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 Pecquonock 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	
10/01/15	12/31/15	

License Numbers	CCNH	RHNS	Other (specify)	Medicare Provider No
	1114-C			07-5011

Medicaid Provider Numbers	CCNH	RHNS	ICF-MR
	0000009589		

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

Name of Facility (as licensed)	License No	Report for Year Ended	Page	of
[illegible]	2214-S	12/31/15	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 [illegible], for the cost for the cost report period beginning 10/01/15 and ending 12/31/15, 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 Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the 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 L. 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 10/01/15	To 12/31/15
Address of Facility 581 Pocquonock Avenue Windsor , CT 06095				
Report Prepared By Mike Granoisen	Phone Number (502) 596-7529		Date 02/14/17	
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	12/31/15	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
Troy Gentile	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	12/31/15	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
Windsor Rehab/HC	2214-C	12/31/15	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
Kindred Nursing Centers East, LLC	680 South 4th Street Louisville, KY 40202	Delaware

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 and 3 A-3			

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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	12/31/15	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 HR	2214-C	12/31/15	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 Ln 14 c 3	421	421
Cornerstone Insurance Co	680 South 4th St, Louisville, KY 40202	☐	☑		Workers Compensation	P15 Ln 1 a 1	(680,659)	(680,659)
RehabCare Group Inc	680 South 4th St Louisville, KY 40202	☑	☐	81%	Therapy Services	P13 Ln B 5 a 9 a & 10a, Pg 28 Ln 6	158,669	145,452
Kindred Healthcare Operating Inc - Health Services Division	680 South 4th St Louisville KY 40202	☐	☑		Home Office Costs	P 16 I n m 12 P 28 I n 4 & Ln 21 & Ln 23	157,403	157,403
Kindred Transitional Care and Rehabilitation-Country Estates	1200 Suffield St Agawam MA 01001	☐	☑		Wage and Benefit Transfers	P10 A 12 c 1	2,665	2,665
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					

* 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/HC	2214-C	12/31/15	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	12/31/15	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	352	352
	☐	☑					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is a Mileage Log Book Maintained for All Leased Vehicles? ☐ Yes ☐ No **Total*** 352

* 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
Manor at Stratford	2214-C	12/31/15	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	$	1392
2	$	
3	$	
4	$	
	Charge for Services Provided	1392

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 Tentindo, Kendall, Cannif & Keefe	617-242-9600
2	
3	
4	
5	

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

1 510 Rutherford Avenue, Boston, MA 02129
2
3
4
5

Services Provided by This Firm *describe fully*)

1 Voluntary Resignation of Kindred Healthcare Emplovee	$	100
2	$	
3	$	
4	$	
5	$	
	Charge for Services Provided	100

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
W[illegible] Rehab [illegible]	2214-C	12/31/15	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 12/31 Total	CCNH	RHNS	(Specify)	Not Applicable Total	CCNH	RHNS	(Specify)
1 Certified Bed Capacity												
A On last day of PREVIOUS report period	108	[illegible]			108	108						
B On last day of THIS report period	108	[illegible]			108	108						
2 Number of Residents												
A As of midnight of PREVIOUS report period	86	[illegible]			86	[illegible]						
B As of midnight THIS report period	84	[illegible]			84	[illegible]						
3 Total Number of Days Care Provided During Period												
A Medicare	636	636			636	[illegible]						
B Medicaid (Conn)	6,053	6,053			6,053	[illegible]						
C Medicaid (other states)												
D Private Pay	330	330			330	[illegible]						
E State SSI for RCH												
F Other (Specify)	707	707			707	[illegible]						
G Total Care Days During Period (3A thru F)	7,726	7,726			7,726	7,726						
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												
5 ***Total Resident Days*** (3G + 4A + 4B)	7,726	7,726			7,726	7,726						

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No	Report for Year Ended	Page	of
Wind ...	2214-C	12/31/15	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			Change in Beds						Capacity After Change			Reason for Change
			(Specify)	Lost			Gained						
	CCNH (1)	RHNS (2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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 December 31 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R C H	ICF-MR
No of Residents	4	60		5				
Per Diem Rate								
a One bed rm	see 9-a & 9-b	205 57		[illegible] 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			[illegible]				

