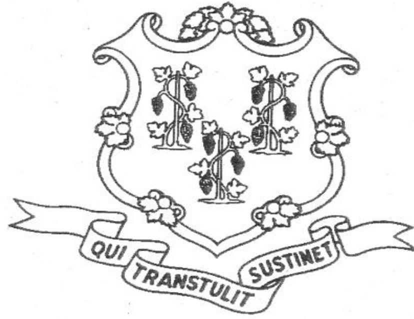
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

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		
☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ Residential Care Home	☑ Residential Care Home
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

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

Medicaid Provider Numbers:	CCNH / RHNS	Residential Care Home	Residential Care Home
	884-C	1712-RCH	

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT 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, 2022 and ending September 30, 2023, 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) Anne Rolfe			Printed Name (Owner) Lisa Clark	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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State of Connecticut

Department of Social Services

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 10/1/2022	To 9/30/2023
Address of Facility 75 Great Pond Road, Simsbury, CT 06070				
Report Prepared By	Phone Number		Date	

Item		Total	CCNH / RHNS	Residential Care Home	Residential Care Home
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.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860)658-3700	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
McLean Health Center	75 Great Pond Road, Simsbury, CT 06070

License Numbers:	CCNH / RHNS	Residential Care Home	Residential Care Home	Medicare Provider No.
	884-C	1712-RCH		07-5216

Type of Facility (Check appropriate box(es))

- ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined
- ☑ Residential Care Home
- ☑ Residential Care Home

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ○ Profit Corp. ⦿ Non-Profit Corp. ○ Government ○ Trust

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Anne Rolfe	002183

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	3	37

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

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	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			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	4	37

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

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⦿ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			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	%**				
McLean Fund	75 Great Pond Road, Simsbury, CT 06070	○	⦿		Gifts to McLean Affiliates, Inc. through inco	Various		
McLean Game Refuge, Inc.	75 Great Pond Road, Simsbury, CT 06070	○	⦿		None - McLean Affiliates, Inc provides	Page 10, 11b		
		○	⦿		(continued) bookkeeping services			
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					

* 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	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	5	37

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

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

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

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

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.

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

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
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	6	37

Square footage of entire facility.	141,249

Outpatient Therapy

Does the Facility provide outpatient therapy services?	Yes

If yes, please complete the following:

1,000	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	Yes

If yes, please complete the following:

all part of indepen	Square footage of kitchen	
0	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
no included in cos	*If yes, please state where costs are reported.*	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
$ -	Please state the salary amounts of specific cooks and/or dietary aides	
0	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	Yes, not

If yes, please complete the following:

0	Square footage of apartments
0	Square footage of independent living
28,993	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Cente	884-C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	Yes

If yes, please complete the following:

1,835	Square footage of adult day care space.
within Assisted	Please state where it is located in relation to the facility.
7	Average number of daily participants.
1	Number of meals per day provided to adult day care.
	Nature of services provided:
	0

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total Residential Care Home	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	Residential Care Home	Residential Care Home	Total	CCNH / RHNS	Residential Care Home	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	73	71		2	73	71		2				
B. As of midnight of THIS report period	73	71		2					73	71		2
3. Total Number of Days Care Provided During Period												
A. Medicare	3,262	3,262			2,600	2,600			662	662		
B. Medicaid (Conn.)	11,687	11,687			8,689	8,689			2,998	2,998		
C. Medicaid (other states)												
D. Private Pay	7,626	7,626			5,551	5,551			2,075	2,075		
E. State SSI for RCH	815			815	569			569	246			246
F. Other (Specify) HMO & Managed Medicare	2,368	2,368			1,701	1,701			667	667		
G. Total Care Days During Period (3A thru F)	25,758	24,943		815	19,110	18,541		569	6,648	6,402		246
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	141	141			73	73			68	68		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	25,899	25,084		815	19,183	18,614		569	6,716	6,470		246

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	Residential Care Home	Residential Care Home	Lost			Gained			CCNH / RHNS	Residential Care Home	Residential Care Home	
	(1)	(2)	(3)	(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	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 / RHNS	CCNH / RHNS	Residential Care Home	CCNH / RHNS	Residential Care Home	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	8	32	CCNH	25			2	
Per Diem Rate								
a. One bed rm.	PDPM	324.00		$544-$595			155.00	
b. Two bed rms.								
c. Three or more bed rms.								

