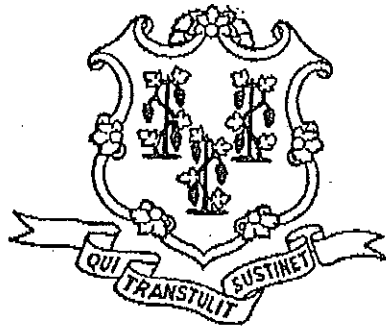
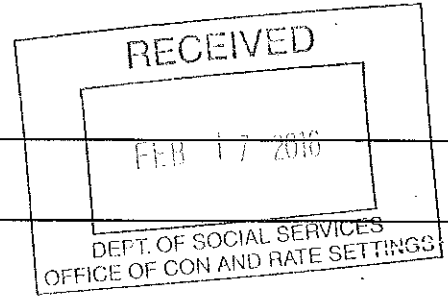


State of Connecticut



15-71

Annual Report of Long-Term Care Facility Cost Year 2015



Name of Facility (as licensed) Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	
Address (No. & Street, City, State, Zip Code) 350 Salmon Brook Street Granby, CT 06035	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2342	RHNS 2342	(Specify)	Medicare Provider No. 07-5367
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Medicaid Provider Numbers:	CCNH 2080C	RHNS 2080C	ICF-MR
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For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd)	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 1	of 37
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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 Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby [facility name] for the cost report period beginning October 01, 2014 and ending September 30, 2015, 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 penalties 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
<i>Christine M. McKinney</i>		2/10/16	<i>[Signature]</i>		
Printed Name (Administrator) Christine McKinney			Printed Name (Owner) Lawrence G. Santilli		
Subscribed and Sworn to before me:	State of Conn	Date 2/10/16	Signed (Notary Public) <i>[Signature]</i>	Comm. Expires 03/31/20	
Address of Notary Public 76 Christine Drive Spartanburg CT 06487					

(Notary Seal)



**MYERS AND
STAUFFER** LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

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 Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 350 Salmon Brook Street Granby, CT 06035				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/10/2016		
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 Report) \$				

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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-653-9888		Report for Year Ended 09/30/15	Page 2	of 37
Name of Facility (as shown on license) Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		Address (No. & Street, City, State, Zip) 350 Salmon Brook Street Granby, CT 06035		
License Numbers:	CCNH 2342	RHNS 2342	(Specify)	Medicare Provider No. 07-5367
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="checkbox"/> PROPRIETORSHIP <input checked="" type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Christine McKinney		Nursing Home Administrator's License No.:	001627	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
Not Applicable				

**General Information and Questionnaire
 Related Parties***

Name of Facility	License No.	Report for Year Ended	Page of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	4 37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

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 Name/Address and complete the information on Page 11 of the report.

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Glastonbury Health Care Center	1175 Hebron Ave, Glastonbury, CT 06033	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Interfacility Loan Payable (\$30,000)		
Valerie Manor	1360 Torrington St, Torrington, CT 06790	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Bank Fees	\$4,687	\$4,687
Athena Captive	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	Workers Comp Captive	\$221,011	\$221,011
Athena Health Care 401k	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	Facility participates in common 401k plan		
Athena Health Care	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	See Attached		
Valerie Manor	1360 Torrington St, Torrington, CT 06790	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Interfacility Loan Payable (\$137,400)		
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				

* Use additional sheets if necessary.

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

Meadowbrook
 RELATED PARTIES QUESTIONNAIRE
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				
Athena Health Care	135 South Rd Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	MIS, Management Fees A/R, Legal, Bank Charges Insurance, Lobbying, Records, Interest Storage, Marketing, Gift Certificates Project Development, Temp Administrator Fill In Data Processing, Training, Maintenance Nurse Fill In	Pg 17 Pg 16, Ln m13 P 16, m3; P 15, 1e&1g P 27, 12D; P 27, 14a P 16, L5, L2, P 32 D7 Pg 16 L2, Pg 22 6a Pg 13 11a	\$336,562	\$279,972
Athena Health Care	135 South Rd Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Self Insured Employee Health & Dental Insurance	Pg 15, 1	\$741,522	\$741,522

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 5	of 37
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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.

Patient Care Consults, Laundry, Housekeeping, Maintenance/Prop Costs, Admin - Alloc on Patient Days

Physical/Speech/Occupational Therapy - Allocated on % of Treatments

Administrative Nursing - Allocated on Direct Nursing Hours

Management Fees - Allocated based on methods above for each expense category

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

Related company expenses were allocated on Methods above except as noted in 1 above.

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.

Not Applicable: No Non-Nursing Home Cost Centers

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	
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015		6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Leaf, 1720A Crete St, Moberly, MO 65270	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	02/07/13	48 Months	\$10,460	\$10,460
Leaf, 1720A Crete St, Moberly, MO 65270	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fax	06/18/13	44 Months	\$602	\$602
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postal Equipment	07/10/14	39 Months	\$1,092	\$1,092
HP Financial Services, 200 Connell Drive, Suite 500, Berkeley Heights, NJ 07922	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	05/16/13	60 Months	\$5,113	\$5,113
HP Financial Services, 200 Connell Drive, Suite 500, Berkeley Heights, NJ 07922	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	09/25/14	60 Months	\$1,190	\$991
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
						Total ***	\$18,258

Is a Mileage Log Book Maintained for All Leased Vehicles ? Yes No Not Applicable - No Vehicles

* 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.

Hewlett-Packard Financial Services Company
200 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922



MEADOWBROOK CENTER, INC.
350 Salmon Brook St, GRANBY, CT, 06035, UNITED STATES
52059499604044USA2

Dear Customer:

Thank you for choosing HP Financial Services as your leasing source. We are glad we could be of assistance in helping you get the technology solutions you need for your business. To expedite the shipment of your equipment, it is very important for you to review the enclosed lease documents and to follow these step-by-step instructions for completing your lease transaction. *Please remember that your equipment can't be shipped until you complete and return these documents.*

1. Please carefully review the enclosed lease documents for the equipment you ordered from CDW. **IF ANY CHANGES NEED TO BE MADE TO THESE DOCUMENTS, PLEASE CALL 1-888-277-5944** and ask for the documentation specialist assigned to your geographic location.
2. Please have an individual authorized to sign legal documents sign, date and initial the documents where indicated.
3. **AN ADVANCE LEASE PAYMENT MAY BE REQUIRED ALONG WITH THE SIGNED DOCUMENTS.** To expedite, please fill out the authorization form (attached to the lease agreement) and attach a copy of a **VOIDED** check. Execution of this form will provide us with authorization to withdraw certain payments from your business account. We will utilize your check number. Upon commencement of your lease agreement, this check will be automatically credited to your account with us. Record the check number, along with the total amount of the total first payment shown on Schedule A which includes the documentation fee of \$100.00, in your check register.
4. **PLEASE FAX THE EXECUTED LEASE, INCLUDING THE SCHEDULES AND EXHIBITS ATTACHED THERETO TO 1-888-277-5945. We will start to process the transaction immediately upon receipt of these documents.**
5. Per the terms of the lease agreement, you agree that you shall be deemed to have irrevocably accepted the equipment under any lease 10 business days after shipment of the equipment to you unless we receive your written rejection prior to the end of the 10-day period. However, you agree to execute and deliver to us a delivery and acceptance certificate upon our request. If a delivery and acceptance certificate is sent to you, when you receive the equipment, please sign such delivery and acceptance certificate and the Schedule A to the lease agreement and return both to us by fax at 1-888-277-5945. "Acceptance Date" means the first business day following the expiration of such 10-day period or such other date set forth in any delivery and acceptance certificate requested by us. The term of the lease shall begin on the Acceptance Date.
6. Your lease agreement requires that you provide proof of all risk replacement cost insurance coverage for the leased equipment, including all rents and other amounts due and owing with respect to such equipment as of the date of payment.
7. You must also always maintain adequate commercial liability insurance coverage on your leased equipment. You must have "Hewlett-Packard Financial Services Company and its assignees" named as an "additional insured(s)" under such liability coverage and upon our request, furnish us with an insurance certificate showing that you have such coverage. The insurance certificate should also include: a) your company name; b) your company address and equipment location; c) the insurance policy period; d) liability coverage amounts; and e) your lease number.