7 Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A Medicare - Part B	27,544	[illegible]		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	18,320	[illegible]		
C Other	111,496	[illegible]		
D ***Total Physical Therapy Treatments***	157,360	157,360		
8 Total Number of Speech Therapy Treatments				
A Medicare - Part B	(520)	(520)		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	585	[illegible]		
C Other	2,095	[illegible]		
D ***Total Speech Therapy Treatments***	2,160	2,160		
9 Total Number of Occupational Therapy Treatments				
A Medicare - Part B	24,878	[illegible]		
B Medicaid (Exclusive of Part B)				
1 Maintenance Treatments				
2 Restorative Treatments	13,200	[illegible]		
C Other	120,762	[illegible]		
D ***Total Occupational Therapy Treatments***	158,840	158,840		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No	Report for Year Ended	Page	of
[illegible]	2214-C	12/31/15	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						
A-13 Total Salary Expenditures	1 212 035	47 458	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)
Total						

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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
Wine [illegible] Rehab [illegible]	2214-C	12/31/15	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 ca Rehab HC	2214-C	12/31/15	12	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 III - Administrators* **										
Troy Guntulis 10/2015 - 12/2015	139.629			Annual Bonus not included in Salary	Administrator	559	A2			
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
[illegible]	2214-C		12/31/15		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						
3 Pharmacist	2,202	40				
4 Podiatrist						
5 Physical Therapy						
a Resident Care	77,267	1,334				
b Other						
6 Social Worker	4,523	72				
7 Recreation Worker						
8 Physicians						
a Medical Director (entire facility)	2,350	47				
b Utilization Review (Title 18 and 19 only) monthly meeting						
c Resident Care**						
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	2,235	42				
b Other						
10 Occupational Therapist						
a Resident Care	70,164	1,321				
b Other Supplies	83					
11 Nurses and aides and attendants						
a RN						
1 Direct Care	1,520	29				
2 Administrative***						
b LPN						
1 Direct Care						
2 Administrative***						
c Aides						
d Other						
12 Other(Specify) See Attached Schedule	845	15				
B 13 Total Fees Paid in Lieu of Salaries	169,400	3,067				

* 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 Physicina Services (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Physiatrist						
Consulting						
Consulting						
Consulting						
Total						

Schedule of Other Fees (Page 13)

Description	CCNH	Hours CCNH	(Specify)
Omnicare Consulting (RN starting IV's # of IV starts, not hours)		12	
Med Recs Consulting			
PICC Lines			
Total		12	

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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	12/31/15	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare; 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	Dental Services	☐	☑	
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-LLC	2214-C	12/31/15	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	(676,489)	(676,489)		
2. Disability Insurance	$	7,333	7,333		
3. Unemployment Insurance	$	28,323	28,323		
4. Social Security (F.I.C.A.)	$	93,705	93,705		
5. Health Insurance	$	119,335	119,335		
6. Life Insurance (employees only) (not-owners and not-operators)	$	749	749		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	-			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts *	$	(16,288)	(16,288)		
d. Accounting and Auditing	$	1,392	1,392		
e. Legal (*Services should be fully described on page 7*)	$	100	100		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	5,959	5,959		
h. Telephone and Cellular Phones					
1. Telephone and Pagers	$	11,769	11,769		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*) *	$				
j. Corporation Business Taxes (*franchise tax*)	$	63	63		
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee		140,266	140,266		
Subtotal	$	(283,783)	(283,783)		

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

(Carry Subtotals forward to next page)

2214-C

Kindred Transitional Care & Rehabilitation - Windsor

12/31/15

Schedule of Employee Benefits

Description	CCNH	RHNS	(Specify)
Workmen's Compensation	(676,489)		
Disability Insurance	7,333		
Unemployment Insurance	28,323		
Social Security (F.I.C.A.)	93,705		
Health Insurance	119,335		
Life Insurance (employees only)	749		
Pensions (Non-Discriminatory)			
Uniform Allowance			
Other (Specify)			
Total	(427,044)		
Pg. 10 Total Salary Expenditures	1,212,035		
Pg. 10 Ln. 12.n. Marketing Salaries	500		
Percentage of Fringe Benefits to Salary Expenditures	-35.23%		
Amount of Fringe Benefits Allocated to Marketing Salaries	(176)		
Non allowable Admission Bonus C009B		C009B	
Non allowable Worker's Comp C001X		C001X	
Disallow on pg 28 ln. 8 Discriminatory Benefits	(176)		

