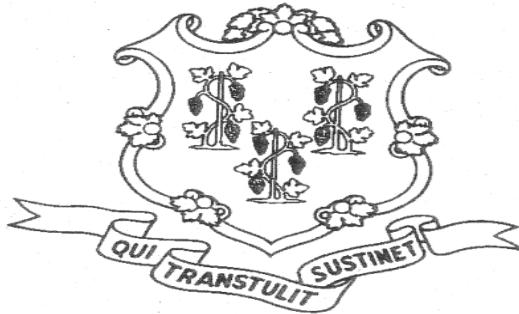


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) McLean Health Center	
Address (No. & Street, City, State, Zip Code) 75 Great Pond Road, Simsbury, CT 06070	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home (RCH)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 884-C	RHNS	Residential Care Home 1712-RCH	Medicare Provider 07-5216
------------------	---------------	------	-----------------------------------	------------------------------

Medicaid Provider Numbers:	CCNH 884-C	RHNS	ICF-IID 1712-RCH
----------------------------	---------------	------	---------------------

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/Members	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) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 1	of 37
--	----------------------	------------------------------------	-----------	----------

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for McLean Health Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

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

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Lisa Clark		Printed Name (Owner) David Bordonaro, President	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility McLean Health Center	Period Covered:		From 10/1/2019	To 9/30/2020	
Address of Facility 75 Great Pond Road, Simsbury, CT 06070					
Report Prepared By McLean Affiliates, Inc.	Phone Number (860) 658-3759		Date 1/27/2021		
Item	Total	CCNH	RHNS	Residential Care Home	
1. Dietary wages paid	\$ 7,499			7,499	
2. Laundry wages paid	\$ 8			8	
3. Housekeeping wages paid	\$ 7,913			7,913	
4. Nursing wages paid	\$				
5. All other wages paid	\$ 69,125			69,125	
6. Total Wages Paid	\$ 84,545			84,545	
7. Total salaries paid	\$ 8,822			8,822	
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 93,367			93,367	

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)658-3700	Report for Year Ended 9/30/2020	Page 2
Name of Facility (as shown on license) McLean Health Center		Address (No. & Street, City, State, Zip) 75 Great Pond Road, Simsbury, CT 06070	
License Numbers:	CCNH 884-C	RHNS 1712-RCH	Residential Care Home Medicare Provider No. 07-5216
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home			
Type of Ownership (Check appropriate box)		<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator			
Name of Administrator Lisa Clark		Nursing Home Administrator's License No.:	001842
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name N/A		License No.:	

General Information and Questionnaire Partners/Members

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3A Rev. 10/2005

**General Information and Questionnaire
Corporate Owners**

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page of 3A 37
--	----------------------	------------------------------------	--------------------

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
McLean Affiliates, Inc	75 Great Pond Road, Simsbury, CT 06070	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached List of			
McLean Affiliate Directors			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page of 3B 37
--	----------------------	------------------------------------	--------------------

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

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**			
McLean Fund	75 Great Pond Road, Simsbury, CT 06070	<input type="radio"/>	<input checked="" type="radio"/>		Gifts to McLean Affiliates, Inc. through inc	Various	
McLean Game Refuge, Inc.	75 Great Pond Road, Simsbury, CT 06070	<input type="radio"/>	<input checked="" type="radio"/>		None - McLean Affiliates, Inc provides	Page 10, 11b	
		<input type="radio"/>	<input checked="" type="radio"/>		(continued) bookkeeping services		
McLean Foundation merged into		<input type="radio"/>	<input checked="" type="radio"/>				
McLean Affiliates (Nursing Home) effective 10/1/19		<input type="radio"/>	<input checked="" type="radio"/>				
Foundation will be disallowed.		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 5	of 37
--	----------------------	------------------------------------	-----------	----------

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
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.

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

The McLean Foundation, Inc., supports certain programs and capital acquisitions of the Health Center via donations and grants. The McLean Fund uses income from investments to fund a portion of the Operating Expenses. Any funding by these entities is at cost.

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.

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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

743

* 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.