Again, thank you for choosing HP Financial Services as your leasing source. If you have any questions or concerns, please don't hesitate to call us.

Sincerely,
Customer Delivery Specialist
1-888-277-5944



Lessee (Complete Legal Name): MEADOWBROOK CENTER, INC.

Lease Agreement Number: 52059499604044USA2

Business Lease Agreement

This lease (including the attached Schedules A and B, this "Lease") refers throughout to Lessee as "you" or "your" and to Lessor as "we", "us" or "our". In consideration of our purchase of the equipment described on Schedule A (the "Equipment"), you hereby lease the Equipment from us for your business purposes only (and not for personal, family or household purposes), subject to all terms and conditions of this Lease. You acknowledge that you selected the vendor as identified in Schedule A (the "Vendor") and all such Equipment without our assistance. You agree that this Lease is a net lease so you will pay, by Lease payment increase or upon our demand, all costs, fees, taxes (e.g. property, sales and use taxes) or other charges connected with the Lease and the Equipment, as well as all costs for insurance, repairs, maintenance, shipping, and filing fees. You authorize us to adjust your Lease payment by up to ten percent (10%) if the actual total cost of the Equipment at acceptance varies from the original estimate. Lease payments shall commence on the Acceptance Date, as defined below, and are due in advance or arrears each monthly or quarterly period ("Period") during the Lease term on the monthly or quarterly anniversary of the Acceptance Date, all as specified in Schedule A. You agree to pay a one-time documentation fee in the amount specified in Schedule A with the first Lease payment to cover account-setup costs. If you do not elect to either purchase the Equipment, renew the Lease or return the Equipment by the end of the Lease term in accordance with the terms of Schedule A hereto, or you fail to comply with your obligations arising from the election, you will continue to pay the original Lease payments for any full or partial Period that you keep the Equipment. If you have selected either a FMV or a 10% End of Term Purchase Option (as indicated on Schedule A), then we and you intend this Lease to be a "Finance Lease" as defined in Article 2A of the Uniform Commercial Code (as enacted and in effect in any applicable jurisdiction, the "UCC") and you authorize us to file a UCC financing statement to give public notice of our ownership of the Equipment. If you have selected a \$1.00 End of Term Purchase Option or if this Lease is otherwise deemed to be a "lease intended for security", then to secure payment and performance of your obligations under this Lease, you hereby grant us a purchase money security interest in the Equipment and in all attachments, accessories, additions, products, replacements, and proceeds (including insurance proceeds) to and of the Equipment, as well as a security interest in any other equipment we have leased to or financed for you, and you authorize us to file a UCC financing statement to perfect such security interest. You hereby appoint us as your attorney-in-fact to: (i) sign any UCC financing statements in your name, (ii) modify Schedule A to reflect any Lease payment adjustment provided for above and to complete or modify any Equipment description in Schedule A or any related document to accurately describe the Equipment actually accepted by you, and (iii) correct all typographical, clerical or legal name errors discovered in any or all of the documentation required in connection with this Lease and execute or initial all such documentation corrections in your name.

EXCEPT AS TO QUIET ENJOYMENT, WE MAKE ABSOLUTELY NO REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, INCLUDING NO WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. You can only make any claim relating to the Equipment against the Vendor or manufacturer, and you waive any such claim against us. We hereby assign any Equipment warranties during the Lease term for your exercise at your expense. **WE WILL NOT BE LIABLE FOR INCIDENTAL, SPECIAL, INDIRECT, OR CONSEQUENTIAL DAMAGES. YOU AGREE TO MAKE PAYMENTS TO US WHEN DUE, UNCONDITIONALLY, WITHOUT ABATEMENT OR OFFSET FOR ANY CAUSE AND REGARDLESS OF ANY PROBLEMS WITH THE EQUIPMENT, VENDOR, OR US AND YOU WAIVE ANY CLAIM OR DEFENSE TO ANY LEASE PAYMENT.**

You agree to indemnify us against third party claims or other loss or damages, including attorneys' fees, arising directly or indirectly out of Equipment defects, use, or operation, and whether arising out of breach of contract, tort, or strict or product liability. You agree not to move the Equipment or to transfer, sell, sublease, or encumber either the Equipment or any rights under this Lease without our prior written consent. We may freely assign our rights and interests under this Lease without notice to you or your consent. You agree that our assignee will have the same rights and remedies as we do and that our assignee's rights will not be subject to any claims or defenses you may have against us. You and any guarantor hereby authorize us to share information about you and any guarantor (including personally identifiable information) with our assignees, potential assignees, the Vendor and other third parties providing services to us.

We own the Equipment and, unless you have selected a \$1.00 End of Term Purchase Option, we retain all benefits of ownership and you agree not to take any position inconsistent with our ownership. We may inspect the Equipment and attach Equipment ownership labels. You are solely responsible for the installation, operation, and maintenance of the Equipment, will keep it in good condition, will use it in compliance with applicable law, and will not attach it to building fixtures. You bear all risk of loss or damage to or from the Equipment arising prior to its return to us and will have it duly insured against all risk of loss and damage up to the greater of its replacement value or the Stipulated Loss Value (as defined below) and against public liability for bodily injury or damage to property arising in connection with the Equipment. You will provide to us a certificate showing that you have such insurance coverages, naming us as loss payee. Upon the occurrence of any loss or irreparable damage to the Equipment ("Casualty Loss"), you agree to immediately (c) replace the affected Equipment with equipment of equivalent or better value and supplied by a manufacturer acceptable to us or (d) pay us an amount ("Stipulated Loss Value") which is the sum of (i) all arrears in Lease payments as of the date of payment of the Stipulated Loss Value, if any (ii) all Lease payments payable from the date of payment of the Stipulated Loss Value up until expiry of the term (discounted at a rate equal to the 3% per annum (the "Discount Rate"), compounded monthly) and (iii) an amount calculated by multiplying the Equipment Total Cost with the applicable percentage specified in the next sentence. The applicable percentage will be 40% for Equipment having an initial Term of less than 24 months; 35% for Equipment having an initial Term of 24 months or greater, but less than 36 months; and 30% for Equipment having an initial Term of 36 months or greater.

You do not and will not: 1) export, re-export, or transfer any Equipment, software, source code or any direct product thereof to a prohibited destination, or to nationals of proscribed countries wherever located, without prior authorization from the United States and other applicable governments; and 2) use any Equipment, software or technology, technical data, or technical assistance related thereto or the products thereof in the design, development, or production of nuclear, missile, chemical, or biological weapons or transfer the same to a prohibited destination, or to nationals of proscribed countries, without prior authorization from the United States and other applicable governments. You are not an entity or person designated by the United States government or any other applicable government with which transacting business without the prior consent of such government is prohibited.

