 1	(1,167,663)	(1,167.663)
RehabCare Group, Inc	680 South 4th St Louisville, KY 40202	☑	☐	84%	Therapy Services	P13 Ln B 5 a, 9 a, & 10a, Pg 28 Ln 6	582,069	539,345
Kindred Healthcare Operating, Inc Health Services Division	680 South 4th St, Louisville, KY 40202	☐	☑		Home Office Costs	P 16 Ln m 12 P 28 J n 4 & Ln 21 & Ln	743,304	743,304
Kindred Nursing and Rehabilitation-Crossings West	89 Viets Street, New London, CT 06320	☐	☑		Wage and Benefit Transfers	P10 A 12 b 2	2	2
Kindred Nursing and Rehabilitation-Crossings East	78 Viets Street, New London, CT 06320	☐	☑		Wage and Benefit Transfers	P10 A 12 c 1	376	376
Kindred Transitional Care and Rehabilitation-Parkway Pavilion	1157 Enfield Street, Enfield CT 06082	☐	☑		Wage and Benefit Transfers	P10 A 4 A 12 b 1, A 12 c 1, A 12 m, A 12 o	6,963	6,963
Kindred Transitional Care and Rehabilitation-Country Estates	1200 Suffield St, Agawam, MA 01001	☐	☑		Wage and Benefit Transfers	P10 A 4, A 12 b 1 A 12 c 1	5,030	5,030
Kindred Assisted Living-Village Crossings	78 Scott Dyer Rd, Cape Elizabeth, MA 04107	☐	☑		Wage and Benefit Transfers	P10 A 5 a	2,118	2,118

* Use additional sheets if necessary
** Provide the percentage amount of revenue received from non-related parties

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General Information and Questionnaire
Related Parties*

Name of Facility	License No	Report for Year Ended	Page	of
[illegible]	2214-C	09/30/15	4a	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ☐ Yes ☑ No — If "Yes", provide the Name/Address and complete the information on Page 11 of the report

Are any individuals or companies which provide goods or services including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ☑ Yes ☐ No — If "Yes," provide the following information

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Kindred East Regional Office	200 Brickstone Square, 5th Floor, Andover MA 01810	☐	☑		Wage and Benefit Transfers	P10 A 2	29,440	29,440
Kindred East Regional Office	200 Brickstone Square, 5th Floor, Andover MA 01810	☐	☑		Wage and Benefit Transfers	P10 A12 a	13,751	13,751
		☐	☑					
		☐	☐					
		☐	☑					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					

* Use additional sheets if necessary

** Provide the percentage amount of revenue received from non-related parties

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Rehab	2214-C	09/30/15	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i e , Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist *(See listing page 13)*
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided

1 In the preparation of this Report, were all costs allocated as required? ☐ Yes ☑ No If "No," explain fully why such allocation was not made

This is not applicable as this facility has only one level of care

2 Explain the allocation of related company expenses and attach copy of appropriate supporting data

See accompanying home office cost report

3 Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e g , Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc)
☐ Yes ☑ No If "No", explain fully why such allocation was not made

This is not applicable as this facility does not have any of the following Assisted Living, Home Health Outpatient Services or Adult Day Services

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General Information and Questionnaire
Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility	License No.	Report for Year Ended	Page of
Kindred Transitional Care & Rehabilitation - Windsor	2214-C	09/30/15	6 | 37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Eco-Lab, 370 Wabasha St, St. Paul, MN 55102	☐	☑	Dishwashing Machine	Oct-97	Auto Renewal	1,407	1,407
Pitney Bowes Global Financial, PO Box 371887, Pittsburgh, PA 15250-7887	☐	☑	Postage Machine	May-11	Auto Renewal	842	842
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
Is a Mileage Log Book Maintained for All Leased Vehicles?	☐ Yes	☐ No			**Total*** **		2,249

* Refer to Page 4 for definition of related. If "Yes", transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No	Report for Year Ended	Page	of
Wing or Rehab/HC	2214-C	09/30/15	7	37

The records of this facility for the period covered by this report were maintained on the following basis

☑ Accrual ☐ Cash ☐ Modified Cash

Is the accounting basis for this period the same as for the previous period? ☑ Yes ☐ No If "No," explain

Independent Accounting Firm

Name of Accounting Firm	Address (No & Street, City, State, Zip Code)
1 Price Waterhouse Coopers	PO Box 75647, Chicago, IL 60675-5647
2	
3	
4	

Services Provided by This Firm *describe fully*)

1 Auditing	$	5481
2	$	
3	$	
4	$	
	Charge for Services Provided	5481

Are These Charges reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No

☑ Yes ☐ No Page 15 Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1	
2	
3	
4	
5	

Address (*No & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm *describe fully*)

1	$	
2	$	
3	$	
4	$	
5	$	
	Charge for Services Provided	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No

☑ Yes ☐ No Page 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No	Report for Year Ended	Page	of
Ward Rehabilitation	2214-C	09/30/15	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (Specify)
1 Certified Bed Capacity												
A On last day of PREVIOUS report period	108	108			108	108			108	108		
B On last day of THIS report period	108	108			108	108			108	108		
2 Number of Residents												
A As of midnight of PREVIOUS report period	82	82			104	104			82	82		
B As of midnight THIS report period	86	86			85	85			86	86		
3 Total Number of Days Care Provided During Period												
A Medicare	3,595	3,595			2,849	2,849			746	746		
B Medicaid (Conn.)	22,657	22,657			16,650	16,650			6,007	6,007		
C Medicaid (other states)												
D Private Pay	2,067	2,067			1,603	1,603			464	464		
E State SSI for RCH												
F Other (Specify)	2,650	2,650			2,019	2,019			631	631		
G Total Care Days During Period (3A thru F)	30,969	30,969			23,121	23,121			7,848	7,848		
4 Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A Medicaid Bed Reserve Days												
B Other Bed Reserve Days	21	21			8	8			13	13		
5 ***Total Resident Days*** (3G + 4A + 4B)	30,990	30,990			23,129	23,129			7,861	7,861		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Rest & HC	2214-C	09/30/15	9	37