General Information and Questionnaire

Accounting Basis

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 7	of 37
--	----------------------	------------------------------------	-----------	----------

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

Accrual Cash Modified Cash

Is the accounting basis for this

period the same as for the Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 Blum, Shapiro & Company, P.C. 2 3 4	Address (No. & Street, City, State, Zip Code) 29 South Main Street, West Hartford, CT 06127
---	--

Services Provided by This Firm (*describe fully*)

1 Independent Audit of 2020 Financials & Employee 401k fund, Preparation of FY 2020 Medicare CR, & Preparation of IRS 990 2 3 4	\$ 68,318 \$ \$ \$
	Charge for Services Provided \$ 68,318

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

Yes No Pg 15, 1D - CCNH \$26,949, RCH \$434, Outpatient/Other not on Annual Report \$40,934 BEFORE ADJUST

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Wiggin & Dana 2 Michalik, Bauer, Silvia 3 Day Pitney, LLP 4 SIEGEL, O'CONNOR, O'DONNELL & BECK P.C. 5 SHIPMAN & GOODWIN LLP	Telephone Number
---	------------------

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

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1 Various Service and Advice - all costs will be adjusted on Pg 28 of the CR 2 3 4 5	\$ 29,913 \$ \$ \$ \$
	Charge for Services Provided \$ 29,913

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

Yes No Pg 15, 1E - CCNH \$12,211 RCH \$189 Outpatient/Other not on Annual Report \$17,514 (see page 28 line 10 adjustment for \$12,211 and \$189)

Schedule of Resident Statistics

Name of Facility McLean Health Center			License No. 884-C				Report for Year Ended 9/30/2020				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	92	89		3	92	89		3				
B. On last day of THIS report period	92	89		3					92	89		3
2. Number of Residents												
A. As of midnight of PREVIOUS report period	82	81		1	82	81		1				
B. As of midnight of THIS report period	71	69		2					71	69		2
3. Total Number of Days Care Provided During Period												
A. Medicare	3,953	3,953			3,057	3,057			896	896		
B. Medicaid (Conn.)	11,018	11,018			8,306	8,306			2,712	2,712		
C. Medicaid (other states)												
D. Private Pay	8,957	8,957			7,006	7,006			1,951	1,951		
E. State SSI for RCH	514			514	330			330	184			184
F. Other (Specify) HMO, Managed Medicare	2,134	2,134			1,663	1,663			471	471		
G. Total Care Days During Period (3A thru F)	26,576	26,062		514	20,362	20,032		330	6,214	6,030		184
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	39	39			39	39						
5. Total Resident Days (3G + 4A + 4B)	26,615	26,101		514	20,401	20,071		330	6,214	6,030		184

Schedule of Resident Statistics (Cont'd)

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 9	of 37
--	----------------------	------------------------------------	-----------	----------

4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home		
				(1)	(2)	(3)	(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	Residential Care Home
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	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	10	31		23			2	
Per Diem Rate								
a. One bed rm.	PDPM	272.04		\$508-\$539			138.37	
b. Two bed rms.	PDPM	272.04		\$498-\$513				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	824	824	Residential Care Home
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	11,846	11,846	
D. Total Physical Therapy Treatments	12,670	12,670	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	33	33	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	347	347	
D. Total Speech Therapy Treatments	380	380	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	509	509	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	9,871	9,871	
D. Total Occupational Therapy Treatments	10,380	10,380	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		884-C	9/30/2020	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Item	CCNH	Hours	RHNS	Hours	Residential Care Home Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)	82,534	661			1,329 11
2. Administrator(s) (Complete also Sec. III of Schedule A1)	107,104	1,135			2,123 22
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	421,049	11,465			5,459 148
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	378,338	22,299			7,499 442
6. Housekeeping Service					
a. Head Housekeeper	19,150	801			719 30
b. Other Housekeeping Workers	191,737	11,709			7,194 439
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	35,164	874			1,319 33
b. Other Maintenance Workers	55,317	1,832			2,076 69
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	22,773	1,849			8 1
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant	40,144	819			646 13
b. Other Accountants	94,011	3,264			1,514 53
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	203,470	4,128			
b. RN					
1. Direct Care	1,691,035	38,730			
2. Administrative**	110,484	2,781			38,034 1,104
c. LPN					
1. Direct Care	272,974	7,321			
2. Administrative**					
d. Aides and Attendants	2,096,402	96,289			22,847 1,157
e. Physical Therapists	326,189	8,430			
f. Speech Therapists	29,764	527			
g. Occupational Therapists	187,960	4,782			
h. Recreation Workers	100,739	4,414			1,997 87
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	70,624	2,437			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	150,597	5,966			1,544 57
A-13. Total Salary Expenditures	6,687,559	232,514			94,308 3,665