If you do not pay or perform any obligation under this Lease within 10 days of when such payment or performance is due, or you or any guarantor die, become insolvent or unable to pay debts when due; stop doing business as a going concern; merge, consolidate, transfer all or substantially all of your assets; make an assignment for the benefit of creditors, file bankruptcy, appoint a trustee or receiver or undergo a material adverse change in your financial or operating condition, we can do any or all of the following: (1) accelerate without notice all payments provided for in this Lease (discounted at the Discount Rate), (2) immediately repossess the Equipment or (absent Equipment repossession or return) claim a further amount equal to Stipulated Loss Value from you, (3) collect all costs of collection, including any bad check charges and reasonable attorneys' fees, (4) collect lost tax benefits and all unpaid amounts due hereunder, (5) sell or relet the Equipment, and (6) exercise all other remedies at law or equity. If we do not receive any payment when due, you will pay a one-time late charge on any overdue payment equal to the greater of \$.10 per dollar for each late payment, or \$15 (to compensate for the cost and expense of collecting and processing the late payment), plus a charge of 1 1/2% of the late payment for every month after the first month in which the payment is late (for damages including our inability to reinvest the late amount), but in any case, never to exceed more than the maximum charge allowed by law. In addition, if you are delinquent in payment, you agree to pay the actual out-of-pocket expenses incurred by us in our collection efforts (including, but not limited to, any bad check charges). Your payments may be applied, as we elect, first to the oldest amount due. Our action or failure to act on any one remedy shall not constitute an election of such as our sole remedy. Any provision of this Lease is severable if unenforceable. Any action or claim by you against us shall be commenced within one year after the cause of action arises or be forever barred.

You agree to sign such other documents and take such other actions as we may require to accomplish the intent and purpose of this Lease. All of your representations, warranties and obligations hereunder shall survive the termination of this Lease. All notices, demands and other communications required to be given under this Lease shall be in writing and shall be deemed to have been given if delivered personally or mailed via certified mail or a nationally recognized overnight courier service.



TIME IS OF THE ESSENCE. THIS LEASE SHALL BE DEEMED FULLY EXECUTED AND PERFORMED IN THE STATE OF NEW JERSEY AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS THEREOF. TO THE EXTENT NOT PROHIBITED BY APPLICABLE LAW, THE PARTIES HERETO EXPRESSLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY JURISDICTION. YOU WAIVE ANY STATUTORY PROVISIONS WHICH CONFLICT WITH THE TERMS OF THIS LEASE, INCLUDING BUT NOT LIMITED TO UCC ARTICLE 2A SECTION 303 AND SECTIONS 508 THROUGH 522. You acknowledge that neither any Vendor nor any Equipment salesperson is an agent of ours nor are they authorized to waive or alter the terms of this Lease. Their representations in no way affect any of our rights and obligations as herein set forth. If an E-Signature Rider is executed and delivered to us in connection with this Lease ("E-Rider"), such E-Rider will apply in the event this Lease and the Delivery and Acceptance Certificate (if requested) are submitted to you for electronic execution. You agree that an executed copy of this Lease bearing our original manual signature and your signature (either an original manual signature or such signature reproduced by means of a reliable electronic form, such as a photocopy, facsimile or, if you have executed this Lease electronically pursuant to an executed E-Rider, a printout of this Lease from our systems bearing your electronic signature), shall be marked "Original" by us and shall constitute the only original document for all effective purposes; all other copies shall be duplicates. To the extent this Lease constitutes chattel paper (as defined in the UCC), no security interest in this Lease may be created except by possession or transfer of the executed copy marked "Original" by us.

You acknowledge that certain personal information may be communicated to us in the course of the performance of the Lease and will be used by us to administer our rights and obligations under the Lease and any other agreement entered into between you and us. You confirm that you have obtained any requisite consent to the disclosure and processing of such information by us for that purpose. All such personal data will be processed in accordance with the Hewlett-Packard privacy policy in force from time to time (available at www.hp.com). You authorize us to share information related to this Lease with our affiliates for any reason and any third party as necessary to fulfill our obligations under this Lease.

By signing and initialing a copy of this Lease where required below (either on paper or electronically) and providing the deposit account information required by Schedule B, you are agreeing to all of the terms and conditions of this Lease, including the terms and conditions contained in Schedules A and B and Annex 1, each of which is hereby incorporated by reference into this Business Lease Agreement. This Lease shall become effective upon our acceptance hereof but we will have no obligation to purchase the Equipment until you have accepted it as set forth below.

LESSEE SIGNATURE HERE AND BELOW*

BY: _____

Print Name and Title of Signatory: Lawrence G. Savelli
Manager

Read Carefully Before Signing

This lease is non-cancellable and is our full and final agreement, merging all prior understandings, and cannot be modified or terminated except by a written agreement signed by you and by a corporate officer of our company. You warrant to us that you have received, reviewed and approved your vendor's written supply contract covering the equipment terms of sale and warranties. You hereby authorize us to purchase the equipment in reliance solely upon your statements herein. By your initials below, you shall be deemed to have irrevocably accepted the equipment 10 business days after shipment of the equipment to you unless we receive your written rejection prior to the end of the 10-day period. However, you agree to execute and deliver to us a delivery and acceptance certificate upon our request. "acceptance date" means the first business day following the expiration of such 10-day period or such other date set forth in any delivery and acceptance certificate requested by us. The term of this lease shall begin on the acceptance date.

* LESSEE (INITIAL) X LES DATE: 9/25/14

ACCEPTED BY: HEWLETT-PACKARD FINANCIAL SERVICES COMPANY¹

BY: _____ DATE: _____

Guaranty

In consideration of this Lease of Equipment to Lessee, and to be legally bound, the undersigned ("Guarantor") personally, irrevocably and unconditionally guarantees payment and performance of, and as a primary debtor agrees to be jointly and severally liable for (without becoming entitled to the benefits of) all obligations under this Lease until such obligations are satisfied. WE MAY PROCEED AGAINST THE GUARANTOR IN THE FIRST INSTANCE WITHOUT RESORTING TO OTHER REMEDIES, AND THE GUARANTOR WAIVES ANY STATUTORY OR OTHER RIGHT TO REQUIRE OTHERWISE. Guarantor waives subrogation rights; waives defenses and rights relating to impairment, invalidity, modification, extension of the Lease, or relating to substitution, dishonor, release or compromise of Lessee; waives demand, protest, presentment; and waives all notices related to any of the foregoing. Guarantor shall pay all costs of enforcement and collection including attorneys' fees. THIS GUARANTY SHALL BE GOVERNED BY THE LAWS OF NEW JERSEY. GUARANTOR CONSENTS TO THE PERSONAL JURISDICTION AND VENUE OF FEDERAL AND STATE COURTS IN NEW JERSEY. THE PARTIES HERETO EXPRESSLY WAIVE ALL RIGHTS TO A TRIAL BY JURY.

GUARANTOR SIGNATURE HERE

BY: X _____

Soc. Sec # : _____

¹Authorized to do business in the name of Hewlett-Packard Financial Services Company Inc. in Alabama and New York.



