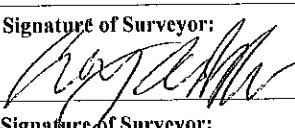


Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 535013	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 04/11/2013
Name of Facility KINDRED TRANSITIONAL CARE AND REHABILITATION		Street Address, City, State, Zip Code 3128 BOXELDER DRIVE CHEYENNE, WY 82001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
Correction Completed		Correction Completed		Correction Completed	
ID Prefix F0309	04/07/2013	ID Prefix F0323	04/07/2013	ID Prefix _____	
Reg. # 483.25		Reg. # 483.25(h)		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Reviewed By _____	Reviewed By BS	Date: 4/18/13	Signature of Surveyor: 	Date: _____	
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	
Followup to Survey Completed on: 02/21/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			