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

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

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

Name of Facility McLean Health Center			License No. 884-C		Report for Year Ended 9/30/2020			Page 11	of 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								
Section I - Operators/Owners										
David J. Bordonaro, CEO, President, McLean Affiliates, Inc. (Amt Claimed on C/R)	50,694		816	Standard Package	President, McLean Affiliates	336	10 A1	McLean Fund, Foundation, Game Refuge, & OP Services	838	128,512
Carol Barno, CFO, Treasurer, McLean Affiliates, Inc (Amt Claimed on C/R)	31,839		513	Standard Package	CFO, McLean Affiliates	336	10 A1	McLean Fund, Foundation, Game Refuge, & OP Services	838	80,714
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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	
McLean Health Center			884-C		9/30/2020			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	Residential Care Home							
Section III - Administrators***										
Lisa Clark, Administrator, Secretary, McLean Affiliates	107,104		2,123	Standard Package	Licensed Administrator	1,157	10 A2	McLean Outpatient Allocation	923	87,129
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 McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	34,064	801		675	16
2. Dentist					
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	70,281	184			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	7,200				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
PHYSICIAN_PROFESIONAL FEES	15,446	480			
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
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	126,990	1,465		675	16

* 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*

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 15	of 37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 138,841	136,829		2,012
2. Disability Insurance	\$ 5,800	5,716		84
3. Unemployment Insurance	\$ 8,220	8,101		119
4. Social Security (F.I.C.A.)	\$ 485,266	478,235		7,031
5. Health Insurance	\$ 405,864	399,984		5,881
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 8,911	8,782		129
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 418,464	412,401		6,063
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 37,272	36,732		540
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 27,383	26,949		434
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 12,400	12,211		189
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 54,280	53,206		1,074
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 12,410	12,213		197
2. Cellular Phones	\$			
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*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 423,196	423,196		
Subtotal	\$ 2,038,308	2,014,554		23,753

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
HUM RES_TRAINING/INSERVICE	\$ 805		\$ 12
EDUCATION_SUPPLIES	\$ 575		\$ 8
EDUCATION_PURCHASED SERVICES	\$ 1,076		\$ 16
EMP BEN_INMUNIZATIONS	\$ 1,851		\$ 27
EMP BEN-EMPLOYEE HEALTH/X RAYS	\$ 1,227		\$ 18
EMP BEN-PRE-EMPLOYMENT EXPENSES	\$ 3,432		\$ 50
EMP BEN_TOTAL BEN ADMIN EXP	\$ 5,262		\$ 77
EMP BEN_WKLY BEN:PENS,FICA,GH-ACCRU	\$ 1,959		\$ 29
EMP BEN_BENEFITS ERGONOMICS	\$ 250		\$ 4
EMP BEN_BENEFITS-EXTENDED ILLNESS	\$ 20,295		\$ 298
Total	\$ 36,732	\$ -	\$ 540

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
Total	\$ -	\$ -	\$ -

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	Residential Care Home
	<i>Subtotals Brought Forward:</i>	2,038,308	2,014,554		23,753
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 6,881	6,716			165
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 3,650	3,597			53
4. Employee Travel	\$ 1,865	1,817			48
5. Education Expenses Related to Seminars and Conventions	\$ 4,036	3,946			90
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 57	55			2
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 2,523	2,512			12
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 46,814	44,587			2,227
4. Fund-Raising***	\$				
5. Medical Records	\$ 20,752	20,752			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 4,207	4,076			131
7. Postage	\$ 6,437	6,335			102
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,795	10,543			252
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 1,190	1,177			13
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 40,158	39,569			590
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 177,518	175,153			2,365
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,365,191	2,335,390			29,801

* 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	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Various Marketing Expenses (Disallowed - See Pg 28)	\$ 44,587		\$ 2,227
Total Other Advertising	\$ 44,587	\$ -	\$ 2,227