Schedule A to Business Lease Agreement

Lease Agreement Number: 52059499604044USA2

Lessee (full legal name): MEADOWBROOK CENTER, INC.			
Billing Address: 350 Salmon Brook St, GRANBY, CT, 06035, UNITED STATES			
Tax ID Number:			
Telephone Number (including area code): 7084488304 Fax Number (including area code):			
Equipment Description: See Attached Annex 1 to this Schedule			
Equipment Location: (if different from Billing Address) 350 Salmon Brook St, GRANBY, CONNECTICUT, 06035, UNITED STATES			
Vendor Information (name): CDW			
Term: 60 Period: Monthly Payable: Arrears	End-of-Term Option: DOLLAR OUT	Periodic Lease Payment: \$93.17	Tax on Periodic Lease Payment (if applicable): \$ 5.92
Advance Lease Payment: \$	Tax on Advance Lease Payment (if applicable) \$	Documentation Fee: \$100.00	Total First Payment: \$199.09 (The Total First Payment shall include any Advance Lease Payment, the first Periodic Lease Payment, any applicable taxes, and the Documentation Fee.)
<p>The payment of any Advance Lease Payment reflected herein shall be a condition to Lessor's agreement to this Lease and may include either or both of the following: (a) applicable taxes, and/or (b) any other "Down Payment" (defined herein below). "Down Payment" shall mean such amount determined by Lessor required upon the execution of this Lease and shall be credited against the original cost of the Equipment leased under this Lease.</p>			

Lessee's end of term options:

If you have on a timely basis fully complied with all the terms and conditions of this Lease, you may choose to exercise one of the following options upon the natural expiration of the term or any extension or renewal term on an "all or none" basis as to each option, provided however, you must give us written notice not less than ninety (90) days before expiration of the relevant term:

1. PURCHASE OPTIONS: You may purchase the Equipment for the Purchase Price (as defined below) on an "as-is, where-is" basis, without any representations or warranties, including no warranties of merchantability or fitness for a particular purpose. "Purchase Price" means (a) if you have selected a FMV End of Term Purchase Option (as indicated above), the then "Fair Market Value" (as defined below) of the Equipment (plus all applicable taxes), or (b) if you have selected a 10% End of Term Purchase Option (as indicated above), an amount equal to ten percent (10%) of the original Equipment cost (plus all applicable taxes), or (c) if you have selected a \$1.00 End of Term Purchase Option (as indicated above), an amount equal to one dollar (\$1.00) (plus all applicable taxes). "Fair Market Value" means the price that a willing buyer (who is neither a lessee in possession nor a used equipment dealer) would pay for the Equipment in an arm's-length transaction to a willing seller under no compulsion to sell; provided, however, that in such determination: (i) the Equipment will be assumed to be in the condition in which it is required to be maintained and returned under this Lease, (ii) in the case of any installed Equipment, that Equipment shall be valued on an installed basis, and (iii) costs of removal from the current location shall not be a deduction from such valuation. If you and we are unable to agree on the Fair Market Value of the Equipment at least thirty (30) days before Lease expiration, we will appoint an independent appraiser (reasonably acceptable to you and at your expense) to determine the Fair Market Value and such appraiser's determination will be final, binding and conclusive.

2. RENEWAL OPTION: You may renew the Lease at the then Fair Market Rental Value. "Fair Market Rental Value" means the amount of periodic rent that would be payable for the Equipment in an arm's length transaction between an informed and willing lessee and an informed and willing lessor, neither under compulsion to lease. Such amount will not be reduced by the costs of removing any Equipment from its current location or moving it to a new location. In the event of such an election, Lessee shall enter into a mutually agreeable renewal agreement with Lessor on or before the last day of the then applicable term confirming the period for which the Lease is to be renewed (the "Renewal Term"), and the amount of Rent and the times at which such Rent is to be payable during the Renewal Term.

3. EQUIPMENT RETURN OPTION: You may return the Equipment, at your expense, to a location designated by us on or before the last day of the Lease term. Upon return, the Equipment must be in the same condition as when you first received it (excepting only reasonable wear and tear) and include all original parts, attachments and accessories. For all Equipment to be returned to us, you agree to (a) remove any of your labels, tags or other identifying marks on the Equipment and wipe clean or permanently delete all data contained on the Equipment, including without limitation, any data contained on internal or external drives, discs, or accompanying media, and (b) pack the Equipment in accordance with the manufacturer's guidelines. You must also return to us all copies of any operating system software (including any certificate of authenticity) you received with the Equipment.

4. AUTOMATIC EXTENSION. IF THE LEASE DOES NOT CONTAIN A \$1.00 END-OF-TERM PURCHASE OPTION, AND YOU FAIL TO DELIVER TO US THE END-OF-TERM NOTICE NOT LESS THAN NINETY (90) DAYS BEFORE THE EXPIRATION OF THE RELEVANT TERM, THEN, WITHOUT ANY ADDITIONAL NOTICE OR DOCUMENTATION, THE THEN RELEVANT TERM SHALL BE AUTOMATICALLY EXTENDED FOR SUCCESSIVE CALENDAR MONTHS WITH RESPECT TO ALL ITEMS OF EQUIPMENT SUBJECT TO THIS LEASE THROUGH THE END OF THE CALENDAR PERIOD FALLING AT LEAST 90 DAYS AFTER THE DATE YOU SHALL HAVE DELIVERED TO US AN END-OF-TERM NOTICE WITH RESPECT TO THIS LEASE AND ALL OTHER PROVISIONS OF THE LEASE SHALL CONTINUE TO APPLY. IF YOU DELIVER SUCH END-OF-TERM NOTICE, BUT SHALL HAVE SUBSEQUENTLY FAILED TO COMPLY WITH ITS OBLIGATIONS ARISING FROM THE ELECTIONS SPECIFIED THEREIN, THEN THE THEN APPLICABLE TERM OF THIS LEASE SHALL, WITHOUT ANY ADDITIONAL NOTICE OR DOCUMENTATION, BE AUTOMATICALLY EXTENDED. FOR EACH CALENDAR PERIOD THAT THE THEN APPLICABLE TERM OF THIS LEASE IS SO EXTENDED, YOU SHALL PAY TO US LEASE PAYMENTS IN AN AMOUNT EQUAL TO THE PERIODIC LEASE PAYMENT IN EFFECT IMMEDIATELY PRIOR TO SUCH EXTENSION AND ALL OTHER PROVISIONS OF THE LEASE SHALL CONTINUE TO APPLY.

Lessee (initial): LG



Annex 1 to the Schedule

Equipment Schedule Number 52059499604044USA2 Forming Part of Lease # 52059499604044USA2 between Lessor Hewlett-Packard Financial Services Company and Lessee MEADOWBROOK CENTER, INC.

QTY	ITEM NO	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
9	3145422	LVO TS TP E545 A-5350 320GB 4GB W8 Mfg#: 20B20011US Contract: MARKET	435.12	3,916.08
2	3262308	HP SB 1910-24G SWITCH Mfg#: JE006AS#ABA Contract: MARKET	270.00	540.00
1	1908445	CYBERNET PWR SUP Mfg#: EPU180W Contract: MARKET	65.74	65.74
9	500817	INTERMEDIATE CUSTOM TAG Mfg#: INTERMD CSTM TAG Contract: MARKET	10.00	90.00
15	2086051	LOGI B100 USB OPT BLK MOU Mfg#: 910-001439 Contract: MARKET	6.50	97.50

Shipping	160.90
Total Amount	4,870.22

The described items constitute all the Equipment covered by the above referenced lease.