4 Were there any changes in the certified bed capacity during the report year? ☐ YES ☑ NO
If "YES", provide the following information

Date of Change	Place of Change: CCNH (1)	RHNS (2)	(Specify) (3)	Change in Beds: Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	Capacity After Change: CCNH	RHNS	(Specify)	Reason for Change

5 If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6 Number of Residents and Rates on September 30 of Cost Year

Item	Medicare CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R C H	Other State Assisted ICF-MR
No of Residents	8	68		6				
Per Diem Rate								
a One bed rm	see 9-a & 9-b	205 57		456 00				
b Two bed rms	see 9-a & 9-b	205 57		424 00				
c Three or more bed rms	see 9-a & 9-b			N/A				

	TOTAL	CCNH	RHNS	(Specify)
7 Total Number of Physical Therapy Treatments				
A Medicare - Part B	55,560	55,560		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	65,200	65,200		
C Other	457,270	457,270		
D *Total Physical Therapy Treatments*	578,030	578,030		
8 Total Number of Speech Therapy Treatments				
A Medicare - Part B	7,917	7,917		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	11,385	11,385		
C Other	55,815	55,815		
D *Total Speech Therapy Treatments*	75,117	75,117		
9 Total Number of Occupational Therapy Treatments				
A Medicare - Part B	44,707	44,707		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	54,520	54,520		
C Other	534,374	534,374		
D *Total Occupational Therapy Treatments*	633,601	633,601		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No	Report for Year Ended	Page	of
[illegible]	2214-C	09/30/15	10	37

Are time records maintained by all individuals receiving compensation? ■ Yes ☐ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A Salaries and Wages*						
1 Operators/Owners (Complete also Sec I of Schedule A1)						
2 Administrator(s) (Complete also Sec III of Schedule A1)						
3 Assistant Administrator (Complete also Sec IV of Schedule A1)						
4 Other Administrative Salaries (telephone operator, clerks, receptionists etc)						
5 Dietary Service						
a Head Dietician						
b Food Service Supervisor						
c Dietary Workers						
6 Housekeeping Service						
a Head Housekeeper						
b Other Housekeeping Workers						
7 Repairs & Maintenance Services						
a Engineer or Chief of Maintenance						
b Other Maintenance Workers						
8 Laundry Service						
a Supervisor						
b Other Laundry Workers						
9 Barber and Beautician Services						
10 Protective Services						
11 Accounting Services						
a Head Accountant						
b Other Accountants						
12 Professional Care of Residents						
a Directors and Assistant Director of Nurses						
b RN						
1 Direct Care						
2 Administrative **						
c LPN						
1 Direct Care						
2 Administrative **						
d Aides and Attendants						
e Physical Therapists						
f Speech Therapists						
g Occupational Therapists						
h Recreation Workers						
i Physicians						
1 Medical Director						
2 Utilization Review						
3 Resident Care***						
4 Other (Specify)						
j Dentists						
k Pharmacists						
l Podiatrists						
m Social Workers/Case Management						
n Marketing						
o Other (Specify) See Attached Schedule	72	3				
A-13 Total Salary Expenditures	4 168 052	179,201	0	0	0	0

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis

** Administrative - costs and hours associated with the following positions MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse Such costs shall be included in the direct care category for the purposes of rate setting

*** This item is not reimbursable to facility For Title 19 residents, doctors should bill DSS directly Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28

Schedule of Other Salaries and Wages (Page 10)

Position	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Respiratory Therapy	78	3				
Total	78	3				

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Schedule A1 - Salary Information for Operators/Owners; Administrators Assistant Administrators and Other Related Parties*

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
N/A										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* No allowance for salaries will be considered unless full information is provided Use additional sheets if required
** Include **all** employment worked during the cost year

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility (as licensed)	License No	Report for Year Ended	Page	of
Wind [illegible] Rehab [illegible]C	2214-C	09/30/15	12	37

Name	Salary Paid CCNH	Salary Paid RHNS	Salary Paid (Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section III - Administrators* **										
Troy Guntulis [illegible]	128.535			Annual Bonus not included in Salary 5,889	Administrator	1,919	A2			
Tom Foran [illegible]	22,646					312				
Section IV - Assistant Administrators										

* No allowance for salaries will be considered unless full information is provided Use additional sheets if required
** Include **all** other employment worked during the cost year
*** If more than one Administrator is reported, include dates of employment for each

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B. Report of Expenditures - Professional Fees

