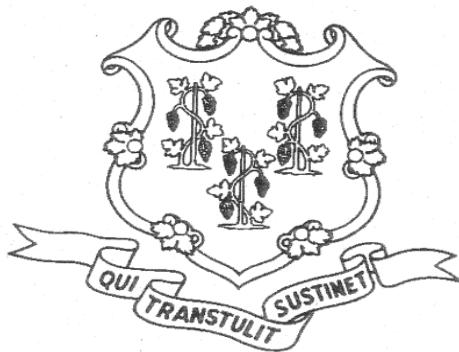


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

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 10/1/2020	Report for Year Ending 9/31/21

License Numbers:	CCNH 884-C	RHNS	Residential Care Home 1712-RCH	Medicare Provider 07-5216
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Medicaid Provider Numbers:	CCNH 884-C	RHNS	ICF-IID 1712-RCH
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### For Department Use Only

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

# Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/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
<b>A. Report of Expenditures - Salaries &amp; Wages</b>	<b>10</b>
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>B. Report of Expenditures - Professional Fees</b>	<b>13</b>
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
<b>C. Expenditures Other than Salaries - Administrative and General</b>	<b>15</b>
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
<b>D. Adjustments to Statement of Expenditures</b>	<b>28</b>
<b>D. Adjustments to Statement of Expenditures (Cont'd)</b>	<b>29</b>
<b>F. Statement of Revenue</b>	<b>30</b>
<b>G. Balance Sheet</b>	<b>31</b>
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
<b>H. Changes in Total Net Worth</b>	<b>36</b>
<b>I. Preparer's/Reviewer's Certification</b>	<b>37</b>

## General Information

Name of Facility (as licensed) McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for McLean Health Center [facility name], for the cost report period beginning October 1, 2020 and ending 9/31/21, 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**

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37																																													
Name of Facility McLean Health Center	Period Covered:		From 10/1/2020	To 9/31/21																																													
Address of Facility 75 Great Pond Road, Simsbury, CT 06070																																																	
Report Prepared By Adam Axelrad	Phone Number (860) 658-3759		Date 2/2/2021																																														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Item</th> <th style="text-align: center;">Total</th> <th style="text-align: center;">CCNH</th> <th style="text-align: center;">RHNS</th> <th style="text-align: center;">Residential Care Home</th> </tr> </thead> <tbody> <tr> <td>1. Dietary wages paid</td> <td style="text-align: right;">\$ 404,496</td> <td style="text-align: right;">394,851</td> <td></td> <td style="text-align: right;">9,645</td> </tr> <tr> <td>2. Laundry wages paid</td> <td style="text-align: right;">\$ 33,974</td> <td style="text-align: right;">33,961</td> <td></td> <td style="text-align: right;">13</td> </tr> <tr> <td>3. Housekeeping wages paid</td> <td style="text-align: right;">\$ 228,976</td> <td style="text-align: right;">220,491</td> <td></td> <td style="text-align: right;">8,485</td> </tr> <tr> <td>4. Nursing wages paid</td> <td style="text-align: right;">\$ 1,741,982</td> <td style="text-align: right;">1,741,982</td> <td></td> <td></td> </tr> <tr> <td>5. All other wages paid</td> <td style="text-align: right;">\$ 4,332,790</td> <td style="text-align: right;">4,240,455</td> <td></td> <td style="text-align: right;">92,335</td> </tr> <tr> <td><b>6. Total Wages Paid</b></td> <td style="text-align: right;"><b>\$ 6,742,218</b></td> <td style="text-align: right;"><b>6,631,741</b></td> <td></td> <td style="text-align: right;"><b>110,478</b></td> </tr> <tr> <td>7. Total salaries paid</td> <td style="text-align: right;">\$</td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b></td> <td style="text-align: right;"><b>\$ 6,742,218</b></td> <td style="text-align: right;"><b>6,631,741</b></td> <td></td> <td style="text-align: right;"><b>110,478</b></td> </tr> </tbody> </table>					Item	Total	CCNH	RHNS	Residential Care Home	1. Dietary wages paid	\$ 404,496	394,851		9,645	2. Laundry wages paid	\$ 33,974	33,961		13	3. Housekeeping wages paid	\$ 228,976	220,491		8,485	4. Nursing wages paid	\$ 1,741,982	1,741,982			5. All other wages paid	\$ 4,332,790	4,240,455		92,335	<b>6. Total Wages Paid</b>	<b>\$ 6,742,218</b>	<b>6,631,741</b>		<b>110,478</b>	7. Total salaries paid	\$				<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$ 6,742,218</b>	<b>6,631,741</b>		<b>110,478</b>
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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 9/31/21	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.
<b>Administrator</b>			
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**