Lessee (initial): LG

General Information and Questionnaire Accounting Basis

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 7	of 37
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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 Marcum LLP	335 Long Wharf Dr, 12th Fl, New Haven, CT 06511
2 Marcum LLP	335 Long Wharf Dr, 12th Fl, New Haven, CT 06511
3 Marcum LLP	335 Long Wharf Dr, 12th Fl, New Haven, CT 06511
4 Marcum LLP	335 Long Wharf Dr, 12th Fl, New Haven, CT 06511

Services Provided by This Firm (*describe fully*)

1 Tax Return & Audit Financial Statements 9/30/15	\$ 26,125
2 2013 Tax Return (Disallow)	\$ 2,063
3 Medicare Cost Report (Disallow)	\$ 2,650
4 2013 Administrative Fees (Disallow)	\$ 440
Charge for Services Provided	
\$31,278	

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

Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman & Goodwin	860-251-5000
2 Murtha Cullina	860-240-6000
3 Rosenthal Law Firm	860-677-7171
4 Probate/State Marshal/Treasurer St of CT	
5 Harrison & Burch	

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

- 1 One Constitution Plaza, Hartford, CT 06130
- 2 118 Asylum St, Hartford, CT 06103
- 3 PO Box 586 Avon, CT 06001
- 4
- 5 400 Seabury Drive #4178, Bloomfield, CT 06002

Services Provided by This Firm (*describe fully*)

1 Employee Matters: Disallow	\$ 3,534
2 Survey & Ownership Matters: Disallow	\$ 6,620
3 A/R Collections: Disallowed	\$ 4,559
4 A/R Collections: Disallowed	\$ 440
5 Note Agreement: Disallow	\$ 5,075
Charge for Services Provided	
\$20,228	

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

Yes No Pg 15, Line 1e

Schedule of Resident Statistics

Name of Facility	License No.		Report for Year Ended		Page of	
	2342/2342		09/30/15		8 37	
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30	Period 7/1 Thru 9/30
1. Certified Bed Capacity						
A. On last day of PREVIOUS report period.....	90	80	10		90	80
B. On last day of THIS report period.....	90	80	10		90	80
2. Number of Residents						
A. As of midnight of PREVIOUS report period.....	84	74	10		84	74
B. As of midnight of THIS report period.....	86	76	10		86	76
3. Total Number of Days Care Provided During Period						
A. Medicare.....	6,567	4,005	2,562		5,023	3,082
B. Medicaid (Conn.).....	19,259	19,258	1		14,453	14,452
C. Medicaid (other states).....						
D. Private Pay.....	3,694	3,477	217		2,656	2,489
E. State SSI for RCH.....						
F. Other (Specify) Managed Care	375	375			251	251
G. Total Care Days During Period (3A thru F).....	29,895	27,115	2,780		22,383	20,274
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds						
A. Medicaid Bed Reserve Days.....	27	27			15	15
B. Other Bed Reserve Days.....	4	4			4	4
5. Total Resident Days (3G + 4A + 4B).....	29,926	27,146	2,780		22,402	20,293
					2,109	7,524
						6,853
						671

Schedule of Resident Statistics (Cont'd)

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		License No. 2342/2342		Report for Year Ended 9/30/2015		Page 9	of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "YES", provide the following information:								
Date of Change	Place of Change		Change in Beds			Capacity After Change		Reason for Change
	CCNH (1)	RHNS (2)	(Specify)			CCNH (Specify)	RHNS (Specify)	
			Lost (1)	(2)	(3)	Gained (1)	(2)	(3)
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		Medicaid		Self-Pay		Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H. ICF-MR
No. of Residents	12		58		12	1	3	
Per Diem Rate								
a. One bed rm.	525.77		242.17	195.68	493.00	465.00	396.81	
b. Two bed rms.	525.77		242.17	195.68	463.00	451.00	396.81	
c. Three or more bed rms.								
7. Total Number of Physical Therapy Treatments						TOTAL	CCNH	RHNS (Specify)
A. Medicare - Part B						3,432	3,432	
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments						332	332	
2. Restorative Treatments								
C. Other						14,654	14,654	
D. Total Physical Therapy Treatments						18,418	18,418	
8. Total Number of Speech Therapy Treatments								
A. Medicare - Part B						1,724	1,724	
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments						198	198	
2. Restorative Treatments								
C. Other						4,009	4,009	
D. Total Speech Therapy Treatments						5,931	5,931	
9. Total Number of Occupational Therapy Treatments								
A. Medicare - Part B						4,056	4,056	
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments						404	404	
2. Restorative Treatments								
C. Other						15,486	15,486	
D. Total Occupational Therapy Treatments						19,946	19,946	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)	113,148	1,942	11,587	199		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	187,719	8,340	19,224	854		
5. Dietary Service						
a. Head Dietitian	25,999	772	2,663	79		
b. Food Service Supervisor	48,696	1,872	4,987	192		
c. Dietary Workers	327,167	24,371	33,505	2,496		
6. Housekeeping Service						
a. Head Housekeeper	40,510	1,892	4,149	194		
b. Other Housekeeping Workers	141,634	11,034	14,505	1,130		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	46,180	1,929	4,729	197		
b. Other Maintenance Workers	31,819	1,960	3,259	201		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	80,597	5,512	8,254	565		
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	147,871	3,127	18,301	387		
b. RN						
1. Direct Care	485,045	13,458	25,449	887		
2. Administrative**	303,487	11,571	37,560	1,432		
c. LPN						
1. Direct Care	613,388	23,825	62,191	2,302		
2. Administrative**						
d. Aides and Attendants	937,929	63,210	128,806	9,248		
e. Physical Therapists	451,560	12,564				
f. Speech Therapists	184,746	3,560				
g. Occupational Therapists	307,004	8,529				
h. Recreation Workers	74,111	4,508	7,590	462		
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	165,008	6,291	16,899	644		
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	4,713,618	210,267	403,658	21,469		

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

Name of Facility	License No.	Report for Year Ended		Page	of				
		2342/2342	9/30/2015						
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									
Not Applicable									
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).									
Not Applicable									

* 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.

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			
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015		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***									
Christine McKinney (10/1/14-9/30/15)	113,148	11,587	Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,141	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	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. Dietitian.....						
2. Dentist.....	8,866	22	908	2		
3. Pharmacist.....	6,210	127	636	13		
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	10,050	175				
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	101,233	362	10,367	37		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	13,807					
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	363	4	37			
9. Speech Therapist						
a. Resident Care.....	5,063	14				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	444	7	54	1		
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	146,036	711	12,002	53		

* 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.

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
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Noble Hospital, 115 West Silver St, Westfield, MA 01085	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Audiology Group, 888 Worcester St, Wellesley, MA 02482	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Onward Healthcare, PO Box 27421 New York, NY 10087	Physical Therapist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Swallowing Diagnostics, 21 Waterville Rd, Avon, CT 06001	Speech Therapist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
ProHealth Physicians, Dr Shastri, 6 Northwesters Drive, Bloomfield, CT 06002	Asst. Medical Director/Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Retina Consultants, PC, 191B Main St, Manchester, CT 06040	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Eyecare Group, 888 Worcester St, Wellesley, MA 02482	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
CT GI Endoscopy Center, 4 Northwestern Dr, Bloomfield, CT 06002	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Omnicare, PO Box 740391, Cincinnati, OH 45274	Pharmacist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Medical Dental, 85 Barnes Rd Suite 207, Wallingford, CT 06492	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Gilberto Ramirez, MD, 421 Cottage Grove Rd, Bloomfield, CT 06002	Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
CT Multispecialty/David Fenton, 100 Retreat Ave #605, Hartford, CT 06106	Asst Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Arrhythmia Consultants of CT, 95 Woodland St, 4th Floor, Hartford, CT 06105	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Connecticut Surgery Center, 81 Gillett St, Hartford, CT 06105	Physician	<input type="checkbox"/>	<input type="checkbox"/>		
Athena Healthcare, 135 South Rd, Farmington, CT 06032	MDS Fill In	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners	
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		

* Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 221,011	203,577	17,434		
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 121,334	111,763	9,571		
4. Social Security (F.I.C.A.).....	\$ 381,008	350,954	30,054		
5. Health Insurance.....	\$ 654,853	603,197	51,656		
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 16,350	15,060	1,290		
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 25,642	22,194	3,448		
d. Accounting and Auditing.....	\$ 31,278	28,372	2,906		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 20,228	18,349	1,879		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies.....	\$ 63,918	57,980	5,938		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 41,720	37,844	3,876		
2. Cellular Phones.	\$ 2,615	2,372	243		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$ 500	454	46		
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 491,007	445,395	45,612		
Subtotal	\$ 2,071,464	1,897,511	173,953		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,071,464	1,897,511	173,953		
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 4,580	4,155	425		
3. Gifts to Staff and Residents.....	\$ 16,001	14,515	1,486		
4. Employee Travel.....	\$ 4,738	4,298	440		
5. Education Expenses Related to Seminars and Conventions	\$ 2,642	2,397	245		
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).....	\$ 3,188	2,892	296		
2. Advertising Telephone Directory (all such expenses)***	\$ 888	806	82		
3. Advertising Other (Specify)***.....	\$ 41,748	37,870	3,878		
See Attached Schedule					
4. Fund-Raising***.....	\$				
5. Medical Records.....	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	\$				
7. Postage.....	\$ 8,127	7,372	755		
* 8. Dues and Membership Fees to Professional Associations (Specify).....	\$ 6,142	5,571	571		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 787	714	73		
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**.....	\$ 159,393	144,586	14,807		
13. Other (Specify).....	\$ 157,204	142,599	14,605		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 2,476,902	2,265,286	211,616		

* 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 Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 37,870	\$ 3,878	
Total Other Advertising	\$ 37,870	\$ 3,878	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Connecticut Association of Health	\$ 5,571	\$ 571	
Total Dues	\$ 5,571	\$ 571	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 2,734	\$ 280	
Licenses	\$ 1,206	\$ 124	
Bank Charges	\$ 4,314	\$ 442	
Payroll Processing Fees	\$ 17,046	\$ 1,746	
MDS Consulting	\$ 18,142	\$ 1,358	
Appraisal Fee	\$ 4,082	\$ 418	
Compliance Consulting	\$ 30,778	\$ 3,152	
Employee Physicals/Background Checks	\$ 13,941	\$ 1,428	
Data Processing Fees	\$ 46,950	\$ 4,808	
AR Temp Fill In	\$ 3,406	\$ 349	
Total Other Administrative and General	\$ 142,599	\$ 14,605	\$ -

Schedule C-1 - Management Services*

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 17	of 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 #	
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$197,927	Contract Attached to a Prior Year	See Below	
Allocation of the above	\$130,632	Admin/Gen 66%	Pg 16, Line 12	
	\$31,668	Indirect 16%	Pg 18, Line 2C	
	\$35,627	Direct 18%	Pg 20, Line 5J	
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$28,761	Admin/Gen - Other Exp	Pg 16, Line 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.

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

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		License No. 2342/2342	Report for Year Ended 9/30/2015	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 186,038	168,756	17,282		
2. Non-Food Supplies.....	\$ 29,755	26,991	2,764		
3. Other (Specify) _____ Dishes = \$1,467	\$ 1,467	1,331	136		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 31,668	28,726	2,942		
d. Other (Specify) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 248,928	225,804	23,124		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	246	223	23		
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify cost. = \$1175		
L. Is any revenue collected from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* 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.

**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
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	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. \$	13,605	12,341	1,264
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) Supplies = \$3,638	\$	3,638	3,300	338
3E. Total Laundry Expenditures (3a + b + c + d)	\$	17,243	15,641	1,602
3F. Laundry Questionnaire				
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
L. Where is the revenue received reported in the Cost Report?	(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.

**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
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015		20	37
Item		Total	CCNH	RHNS	(Specify)	
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	18,120	16,437	1,683		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel					
	Amt. \$					
c. Management Services*	\$					
d. Other (<i>Specify</i>)	\$					
4E. Total Housekeeping Expenditures (4a + b + c + d)...	\$	18,120	16,437	1,683		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....	\$					
2. Purchased from Omni Care	\$	241,517	239,609	1,908		
b. Medicine Cabinet Drugs.....	\$	1,731	1,570	161		
c. Medical and Therapeutic Supplies.....	\$	185,206	168,001	17,205		
d. Ambulance/Limousine***	\$	868	868			
e. Oxygen						
1. For Emergency Use.....	\$					
2. Other***	\$	26,350	23,448	2,902		
f. X-rays and Related Radiological Procedures***	\$	23,596	23,596			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$					
h. Laboratory***	\$	19,765	19,765			
i. Recreation.....	\$	21,123	19,161	1,962		
j. Other (Specify)**** See Attached Schedule	\$	109,628	104,895	4,733		
5K. Total Resident Care Expenditures (5a - 5j).....	\$	629,784	600,913	28,871		

* 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.

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

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

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

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	117,957	106,999	10,958			
b. Heat..... \$	105,872	96,037	9,835			
c. Light & Power..... \$	117,513	106,597	10,916			
d. Water..... \$	38,032	34,499	3,533			
e. Equipment Lease (<i>Provide detail on page 6</i>)..... \$	18,258	16,562	1,696			
f. Other (<i>itemize</i>)..... \$	67,729	61,437	6,292			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f) \$	465,361	422,131	43,230			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements..... \$						
b. Building & Building Improvements..... \$						
c. Non-Movable Equipment..... \$	4,281	3,805	476			
d. Movable Equipment..... \$	47,305	42,049	5,256			
*7e. Total Depreciation Costs (7a + b + c + d) \$	51,586	45,854	5,732			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense..... \$	5,199	4,716	483			
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	24,729	21,981	2,748			
d. Other (<i>Specify</i>)..... \$						
*8e. Total Amortization Costs (8a + b + c + d) \$	29,928	26,697	3,231			
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	762,894	678,128	84,766			
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	118,345	105,196	13,149			
c. Personal property taxes..... \$	14,328	12,736	1,592			
11. Total Property Expenses (7e + 8e + 9 + 10) \$	977,081	868,611	108,470			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 13,578	\$ 1,391	
Rubbish Removal	\$ 19,587	\$ 2,006	
Snow Removal	\$ 18,596	\$ 1,904	
Supplies	\$ 9,676	\$ 991	
Total Other Repairs and Maintenance	\$ 61,437	\$ 6,292	\$ -

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.		Report for Year Ended				Page	of
	23-42123-42		9/30/2015					
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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal.....								
B. Building and Building Improvements								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal.....								
C. Non-Movable Equipment								
1. Acquired prior to this report period	35,753		35,753	4,272	SL	Various	4,141	
2. Disposals (attach schedule)	2,800		2,800		SL	Various	140	
3. Acquired during this report period (attach schedule)								
C-4. Subtotal.....								4,281
D. Movable Equipment								
1. Motor Vehicles (Specify name, model and year of each vehicle)								
a.								
b.								
c.								
d.								
2. Movable Equipment								
a. Acquired prior to this report period			80,171	17,436	S/L	Various	16,396	
b. Disposals (attach schedule)								
c. Acquired during this report period (attach schedule)			37,749		S/L	Various	4,021	
2.a. Leased Movable Equipment **								
a. Acquired prior to this report period			625,028	511,441	SL	Var	29,935	
b. Acquired during this report period (attach schedule)								
D-3. Subtotal.....								20,417
E. Total Depreciation.....								24,698

** Leased movable equipment is shown for Cost Reporting purposes and is NOT included in the total Facility expense. Therefore, this allowable capital cost was added back on Page 29, line 39.