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Terrace HC	2214-C	09/30/15	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
***B. Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1 Dietician						
2 Dentist	13,808	138				
3 Pharmacist	7,963	145				
4 Podiatrist						
5 Physical Therapy						
a Resident Care	230,073	4,663				
b Other						
6 Social Worker	37,647	849				
7 Recreation Worker						
8 Physicians						
a Medical Director (entire facility)	18,000	132				
b Utilization Review (Title 18 and 19 only) monthly meeting						
c Resident Care**	743					
d Administrative Services Facility						
1 Infection Control Committee (Quarterly Meetings)						
2 Pharmaceutical Committee (Quarterly Meetings)						
3 Staff Development Committee (Once annually)						
e Other (Specify) See Attached Schedule						
9 Speech Therapist						
a Resident Care	59,506	1,032				
b Other						
10 Occupational Therapist						
a Resident Care	272,127	4,160				
b Other Supplies	1,129					
11 Nurses and aides and attendants						
a RN						
1 Direct Care	10,063					
2 Administrative***						
b LPN						
1 Direct Care						
2 Administrative***						
c Aides						
d Other						
12 Other(Specify) See Attached Schedule	494	8				
B 13 Total Fees Paid in Lieu of Salaries	674,106	13,378				

* Do not include in this section management consultants or services which must be reported on page 16 item M-12 and supported by required information, Page 17

** This item is not reimbursable to facility For Title 19 residents, doctors should bill DSS directly Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28

*** Administrative - costs and hours associated with the following positions MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse Such costs shall be included in the direct care category for the purposes of rate setting

Schedule of Other Fees (Page 13) Description	Hours CCNH	Hours CCNH	(Specify)
Omnicare Consulting (RN starting IV's # of IV starts, not hours)	594	58	
Total	594	58	

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Report of Expenditures

Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare, Inc., 201 East Fourth St.; Cincinnati, OH 45202	Pharmacist	☐	☒	
RehabCare Group, Inc 680 South 4th Street Louisville, KY	Therapy	☒	☐	100 % Ownership
Hartford Hospital, Dr. Robbins, PO Box 5037, Hartford, CT 06102-5037	Medical Director	☐	☒	
Healthdrive Eye Care Group, 888 Worcester St.; Ste. 130, Wellesley, MA 02482	Eye Care	☐	☒	
Healthdrive Dental Group, 888 Worcester St.; Ste. 130, Wellesley, MA 02482	Dental	☐	☒	
Day Hill Dental, 1060 Day Hill Road, Windsor, CT 06095	Dental	☐	☒	
Healthdrive Audiology Group, 888 Worcester St., Wellesley, MA 02482	Hearing Tests	☐	☒	
William Johnson, M.S.W.; P.O.Box 1354, Belchertown, MA 01007	Social Worker	☐	☒	
		☐	☐	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Windsor Rehab/LTC	2214-C	09/30/15		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	(1,144,329)	(1,144,329)		
2. Disability Insurance	$	23,977	23,977		
3. Unemployment Insurance	$	91,872	91,872		
4. Social Security (F.I.C.A.)	$	312,455	312,455		
5. Health Insurance	$	421,582	421,582		
6. Life Insurance (employees only) (not-owners and not-operators)	$	3,188	3,188		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$	340	340		
9. Other (*Specify*) See Attached Schedule	$	-			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts *	$	35,768	35,768		
d. Accounting and Auditing	$	5,481	5,481		
e. Legal (*Services should be fully described on page 7*)	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	19,872	19,872		
h. Telephone and Cellular Phones					
1. Telephone and Pagers	$	61,008	61,008		
2. Cellular Phones	$	182	182		
i. Appraisal (*Specify purpose and attach copy*) *	$				
j. Corporation Business Taxes (*franchise tax*)	$	204	204		
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$	2	2		
3. Resident Day User Fee		543,850	543,850		
Subtotal	$	375,452	375,452		

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales and Use Tax	2		
Total	2		

Schedule of Employee Benefits

Description	CCNH	RHNS	(Specify)
Workmen's Compensation	(1,144,329)		
Disability Insurance	23,977		
Unemployment Insurance	91,872		
Social Security (F.I.C.A.)	312,455		
Health Insurance	421,582		
Life Insurance (employees only)	3,188		
Uniform Allowance	340		
Other (Specify)			
Total	(290,915)		
Pg. 10 Total Salary Expenditures	4,168,052		
Pg. 10 Ln. 12.n. Marketing Salaries	3,586		
Percentage of Fringe Benefits to Salary Expenditures	-6.98%		
Amount of Fringe Benefits Allocated to Marketing Salaries	(250)		
Non allowable Admission Bonus C009B			C009B
Non allowable Worker's Comp C001X			C001X
Disallow on pg 28 ln. 8 Discriminatory Benefits	(250)		

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C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Windsor Rehabilit	2214-C	09/30/15		16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward		375,452	375,452		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	5,350	5,350		
2. Holiday Parties for Staff	$	1,430	1,430		
3. Gifts to Staff and Residents	$	11,190	11,190		
4. Employee Travel	$	13,744	13,744		
5. Education Expenses Related to Seminars and Conventions	$	1,533	1,533		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (Specify)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	9,766	9,766		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber & Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,500	2,500		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	10,412	10,412		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org*	$	555	555		
9. Subscriptions	$	1,500	1,500		
10. Contributions*	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$				
12. Administrative Management Services**	$	743,304	743,304		
13. Other (*Specify*)	$	194,102	194,102		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,370,838	1,370,838		

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Facility should self-disallow the expense on Page 28 of the Cost Report

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Office Supplies	24		
Public Relations	2,470		
Marketing	7,272		
Total Other Advertising	9,766		

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues & Subscriptions	2,767		
AHCA State Dues	7,645		
Total Dues	10,412		

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Iron Mountain Record Retention	2,606		
Professional Fees - Other	14,248		
Thomas J Pfund Medicaid App Processing - $12,250			
Resident Fund Management Service Account Fees - $1,998			
Patient Relations:	18		
Cake for Resident Party			
Miscellaneous	(182)		
Employee Drug Testing	847		
Employee Background Check	3,940		
Employee Vaccines	2,844		
Fees & License	700		
Other Operating	3		
Employee Relations:	5,563		
Food for meetings - $4,143			
Christmas Party - $1,420			
Allscripts Reference Mgmt System	807		
Collection	20,106		
Accrued Annual Bonus - ED and DON	53,994		
Occupational Incentitive Compensation	(15,248)	auditors - see below	
Severance	8,461		
Corp Allocated-Marketing Expenses	79,862		
Cable Expense (input)	15,533		
Total Other Administrative and General	194,102		

Occupational Incentive Compensation. This represents a budgetary incentive program for the facilities and is neith expense nor revenue to the facility. For that reason, the expense is classifed as Other A & G and appropriately self-disallowed.