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page of 3A   37
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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 9/31/21	Page of 3B   37
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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 9/31/21			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" 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 checked="" type="radio"/> Yes <input 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			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	<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 9/31/21	Page 5 of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-6 Rev. 9/2002

**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 9/31/21			Page 6      of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Mailfinance (Formerly Neopost), 478 Weelers Farm Rd, Milford, CT 06461	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter	05/24/11	Paid Quarterly	1,716	743
TCF National Bank, P.O. BOX 77077, MINNEAPOLIS, MN 55480-7777	<input type="radio"/>	<input checked="" type="radio"/>	Service Bus	11/15/16	Monthly	13,380	(adjusted on pg. 28)
	<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"/>					
	<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"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		<b>Total ***</b>	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 9/31/21	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

Is the accounting basis for this

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

#### Independent Accounting Firm

Name of Accounting Firm 1 CliftonLarsonAllen LLP 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 2021 Financials & Employee 401k fund, Preparation of FY 2021 Medicare CR, Preparation of IRS 990, CO	\$ 29,586
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 29,586

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 \$30,092, RCH \$572, Outpatient/Other not on Annual Report

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1 Day Pitney, LLP 2 SHIPMAN & GOODWIN LLP 3 Wiggin & Dana 4 Michalik, Bauer, Silvia 5	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	\$ 37,060
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 37,060

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 \$15,729 RCH \$279 Outpatient/Other not on Annual Report \$21,052 (see page 28 line 10 adjustment for \$15,729 and \$279)

## Schedule of Resident Statistics

Name of Facility McLean Health Center			License No. 884-C				Report for Year Ended 9/31/21				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	71	69		2	71	69		2				
B. As of midnight of THIS report period	74	72		2					74	72		2
3. Total Number of Days Care Provided During Period												
A. Medicare	4,124	4,124			3,184	3,184			940	940		
B. Medicaid (Conn.)	10,617	10,617			7,941	7,941			2,676	2,676		
C. Medicaid (other states)												
D. Private Pay	8,036	8,036			5,752	5,752			2,284	2,284		
E. State SSI for RCH	596			596	453			453	143			143
F. Other (Specify) HMO, Managed Medicare	1,623	1,623			1,160	1,160			463	463		
G. Total Care Days During Period (3A thru F)	24,996	24,400		596	18,490	18,037		453	6,506	6,363		143
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	92	92			52	52			40	40		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>25,088</b>	<b>24,492</b>		<b>596</b>	<b>18,542</b>	<b>18,089</b>		<b>453</b>	<b>6,546</b>	<b>6,403</b>		<b>143</b>

## Schedule of Resident Statistics (Cont'd)

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page 9	of 37
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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	13	26		28			2	
Per Diem Rate								
a. One bed rm.	PDPM	317.75		\$508-\$555			146.44	
b. Two bed rms.	PDPM	317.75		\$508-\$555				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	974	974	Residential Care Home
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	11,358	11,358	
<b>D. Total Physical Therapy Treatments</b>	<b>12,332</b>	<b>12,332</b>	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	266	266	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	458	458	
<b>D. Total Speech Therapy Treatments</b>	<b>724</b>	<b>724</b>	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	296	296	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	10,443	10,443	
<b>D. Total Occupational Therapy Treatments</b>	<b>10,739</b>	<b>10,739</b>	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		884-C	9/31/21	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
<b>A. Salaries and Wages*</b>					
1. Operators/Owners (Complete also Sec. I of Schedule A1)	83,358	655			1,584 12
2. Administrator(s) (Complete also Sec. III of Schedule A1)	114,574	1,204			2,799 29
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	460,419	12,444			6,038 165
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	394,851	22,292			9,645 545
6. Housekeeping Service					
a. Head Housekeeper	15,801	672			608 26
b. Other Housekeeping Workers	204,690	12,099			7,877 466
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	35,358	885			1,361 34
b. Other Maintenance Workers	54,903	1,846			2,113 71
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	33,961	2,124			13 1
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant	41,915	835			797 16
b. Other Accountants	87,454	3,156			1,662 60
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	112,918	2,088			
b. RN					
1. Direct Care	1,741,982	40,523			
2. Administrative**	133,263	3,383			36,668 1,122
c. LPN					
1. Direct Care	262,340	8,037			
2. Administrative**					
d. Aides and Attendants	2,035,475	95,801			36,688 1,839
e. Physical Therapists	310,037	8,591			
f. Speech Therapists	52,994	939			
g. Occupational Therapists	215,911	5,552			
h. Recreation Workers	101,127	4,476			2,470 109
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	81,749	2,656			
n. Marketing					
o. Other (Specify)	56,660	2,689			155 9
See Attached Schedule					
<b>A-13. Total Salary Expenditures</b>	<b>6,631,741</b>	<b>232,948</b>			<b>110,478 4,503</b>