Item	TOTAL	CCNH / RHNS	Residential Care Home	Outpatient	Residential Care Home
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	2,023	2,023			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	11,890	11,890			
D. ***Total Physical Therapy Treatments***	13,913	13,913			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	208	208			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	500	500			
D. ***Total Speech Therapy Treatments***	708	708			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,231	1,231			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	10,893	10,893			
D. ***Total Occupational Therapy Treatments***	12,124	12,124			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	Residential Care Home	Adjustment	Hours	Residential Care Home	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)	79,177		558	1,831		13			
2. Administrator(s) (Complete also Sec. III of Schedule A1)	155,416		1,965						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	512,490		11,958	10,210		221			
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	463,808		23,334	15,070		758			
6. Housekeeping Service									
a. Head Housekeeper	6,279		232	255		9			
b. Other Housekeeping Workers	187,093		10,301	7,591		418			
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	40,826		932	1,656		38			
b. Other Maintenance Workers	52,757		1,845	2,140		75			
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	38,597		2,102	22		1			
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant	37,586		684	869		16			
b. Other Accountants	81,091		2,714	1,876		63			
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	141,365		2,080						
b. RN									
1. Direct Care	1,846,590		38,688						
2. Administrative**	231,276		5,085	57,840		1,698			
c. LPN									
1. Direct Care	338,535		8,536						
2. Administrative**									
d. Aides and Attendants	1,956,317		78,298	57,277		2,318			
e. Physical Therapists	358,033		9,176						
f. Speech Therapists	37,680		686						
g. Occupational Therapists	215,149	(215,149)	5,378						
h. Recreation Workers	118,600		4,909	3,853		159			
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	99,590		2,683						
n. Marketing									
o. Other (Specify) See Attached Schedule	48,011		2,084						
A-13. Total Salary Expenditures	7,046,266	(215,149)	214,228	160,490		5,787			

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			Residential Care Home			Residential Care Home		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Medical Records	$ 48,011		2,084						
Total	$ 48,011	$ -	2,084	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			Residential Care Home			Residential Care Home		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	Residential Care Home	Residential Care Home							
Section I - Operators/Owners										
Carol Barno, CFO, Treasurer, McLean Affiliates, Inc (Amt Claimed on C/R)	31,107	720		Standard Package	CFO, McLean Affiliates	540	10 A1		814	94,637
Lisa Clark, CEO, President, McLean Affiliates, Inc. starting 7/1/22 (Amt Claimed on C/R)	40,206	930		Standard Package	President, McLean Affiliates starting 7/1/22	561	10 A1		845	122,320
David Bordonaro	7,864	182		Standard Package		26	10 A1		39	23,924
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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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	9/30/2023	12	37

Name	Salary Paid: CCNH / RHNS	Salary Paid: Residential Care Home	Salary Paid: Residential Care Home	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section III - Administrators* **										
Anne Rolfe	155,416			Standard Package	Nursing Home administrator	1,965	10 A2			
Section IV - Assistant Administrators										

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

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

*** If more than one Administrator is reported, include dates of employment for each.

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CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	13	37

Item	CCNH / RHNS	Adjustment	Hours	Residential Care Home	Adjustment	Hours	Residential Care Home	Adjustment	Hours
	Total Cost and 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									
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)	71,680		63						
b. Utilization Review									
(Title 18 and 19 only) monthly meeting									
c. Resident Care**	3,600	(3,600)							
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 - Professional Fees	14,280		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	4,957		73						
2. Administrative***									
b. LPN									
1. Direct Care	31,111		504						
2. Administrative***									
c. Aides	360,506		10,153	1,785		37			
d. Other									
12. Other (Specify)									
See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	486,134	(3,600)	11,273	1,785		37			

* 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 in the Adjustment column.