Schedule of Land Improvements Acquired during this report period

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 period

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-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Jun-15	TNT Refridgeration-Condensing Unit	\$ 2,800	10	\$ 140
Total additions for Non-Movable Equipment		\$ 2,800		\$ 140 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility	License No.		Report for Year Ended		Page	of			
	2342/2342		9/30/2015						
Item	Date of Acquisition		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
	Month	Year							
A. Organization Expense									
1.	9	2014	10 yrs	44,164	5,367	SL		4,416	
2.	9	2015	10 yrs	15,658		SL		783	
3.									
A-4. Subtotal.....									5,199
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal.....									
C. Leasehold Improvements and Other (Specify)									
1. Acquired prior to this report period	9	2014	Various	1,007,711	165,424	SL	Var	24,523	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2015	Various	6,913		S/L	Var	206	
C-4. Subtotal.....									24,729
D. Total Amortization									29,928

* 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.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.	Report for Year Ended	Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	24A	37
C. Leasehold Improvements (Specify)				
1. Acquired prior to this report period	Various	21,315 SL	24,523	
2. Disposals (attach schedule)				
3. Acquired during this report period	Various	6,913 S/L	206	
C-4. Subtotal.....				24,729
C. Other (Specify)				
1. Bed License Purchase	None	144,109 None		
2.				
C-4. Subtotal.....				
Total Acquired prior to this report period	Various	165,424 SL	24,523	
Total Disposals				
Total Acquired during this report period	Various	6,913 S/L	206	

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

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party*? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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	10/01/1991			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	10/01/91			
5. Total Licensed Bed Capacity	90			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building	6,048,250			
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 9/30/2015				
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
Baygrape Associates 64 Higley Road, Granby, CT 06090	Real & Personal Property	06/01/13	10 yrs	762,894

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.

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

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		License No. 2342/2342	Report for Year Ended 9/30/2015			Page 26	of 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)

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

Name of Facility	License No.	Report for Year Ended			Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015			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).....		\$	6,389	5,679	710	
A. Item	Rate	Amount				
	5.00%	319,346				
Lender						
Baygrape Associates						
Address of Lender						
64 Higley Rd, Granby, CT 06090						
B. Item	Rate	Amount				
		-				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest						
Expense (C1 + 2).....		\$	6,389	5,679	710	
12. D. Other Interest Expense (Specify)..... \$						
Vender Interest = \$3,652			3,652	3,246	406	
13. Total All Interest Expense (12B7 + 12C3 + 12D).....\$						
			10,041	8,925	1,116	
14. Insurance						
a. Insurance on Property (buildings only).....		\$	66,166	58,814	7,352	
b. Insurance on Automobiles.....		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage).....		\$				
2. Fire and Extended Coverage.....		\$				
3. Other (Specify).....		\$				
14d. Total Insurance Expenditures (14a + b + c)...						
		\$	66,166	58,814	7,352	
15. Total All Expenditures (A-13 thru C-14).....						
		\$	10,184,940	9,342,216	842,724	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby			2342/2342	9/30/2015	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.			Salaries not related to Resident Care....	\$			
3.	10	A12g	Occupational Therapy.....	\$ 307,004	307,004		
4.	Var	Var	Other - See attached Schedule.....	\$ 65,924	59,800	6,124	
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **.....	\$ 13,807	13,807		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 25,642	22,194	3,448	
10.	15	1d&e	Accounting & Legal.....	\$ 25,381	23,023	2,358	
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 1,175	1,066	109	
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 16,001	14,515	1,486	
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 42,636	38,676	3,960	
19.	15	IJ&K1 &2	Income Tax / Corporate Business Tax...	\$ 500	454	46	
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 37,350	33,880	3,470	
	18	2c		\$ 9,054	8,213	841	
	20	5j		\$ 10,186	9,240	946	
22.			Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 66,200	60,050	6,150	
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 1,175	1,066	109	
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 622,035	592,988	29,047	

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby			2342/2342	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 622,035	592,988	29,047	
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs.....	\$ 241,517	239,609	1,908	
28.	20	5d	Ambulance/Limousine.....	\$ 868	868		
29.	20	5f	X-rays, etc.....	\$ 23,596	23,596		
30.	20	5h	Laboratory.....	\$ 19,765	19,765		
31.	20	5c	Medical Supplies.....	\$ 14,096	12,787	1,309	
32.	20	5e2	Oxygen (non emergency).....	\$ 26,350	23,448	2,902	
33.	20	5j	Occupational Therapy.....	\$ 376	376		
34.	Var	Var	Other - See Attached Schedule.....	\$ 17,618	17,618		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ (3,047)	(2,764)	(283)	
36.			Depreciation on Unallowable Motor Vehicles.....	\$			
37.			Unallowable Property and Real Estate Taxes.....	\$			
38.			Rental of Building Space or Rooms.....	\$			
39.			Other - See Attached Schedule.....	\$			
Page 27 - Insurance							
40.			Mortgage Insurance.....	\$			
41.			Property Insurance.....	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities.....	\$			
43.	20	5j	Radio and Television Revenue.....	\$ 8,412	7,631	781	
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	rv5	Interest Income on Accounts Rec.....	\$ 25	23	2	
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 971,611	935,945	35,666	

*** 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	5j	Medical Equipment Rental	17,618		
Total Other Ancillary Costs			\$ 17,618	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7c	Leased Moveable Equipment Depreciation	(27,154)	(2,781)	
22	7e	Excess Moveable Equipment Depreciation	24,390	2,498	
Total Excess Movable Equipment Depreciation			(2,764)	(283)	

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments					

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			\$	\$	\$

eadow Brook Moveable Equipment Carryforward Schedu

Cost Year Amount Totals

2013

Purchase

Step up

Cost Year	Cost Term	Amount	Totals
	Cost	\$ 188,216	\$ 188,216
	Term	\$ 7	
2013	Deprec	\$ 26,888	\$ 26,888
2013	Book Value	\$ 161,328	\$ 161,328
2014	Deprec	\$ 26,888	\$ 26,888
2014	Book Value	\$ 134,440	\$ 134,440
2015	Deprec	\$ 26,888	\$ 26,888
2015	Book Value	\$ 107,552	\$ 107,552
2016	Deprec	\$ 26,888	\$ 26,888
2016	Book Value	\$ 80,663	\$ 80,663
2017	Deprec	\$ 26,888	\$ 26,888
2017	Book Value	\$ 53,775	\$ 53,775
2018	Deprec	\$ 26,888	\$ 26,888
2018	Book Value	\$ 26,887	\$ 26,887
2019	Deprec	\$ 26,887	\$ 26,887
2019	Book Value	\$ -	\$ -
2020	Deprec	\$ -	\$ -
2020	Book Value	\$ -	\$ -
2021	Deprec	\$ -	\$ -
2021	Book Value	\$ -	\$ -
2022	Deprec	\$ -	\$ -
2022	Book Value	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only).....	\$ 8,989,995	8,989,530	465			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (4,330,829)	(4,330,559)	(270)			
2. a. Medicaid (All other states).....	\$					
b. Other States Room and Board Contractual Allowance **.....	\$					
3. a. Medicare Residents (all inclusive).....	\$ 2,394,147	1,507,314	886,833			
b. Medicare Room and Board Contractual Allowance **.....	\$ 508,949	255,576	253,373			
4. a. Private-Pay Residents and Other.....	\$ 2,488,134	2,124,420	363,714			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (90,519)	(67,056)	(23,463)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare.....	\$ 198,917	198,917				
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (198,917)	(198,917)				
c. Prescription Drugs - Non-Medicare.....	\$ 85,694	85,694				
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (85,694)	(85,694)				
2. a. Medical Supplies - Medicare.....	\$ 5,096	5,096				
b. Medical Supplies - Medicare Contractual Allowance **.....	\$ (3,292)	(3,292)				
c. Medical Supplies - Non-Medicare.....	\$ 1,311	1,133	178			
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (1,311)	(1,133)	(178)			
3. a. Physical Therapy - Medicare.....	\$ 726,054	726,054				
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (628,173)	(628,173)				
c. Physical Therapy - Non-Medicare.....	\$ 177,888	177,888				
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (177,888)	(177,888)				
4. a. Speech Therapy - Medicare.....	\$ 386,846	386,846				
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (315,237)	(315,237)				
c. Speech Therapy - Non-Medicare.....	\$ 81,420	81,420				
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (81,420)	(81,420)				
5. a. Occupational Therapy - Medicare.....	\$ 811,470	811,470				
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (693,774)	(693,774)				
c. Occupational Therapy - Non-Medicare.....	\$ 191,655	191,655				
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (191,655)	(191,655)				
6. a. Other (Specify) - Medicare.....	\$					
b. Other (Specify) - Non-Medicare.....	\$ 2,519	2,519				
III Total Resident Revenue (Section I.thru Section II.).....	\$ 10,251,386	8,770,734	1,480,652			
IV. Other Revenue*						
1. Meals sold to guests, employees & others.....	\$					
2. Rental of rooms to non-residents.....	\$					
3. Telephone.....	\$					
4. Rental of Television and Cable Services.....	\$					
5. Interest Income (Specify).....	\$ 25	23	2			
6. Private Duty Nurses' Fees.....	\$					
7. Barber, Coffee, Beauty and Gift shops.....	\$					
8. Other (Specify).....	\$ 39,318	39,318				
V. Total Other Revenue (1 thru 8).....	\$ 39,343	39,341	2			
VI. Total All Revenue (III + V).....	\$ 10,290,729	8,810,075	1,480,654			