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	17	37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Kindred Nursing Centers, East, Inc.; 680 South 4th Ave.; Louisville, KY 40202	$ 743,304	See Home Office Cost Report	Pg 16, Ln m.12, Pg 28 Ln 4 & Ln 21 & Ln 23
	$ -		
	$ -		
	$ -		
	$ -		
	$ -		

* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

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C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs

(See Note on page 5)

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	225,428	225,428		
2. Non-Food Supplies	$	25,226	25,226		
3. Other (*Specify*) _____	$				
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	$				
c. Management Services**	$				
d. Other (*Specify*) _____	$				
2E. *Total Dietary Expenditures* (2a + b + c + d)	$	250,654	250,654		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		3	3		
H. Is cost of employee meals included in 2E?		☐ Yes	☑ No		
I. Did you receive revenue from employees?		☐ Yes	☑ No	If yes, specify amount.	
J. Where is the revenue received reported in the Cost Report? (Page/Line Iter		N/A			
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?		☑ Yes	☐ No	If yes, specify cost.	$ 6.80
L. Is any revenue collected from these people?		☑ Yes	☐ No	If yes, specify amount.	
M. Where is the revenue received reported in the Cost Report? (Page/Line Iter		Page 30 Line IV.1.			
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		☐ Yes	☑ No	If yes, specify cost.	
O. Is any revenue collected from employees?		☐ Yes	☑ No	If yes, specify amount.	
P. Where is the revenue received reported in the Cost Report? (Page/Line Iter		N/A			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

Backup for page 18 line 2K
2214-C
Kindred Transitional Care & Rehabilitation - Windsor
09/30/15

Cost of Meals
follow format of Medicare Cost Report

Patient Days	**30,969**	**Dietary Expense**	**632,036**
3 meals/day	**3**	**Meals**	**92,907**
Regular Meals	**92,907**		
Total Meals	**92,907**	**Meal Cost**	**6.80**

Dietary Expense includes all dietary costs not just raw food

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CSP-19 Rev. 9/2002

C. Expenditures Other Than Salaries (cont'd) Laundry-Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
Windsor Rehab/HC	2214-C	09/30/15	19 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing *	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items, including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	4,805	4,805		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	$	214,567	214,567		
c. Management Services**.....	$				
d. Other (*Specify*) Supplies	$	72	72		
3E. *Total Laundry Expenditures* (3a + b + c + d)	$	219,444	219,444		

3F.	Laundry Questionnaire				
G.	Is cost of employee laundry included in 3E?	☐ Yes	☑ No	If yes, specify cost.	
H.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.	
I.	Where is the revenue received reported in the Cost Repo	N/A	(Page/Line Item)		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	☐ Yes	☑ No	If yes, specify cost.	
K.	Did you receive revenue from these people?	☐ Yes	☑ No	If yes, specify amount.	
L.	Where is the revenue received reported in the Cost Repo	N/A	(Page/Line Item)		

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Pounds of Laundry only required for multi-level facilities.

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CSP-20 Rev.9/2002

C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	20	37

Item			Total	CCNH	RHNS	(*Specify*)
4. Housekeeping	Sq Ft Serviced by Personnel					
a. In-House Care						
1. Supplies-Cleaning (*Mops, pails, brooms, etc.*)	Amt	$	463	463		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq ft Serviced by Personnel					
	Amt	$	342,501	342,501		
c. Management Services*		$				
d. Other (Specify) _____		$				
4E. *Total Housekeeping Expenditures* (4a + b + c + d)		$	342,964	342,964		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	192,453	192,453		
b. Medicine Cabinet Drugs		$	1,364	1,364		
c. Medical and Therapeutic Supplies		$	132,730	132,730		
d. Ambulance/Limousine***		$	18,055	18,055		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	3,751	3,751		
f. X-rays and Related Radiological Procedures***		$	10,560	10,560		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	18,540	18,540		
i. Recreation		$	3,466	3,466		
j. Other (Specify)**** See Attached Schedule		$	119,130	119,130		
5K. *Total Resident Care Expenditures (5a-5j)*		$	500,049	500,049		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facilty should self-disallow the expense on Page 29 of the Cost Report

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Ancillary Cost-Other Resident Care Supplies	17,487		
Ancillary Cost-Prosthetics/Orthotics	2,677		
Ancillary Cost-Equipment rental	58,003		
Patient Personal Services	2,558		
Ancillary Cost- IV Therapy	29,229		
Ancillary Cost - Nutritional Therapy	838		
Ancillary Cost - Outpatient Surgery & Tests	722		
Ancillary Cost - Admin	883		
Ancillary Cost - Other	3,212		
Ancillary Cost - Respiratory Therapy	3,521		
Total Other Resident Care	119,130		