*** 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Sodexo Inc & Affiliates, P.O. Box 360170, Pittsburgh, PA 15251-6170	Dietary Consultant/Dietician	○	⦿	
PAULEKAS, WAYNE M.D., 251 Wickham Road, Glastonbury, CT 06033	Medical Director	○	⦿	
Sodexo Inc & Affiliates, P.O. Box 360170, Pittsburgh, PA 15251-6170	Housekeeping Services	○	⦿	
COLLITON, MATTHEW M.D. , 20 Isham Rd West Hartford, CT 06107	Assistant Medical Director	○	⦿	
The Center for Geriatric & Psychiatric Services, 55 Nye Road, Suite 102, Glastonbury, CT 06033	Psych Services to Patients	○	⦿	
Kare Tehcnologies, PO Box 4738 Houston Texas 77210	CNA & Nurse Pool	○	⦿	
Intelycare Inc. PO Box 787317 Philadelphia PA 19178	CNA & Nurse Pool	○	⦿	
Elder Crew 123 Farmington Ave 291 Bristol CT 06010	CNA & Nurse Pool	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	15	37

Item		Total Including Adjustment	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	74,231	72,578		1,653			
2. Disability Insurance	$	7,552	7,384		168			
3. Unemployment Insurance	$	9,305	9,098		207			
4. Social Security (F.I.C.A.)	$	532,816	520,950		11,866			
5. Health Insurance	$	514,241	502,789		11,452			
6. Life Insurance (employees only) (not-owners and not-operators)	$	3,512	3,434		78			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	450,769	440,731		10,038			
8. Uniform Allowance	$							
9. Other (*Specify*) See Attached Schedule	$	31,497	30,796		701			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		101,994	(101,994)				
d. Accounting and Auditing	$	25,044	24,478		566			
e. Legal (*Services should be fully described on Page 15b)*	$		4,703	(4,703)	108	(108)		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	33,460	31,657		1,803			
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$							
2. Cellular Phones	$	10,569	10,346		223			
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$							
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	413,842	413,842					
Subtotal	$	2,106,838	2,174,780	(106,697)	38,863	(108)		

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Immunizations	$ 70		$ 2			
EE Health/X Rays	(4)		-			
Extended Illness	10,616		242			
Pre Employment Expense	5,670		129			
TBA Expense	5,390		123			
Purchased Services	5,004		114			
Supplies	113		2			
Training / Inservice	3,937		89			
Total	$ 30,796	$ -	$ 701	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	15b	37

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

◉ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ◉ Yes ○ No

If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Clifton Larson Allen	
2 Marcum	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit, 990 tax, benefit audit, Medicare cost report	$ 25,044
2		$
3		$
4		$
	Charge for Services Provided	$ 25,044

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

◉ Yes ○ No

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Disallowed	$ 4,811
2		$
3		$
4		$
5		$
	Charge for Services Provided	$ 4,811

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

◉ Yes ○ No

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	16	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:		2,106,838	2,174,780	(106,697)	38,863	(108)		
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$		5,602	(5,602)	189	(189)		
2. Holiday Parties for Staff	$							
3. Gifts to Staff and Residents	$		6,199	(6,199)	141	(141)		
4. Employee Travel	$	1,904	1,849		55			
5. Education Expenses Related to Seminars and Conventions	$	3,529	3,378		151			
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*)	$	21,539	21,059		480			
2. Advertising Telephone Directory (*all such expenses*)***	$	48,402	43,210		5,192			
3. Advertising Other (*Specify*)***	$		43,209	(43,209)	5,192	(5,192)		
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$	108,704	111,570	(2,866)				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				1,317	(1,317)		
7. Postage	$	5,274	5,155		119			
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	10,712	10,269		443			
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	623	623					
10. Contributions***	$							
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	40,374	39,473		901			
12. Administrative Management Services**	$							
13. Other (*Specify*)	$	184,440	191,359	(9,884)	3,171	(206)		
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	2,532,339	2,657,735	(174,457)	56,214	(7,153)		