\* 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 9/31/21			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								
<b>Section I - Operators/Owners</b>										
David J. Bordonaro, CEO, President, McLean Affiliates, Inc. (Amt Claimed on C/R)	51,216		974	Standard Package	President, McLean Affiliates	334	10 A1	McLean Fund, Foundation, Game Refuge, & OP Services	816	127,501
Carol Barno, CFO, Treasurer, McLean Affiliates, Inc (Amt Claimed on C/R)	32,167		612	Standard Package	CFO, McLean Affiliates	334	10 A1	McLean Fund, Foundation, Game Refuge, & OP Services	816	80,080
<b>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).</b>										

\* 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		9/31/21			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							
<b>Section III - Administrators***</b>										
Lisa Clark, Administrator, McLean Affiliates	114,574		2,799	Standard Package	Licensed Administrator	1,233	10 A2	McLean Outpatient Allocation	847	80,568
<b>Section IV - Assistant Administrators</b>										

\*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 9/31/21		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>					
1. Dietitian	33,081	850		808	21
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)	77,653	162			
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)					
<b>PHYSICIAN_PROFESIONAL FEES</b>	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					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	132,214	1,492		808	21

\* 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 9/31/21	Page 15	of 37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 129,638	127,513		2,125
2. Disability Insurance	\$ 5,617	5,525		92
3. Unemployment Insurance	\$ 10,300	10,131		169
4. Social Security (F.I.C.A.)	\$ 486,838	478,858		7,980
5. Health Insurance	\$ 391,688	385,267		6,421
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 7,780	7,652		128
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 441,601	434,362		7,239
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 25,395	24,979		416
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 21,614	21,614		
d. Accounting and Auditing	\$ 30,664	30,092		572
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 16,004	15,725		279
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 50,782	48,957		1,825
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 13,384	13,135		250
2. Cellular Phones	\$ 629	629		
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	\$ 393,678	393,678		
<b>Subtotal</b>	\$ 2,025,614	1,998,119		27,495

\* 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
EE WEEKLY BENEFITS ACCRUED	\$ 4,233		\$ 71
ERGONOMICS	\$ 239		\$ 4
EMPL BEN_OTHER	\$ 1,817		\$ 30
EE HEALTH/X RAYS	\$ 332		\$ 6
PRE EMPLOYMENT EXPENSE	\$ 5,023		\$ 84
TBA EXPENSE	\$ 5,390		\$ 90
EXTENDED ILLNESS	\$ 7,325		\$ 122
SUPPLIES	\$ 1,032		\$ 17
PURCHASED SERVICES	\$ (1,551)		\$ (26)
TRAINING/INSERVICE	\$ 1,140		\$ 19
<b>Total</b>	<b>\$ 24,979</b>	<b>\$ -</b>	<b>\$ 416</b>

**Schedule of Other Taxes**

Description	CCNH	RHNS	Residential Care Home
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21		Page 16	of 37
Item		Total	CCNH	RHNS	Residential Care Home
	<b><i>Subtotals Brought Forward:</i></b>	2,025,614	1,998,119		27,495
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 5,389	5,254			134
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 6,431	6,325			105
4. Employee Travel	\$ 739	723			16
5. Education Expenses Related to Seminars and Conventions	\$ 2,852	2,767			85
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 4,879	4,850			29
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 70,706	66,851			3,855
4. Fund-Raising***	\$				
5. Medical Records	\$ 26,480	26,480			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 494				494
7. Postage	\$ 6,402	6,283			119
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 11,693	11,364			329
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 501	498			3
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> )	\$ 39,565	38,906			660
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 194,887	191,882			3,005
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 2,396,632	2,360,301			36,331

\* 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
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	Residential Care Home
SNF Marketing	\$ 6,455		\$ -
AL Advertising HR	\$ -		\$ 77
AL Marketing	\$ -		\$ 2,631
Marketing Supplies	\$ 8,206		\$ 156
Marketing Meetings	\$ (10)		\$ (0)
Admin Advertising HR	\$ 451		\$ 9
General Marketing	\$ 51,749		\$ 984
<b>Total Other Advertising</b>	<b>\$ 66,851</b>	<b>\$ -</b>	<b>\$ 3,855</b>

**Schedule of Dues**

Description	CCNH	RHNS	Residential Care Home
AL Dues & Fees	\$ -		\$ 118
Admin Dues & Fees	\$ 11,128		\$ 211
SNF Dues & Fees	\$ 236		\$ -
<b>Total Dues</b>	<b>\$ 11,364</b>	<b>\$ -</b>	<b>\$ 329</b>