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab HC	2214-C	12/31/15	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward		(283,783)	(283,783)		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	1,605	1,605		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	4,814	4,814		
4. Employee Travel	$	2,083	2,083		
5. Education Expenses Related to Seminars and Conventions	$	976	976		
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*)*** See Attached Schedule	$	735	735		
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	$	500	500		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	3,167	3,167		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org*	$				
9. Subscriptions	$	288	288		
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**	$	157,403	157,403		
13. Other (*Specify*) See Attached Schedule	$	17,706	17,706		
C-14 Total Administrative & General Expenditures	$	(94,506)	(94,506)		

* 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)
Public Relations	544		
Marketing	191		
Total Other Advertising	735		

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues & Subscriptions	710		
AHCA State Dues	2,457		
Total Dues	3,167		

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Iron Mountain Record Retention	827		
Professional Fees - Other	500		
Resident Fund Management Service Account Fees - $500.00			
Employee Drug Testing	847		
Employee Background Check	659		
Employee Vaccines	387		
Employee Relations:	1,210		
Food for meetings - $1,117			
Christmas Decorations for Facility - $33			
Staff Gifts - $60			
Awards			
Collection	37,955		
Accrued Annual Bonus - ED and DON	(41,690)		
Occupational Incentitive Compensation	4,232	auditors - see below	
Corp Allocated-Marketing Expenses	8,896		
Cable Expense (input)	3,883		
Total Other Administrative and General	17,706		

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	12/31/15	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	$ 157,403	See Home Office Cost Report	Pg 16, Ln m.12
	$ -		
	$ -		
	$ -		
	$ -		
	$ -		

* 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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CSP-18 Rev. 9/2002

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	12/31/15	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	60,305	60,305		
2. Non-Food Supplies	$	5,660	5,660		
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)	$	65,965	65,965		

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.	$	7.04
L.	Is any revenue collected from these people?	☑ Yes	☐ No	If yes, specify amount.		$29.00
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
12/31/15

Cost of Meals
follow format of Medicare Cost Report

Patient Days	**7,726**	**Dietary Expense**	**163,138**
3 meals/day	**3**	**Meals**	**23,178**
Regular Meals	**23,178**		
Total Meals	**23,178**	**Meal Cost**	**7.04**

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	12/31/15	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. $	1,883	1,883		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	$	53,775	53,775		
c. Management Services**.....	$				
d. Other (*Specify*) Supplies	$				
3E. *Total Laundry Expenditures* (3a + b + c + d)	$	55,658	55,658		

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	12/31/15		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 $	(40)	(40)		
b. **Purchased Services** (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq ft Serviced by Personnel				
	Amt. $	85,784	85,784		
c. **Management Services***	$				
d. **Other (Specify)**	$				
4E. *Total Housekeeping Expenditures* (4a + b + c + d)	$	85,744	85,744		
5. **Resident Care (Supplies)****					
a. **Prescription Drugs*****					
1. **Own Pharmacy**	$				
2. **Purchased from**	$	34,004	34,004		
b. **Medicine Cabinet Drugs**	$	206	206		
c. **Medical and Therapeutic Supplies**	$	30,536	30,536		
d. **Ambulance/Limousine*****	$	1,471	1,471		
e. **Oxygen**					
1. **For Emergency Use**	$				
2. **Other*****	$	861	861		
f. **X-rays and Related Radiological Procedures*****	$	904	904		
g. **Dental** (*Not dentists who should be included under salaries or fees*)	$				
h. **Laboratory*****	$	677	677		
i. **Recreation**	$	862	862		
j. **Other (Specify)****** See Attached Schedule	$	12,003	12,003		
5K. *Total Resident Care Expenditures (5a-5j)*	$	81,524	81,524		

* 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	2,105		
Ancillary Cost-Prosthetics/Orthotics	733		
Ancillary Cost-Equipment rental	2,487		
Patient Personal Services	625		
Ancillary Cost- IV Therapy	3,570		
Ancillary Cost - Outpatient Surgery & Tests	56		
Ancillary Cost - Admin	237		
Ancillary Cost - Other	2,069		
Ancillary Cost - Respiratory Therapy	121		
Total Other Resident Care	12,003		