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Total Other Travel and Entertainment	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Marketing	$ 2,084	$ (2,084)	$ 4,313	$ (4,313)		
Marketing PA	3,153	(3,153)				
Marketing	34,316	(34,316)	794	(794)		
Activities	79	(79)	2	(2)		
Supplies	3,326	(3,326)	77	(77)		
Advertising - HR	251	(251)	6	(6)		
Total Other Advertising	$ 43,209	$ (43,209)	$ 5,192	$ (5,192)	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
AL Dues and Fees			$ 205			
Admin Dues & Fees	10,269		238			
Total Dues	$ 10,269	$ -	$ 443	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Total Contributions	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
Computer Support Fees	$ 36,113					
Purchased Services	15,629					
License Permit	728		17			
Bank Charges	7,511	(7,511)	174	$ (174)		
Acretion	3,848		156			
Computer Support Fees	125,197		2,771			
Equipment Non Capital	540		12			
Purchased Services	1,793		41			
Bookkeeping McLean Game Refuge		$ (2,373)		$ (32)		
Total Other Administrative and General	$ 191,359	$ (9,884)	$ 3,171	$ (206)	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/30/2023	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.**

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	18	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	343,021	346,463	(14,699)	11,257			
2. Non-Food Supplies	$	72,612	70,327		2,285			
3. Other (*Specify*)____________________	$	163,563	158,416		5,147			
Dues & Fees, Service Contracts and Sodexo Control								
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)________________________	$	257,929	249,812		8,117			
Sodexo Consultant Management								
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	837,125	825,018	(14,699)	26,806			

2E. Dietary Questionnaire	Total	CCNH / RHNS	Residential Care Home	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				

	Question	Yes	No		
G.	Is cost of employee meals included in 2D?	○ Yes	⦿ No		
H.	Did you receive revenue from employees?	○ Yes	⦿ 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?	⦿ Yes	○ No	If yes, specify cost.	14699
K.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.	14699
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg30 Line IV1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	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.

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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
McLean Health Center	884-C	9/30/2023	19	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
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. $	6,414	6,220		194			
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Service Contracts	$	60,345	58,446		1,899			
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	66,759	64,666		2,093			

3E. Laundry Questionnaire			
F. Is cost of employee laundry included in 3D?	○ Yes	⦿ No	If yes, specify cost.
G. Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⦿ No	If yes, specify cost.
J. Did you receive revenue from these people?	○ Yes	⦿ 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.

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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	9/30/2023	20	37

Item			Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
4. Housekeeping	Sq. Ft. Serviced								
a. In-House Care	by Personnel								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	41,271	39,662		1,609			
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel								
(Complete Schedule C-2 att. Page 21)	Amt.	$							
C. Other (*Specify*) Purchased Services / Service Contractors		$	86,835	83,449		3,386			
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	128,106	123,111		4,995			
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from		$	408	165,349	(164,941)				
b. Medicine Cabinet Drugs		$	31,005	31,005					
c. Medical and Therapeutic Supplies		$	223,577	223,428		149			
d. Ambulance/Limousine***		$		3,987	(3,987)				
e. Oxygen									
1. For Emergency Use		$	9,448	9,448					
2. Other***		$		13,203	(13,203)				
f. X-rays and Related Radiological Procedures***		$	118	32,175	(32,057)				
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$		18,944	(18,944)				
i. Recreation		$	26,388	25,558		830			
j. Direct Management Services*		$							
k. Indirect Management Services*		$							
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$	46,696	50,368	(4,342)	670			
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	337,640	573,465	(237,474)	1,649			