**Schedule of Contributions**

Description	CCNH	RHNS	Residential Care Home
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	Residential Care Home
ACRETION	\$ 1,241		\$ 48
BANK CHARGES	\$ 7,243		\$ 138
COMPUTER SUPPORT FEES	\$ 159,423		\$ 2,403
EQUIPMENT NON CAPITAL	\$ 8,871		\$ 148
LICENSE PERMIT	\$ 779		\$ 15
PURCHASED SERVICES	\$ 14,325		\$ 254
<b>Total Other Administrative and General</b>	<b>\$ 191,882</b>	<b>\$ -</b>	<b>\$ 3,005</b>

**Schedule C-1 - Management Services\***

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	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	9/31/21		18   37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 283,253	276,500		6,754
2. Non-Food Supplies	\$ 52,305	51,057		1,247
3. Other (Specify) _____ SODX NON CONTROL DUES & FEES	\$ 52,595	51,341		1,254
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 5,991	5,848		143
c. Other (Specify) _____ SODX CONSUL MANAGEMENT EQUIPMENT NON CAPITAL	\$ 116,387	113,611		2,775
2D. <b>Total Dietary Expenditures</b> (2a + b + c + d)	\$ 510,531	498,358		12,173
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*	206	201		5
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)				N/A
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.	\$30,554
K. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	
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 type="radio"/> Yes <input checked="" 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 9/31/21		Page of 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.	6,686	6,683	3
	Amt. \$	8,629	8,443	185
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) LAUNDRY SERVICE CONTRACTS	\$	54,729	53,424	1,305
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	\$	63,358	61,867	1,490
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)			
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)			N/A

\* 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	9/31/21		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. \$	39,151	37,701		1,451
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> )	\$	52,670	50,718		1,952
<u>HOUSEKPG CONTRACTED SERVICES</u>					
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>91,821</b>	<b>88,419</b>		<b>3,402</b>
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare	\$	180,813	180,813		
b. Medicine Cabinet Drugs	\$	31,001	31,001		
c. Medical and Therapeutic Supplies	\$	260,146	250,281		9,865
d. Ambulance/Limousine***	\$	8,409	8,409		
e. Oxygen					
1. For Emergency Use	\$	4,472	4,472		
2. Other***	\$	10,811	10,811		
f. X-rays and Related Radiological Procedures***	\$	24,494	24,494		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	32,906	32,906		
i. Recreation	\$	11,943	11,658		285
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	36,759	36,326		433
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>601,754</b>	<b>591,172</b>		<b>10,582</b>

\* 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
SUPPLIES_MCR	\$ 767		
BLOOD TEST ACCUCHEC	\$ 1,675		
CONSULTANTS	\$ 14,352		
PHARM CONSULTANT	\$ 11,642		
SUPPLIES	\$ 1,381		
PURCHASED SERVICES ST	\$ 1,986		
COMPUTER SUPPORT FEES	\$ 3,900		
TRAINING/INSERVICE	\$ 624		
CONSULTANTS	\$ -		\$ 433
<b>Total Other Resident Care</b>	<b>\$ 36,326</b>	<b>\$ -</b>	<b>\$ 433</b>

**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 9/31/21			Page 22	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	173,627	167,611			6,016
b. Heat	\$	26,041	25,076			965
c. Light & Power	\$	131,202	126,341			4,862
d. Water	\$	9,483	9,131			351
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	773	758			14
f. Other <i>(itemize)</i>	\$	44,916	43,251			1,664
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	386,041	372,168			13,873
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	98,911	95,673			3,238
b. Building & Building Improvements	\$	257,791	245,173			12,618
c. Non-Movable Equipment	\$	240,081	234,304			5,776
d. Movable Equipment	\$	80,281	78,656			1,626
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	677,064	653,805			23,259
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (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. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	677,064	653,805			23,259

\* 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**

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
	Please see attached.			
<b>Total additions for Land Improvement</b>		\$ 95,000	Various	\$ 8,299 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvement</b>		\$ -		\$ - **