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
AL CALA	\$ -		\$ 71
ALTCFM	\$ 268		\$ 4
CALTC	\$ 394		\$ 6
CHA	\$ 2,193		\$ 35
Leading Age	\$ 6,253		\$ 101
Misc Adjust (Page 28)	\$ 1,434		\$ 35
Total Dues	\$ 10,543	\$ -	\$ 252

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
NURSING PURCHASED SERVICES	\$ 723		\$ -
NURSING COMPUTER SUPPORT FEES	\$ 24,741		\$ -
NURSING FORMS	\$ 1,072		\$ -
ADMISSIONS-COMPUTER SUPPORTFEES	\$ 3,957		\$ 28
ADMISSIONS-EQUIPMENT	\$ 1,378		\$ 10
ADMIN LICENSE PERMITS. REGIST	\$ 842		\$ 14
ADMIN PROFESSIONAL FEES	\$ 1,814		\$ 29
ADMINISTRATION-EQUIPMENT	\$ 2,314		\$ 37
BUS OFF COMPUTER SUPPORT FEES	\$ 10,144		\$ 163
BUS OFF BANK CHARGES	\$ 6,718		\$ 108
MRKTG,SALES-EQUIPMENT	\$ 1,188		\$ 19
HUM RES PURCHASED SERVICES	\$ 1,902		\$ 28
HUMAN RESOURCES-EQUIPMENT	\$ 1,704		\$ 25
TRAINING-EQUIPMENT	\$ 782		\$ 11
INF SYS PURCHASED SERVICES	\$ 1,133		\$ 18
INF SYS COMPUTER SUPPORT FEES	\$ 113,517		\$ 1,828
ACRETION EXPENSE MCLEAN	\$ 1,225		\$ 46
Total Other Administrative and General	\$ 175,153	\$ -	\$ 2,365

Schedule C-1 - Management Services*

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Sodexo Inc & Affiliates, P.O. Box 360170, Pittsburgh, PA 15251-6170		Inpatient Dietary Mgmt	Pg 18, 2c
Sodexo Inc & Affiliates, P.O. Box 360170, Pittsburgh, PA 15251-6170		Housekeeping Services	Pg 20, 4c

*** 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	License No.	Report for Year Ended		Page of
	884-C	9/30/2020		18 37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 264,934	259,785		5,149
2. Non-Food Supplies	\$ 75,424	73,958		1,466
3. Other (Specify) _____ Laundry, Linen, Dues & Fees, Non-Controllables	\$ 53,595	52,553		1,042
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) _____ Management Fee	\$ 116,372	114,110		2,262
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 510,325	500,406		9,919
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*	217	213		4
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	\$62,909
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	\$62,909
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30, Line IV 1
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				N/A

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

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020		Page 19 37
Item	Total	CCNH	RHNS	Residential Care Home
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.	6,886	6,884	2
	Amt. \$	9,288	9,129	160
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) LAUNDRY_CONTRACTED SRVC FEES	\$	50,434	49,453	980
3D. Total Laundry Expenditures (3a + b + c)	\$	59,722	58,582	1,140
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)		N/A	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. 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 3D.

*** 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
McLean Health Center	884-C	9/30/2020		20	37
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel	37,488	36,132		1,356
a. In-House Care	Amt. \$	53,589	51,651		1,938
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
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. Other (<i>Specify</i>)	\$	54,626	52,650		1,975
<u>HOUSEKPG CONTRACTED SERVICES</u>					
4D. Total Housekeeping Expenditures (4a + b + c)	\$	108,214	104,301		3,913
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare	\$	136,247	136,247		
b. Medicine Cabinet Drugs	\$	21,085	21,085		
c. Medical and Therapeutic Supplies	\$	371,926	366,843		5,083
d. Ambulance/Limousine***	\$	6,852	6,852		
e. Oxygen					
1. For Emergency Use	\$	5,512	5,512		
2. Other***	\$	9,164	9,164		
f. X-rays and Related Radiological Procedures***	\$	25,683	25,683		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	39,315	39,315		
i. Recreation	\$	10,275	10,075		200
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** <i>See Attached Schedule</i>	\$	28,925	27,942		984
5M. Total Resident Care Expenditures (5a - 5j)	\$	654,985	648,718		6,267

* 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.

Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
NURSING CONSULTANTS	\$ 8,854		\$ -
NURSING PHARM CONSULTANT	\$ 9,759		\$ -
NURSING TRAINING/INSERVICE	\$ 200		\$ -
NRSG SUPPL BILL/BLOOD TEST ACCUCHEC	\$ 3,686		\$ -
NRSG SUPPLIES MCR	\$ (121)		\$ -
REHAB SUPPLIES	\$ 498		\$ -
REHAB PURCHASED SERVICES ST	\$ 300		\$ -
REHAB COMPUTER SUPPORT FEES	\$ 3,735		\$ -
REHAB TRAINING/INSERVICE	\$ 1,030		\$ -
ASTD LIV PLUS-CONSULTANTS	\$ -		\$ 315
ASTD LIV PLUS-PURCHASED CNA	\$ -		\$ 668
Total Other Resident Care	\$ 27,942	\$ -	\$ 984

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

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	162,537	157,325			5,212
b. Heat	\$	30,748	29,636			1,112
c. Light & Power	\$	127,695	123,077			4,618
d. Water	\$	10,670	10,284			386
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	782	769			12
f. Other <i>(itemize)</i>	\$	40,597	39,129			1,468
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	373,029	360,220			12,809
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	93,526	90,662			2,864
b. Building & Building Improvements	\$	245,603	236,175			9,428
c. Non-Movable Equipment	\$	222,048	217,236			4,812
d. Movable Equipment	\$	75,797	74,486			1,312
*7e. Total Depreciation Costs (7a + b + c + d)	\$	636,974	618,559			18,415
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	636,974	618,559			18,415

* 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	Residential Care Home
PLANT UTILITIES-REFUSE REMOVAL	\$ 11,047		\$ 414
PLANT UTILITIES-CABLE TV	\$ 16,067		\$ 603
PLANT UTILITIES SEWER	\$ 12,015		\$ 451
Total Other Repairs and Maintenance	\$ 39,129	\$ -	\$ 1,468

Depreciation Schedule

Name of Facility McLean Health Center				License No. 884-C			Report for Year Ended 9/30/2020				Page 23	of 37
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period				2,191,181		2,191,181	884,907	SL	Various	193,880		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				92,605		92,605		SL	Various	5,328		
A-4. Subtotal											199,208	
B. Building and Building Improvements												
1. Acquired prior to this report period				15,872,658		15,872,658	9,257,389	SL	Various	594,365		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				566,690		566,690		SL	Various	28,536		
B-4. Subtotal											622,901	
C. Non-Movable Equipment												
1. Acquired prior to this report period				6,511,713		6,511,713	3,890,856	SL	Various	327,021		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				1,405,797		1,405,797				115,748		
C-4. Subtotal											442,769	
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.	X	Var	Var	42,442		42,442	42,442	SL	Various			
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period				2,965,981		2,965,981	2,195,863			138,557		
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)				164,264		164,264				9,473		
D-3. Subtotal											148,030	
E. Total Depreciation											1,412,908	

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
	Please see attached.			
Total additions for Land Improvement		\$ 92,605	Various	\$ 5,328 *
Deletions:				
Total deletions for Land Improvement		\$ -		\$ - **

*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:				
	Please see attached.			
Total additions for Building Improvement		\$ 566,690	Various	\$ 28,536 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

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

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility McLean Health Center			License No. 884-C		Report for Year Ended 9/30/2020			Page 24	of 37
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.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Please see attached memo.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* 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.

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 25	of 37
--	----------------------	------------------------------------	------------	----------

11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?