* 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 in the Adjustment column.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
BLOOD TEST ACCUCHEC	$ 1,573					
CONSULTANTS	16,246					
PHARM CONSULTANT	14,849					
SUPPLIES_MCR	4,342	(4,342)				
TRAINING/INSERVICE	936					
COMPUTER SUPPORT FEES	7,098					
PURCHASED SERVICES ST	3,298					
SUPPLIES	1,561					
TRAINING/INSERVICE	465					
CONSULTANTS			653			
COMPUTER SUPPORT FEES			17			
Total Other Resident Care	$ 50,368	$ (4,342)	$ 670	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	Residential Care Home	Residential Care Home	Pg	Line
Please see attached.		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	22	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	230,468	221,925		8,543			
b. Heat	$	42,149	40,506		1,643			
c. Light & Power	$	208,466	200,338		8,128			
d. Water	$	8,844	8,499		345			
e. Equipment Lease (*Provide detail on page 22b*)	$	878	858		20			
f. Other (*itemize*)	$	45,617	43,838		1,779			
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	536,422	515,964		20,458			
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	102,895	98,883		4,012			
b. Building & Building Improvements	$	361,009	346,933		14,076			
c. Non-Movable Equipment	$	245,142	241,745	(6,184)	9,808	(227)		
d. Movable Equipment	$	82,319	79,109		3,210			
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	791,365	766,670	(6,184)	31,106	(227)		
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$							
d. Other (*Specify*)	$							
*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)	$	791,365	766,670	(6,184)	31,106	(227)		

* 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	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
CABLE TV	$ 19,232		$ 780			
MEETINGS	112		5			
SEWER	9,676		393			
TRASH REMOVAL	14,818		601			
Total Other Repairs and Maintenance	$ 43,838	$ -	$ 1,779	$ -	$ -	$ -

----

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
McLean Health Center	884-C	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Mailfinance (Formerly Neopost), 478 Weelers Farm Rd, Milford, CT 06461	○	⦿	Postage Meter	05/24/11	Paid Quarterly	2,611	878
TCF National Bank, P.O. BOX 77077, MINNEAPOLIS, MN 55480-7777	○	⦿	Service Bus	11/15/16	Monthly	13,353	disallowed
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No

Total *** 878

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	2,387,139		2,387,139	1,489,532	SL	Various	199,456	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	318,139		318,139		SL	Various	29,657	
A-4. Subtotal								229,113
B. **Building and Building Improvements**								
1. Acquired prior to this report period	19,525,661		19,525,661	11,270,747	SL	Various	781,389	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	280,780		280,780		SL	Various	22,458	
B-4. Subtotal								803,847
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	9,422,970		9,422,970	5,332,895	SL	Various	527,273	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	395,778		395,778		SL	Various	32,852	
C-4. Subtotal								560,124

	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					3,508,330		3,508,330	2,676,793	SL	Various	182,012	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			Var	Var	27,742		27,742		SL	Various	835	
d. Standard Resident			Var	Var	39,967		39,967		SL	Various	448	
e. Specialized Resident												
Total Acquired during this report period					67,709		67,709				1,283	
D-3. Subtotal												183,295
E. ***Total Depreciation***												1,776,379

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 Improvements		$ 318,139	Various	$ 29,657	*
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:					
	Please see attached				
Total additions for Building Improvements		$ 280,780	Various	$ 22,458	*
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:					
	Please see attached				
Total additions for Non-Movable Equipment		$ 395,778	Various	$ 32,852	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
	Please see attached	Administrative	$ 27,742	Various	$ 835	
	Please see attached	Standard Resident	$ 39,967	Various	$ 448	
	Please see attached	Specialized Resident	$ -	Various	$ -	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 67,709	Various	$ 1,283	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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.									
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	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	25 | 37

11. Property Questionnaire

Part A

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

○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	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)				
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	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	26	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
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
McLean Health Center	884-C	9/30/2023	27	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	Residential Care Home	Adjustment	Residential Care Home	Adjustment
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)	$	84,324	81,036		3,288			
b. Insurance on Automobiles	$		3,239	(3,239)	131	(131)		
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)***	$	84,324	84,275	(3,239)	3,419	(131)		
15. ***Total All Expenditures (A-13 thru C-14)***	$	12,790,006	13,143,304	(654,802)	309,015	(7,511)		