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

**\*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 C3

**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

## FY 21 Capital

Type	Acquisition Date	Description	Cost	Useful Life	Allocation Stat Name	Allocation Stat #	2021 Actuals		
							SNF	RCH	Other
<b>LAND IMPROVEMENTS</b>									
LI	4/12/21	Benches	\$2,320	15	Square Ft.	8	\$987	\$38	\$1,295
LI	3/31/21	Chapel Upgrades Landscaping	\$1,634	10	Days Including Village Units	5.1	\$714	\$17	\$902
LI	12/11/20	External Signage (Front Entrance)	\$80,156	10	Square Ft.	8	\$34,100	\$1,312	\$44,744
LI	11/11/20	External Way Finding Signs	\$1,200	10	Square Ft.	8	\$510	\$20	\$670
LI	4/15/21	Paving	\$7,545	8	Square Ft.	8	\$3,210	\$124	\$4,212
LI	4/21/21	Sculpture	\$2,145	5	Square Ft.	8	\$913	\$35	\$1,197
<b>Land Improvement Totals</b>			<b>\$95,000</b>				<b>\$40,434</b>	<b>\$1,546</b>	<b>\$53,021</b>
<b>BUILDINGS</b>									
BD	10/19/20	External Light Fixture	\$360	10	Square Ft.	8	\$153	\$6	\$201
BD	7/1/21	Domestic Water Booster Pump	\$46,400	10	Square Ft.	8	\$19,739	\$760	\$25,901
BD	7/22/21	Shed	\$1,524	10	Square Ft.	8	\$648	\$25	\$851
BD	9/29/21	Loading Dock Door Upgrades	\$17,650	10	Square Ft.	8	\$7,509	\$289	\$9,853
BD	3/31/20	Chapel Roof	\$370,007	20	Days Including Village Units	5.1	\$161,782	\$3,952	\$204,272
BD	9/30/21	Reclass 2020 Beauty Salon Flooring to FE	(\$35,164)	10	InPatient Days	1	(\$20,402)	(\$498)	(\$14,264)
BD	9/30/21	Electrical Infrastructure Upgrades (Panels)	\$17,925	20	Square Ft.	8	\$7,626	\$293	\$10,006
<b>Building Totals</b>			<b>\$418,701</b>				<b>\$177,055</b>	<b>\$4,826</b>	<b>\$236,820</b>

## FY 21 Capital

### NON-MOVABLE EQUIPMENT

FE	8/1/21	Café Heat Pump/Air curtain	\$4,900	15	Square Ft.	8	\$2,085	\$80	\$2,735
FE	12/15/20	Carpet (Admissions Office)	\$2,309	5	InPatient Days	1	\$1,340	\$33	\$937
FE	9/28/21	Carpet (Basement/Lower Level)	\$30,431	5	Square Ft.	8	\$12,946	\$498	\$16,987
FE	10/1/20	Carpet (Lobby/Living Room Reno)	\$43,833	5	Square Ft.	8	\$18,647	\$718	\$24,468
FE	4/19/21	Chiller controls	\$27,593	15	Meals w/ADC	2	\$14,093	\$344	\$13,156
FE	9/30/21	Reclass 2020 Beauty Salon Flooring from BD	\$35,164	10	InPatient Days	1	\$20,402	\$498	\$14,264
FE	12/16/20	Customized Seating for fireplace (Lobby/Living Room)	\$1,574	5	Square Ft.	8	\$670	\$26	\$879
FE	2/25/21	Decorative Artwork (Painted Pillars in lobby)	\$2,952	5	Square Ft.	8	\$1,256	\$48	\$1,648
FE	3/11/21	Domestic Hot Water Mixing Valve	\$9,380	10	Square Ft.	8	\$3,990	\$154	\$5,236
FE	5/13/21	Gift Shop Heat Pump/Air curtain	\$965	15	Other	31	\$0	\$0	\$965
FE	11/20/20	Heat Pump	\$2,716	10	Other	31	\$0	\$0	\$2,716
FE	10/15/20	Lobby Carpet	\$43,833	5	Square Ft.	8	\$18,647	\$718	\$24,468
FE	12/11/20	Lobby wallpaper	\$42,597	5	Square Ft.	8	\$18,122	\$697	\$23,779
FE	4/1/21	Paint (Basement/Lower Level)	\$15,857	5	Square Ft.	8	\$6,746	\$260	\$8,852
FE	3/10/21	Paint (Eddy Ceiling)	\$20,036	5	Square Ft.	8	\$8,524	\$328	\$11,184
FE	3/2/21	Paint (Lobby)	\$750	5	Square Ft.	8	\$319	\$12	\$419
FE	6/24/21	Penthouse Chiller Pump	\$61,500	15	Other	31	\$0	\$0	\$61,500
FE	6/30/21	Recognition Signage	\$5,415	10	Other	31	\$0	\$0	\$5,415
FE	9/30/21	Reclass of FY20 Wellness Screener install to ME	(\$1,312)	6	Square Ft.	8	(\$558)	(\$21)	(\$732)
FE	9/30/21	Restroom Upgrade	\$116,519	10	Square Ft.	8	\$49,569	\$1,907	\$65,042
FE	3/23/21	Vinyl Flooring (Basement Laundry)	\$4,678	10	InPatient Days	1	\$2,714	\$66	\$1,897
FE	3/1/21	Welding and Metal for Awning	\$4,950	15	Square Ft.	8	\$2,106	\$81	\$2,763
FE	7/14/21	Wiring for security camera upgrades	\$2,333	5	Square Ft.	8	\$992	\$38	\$1,302

## FY 21 Capital

FE	3/31/21	Chapel Interior FE	\$262,071	15	Days Including Village Units	5.1	\$114,588	\$2,799	\$144,684
FE	9/30/21	Direct Digital Controls	\$146,216	10	Other	31	\$0	\$0	\$146,216
		<b>Non-Movable Totals</b>	<b>\$887,259</b>				<b>\$297,195</b>	<b>\$9,284</b>	<b>\$580,779</b>