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CSP-21 Rev. 10/2001

Report of Expenditures
Schedule C-2 - Individuals or Firms Providing Services by Contract*

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
RehabCare Group, Inc.	680 South 4th St.;Louisville, KY 40202	☑	☐	100% Owner	Therapy Services	582,069			13 28& 28a	B.5. B.9.a B.10. a 6
Healthcare Services Group, Inc.	Suite 300, 3220 Tillman Drive: Bensalem, PA 19020	☐	☑		Laundry & Housekeeping Services	557,068			19 & 20	3.b. & 4.b.
USA Hauling & Recycling, Inc.	PO Box 808; East Windsor, CT 06088	☐	☑		Garbage Removal	53,198			22	6.f.
Countryside Landscaping	17 Sunnyside Circle, Windsor, CT 06065	☐	☑		Lawn Service	22,727			22	6.a.
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	143,319	143,319		
b. Heat	$	62,651	62,651		
c. Light & Power	$	86,750	86,750		
d. Water	$	18,126	18,126		
e. Equipment Lease (*Provide detail on page 6*)	$	2,249	2,249		
f. Other (itemize)	$	55,715	55,715		
See Attached Schedule					
6g. *Total Maint & Operating Expense* (6a - 6f)	$	368,810	368,810		
7. Depreciation (*complete schedule page 23* *)					
a. Land Improvements	$	2,404	2,404		
b. Building & Building Improvements	$	47,645	47,645		
c Non-Movable Equipment	$				
d. Movable Equipment	$	48,766	48,766		
*7e. *Total Depreciation Costs* (7a + b + c + d)	$	98,815	98,815		
8. Amortization (*Complete att Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	72,784	72,784		
d. Other (Specify)	$				
*8e. *Total Amortization Costs* (8a + b + c + d)	$	72,784	72,784		
9. Rental Payments on leased real property less real estate taxes included in item 10b	$	1,187,354	1,187,354		
10. Property Taxes					
a. Real estate taxes paid by owner	$	53,908	53,908		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	6,873	6,873		
11. *Total Property Expenses* (7e + 8e + 9 + 10)	$	1,419,734	1,419,734		

* Amounts entered in these items must agree with detail on Schedule for Deprecation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Mantenance

Description	CCNH	RHNS	(Specify)
Trash Removal	53,966		
Recycling	361		
Water Cooler Rental	1,388		
Total Other Repairs and Maintenance	55,715		

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214 C	09 30 15	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements								
1. Acquired prior to this report period	166,410		166,410	153,553	S/L	various	2,404	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								2,404
B. Building and Building Improvements								
1. Acquired prior to this report period	2,658,830		2,658,830	2,562,125	S/L	various	47,645	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								47,645
C. Non-Movable Equipment								
1. Acquired prior to this report period	178,147		178,147	178,147	S/L	various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquistion		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment (attach schedule)												
a. Acquired prior to this report period			various		760,094		760,094	561,360	S/L	various	45,133	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					31,814		31,814				3,633	
D-3. Subtotal												48,766
E. *Total Depreciation*												98,815

Schedule of Land Improvements Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvements		$		$ *
Deletions:				
Total deletions for Land Improvements		$		$ **

*Ties to Page 23, Line A3
**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total Additions for Building Improvements		$		$ *
Deletions:				
Total deletions for Building Improvements		$		$ **

*Ties to Page 23, Line B3
**Ties to Page 23, Line B2

Schedule of Non-Moveable Equipment Acquired during this repor

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Moveable Equipment		$		$ *
Deletions:				
Total deletions for Non-Moveable Equipment		$		$ **

SUBTRACTED THE TAX DISPOSAL ASSETS FROM TOTAL
*Ties to Page 23, Line C3
**Ties to Page 23, Line C2

Schedule of Moveable Equipment Acquired during this report perioc

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2014	Ice Machine S/S Prodigy Cuber	3,626	120	363
10/10/2014	Mattress Geo Max 80x35 W/Fire	4,241	60	848
10/10/2014	Device Spot NIBP, Pulse Ox, S	1,969	84	281
10/10/2014	Device Spot NIBP, Pulse Ox, S	1,969	84	281
10/10/2014	Device Spot NIBP, Pulse Ox, S	1,969	84	281
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
4/30/2015	I148209-Install Desktops	6,492	60	649
8/1/2014	Overbed Table Auto C-Base 12 1/2" to 45"	2,629	180	175
8/1/2014	Bedside Cabinet 1Drawer 1Door Classic	2,036	180	432
Total additions for Moveable Equipment		$ 31,814		$ 3,633 *
Deletions:				
Total deletions for Moveable Equipment		$		$ **

*Ties to Page 23, Line D2c
**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report perioc

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/6/2014	Door Hardware - Linen Closets	2,509	120	251
12/23/2014	Hot Water Storage Tank	13,294	240	554
3/3/2015	Baseboard Heating Unit	4,467	180	174
3/30/2015	Exhaust Fan - Remove Old - Install New	3,914	240	114
7/8/2015	Exhaust Fan - Materials	9,128	240	114
Total additions for Leasehold Improvemen		$ 33,312		$ 1,207 *
Deletions:				
Total deletions for Leasehold Improvemen		$		$ **

*Ties to Page 24, Line C3
**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/Hc	2214-C	09/30/15	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. To Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other (Specify)									
1. Acquired prior to this report period	various	various	various	1,750,048	1,326,848			71,577	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				33,312				1,207	
C-4. Subtotal									72,784
D. *Total Amortization*									72,784

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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C. Expenditures Other Than Salaries (con't) - Property Questionnaire