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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	12/31/15	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	158,669			13 & 28	B.5. B.9.a B.10. a 6
Healthcare Services Group, Inc.	Suite 300, 3220 Tillman Drive; Bensalem, PA 19020	☐	☑		Laundry & Housekeeping Services	139,559			19 & 20	3.b. & 4.b.
USA Hauling & Recycling, Inc.	PO Box 808; East Windsor, CT 06088	☐	☑		Garbage Removal	12,175			22	6.f.
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* 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	12/31/15	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	59,094	59,094		
b. Heat	$	16,252	16,252		
c. Light & Power	$	20,202	20,202		
d. Water	$	4,439	4,439		
e. Equipment Lease (*Provide detail on page 6*)	$	352	352		
f. Other (itemize)	$	12,287	12,287		
See Attached Schedule					
6g. *Total Maint & Operating Expense* (6a - 6f)	$	112,626	112,626		
7. Depreciation (*complete schedule page 23* *)					
a. Land Improvements	$	425	425		
b. Building & Building Improvements	$	5,724	5,724		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	10,826	10,826		
*7e. *Total Depreciation Costs* (7a + b + c + d)	$	16,975	16,975		
8. Amortization (*Complete att Schedule Page 24* *)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	17,523	17,523		
d. Other (Specify)	$				
*8e. *Total Amortization Costs* (8a + b + c + d)	$	17,523	17,523		
9. Rental Payments on leased real property less real estate taxes included in item 10b	$	286,579	286,579		
10. Property Taxes					
a. Real estate taxes paid by owner	$	13,585	13,585		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	2,192	2,192		
11. *Total Property Expenses* (7e + 8e + 9 + 10)	$	336,854	336,854		

* 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	12,175		
Recycling	112		
Total Other Repairs and Maintenance	12,287		

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	12/31/15	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	155,957	S/I	various	425	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								425
B. Building and Building Improvements								
1. Acquired prior to this report period	2,658,830		2,658,830	2,609,770	S/L	various	5,724	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								5,724
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		791,908		791,908	610,125	S/L	various	10,785	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					4,914		4,914				41	
D-3. Subtotal												10,826
E. *Total Depreciation*												16,975

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:					
Dryer 75lb Nat Gas Programmable		4,914		41	
Total additions for Moveable Equipment		$ 4,914		$ 41	*
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:					
12/31/2015	Generator Transfer Switch	9,416	144	65	
Total additions for Leasehold Improvement		$ 9,416		$ 65	*
Deletions:					
Total deletions for Leasehold Improvement		$		$	**

*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	12/31/15	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	1,783,360	1,399,631			17,458	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				9,416				65	
C-4. Subtotal									17,523
D. *Total Amortization*									17,523

* 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	12/31/15	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	20 Years	334,384
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	12/31/15	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	12/31/15	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)			$	6,005	6,005		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$	(1,662)	(1,662)		
Insurance - Liability			(2,174)				
Insurance - Crime			192				
Insurance - Bond			320				
14d. *Total Insurance Expenditures (14a + b + c)*			$	4,343	4,343		
15. *Total All Expenditures (A-13 thru C-14)*			$	2,029,643	2,029,643		

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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	12/31/15	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	$	500	500		
3.			Occupational Therapy	$				
4.	28A		Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.	13	B.8.c.	Resident Care Physicians**	$				
6.	13	10 a & b	Occupational Therapy	$	79,245	79,245		
7.	28A		Other - See attached Schedule	$				
Page 15 & 16 - Administrative and General								
8.	15a & 16a		Discriminatory Benefits	$	(176)	(176)		
9.	15	l.c	Bad Debts	$	(16,288)	(16,288)		
10.	15	l.e.	Accounting & Legal	$	796	796		
11.	15	l.h.1.	Telephone	$	2,900	2,900		
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	$	4,814	4,814		
15.	16	l.5.	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	976	976		
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	$				
17.	16	l.6.	Automobile Expense (e.g. personal use)	$				
18.	16	m.2&3	Unallowable Advertising *	$	735	735		
19.	15	l.j.	Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.	16	m.12	Unallowable Management Fees	$	(89,011)	(89,011)		
22.			Barber and Beauty	$				
23.	28A		Other - See attached Schedule	$	11,115	11,115		
Page 18 - Dietary Expenditures								
24.	18	2.d	Meals to employees, guests and others who are not residents	$	29	29		
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)	$	(4,366)	(4,366)		

* 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.