Yes

No

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

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

Description	Total			
1. Date Land Purchased	Unknown, Prior to 1930			
2. Date Structure Completed	1971, Additions '74,'89 & '01			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	92			
6. Square Footage	141,249			
7. Acquisition Cost				
a. Land	29,950			
b. Building	1,460,189			

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	Please see attached n			
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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 McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020			Page 26	of 37
Item			Total	CCNH	RHNS	Residential Care Home
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	\$			Please see attached memo.		
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 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 36,756	36,174			582
b. Insurance on Automobiles		\$ 2,551	2,511			40
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$ 2,062	2,029			33
3. Other (Specify)		\$ 13,517	13,303			214
Management Liability, Fiduciary, Cyber						
14d. Total Insurance Expenditures (14a + b + c)		\$ 54,886	54,017			869
15. Total All Expenditures (A-13 thru C-14)		\$ 11,672,860	11,494,743			178,117

D. Adjustments to Statement of Expenditures

Name of Facility McLean Health Center			License No. 884-C	Report for Year Ended 9/30/2020		Page 28 of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 187,960	187,960		
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.	13	B8c &	Resident Care Physicians **	\$ 14,223	14,223		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,478	1,441		37
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$ 42,195	29,913		12,281
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
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.	27	14A&	Automobile Expense (e.g. personal use)	\$ 2,551	2,511		40
18.	16	M3	Unallowable Advertising *	\$ 47,011	44,784		2,227
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.	16	M6	Barber and Beauty	\$ 4,193	4,063		130
23.			Other - See attached Schedule	\$ 12,827	12,630		197
<i>Page 18 - Dietary Expenditures</i>							
24.	30	IV 1	Meals to employees, guests and others who are not residents	\$ 30,629	30,002		627
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 343,066	327,527			15,539

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M13	ACCOUNTING_BANK CHARGES	\$ 6,752		\$ 108
16	L3	HUM RES_PERS RECOG Unsupported Portion	\$ 3,622		\$ 53
16	L5	ADMIN_MEETINGS	\$ 2,256		\$ 36
Total Other A&G Adjustments			\$ 12,630	\$ -	\$ 197

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

Name of Facility McLean Health Center			License No. 884-C	Report for Year Ended 9/30/2020		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	\$ 343,066	327,527		15,539
<i>Page 20 - Resident Care Supplies***</i>							
27.	20	5 a2	Prescription Drugs	\$ 136,247	136,247		
28.	20	5 d	Ambulance/Limousine	\$ 6,852	6,852		
29.	20	5 f	X-rays, etc	\$ 25,683	25,683		
30.	20	5 h	Laboratory	\$ 39,315	39,315		
31.			Medical Supplies	\$			
32.	20	5 e2	Oxygen (non emergency)	\$ 9,164	9,164		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
<i>Page 22 - Maintenance and Property</i>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
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	\$ 6,411	6,184		227
<i>Page 27 - Insurance</i>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<i>Other - Miscellaneous</i>							
42.			Other - Indirect	\$ 12,211	11,873		338
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<i>Not For Profit Providers Only</i>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)			\$ 578,950	562,847			16,103

*** 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

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

Total Unallowable Building Interest	\$ -	\$ -	\$ -
--	------	------	------

F. Statement of Revenue

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020			Page 30 37
Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,530,885	5,442,505			88,379
b. Medicaid Room and Board Contractual Allowance **	\$ (2,429,871)	(2,418,664)			(11,207)
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,753,847	2,753,847			
b. Medicare Room and Board Contractual Allowance **	\$ 352,496	352,496			
4. a. Private-Pay Residents and Other	\$ 5,709,182	5,709,182			
b. Private-Pay Room and Board Contractual Allowance **	\$ (196,228)	(196,228)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 99,495	99,495			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (99,495)	(99,495)			
c. Prescription Drugs - Non-Medicare	\$ 46,041	46,041			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (47,548)	(47,548)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 404,044	404,044			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (368,655)	(368,655)			
c. Physical Therapy - Non-Medicare	\$ 234,163	234,163			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (215,846)	(215,846)			
4. a. Speech Therapy - Medicare	\$ 16,231	16,231			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (12,987)	(12,987)			
c. Speech Therapy - Non-Medicare	\$ 16,696	16,696			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (8,467)	(8,467)			
5. a. Occupational Therapy - Medicare	\$ 345,202	345,202			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (322,602)	(322,602)			
c. Occupational Therapy - Non-Medicare	\$ 181,698	181,698			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (176,487)	(176,487)			
6. a. Other (<i>Specify</i>) - Medicare	\$ (2,280)	(2,280)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (2,167)	(2,167)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,807,346	11,730,174			77,173
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 62,909	61,761			1,148
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$ 17,110	9,500			7,610
5. Interest Income (<i>Specify</i>)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 11,828	8,738			3,090
8. Other (<i>Specify</i>)	\$ 7,500	7,500			
V. Total Other Revenue (1 thru 8)	\$ 99,347	87,500			11,848
VI. Total All Revenue (III +V)	\$ 11,906,694	11,817,673			89,020