Name of Facility	License No.	Report for Year Ended	Page	of
Kindred Transitional Care & Re	2214-C	09/30/15	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or Leased from a Related Party?* ☐ Yes ☑ No

If "Yes", complete Part B.
If "No", complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If NOT Original Owner, Date of Purchase	9/1971
4. Date of Initial Licensure	1964
5. Total Licensed Bed Capacity	108
6. Square Footage	23,837
7. Acquisition Cost	
a. Land	N/A
b. Building	N/A

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Ventas Realty, Limited Partnership	Windsor Rehab/HC	5/1/1998	15 Years	1,317,023
10350 Ormsby Park Place	581 Pocquonock Avenue			
Suite 300	Windsor CT 06095			
Louisville, KY 40223				

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	26	37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender -				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender -				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender -				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender -				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. *Total Building Interest Expense* (A1 - A4 + B5) $				

(Carry Subtotals forward to next page)

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C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.	Report for Year Ended			Page	of
Windsor Rehab/HC	2214-C	09/30/15			27	37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender -							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender -							
B. Item	Rate	Amount					
Lender							
Address of Lender -							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*)			$				
Note Payable Interest							
13. *Total All Interest Expense* (12B7 + 12C3 +12D)			$				
14. Insurance							
a. Insurance on Property (buildings only)			$	13,921	13,921		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$	(3,288)	(3,288)		
Insurance - Liability			(4,394)				
Insurance - Crime			786				
Insurance - Bond			320				
14d. *Total Insurance Expenditures (14a + b + c)*			$	10,633	10,633		
15. *Total All Expenditures (A-13 thru C-14)*			$	9,325,284	9,325,284		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	28	37

	Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
	Page 10 - Salaries and Wages								
	1.			Outpatient Service Costs	$				
	2.	10	12.n.	Salaries not related to Resident Care	$	3,586	3,586		
	3.			Occupational Therapy	$				
	4.	28A		Other - See attached Schedule	$				
	Page 13 - Professional Fees								
	5.	13	B.8.c.	Resident Care Physicians**	$	743	743		
	6.	13	10.a & b	Occupational Therapy	$	273,376	273,376		
	7.	28A		Other - See attached Schedule	$	594	594		
	Page 15 & 16 - Administrative and General								
	8.	15a & 16a		Discriminatory Benefits	$	(250)	(250)		
	9.	15	l.c	Bad Debts	$	35,768	35,768		
	10.	15	l.e.	Accounting & Legal	$	2,741	2,741		
	11.	15	l.h.1.	Telephone	$	15,329	15,329		
	12.	15	l.h.2.	Cellular Telephone	$				
	13.			Life Insurance premiums on the life of Owners, Partners, Operators	$				
	14.	16	l.3.	Gifts, flowers and coffee shops	$	11,190	11,190		
	15.	16	l.5.	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
C025X	16.	16	l.l.4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$	236	236		
c027	17.	16	l.6.	Automobile Expense (e.g. personal use)	$				
	18.	16	m.2&3	Unallowable Advertising *	$	9,766	9,766		
	19.	15	1.j.	Income Tax / Corporate Business Tax	$				
	20.			Fund Raising / Contributions	$				
	21.	16	m.12	Unallowable Management Fees	$	496,890	496,890		
	22.			Barber and Beauty	$				
	23.	28A		Other - See attached Schedule	$	166,005	166,005		
	Page 18 - Dietary Expenditures								
	24.	18	2.d	Meals to employees, guests and others who are not residents	$				
	Page 19 - Laundry Expenditures								
	25.			Laundry services to employees, guests and others who are not residents	$				
	Page 20 - Housekeeping Expenditures								
	26.			Housekeeping services to employees and others who are not residents	$				
				Subtotal (Items 1-26)	$	1,015,973	1,015,973		

* All except "Help Wanted"

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			0	0	0

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B.12	Omnicare Consulting	594		
Total Other Fees Adjustments			594	0	0

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	l.k.3	Resident Day User Fee	(63)		
16	m.8.a.	Dues to Chamber of Commerce	555		
16	m.13.	Allscripts Reference Mgmt System	807		
16	m.13.	Employee Relations (pg 16.a.)	5,563		
16	m.13.	Collection	20,106		
16	m.13.	Corp Allocated-Marketing Expenses	79,862		
16	m.13.	Accrued Annual Bonus - ED and DON	53,994		
16	m.13.	Occupational Incentitive Compensation	(15,248)		
16	m.13.	Severance	8,461		
16	m.13.	Cable Over Limit	11,933		
		A&G Outpatient Amount	35		
Total Other A&G Adjustments			166,005	0	0

Schedule of Unallowable Management Fees due to cap

Page Ref	Line Ref	Description			
16	m.12.	Administrative Management Services**	743,304		
		Adjustment to cap Management Fees	(246,414)		
Total of Unallowable Management Fees			496,890	0	0