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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)
Total Other Fees Adjustments			0	0	0

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	l.k.3	Resident Day User Fee	229		
16	m.13.	Employee Relations (pg 16.a.)	1,210		
16	m.13.	Collection	37,955		
16	m.13.	Corp Allocated-Marketing Expenses	8,896		
16	m.13.	Accrued Annual Bonus - ED and DON	(41,690)		
16	m.13.	Occupational Incentitive Compensation	4,232		
16	m.13.	Cable Over Limit	283		
Total Other A&G Adjustments			11,115	0	0

Schedule of Unallowable Management Fees due to cap

Page Ref	Line Ref	Description	
16	m.12.	Administrative Management Services**	157,403
		Adjustment to cap Management Fees	(246,414)
Total of Unallowable Management Fees			(89,011) 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	12/31/15	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	(4,366)	(4,366)		
*Page 20 - Resident Care Supplies****							
27.	20	5.a.1	Prescription Drugs $	34,004	34,004		
28.	20	5.d	Ambulance/Limousine $	1,471	1,471		
29.	20	5.f	X-rays, etc. $	904	904		
30.	20	5.h	Laboratory $	677	677		
31.	20	5.c.	Medical Supplies $				
32.	20	5.e.2	Oxygen (non emergency) $	861	861		
33.			Occupational Therapy $				
34.	29A		Other - See Attached Schedule..... $	9,898	9,898		
Page 22 - Maintenance and Property							
35.	22 A		Excess Movable Equipment Depreciation See Attached $	379	379		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $	67	67		
38.			Rental of Building Space or Rooms $				
39.	29A		Other - See Attached Schedule..... $	(3,183)	(3,183)		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14.3	Property Insurance $	(3,027)	(3,027)		
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 $	27	27		
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. $				
49.	16	m. 13	Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $	145	145		
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)* $	37,857	37,857		

*** 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	625		
20	5.j.	IV Therapy	3,570		
20	5.j.	Ancillary Cost-Prosthetics/Orthotics	733		
20	5.j.	Ancillary Cost-Equipment rental	2,487		
20	5.j.	Ancillary Cost - Outpatient Surgery & Tests	56		
20	5.j.	Ancillary Cost - Admin	237		
20	5.j.	Ancillary Cost - Other	2,069		
20	5.j.	Ancillary Cost - Respiratory Therapy	121		
Total Other Ancillary Costs			9,898		

Schedule of Moveable Equipment Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7.d	Telephone Depreciation Adjustment	379		
Total Moveable Equipment Adjustments			379		

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6.f.	Capital Expense Items	(3,183)		
Total Other Property Adjustments			(3,183)		

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30a		Other Resident Revenue - Equipment Rent			
		Miscellaneous Income	85		
		Medical Record Sales	60		
Total Other Adjustments			145		

EXPENSED ASSETS

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	12/31/15	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,583,304	2,583,304		
b. Medicaid Room and Board Contractual Allowance **	$	(1,338,989)	(1,338,989)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	274,880	274,880		
b. Medicare Room and Board Contractaul Allowance **	$	75,353	75,353		
4. a. Private-Pay Residents and Other	$	448,392	448,392		
b. Private-Pay Room and Board Contractual Allowance **	$	(64,880)	(64,880)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	16,177	16,177		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(16,177)	(16,177)		
c. Prescription Drugs - Non-Medicare	$	19,110	19,110		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(19,110)	(19,110)		
2. a. Medical Supplies - Medicare	$	703	703		
b. Medical Supplies - Medicare Contractual Allowance **		(703)	(703)		
c. Medical Supplies - Non-Medicare					
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	96,584	96,584		
b. Physical Therapy - Medicare Contractual Allowance **		(78,276)	(78,276)		
c. Physical Therapy - Non-Medicare		60,776	60,776		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(50,201)	(50,201)		
4. a. Speech Therapy - Medicare	$	(115)	(115)		
b. Speech Therapy - Medicare Contractual Allowance **		207	207		
c. Speech Therapy - Non-Medicare		2,275	2,275		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(1,850)	(1,850)		
5. a. Occupational Therapy - Medicare	$	95,318	95,318		
b. Occupational Therapy - Medicare Contractual Allowance **		(78,790)	(78,790)		
c. Occupational Therapy - Non-Medicare		63,522	63,522		
d. Occupational Therapy - Non-Medicare Contractual Allowance *	$	(45,172)	(45,172)		
6. a. Other (*Specify*) - Medicare	$	(673)	(673)		
b. Other (*Specify*) - Non-Medicare		(155,736)	(155,736)		
III *Total Resident Revenue* (Section I. Thru Section II.)	$	1,885,929	1,885,929		
IV. Other Revenue *					
1. Meals sold to guests, employees & others	$	29	29		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Televisions and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8 Other (*Specify*)	$	172	172		
V. *Total Other Revenue* (1 thru 8)	$	201	201		
VI. *Total All Revenue* (III + V)	$	1,886,130	1,886,130		