## FY 21 Capital

### MOVABLE EQUIPMENT

ME	10/1/21	MIP Accounting Software	\$78,408	5	Other	31	\$0	\$0	\$78,408
ME	9/30/21	Bladder scanner	\$9,452	5	Nurse Supp. Rev	10	\$9,452	\$0	\$0
ME	9/30/21	Stair Chairs	\$13,288	5	InPatient Days	1	\$7,710	\$188	\$5,390
ME	9/30/21	Patient lifts (SNF)	\$3,690	10	Nurse Supp. Rev	10	\$3,690	\$0	\$0
ME	9/30/21	Feeding pump	\$2,243	10	Nurse Supp. Rev	10	\$2,243	\$0	\$0
ME	9/30/21	Collins Conference room furniture	\$4,987	10	Square Ft.	8	\$2,122	\$82	\$2,784
ME	9/30/21	Drywall repair for Lobby upgrades	\$1,653	5	Square Ft.	8	\$703	\$27	\$923
ME	9/30/21	Reclass of FY20 Wellness Screener install fro FE	\$1,312	6	Square Ft.	8	\$558	\$21	\$733
ME	9/30/21	Patient lift (AL)	\$298	10	Other	31	\$0	\$0	\$298
ME	9/21/21	Press tool kit	\$2,459	5	Square Ft.	8	\$1,046	\$40	\$1,373
ME	7/1/21	EMS system Upgrade	\$2,895	5	InPatient Days	1	\$1,680	\$41	\$1,174
ME	7/1/21	OP Therapy Equipment	\$4,812	5	Other	31	\$0	\$0	\$4,812
ME	6/30/21	Cleaning equipment	\$20,157	5	Square Ft.	8	\$8,575	\$330	\$11,252
ME	4/29/21	AL Wheelchairs	\$2,604	5	Other	31	\$0	\$0	\$2,604
ME	4/27/21	Table in living room/lobby	\$1,073	5	Square Ft.	8	\$456	\$18	\$599
ME	3/30/21	Chairs for Chapel	\$41,278	15	Days Including Village Units	5.1	\$18,049	\$441	\$22,789
ME	3/1/21	Decorative Artwork	\$25,823	5	Other	31	\$0	\$0	\$25,823
ME	2/23/21	Artwork Installation	\$1,672	5	Square Ft.	8	\$711	\$27	\$933
ME	12/22/20	Snowblower	\$2,929	10	Square Ft.	8	\$1,246	\$48	\$1,635
ME	11/19/20	Hi- Lo Mat Platfrm	\$3,437	10	Nurse Supp. Rev	10	\$3,437	\$0	\$0
ME	10/31/20	Homecare software Revenue Management (RCM) Set up fee	\$2,500		Other	31	\$0	\$0	\$2,500
ME	10/19/20	Office Furniture	\$7,094	10	Other	31	\$0	\$0	\$7,094

## FY 21 Capital

Movable Totals	\$234,065			\$61,679	\$1,263	\$171,123
<b>TOTAL</b>	<b>\$1,635,025</b>			<b>\$576,363</b>	<b>\$16,920</b>	<b>\$1,041,743</b>

**Amortization Schedule\***

Name of Facility McLean Health Center			License No. 884-C		Report for Year Ended 9/31/21			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- 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 9/31/21	Page 25	of 37
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#### 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 9/31/21			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	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	<b>\$</b>					

(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 9/31/21			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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>		\$				
14. Insurance						
a. Insurance on Property (buildings only)	\$	41,918	41,136			782
b. Insurance on Automobiles	\$	2,603	2,554			49
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)	\$	9,938	9,752			185
2. Fire and Extended Coverage	\$	2,169	2,129			40
3. Other (Specify)	\$	5,208	5,111			97
Fiduciary & Cyber						
14d. <b>Total Insurance Expenditures (14a + b + c)</b>		\$	61,836	60,684		1,153
15. <b>Total All Expenditures (A-13 thru C-14)</b>		\$	11,664,277	11,450,729		213,548

## **D. Adjustments to Statement of Expenditures**

Name of Facility McLean Health Center			License No. 884-C	Report for Year Ended 9/31/21		Page 28   of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 215,911	215,911		
4.			Other - See attached Schedule	\$ 15,252	14,982		270
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	B8c	Resident Care Physicians **	\$ 7,200	7,200		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,930	1,778		152
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 21,614	21,614		
10.			Accounting	\$			
10a.			Legal	\$ 16,011	15,732		279
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)	\$ 7,987	7,810		177
18.	16	M3	Unallowable Advertising *	\$ 70,706	66,851		3,855
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.	16	M6	Barber and Beauty	\$ 494			494
23.			Other - See attached Schedule	\$			
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.	30	IV 1	Meals to employees, guests and others who are not residents	\$ 30,554	30,554		
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 387,658	382,431			5,227