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D. Adjustments to Statement of Expenditures (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,015,973	1,015,973		
*Page 20 - Resident Care Supplies****							
27.	20	5.a.1	Prescription Drugs $	192,453	192,453		
28.	20	5.d	Ambulance/Limousine $	18,055	18,055		
29.	20	5.f	X-rays, etc. $	10,560	10,560		
30.	20	5.h	Laboratory $	18,540	18,540		
31.	20	5.c.	Medical Supplies $	2,450	2,450		
32.	20	5.e.2	Oxygen (non emergency) $	3,751	3,751		
33.			Occupational Therapy $				
34.	29A		Other - See Attached Schedule..... $	119,130	119,130		
Page 22 - Maintenance and Property							
35.	22 A		Excess Movable Equipment Depreciation See Attached $	1,518	1,518		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $	134	134		
38.			Rental of Building Space or Rooms $				
39.	29A		Other - See Attached Schedule..... $	(23,506)	(23,506)		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14.3	Property Insurance $	(15,639)	(15,639)		
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.	16	m. 13	Vending Machine Revenue $				
45.	16	m. 6	Purchase Discounts and Allowances $	472	472		
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.	16	m. 13	Interest Income on Accounts Rec. $	361	361		
49.	16	m. 13	Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $	1,262	1,262		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule..... $				
51. *Total Amount of Decrease (Items 1 - 50)*			$	1,345,514	1,345,514		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5.j.	Patient Personal Services	2,558		
20	5.j.	IV Therapy	29,229		
20	5.j.	Nutritional Therapy	838		
20	5.j.	Ancillary Cost-Prosthetics/Orthotics	2,677		
20	5.j.	Ancillary Cost-Equipment rental	58,003		
20	5.j.	Ancillary Cost - Outpatient Surgery & Tests	722		
20	5.j.	Ancillary Cost - Admin	883		
20	5.j.	Ancillary Cost - Other	3,212		
20	5.j.	Ancillary Cost - Respiratory Therapy	3,521		
20	5.j.	Ancillary Cost-Other Resident Care Supplies	17,487		
Total Other Ancillary Costs			119,130		

Schedule of Moveable Equipment Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7.d	Telephone Depreciation Adjustment	1,518		
Total Moveable Equipment Adjustments			1,518		

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6.f.	Capital Expense Items	(23,514)		
		Capital Outpatient	8		
Total Other Property Adjustments			(23,506)		

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30a		Other Resident Revenue - Equipment Rent			
30a		Miscellaneous Income	37		
		Medical Record Sales	1,191		
		Indirect Outpatient	34		
Total Other Adjustments			1,262		

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page of
Windsor Rehab/HC	2214-C	09/30/15			30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,583,369	9,583,369		
b. Medicaid Room and Board Contractual Allowance **	$	(4,919,074)	(4,919,074)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,546,667	1,546,667		
b. Medicare Room and Board Contractaul Allowance **	$	346,192	346,192		
4. a. Private-Pay Residents and Other	$	2,017,690	2,017,690		
b. Private-Pay Room and Board Contractual Allowance **	$	(296,750)	(296,750)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	115,079	115,079		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(115,079)	(115,079)		
c. Prescription Drugs - Non-Medicare	$	72,460	72,460		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(73,042)	(73,042)		
2. a. Medical Supplies - Medicare	$	7,866	7,866		
b. Medical Supplies - Medicare Contractual Allowance **		(7,256)	(7,256)		
c. Medical Supplies - Non-Medicare		15,533	15,533		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(13,693)	(13,693)		
3. a. Physical Therapy - Medicare	$	387,240	387,240		
b. Physical Therapy - Medicare Contractual Allowance **		(349,286)	(349,286)		
c. Physical Therapy - Non-Medicare		192,870	192,870		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(172,233)	(172,233)		
4. a. Speech Therapy - Medicare	$	42,207	42,207		
b. Speech Therapy - Medicare Contractual Allowance **		(29,145)	(29,145)		
c. Speech Therapy - Non-Medicare		33,585	33,585		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(6,020)	(6,020)		
5. a. Occupational Therapy - Medicare	$	417,784	417,784		
b. Occupational Therapy - Medicare Contractual Allowance **		(388,537)	(388,537)		
c. Occupational Therapy - Non-Medicare		215,817	215,817		
d. Occupational Therapy - Non-Medicare Contractual Allowance	$	(176,941)	(176,941)		
6. a. Other (*Specify*) - Medicare	$	(1,654)	(1,654)		
b. Other (*Specify*) - Non-Medicare		14,225	14,225		
III *Total Resident Revenue* (Section I. Thru Section II.)	$	8,459,874	8,459,874		
IV. Other Revenue *					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Televisions and Cable Services	$				
5. Interest Income *(Specify)*	$	361	361		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8 Other (*Specify*)	$	1,700	1,700		
V. *Total Other Revenue* (1 thru 8)	$	2,061	2,061		
VI. *Total All Revenue* (III + V)	$	8,461,935	8,461,935		

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report

** Facility should report all contractual allowances and/or payer discounts

Schedule of Other Resident Revenue - Medicare Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II.6.a.	Medicare Contractual Allowance	(1,654)		
Total Other Resident Revenue - Medicare		(1,654)		

Schedule of Other Resident Revenue Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II.6.b.	P&O	66		
II.6.b.	Nutritional Therapy	79		
II.6.b.	Medicaid CY and PY Cost Report	1,536		
II.6.b.	Laboratory	12,497		
II.6.b.	Radiology	47		
Total Other Resident Revenue		14,225		

Interest Income

Page Ref	Account	CCNH	RHNS	(Specify)
IV.5.	Interest paid by insurance company for paying late	361		
	Total Interest Income	361		

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV.8.	Cash Discounts Adjustments	472		
IV.8.	Miscellaneous Income	37		
IV.8.	Medical Record Sales	1,191		
	.			
Total Other Revenue		1,700		