* 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	(673)		
Total Other Resident Revenue - Medicare		(673)		

Schedule of Other Resident Revenue Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II.6.b.	Medicaid CY and PY Cost Report	(158,885)		
II.6.b.	Laboratory	3,149		
Total Other Resident Revenue		(155,736)		

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV.8.	Cash Discounts Adjustments	27		
IV.8.	Miscellaneous Income	85		
IV.8.	Medical Record Sales	60		
	.			
Total Other Revenue		172		

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Windsor Rehab/HC	2214-C	12/31/15	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (on hand and in banks)				$ 35,899
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 747,946
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 216
4. Inventories				$ 21,058
5. Prepaid Expenses a. _____ 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)				$ 805,119
B. Fixed Assets				
1. Land				$ 70,000
2. Land Improvements	*Historical Cost	166,410		$ 10,028
	Accum Depreciation	156,382	Net	
3. Buildings	*Historical Cost	2,658,830		$ 43,336
	Accum Depreciation	2,615,494	Net	
4. Leasehold Improvements	*Historical Cost	1,792,776		$ 375,622
	Accum Depreciation	1,417,154	Net	
5. Non-Movable Equipment	*Historical Cost	178,147		$
	Accum Depreciation	178,147	Net	
6. Movable Equipment	*Historical Cost	796,822		$ 175,871
	Accum Depreciation	620,951	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (itemize) Fixed Assets - Cost Report VS T/B		- -		$ (320,104)
B-10 *Total Fixed Assets (Lines B1 thru 9)*				$ 354,753

* 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	12/31/15	32	37

Account			Amount
		Total Brought Forward:	$ 1,159,872
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)			$ 1,159,872

* 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	12/31/15	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 167,133
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)*	$ 178,276
5. Accrued Payroll *(Owners and/or Stockholders Only)*	$
6. Accrued Payroll Taxes Payable	$
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)*	$ 6,776,338

RE Taxes Payable	$ (27,170)	RSP#3	$ 9,177		
Personal Prop Taxes Pay	$ (4,365)	Unclaimed Propert	$ -		
Use Tax Payable	$ 140,308	Provider Tax	$ -		
Intercompany	$ 6,658,388	Employee Litigatio	$ -		

A-13. *Total Current Liabilities* (Lines A1 thru 12)	$ 7,121,747

* 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	12/31/15	34	37

Account	Amount
Total Brought Forward:	7,121,747
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)*	$	8,308
Due to Third Party Payors	-	
Deferred Lease Payments - Ventas	-	
Deferred Gain-Ventas Rent Reset	7,115	
Deferred Gain-Ventas Reset Payment	1,193	
B-5. *Total Long-Term Liabilities* (Lines B1 thru 4)	$	8,308
C. *Total All Liabilities* (Lines A-13 + B-5)	$	7,130,055

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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	12/31/15	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	$ (7,897,549)
6. Gain or Loss for Period 10/01/15 thru 12/31/15	$ 1,531,500
7. Total Net Worth	$ (5,970,183)
C. *Total Reserves and Net Worth*	$ (5,970,183)
D. *Total Liabilities, Reserves, and Net Worth*	$ 1,159,872

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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	12/31/15	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 9/30/15			$ (7,501,682)
B.	Total Revenue *(From Statement of Revenue Page 30)*			$ 1,886,130
C.	Total Expenditures *(From Statement of Expenditures Page 27)*			$ 354,630
D.	Net Income or Deficit			$ 1,531,500
E.	Balance			$ (5,970,182)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
		$		
		$		
		$		
		$		
		$	$	
	2. Other (*itemize*)			
		$		
		$		
		$		
		$	$	
F-3.	Total Additions			$
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*		$ (5,970,182)

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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.	2,029,643
C/R Depreciation vs F/S Depreciation	10,329
Actuarial Adjustments	(1,527,943)
Mgt Fees vs. Home Office Cost	(157,403)
Rounding	4
Total Expenditures Line C.	354,630

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 12/31/15 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	12/31/15	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 Groneiser		
Address		**Phone Number**
Kindred Healthcare Operating, Inc.; 680 S. 4th Ave.; Louisville, KY 40202		(502) 596-7529