\* 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
16	M13	ACCOUNTING_BANK CHARGES	\$ 7,134		\$ 136
16	L3	HUM RES_PERS RECOG	\$ 6,325		\$ 105
16	L5	ADMIN_MEETINGS	\$ 1,523		\$ 29
<b>Total Other Salaries Adjustment</b>			\$ 14,982	\$ -	\$ 270

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M08	ADMIN_DUES & FEES	\$ 1,778		\$ 34
16	M08	DUES & FEES (AL)			\$ 118
<b>Total Other Fees Adjustments</b>			\$ 1,778	\$ -	\$ 152

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Other A&amp;G Adjustments</b>			\$ -	\$ -	\$ -

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of	
McLean Health Center			884-C	9/31/21		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	\$ 387,658	382,431		5,227
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5 a2	Prescription Drugs	\$ 180,813	180,813		
28.	20	5 d	Ambulance/Limousine	\$ 8,409	8,409		
29.	20	5 f	X-rays, etc	\$ 24,494	24,494		
30.	20	5 h	Laboratory	\$ 31,734	31,734		
31.			Medical Supplies	\$			
32.	20	5 e2	Oxygen (non emergency)	\$ 10,811	10,811		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
<b>Page 22 - Maintenance and Property</b>							
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
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 22,085	22,053	32	
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 21,614	21,614		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 694,030	688,544	32	5,454

\*\*\* 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**

<b>Total Unallowable Building Interest</b>	\$ -	\$ -	\$ -
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**F. Statement of Revenue**

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21			Page 30   37
Item		Total	CCNH	RHNS	Residential Care Home
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 5,334,330	5,334,330			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,275,529)	(2,275,529)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,396,135	2,396,135			
b. Medicare Room and Board Contractual Allowance **	\$ 346,706	346,706			
4. a. Private-Pay Residents and Other	\$ 5,186,107	5,186,107			
b. Private-Pay Room and Board Contractual Allowance **	\$ (132,956)	(132,956)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 128,809	128,809			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (128,981)	(128,981)			
c. Prescription Drugs - Non-Medicare	\$ 50,402	50,402			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (47,530)	(47,530)			
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	\$ 128,809	128,809			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (128,981)	(128,981)			
c. Physical Therapy - Non-Medicare	\$ 50,402	50,402			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (47,530)	(47,530)			
4. a. Speech Therapy - Medicare	\$ 48,478	48,478			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (23,847)	(23,847)			
c. Speech Therapy - Non-Medicare	\$ 18,175	18,175			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ 410	410			
5. a. Occupational Therapy - Medicare	\$ 409,052	409,052			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (383,962)	(383,962)			
c. Occupational Therapy - Non-Medicare	\$ 139,438	139,438			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (144,311)	(144,311)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 8	8			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 3,921	3,921			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,927,556	10,927,556			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$ 30,554	30,554			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$ 19,680	19,680			
5. Interest Income ( <i>Specify</i> )	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 15,714	15,714			
8. Other ( <i>Specify</i> )	\$ 8,406	8,406			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 74,354	74,354			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,001,910	11,001,910			

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

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

**G. Balance Sheet**

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 6,970,105	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,464,792	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 343,292	
a. _____				
b. _____				
c. _____				
d. See Schedule		343,292		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 28,344	
See Schedule		28,344		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 8,806,533	
B. Fixed Assets				
1. Land			\$ 29,950	
2. Land Improvements	*Historical Cost	2,378,786	\$ 1,088,929	
	Accum. Depreciation	1,289,857	Net	
3. Buildings	*Historical Cost	16,858,049	\$ 6,335,685	
	Accum. Depreciation	10,522,364	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	8,804,768	\$ 3,995,270	
	Accum. Depreciation	4,809,499	Net	
6. Movable Equipment	*Historical Cost	3,364,311	\$ 862,636	
	Accum. Depreciation	2,501,676	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> )			\$ 42,108,947	
See Schedule		42,108,947		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 54,421,416	

\* 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 Other Resident Revenue - Medicare****Related Exp**

Page Ref	Description	CCNH	RHNS	Residential Care Home
	FLU VACCINE Medicare	\$ 1,984		
	REVENUE XRAY Medicare	\$ 17,393		
	REVENUE LABORATORY Medicare	\$ 21,434		
	REVENUE OXYGEN Medicare	\$ 2,207		
	ALLOWANCE XRAY Medicare	\$ (18,139)		
	ALLOWANCE LAB Medicare	\$ (22,634)		
	ALLOWANCE OXYGEN Medicare	\$ (2,237)		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ 8</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Non-Medicare Resident Revenue****Related Exp**