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (on hand and in banks)			$ 42,724
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 639,305
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$ 1,517
4. Inventories			$ 21,058
5. Prepaid Expenses			$ 1,842
a. AHCA Dues			
b.			
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (itemize)			$
A-9 *Total Current Assets* (Lines A1 thru 8)			$ 706,446
B. Fixed Assets			
1. Land			$ 70,000
2. Land Improvements	*Historical Cost	166,410	$ 10,453
	Accum Depreciation	155,957 Net	
3. Buildings	*Historical Cost	2,658,830	$ 49,060
	Accum Depreciation	2,609,770 Net	
4. Leasehold Improvements	*Historical Cost	1,783,360	$ 383,728
	Accum Depreciation	1,399,632 Net	
5. Non-Movable Equipment	*Historical Cost	178,147	$ 0
	Accum Depreciation	178,147 Net	
6. Movable Equipment	*Historical Cost	791,908	$ 181,782
	Accum Depreciation	610,126 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (itemize)			$ (315,535)
Fixed Assets - Cost Report VS T/B		-	
		-	
B-10 *Total Fixed Assets (Lines B1 thru 9)*			$ 379,488

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	32	37

Account				Amount
			Total Brought Forward:	$ 1,085,934
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 *Total Leasehold or Like Properties* (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum Depreciation		Net	$
4. Goodwill (Purchased Only).				$
5. Investments Related to Resident Care *(itemize)*				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets *(itemize)*				$
Assets Under Construction				
D-8 *Total Investments and Other Assets* (Lines D1 thru 7)				$
D-9 *Total All Assets* (lines A9 + B10 + C8 + D8)				$ 1,085,934

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 183,464
2. Notes Payable *(itemize)*	$
3. Loans Payable for Equipment *(Current portion) (itemize)*	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll *(Exclusive of Owners and/or Stockholders only)*	$ 275,981
5. Accrued Payroll *(Owners and/or Stockholders Only)*	$
6. Accrued Payroll Taxes Payable	$ 5,428
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable *(Current Portion)*	$
10. Interest Payable *(Exclusive of Owner and/or Related Parties)*	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities *(itemize)*	$ 8,066,632

RE Taxes Payable	$	(39,601)	RSP#3	$	2,276
Personal Prop Taxes Pay	$	(6,361)	Unclaimed Proper	$	-
Use Tax Payable	$	140,324	Provider Tax	$	-
Intercompany	$	7,969,994	Employee Litigati	$	-

A-13. *Total Current Liabilities* (Lines A1 thru 12)	$ 8,531,505

* Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	34	37

Account	Amount
Total Brought Forward:	8,531,505
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment *(itemize)*	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans to Owners or Related Parties *(itemize)*	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities *(itemize)*		$ 56,114
Due to Third Party Payors		
Deferred Lease Payments - Ventas	40,915	
Deferred Gain-Ventas Rent Reset	7,877	
Deferred Gain-Ventas Reset Payment	7,321	
B-5. *Total Long-Term Liabilities* (Lines B1 thru 4)		$ 56,114
C. *Total All Liabilities* (Lines A-13 + B-5)		$ 8,587,619

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G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	35	37

Account	Amount
A. Reserves	
1. Reserve for value of leased land	$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3. Reserve for depreciation value of leased personal property *(Equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. Net Worth	
1. Owner's Capital	$
2. Capital Stock	$
3. Paid-in Surplus	$ 395,866
4. Treasury Stock	$
5. Cumulated Earnings	$ (6,192,893)
6. Gain or Loss for Period 10/01/14 thru 09/30/15	$ (1,704,658)
7. Total Net Worth	$ (7,501,685)
C. *Total Reserves and Net Worth*	$ (7,501,685)
D. *Total Liabilities, Reserves, and Net Worth*	$ 1,085,934

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	09/30/15	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 9/30/14			$ (6,921,974)
B.	Total Revenue *(From Statement of Revenue Page 30)*			$ 8,461,935
C.	Total Expenditures *(From Statement of Expenditures Page 27)*			$ 10,166,592
D.	Net Income or Deficit			$ (1,704,657)
E.	Balance			$ (8,626,631)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
		$		
		$		
		$		
		$		
		$	$	
	2. Other (*itemize*)			
	Reversal of prior year elimination of profitability for Related Party-RehabCare	$	1,124,949.00	
		$		
		$		
		$	$ 1,124,949.00	
F-3.	Total Additions			$ 1,124,949
G.	Deductions			
	1. Drawings of Owners/Operators/Partners *(Specify)*			$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings (Specify)		$
Purpose	Amount	
3. Total Deductions		$
H. *Balance at End of Period*		$ (7,501,682)

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Kindred Transitional Care & Rehabilitation - Windsor
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Page 36 Notes.

Line C.

Expenditures do not match page 27 because of C/R Depreciation vs F/S Depreciation, and Actuarial Adjustments to Malpractice and Workers' Comp.

Total Expenses page 27.	9,325,284
C/R Depreciation vs F/S Depreciation	(54,973)
Actuarial Adjustments	1,490,525
Mgt Fees vs. Home Office Cost	(594,244)
Rounding	0
Total Expenditures Line C.	10,166,592

This Adjustment allows Line D. Net Income or Deficit to agree to page 35 B6.

This adjustment allows Line H. to agree to page 35 B7 and agree to the 09/30/15 facility balance sheet.

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ende	Page	of
Windsor Rehab/HC	2214-C	09/30/15	37	37

Check appropriate category		
CCNH	RHNS	Other (*Specify*)
☑	☐	☐

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
	Reimbursement Analyst	
Printed Name of Preparer Mike Gruneisen		
Address Kindred Healthcare Operating, Inc.; 680 S. 4th Ave.; Louisville, KY 40202		Phone Number (502) 596-7529