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	PHARMACY MEDICARE-FLU VACCINE	\$ (2,450)		
	XRAY MCR I SUB	\$ (11,808)		
	XRAY MCR SNF LT	\$ (925)		
	XRAY MCARE SNF SC	\$ -		
	LAB MCR I SUB	\$ (20,994)		
	LAB MCR SNF LT	\$ (3,701)		
	LAB MCR SNF SC	\$ -		
	OXYGEN MCR I SUB	\$ (1,424)		
	OXYGEN MCR I LT	\$ -		
	OXYGEN MCR SNF LT	\$ (487)		
	ALLOW XRAY MCR I SUB	\$ 11,808		
	ALLOW XRAY MCR SNF LT	\$ 925		
	ALLOW XRAY MCARE SNF SC	\$ -		
	ALLOW LAB MCR I SUB	\$ 20,994		
	ALLOW LAB MCR SNF LT	\$ 3,701		
	ALLOW LAB MCR SNF SC	\$ -		
	ALLOW OXY MCR I SUB	\$ 1,424		
	ALLOW OXY MCR SNF LT	\$ 657		
Total Other Resident Revenue - Medicare		\$ (2,280)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	XRAY PRI I SUB	\$ 140		
	XRAY PVT SNF HOSPICE	\$ -		
	XRAY PVT SNF LT	\$ -		
	XRAY HMO I SUB	\$ (7,710)		
	XRAY HMO SNF LT	\$ (546)		
	LAB PVT SNF SUB	\$ (35)		
	LAB HMO I SUB	\$ (9,975)		
	LAB HMO SNF LT	\$ (1,354)		
	OXYGEN PVT I SUB	\$ (164)		
	OXYGEN-PVT SNF HSP	\$ (11)		
	OXYGEN PVT SNF I LT	\$ -		
	OXYGEN PRIVATE SNF LT HSP	\$ 66		
	OXYGEN PRIVATE SNF LT	\$ (1,870)		
	OXYGEN PVT ICF LT	\$ -		
	OXYGEN HMO SNF SUB	\$ (1,590)		
	OXYGEN HMO SNF LT	\$ (315)		
	OXYGEN MCD SNF LT	\$ (119)		
	ALLOW XRAY HMO I SUB	\$ 7,710		
	ALLOW XRAY HMO SNF LT	\$ 546		
	ALLOW LAB HMO I SUB	\$ 9,975		
	ALLOW LAB HMO SNF LT	\$ 1,354		
	ALLOW OXY HMO SNF SUB	\$ 1,296		
	ALLOW OXY HMO SNF LT	\$ 315		
	ALLOW OXYGEN MCD I SUB	\$ -		
	ALLOW OXY MEDICAID HSP	\$ -		
	ALLOW OXY MEDICAID SNF LT	\$ 119		
Total Other	Resident Revenue	\$ (2,167)	\$ -	\$ -

Interest Income

Account

Schedule of Other Revenue

G. Balance Sheet

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	6,239,337
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,703,015
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	375,788
a. _____				
b. _____				
c. _____				
d. See Schedule		375,788		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	26,028
See Schedule		26,028		
A-9. Total Current Assets (Lines A1 thru 8)			\$	8,344,168
B. Fixed Assets				
1. Land			\$	29,950
2. Land Improvements	*Historical Cost	2,283,786	\$	1,199,671
	Accum. Depreciation	1,084,114 Net		
3. Buildings	*Historical Cost	16,439,348	\$	6,559,058
	Accum. Depreciation	9,880,290 Net		
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	Net		
5. Non-Movable Equipment	*Historical Cost	7,917,510	\$	3,583,885
	Accum. Depreciation	4,333,625 Net		
6. Movable Equipment	*Historical Cost	3,130,245	\$	786,353
	Accum. Depreciation	2,343,893 Net		
7. Motor Vehicles	*Historical Cost	42,442	\$	
	Accum. Depreciation	42,442 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	18,594,189
See Schedule		18,594,189		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	30,753,106