Page Ref	Description	CCNH	RHNS	Residential Care Home
	REVENUE LABORATORY HMO/Managed Care	\$ 10,464		
	REVENUE OXYGEN Private	\$ 1,872		
	REVENUE OXYGEN HMO/Managed Care	\$ 1,583		
	ALLOWANCE LAB HMO/Managed Care	\$ (9,264)		
	ALLOWANCE OXYGEN HMO/Managed Care	\$ (1,652)		
	REVENUE XRAY HMO/Managed Care	\$ 6,729		
	ALLOWANCE XRAY HMO/Managed Care	\$ (5,811)		
	<b>Total Other Resident Revenue</b>	<b>\$ 3,921</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
	<b>Total Interest Income</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	Residential Care Home
	BOOKKEEPING_REFUGE	\$ 6,000		
	REVENUE RENT MTG ROOMS	\$ 2,406		
	<b>Total Other Revenue</b>	<b>\$ 8,406</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		AR OTHER AUXILIARY C CARD	\$ 479
		PREPAID IL EXPENSE	\$ 46,274
		PREPAID EXPENSE	\$ 77,954
		PREPAID INSURANCE LIABILITY	\$ 107,553
		PREPAID PROPERTY TAXES	\$ 111,032
		<b>Total Prepaid Expenses</b>	<b>\$ 343,292</b>

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

Page Ref	Line Ref	Description	
		Due from Related Party	\$ 28,344
		<b>Total Other Current Assets (Itemize)</b>	<b>\$ 28,344</b>

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

Page Ref	Line Ref	Description	
		Construction in Progress	\$ 33,142,749
		Village and Village Net Asset (Independent Living)	\$ 8,966,198
		<b>Total Other Other Fixed Assets (Itemize)</b>	<b>\$ 42,108,947</b>

## Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Assets Whos Use Is Limited	\$ 40,073,933
		Interest in McLean Foundation (Charitable Remainder Trust, Net)	\$ 892,972
		<b>Total Other Assets</b>	<b>\$ 40,966,905</b>

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		<b>Total Notes Payable</b>	<b>\$ -</b>

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

Page Ref	Line Ref	Description	
		Deferred Revenue	\$ 386,610
		Deposits Held for Residents	\$ 2,028,996
		Accrued Payables	\$ 456,502
		Entrance fee refunds payable	478,060
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 3,350,168</b>

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

Page Ref	Line Ref	Description	
		Bonds payable, net	\$ 65,236,129
		Refundable Entrance Fees	\$ 4,113,125
		FIN 47 Asset Retirement Obligation	\$ 59,368
		Deferred Revenue from Nonrefundable Entrance Fees	5,339,020
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 74,747,642</b>

## G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/31/21	32   37
Account		Amount	
		Total Brought Forward:	\$ 63,227,949
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 <b>Total Leasehold or Like Properties</b> (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 ( <i>itemize</i> )			\$ 14,833,284
PLANT REPLACEMENT TRADE REC-SCHW	14,833,284		
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$
Name and Address	Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$ 40,966,905
See Schedule	40,966,905		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ 55,800,189
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 119,028,138

\* 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 9/31/21	Page 33	of 37
Account				Amount
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 5,658,207
2. Notes Payable ( <i>itemize</i> )				\$
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 1,574,379
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> )				\$ 3,350,168
See Schedule				3,350,168
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				<b>\$ 10,582,754</b>

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

*(Carry Total forward to next page)*

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-34 Rev. 6/95

**G. Balance Sheet (cont'd)**

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page 34	of 37
Account			Amount	
Total Brought Forward:			10,582,754	
<b>Liabilities (cont'd)</b>				
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> )				\$ 74,747,642
See Schedule	74,747,642			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 74,747,642
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 85,330,396

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

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	Page 35	of 37
Account				Amount
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 32,787,831
6. Gain or Loss for Period		10/1/2020	thru	9/31/21
7. Total Net Worth				\$ 33,697,742
<b>C. Total Reserves and Net Worth</b>				\$ 33,697,742
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 119,028,138

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
McLean Health Center	884-C	9/31/21	36	37		
Account				Amount		
A. ##				\$ 32,787,831		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 27,656,371		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 29,143,742		
D. Net Income or Deficit				\$ (1,487,371)		
E. Balance				\$ 31,300,460		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Interest and Dividend Income				728,075		
Change in Unrealized Losses on Investment				1,586,121		
Changes in Net Assets With Donor Restrictions				83,086		
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ 2,397,282		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$		
Name and Address (No., City, State, Zip )		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ 33,697,742		

## I. Preparer's/Reviewer's Certification

Name of Facility McLean Health Center	License No. 884-C	Report for Year Ended 9/31/21	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		