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	Residential Care Home	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,578,445	6,406,394	172,051	
b. Medicaid Room and Board Contractual Allowance **	$	(2,706,021)	(2,688,355)	(17,666)	
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,898,711	1,898,711		
b. Medicare Room and Board Contractual Allowance **	$	169,199	169,199		
4. a. Private-Pay Residents and Other	$	5,728,434	5,728,434		
b. Private-Pay Room and Board Contractual Allowance **	$	(467,964)	(467,964)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	106,864	106,864		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(102,223)	(102,223)		
c. Prescription Drugs - Non-Medicare	$	60,070	60,070		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(61,228)	(61,228)		
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	$	420,932	420,932		
b. Physical Therapy - Medicare Contractual Allowance **	$	(334,243)	(334,243)		
c. Physical Therapy - Non-Medicare	$	265,546	265,546		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(245,716)	(245,716)		
4. a. Speech Therapy - Medicare	$	44,817	44,817		
b. Speech Therapy - Medicare Contractual Allowance **	$	(25,484)	(25,484)		
c. Speech Therapy - Non-Medicare	$	20,238	20,238		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(11,512)	(11,512)		
5. a. Occupational Therapy - Medicare	$	374,276	374,276		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(311,631)	(311,631)		
c. Occupational Therapy - Non-Medicare	$	235,736	235,736		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(228,594)	(228,594)		
6. a. Other *(Specify)* - Medicare	$	10,434	10,434		
b. Other *(Specify)* - Non-Medicare	$	(8,690)	(8,690)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	11,410,393	11,256,008	154,385	
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	14,704	14,704		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$	16,430	16,430		
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	29,210	29,210		
8. Other (*Specify*)	$	16,500	16,500		
V. Total Other Revenue (1 thru 8)	$	76,843	76,843		
VI. Total All Revenue (III +V)	$	11,487,237	11,332,852	154,385	

* *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	Residential Care Home
30 II 6a	REVENUE XRAY	$ 17,038		
30 II 6a	REVENUE LABORATORY	$ 12,101		
30 II 6a	REVENUE OXYGEN	$ 4,337		
30 II 6a	ALLOWANCE XRAY	$ (6,605)		
30 II 6a	ALLOWANCE LAB	$ (12,101)		
30 II 6a	ALLOWANCE OXYGEN	$ (4,337)		
Total Other Resident Revenue - Medicare		$ 10,434	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	Residential Care Home	Residential Care Home
30 II 6b	REVENUE XRAY	$ 9,606		
30 II 6b	REVENUE LABORATORY	$ 6,027		
30 II 6b	REVENUE OXYGEN	$ 3,859		
30 II 6b	ALLOWANCE XRAY	$ (19,677)		
30 II 6b	ALLOWANCE LAB	$ (5,971)		
30 II 6b	ALLOWANCE OXYGEN	$ (2,534)		
Total Other Resident Revenue		$ (8,690)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	Residential Care Home	Residential Care Home
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	Residential Care Home	Residential Care Home
30 IV 8	BOOKKEEPING_REFUGE	$ 6,000		
30 IV 8	REVENUE RENT MTG ROOMS	$ 10,500		
Total Other Revenue		$ 16,500	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,387,140
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,651,378
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 705,643
a.				
b.				
c.				
d. See Schedule		705,643		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 20,015,900
See Schedule		20,015,900		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 24,760,061
B. Fixed Assets				
1. Land				$ 29,950
2. Land Improvements	*Historical Cost	3,933,611		$ 2,214,144
	Accum. Depreciation	1,719,467	Net	
3. Buildings	*Historical Cost	19,806,441		$ 7,731,848
	Accum. Depreciation	12,074,593	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	9,818,749		$ 3,925,730
	Accum. Depreciation	5,893,019	Net	
6. Movable Equipment	*Historical Cost	3,576,038		$ 716,251
	Accum. Depreciation	2,859,787	Net	
7. Motor Vehicles	*Historical Cost	42,442		$
	Accum. Depreciation	42,442	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 65,814,748
See Schedule		65,814,748		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 80,432,671