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		AR OTHER AUXILIARY C CARD	\$ 191
		PREPAID INSURANCE-LIABILITY	\$ 94,914
		PPD VILLAGE EXPENSE	\$ 42,630
		PREPAID EXPENSE	\$ 126,295
		PREPAID PROPERTY TAXES	\$ 111,758
		Total Prepaid Expenses	\$ 375,788

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
		Due from Related Party	\$ 26,028
		Total Other Current Assets (Itemize)	\$ 26,028

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
		Construction in Progress	\$ 9,028,481
		Village and Village Net Asset (Independent Living)	\$ 9,565,708
		Total Other Other Fixed Assets (Itemize)	\$ 18,594,189

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Assets Whos Use Is Limited	\$ 60,767,092
		Interest in McLean Foundation (Charitable Remainder Trust, Net)	\$ 806,402
		Total Other Assets	\$ 61,573,494

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Total Notes Payable	\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
		Deferred Revenue	\$ 369,406
		Deposits Held for Residents	\$ 1,867,209
		Accrued Payables	\$ 558,373
		Entrance fee refunds payable	\$ 469,486
		Total Other Current Liabilities (Itemize)	\$ 3,264,474

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
		Bonds payable, net	\$ 65,246,073
		Refundable Entrance Fees	\$ 3,551,525
		FIN 47 Asset Retirement Obligation	\$ 56,452
		Deferred Revenue from Nonrefundable Entrance Fees	4366096
		Total Other Current Liabilities (Itemize)	\$ 73,220,146

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2020	32 37
Account		Amount	
		Total Brought Forward:	\$ 39,097,274
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost _____ Accum. Depreciation _____	Net	\$
3. Buildings	*Historical Cost _____ Accum. Depreciation _____	Net	\$
4. Non-Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$
5. Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$
6. Motor Vehicles	*Historical Cost _____ Accum. Depreciation _____	Net	\$
7. Minor Equipment-Not Depreciable			\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost _____ Accum. Depreciation _____	Net	\$
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care (itemize)			\$ 12,558,274
PLANT REPLACEMENT TRADE REC-SCHW	12,558,274		
6. Loans to Owners or Related Parties (itemize)			\$
Name and Address	Amount	Loan Date	
7. Other Assets (itemize)			\$ 61,573,494
See Schedule	61,573,494		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 74,131,768
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 113,229,042

* 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 McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 33	of 37										
Account				Amount										
Liabilities														
A. Current Liabilities														
1. Trade Accounts Payable				\$ 2,513,969										
2. Notes Payable (<i>itemize</i>)				\$										
See Schedule														
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> <th style="text-align: left; padding: 2px;"></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td></td></tr> </tbody> </table>					Name of Lender	Purpose	Amount	Date Due						
Name of Lender	Purpose	Amount	Date Due											
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 1,442,622										
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$										
6. Accrued Payroll Taxes Payable				\$										
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>)				\$ 3,264,474										
See Schedule				3,264,474										
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 7,221,065										

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			7,221,065	
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 73,220,146
See Schedule	73,220,146			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 73,220,146
C. Total All Liabilities (Lines A-13 + B-5)				\$ 80,441,211

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 35	of 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>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	29,704,985
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 3,082,846
7. Total Net Worth			\$	32,787,831
C. Total Reserves and Net Worth			\$	32,787,831
D. Total Liabilities, Reserves, and Net Worth			\$	113,229,042

H. Changes in Total Net Worth

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 36	of 37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	29,704,985
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	28,352,712
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	30,246,092
D. Net Income or Deficit			\$	(1,893,380)
E. Balance			\$	27,811,605
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Interest and Dividend Income		145,078		
Change in Unrealized Losses on Investment		686,826		
Changes in Net Assets With Donor Restrictions		4,144,322		
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	4,976,226
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawals (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period	09/30/20		\$	32,787,831

I. Preparer's/Reviewer's Certification

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Adam Axelrad		
Address		Phone Number
75 Great Pond Road, Simsbury, CT 06070		(860) 658-3749
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Adam Axelrad		(860) 658-3749
Contact Email Address		
adam.axelrad@mcleancare.org		