* 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..

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	145,644
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	541,052
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	31,105
5. Prepaid Expenses.....			\$	112,530
a. Prepaid Insurance	112,530			
b. _____				
c. _____				
d. _____				
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	20,651
A/R Related	20,651			
A-9. Total Current Assets (Lines A1 thru 8)			\$	850,982
B. Fixed Assets				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
3. Buildings	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
4. Leasehold Improvements	*Historical Cost.....	164,130	\$	118,086
	Accum. Depreciation	(46,044) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	38,553	\$	30,001
	Accum. Depreciation	(8,552) Net.....		
6. Movable Equipment	*Historical Cost.....	282,236	\$	163,719
	Accum. Depreciation	(118,517) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	23,900
Excluded Movable Equipment	23,900			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	335,706

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

(Carry Total forward to next page)

eadow Brook Moveable Equipment Carryforward Schedu

Cost Year Amount Totals

2013

Purchase
Step up

Cost	\$ 188,216	\$ 188,216
Term	7	
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 161,328	\$ 161,328
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 134,440	\$ 134,440
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 107,552	\$ 107,552
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 80,663	\$ 80,663
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 53,775	\$ 53,775
Deprec	\$ 26,888	\$ 26,888
Book Value	\$ 26,887	\$ 26,887
Deprec	\$ 26,887	\$ 26,887
Book Value	\$ -	\$ -
Deprec	\$ -	\$ -
Book Value	\$ -	\$ -
Deprec	\$ -	\$ -
Book Value	\$ -	\$ -
Deprec	\$ -	\$ -
Book Value	\$ -	\$ -
Deprec	\$ -	\$ -
Book Value	\$ -	\$ -

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	1,186,688
C. Leasehold or like property recorded for Equity Purposes.					
1. Land..... \$					
2. Land Improvements		*Historical Cost.....	Net.....	\$	
		Accum. Depreciation			
3. Buildings		*Historical Cost.....	Net.....	\$	
		Accum. Depreciation			
4. Non-Movable Equipment		*Historical Cost.....	Net.....	\$	
		Accum. Depreciation			
5. Movable Equipment		*Historical Cost.....	625,028		
		Accum. Depreciation	(541,376)	Net.....	\$ 83,652
6. Motor Vehicles		*Historical Cost.....	Net.....	\$	
		Accum. Depreciation			
7. Minor Equipment-Not Depreciable..... \$					
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$	83,652
D. Investment and Other Assets					
1. Deferred Deposits..... \$					
2. Escrow Deposits..... \$					
3. Organization Expense		*Historical Cost.....	59,822		
		Accumulated Deprec	(10,566)	Net.....	\$ 49,256
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)..... \$					
D-8. Total Investments and Other Assets (Lines D1 thru 7)..... \$ 49,256					
D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....				\$	1,319,596

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable.....				\$	746,589
2. Notes Payable (<i>itemize</i>).....				\$	167,400
Interfacility Loans					167,400
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>).....				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>).....				\$	155,941
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....				\$	
6. Accrued Payroll Taxes Payable.....				\$	4,701
7. Medicare Final Settlement Payable.....				\$	
8. Medicare Current Financing Payable.....				\$	
9. Mortgage Payable (<i>Current Portion</i>).....				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>).....				\$	
11. Accrued Income Taxes*.....				\$	
12. Other Current Liabilities (<i>itemize</i>).....				\$	155,267
Acc'd Operating Expenses					29,236
Acc'd Expense - Sales Tax					332
Provider Taxes Due					125,699
A-13. Total Current Liabilities (Lines A1 thru 12).....				\$	1,229,898

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

MEADOWBROOK
ACCRUED EXPENSES-OPERATIONS
September 30, 2015

ACCT. # 2170

Athena 401k 9/26/15	\$2,449.30	2568/5366
Athena Food Rebate	(\$1,840.28)	6334
IBNR Health Insurance	\$24,372.40	5364
Marcum Tax 2015	\$4,125.00	5126
The Hartford	\$130.00	1530/9760

Balance 9/30/15

\$29,236.42

G. Balance Sheet (cont'd)

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		License No. 2342/2342	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,229,898	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>).....\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable.....\$					
3. Loans from Owners or Related Parties (<i>itemize</i>).....\$ 136,438					
Name and Address of Lender	Amount	Loan Date			
Accr'd Rent	136,438				
4. Other Long-Term Liabilities (<i>itemize</i>).....\$					

B-5. Total Long-Term Liabilities (Lines B1 thru 4).....\$ 136,438					
C. Total All Liabilities (Lines A-13 + B-5).....\$ 1,366,336					

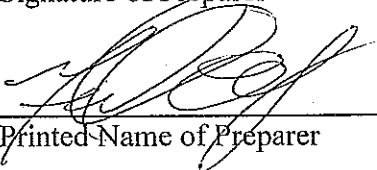
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	2342/2342	9/30/2015	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 (<i>Equity</i>) ..			\$	83,652
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.....			\$	83,652
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	
3. Paid-in Surplus.....			\$	(113,898)
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(122,283)
6. Gain or Loss for Period				
	10/1/2014	thru	9/30/2015	\$ 105,789
7. Total Net Worth.....			\$	(130,392)
C. Total Reserves and Net Worth			\$	(46,740)
D. Total Liabilities, Reserves, and Net Worth			\$	1,319,596

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of		
Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby		2342/2342	9/30/2015	36	37		
Account				Amount			
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(122,284)		
B.	Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	10,290,729		
C.	Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	10,184,940		
D.	Net Income or Deficit.....			\$	105,789		
E.	Balance.....			\$	(16,495)		
F.	Additions						
	1. Additional Capital Contributed (<i>itemize</i>)						
	Additional Rent	(113,897)					
	2. Other (<i>itemize</i>)						
F-3.	Total Additions.....					\$	(113,897)
G.	Deductions						
	1. Drawings of Owners/Operators/Partners (<i>Specify</i>).....			\$			
	Name and Address (<i>No., City, State, Zip</i>)		Title	Amount			
	2. Other Withdrawings (<i>Specify</i>).....			\$			
	Purpose		Amount				
	3. Total Deductions.....			\$			
H.	Balance at End of Period		09/30/15	\$	(130,392)		

I. Preparer's/Reviewer's Certification

Name of Facility Athena Meadowbrook, LLC d/b/a Meadowbrook of Granby	License No. 2342/2342	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (<i>Specify</i>)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer 	Title CFE	Date Signed 2/12/16		
Printed Name of Preparer Athena Health Care Associates, Inc				
Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900		

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.