* 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	
31	A5	AR OTHER AUXILIARY C CARD	$ 508
31	A5	PREPAID INSURANCE LIABILITY	151,322
31	A5	PPD VILLAGE EXPENSE	67,795
31	A5	PREPAID EXPENSE	246,957
31	A5	PREPAID PROPERTY TAXES	239,061
Total Prepaid Expenses			$ 705,643

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

Page Ref	Line Ref	Description	
31	A8	Investments	$ 13,991,698
31	A8	Assets whose use is limited	5,224,764
31	A8	Charitable Remainder Trust, Net	799,438
Total Other Current Assets (Itemize)			$ 20,015,900

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

Page Ref	Line Ref	Description	
31	B9	Construbtion in Progress	$ 730,350
31	B9	Village and Village Net Asset (Independent Living)	65,084,398
Total Other Other Fixed Assets (Itemize)			$ 65,814,748

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
33	A2	Entrance Fee Refunds Payable	$ 4,887
33	A2	Accrued Expenses	362,538
33	A2	Contract Liabilities	230,472
33	A2	Due to Related Party	455,018
33	A2	Deposits Helf for Residents	757,368
Total Notes Payable			$ 1,810,283

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
34	B4	Bonds Payable, Net	$ 51,191,244
34	B4	Refundable Entrance Fees	11,134,438
34	B4	Contract Liabilities from Nonrefundable Entrance Fees	16,650,448
34	B4	Other Liabilities	44,570
Total Other Current Liabilities (Itemize)			$ 79,020,700

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	32 | 37

Account				Amount
			Total Brought Forward:	$ 105,192,732
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 105,192,732

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,063,730
2. Notes Payable (*itemize*)				$ 1,810,283
See Schedule		1,810,283		
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 1,285,570
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$
See Schedule				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 5,159,583

* 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	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	34 | 37

Account	Amount
Total Brought Forward:	5,159,583
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 79,020,700
See Schedule	79,020,700	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 79,020,700
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 84,180,283

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

Name of Facility	License No.	Report for Year Ended	Page of
McLean Health Center	884-C	9/30/2023	35 | 37

Account					Amount
A. **Reserves**					
1. Reserve for value of leased land				$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$	
3. Reserve for depreciation value of leased personal property (*Equity*)				$	
4. Reserve for leasehold real properties on which fair rental value is based				$	
5. Reserve for funds set aside as donor restricted				$	
6. Total Reserves				$	
B. **Net Worth**					
1. Owner's Capital				$	
2. Capital Stock				$	
3. Paid-in Surplus				$	
4. Treasury Stock				$	
5. Cumulated Earnings				$	27,602,370
6. Gain or Loss for Period	10/1/2022	thru	9/30/2023	$	(6,589,921)
7. Total Net Worth				$	21,012,449
C. ***Total Reserves and Net Worth***				$	21,012,449
D. ***Total Liabilities, Reserves, and Net Worth***				$	105,192,732

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page 36 of 37
McLean Health Center	884-C	9/30/2023	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ 27,602,370
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 30,439,290
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 38,825,370
D.	Net Income or Deficit			$ (8,386,080)
E.	Balance			$ 19,216,290
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Other Income and Expense	40,086		
	Interest and Dividend Income	590,395		
	Change in Net Unrealized Gain (Loss) on Inv	601,695		
	Change in Net Assets With Donor Restrictions	563,983		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 1,796,159
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings (*Specify*)			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/23			$ 21,012,449

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
McLean Health Center	884-C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ Residential Care Home	☑ 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
Carol Barno

Addres Address	Phone Number
75 Great Pond Road, Simsbury, CT 06070	860-658-3759

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
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