State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) Miller Memorial Community		
Address (No. & Street, City, State, Zip Code) 360 Broad St. Meriden, CT 06450		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☑ Other		
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	Other	Medicare Provider
	992-C			07-5295

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	209928		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	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 Miller Memorial Community [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Edward Baker			Printed Name (Owner) James W. Batten, President	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Miller Memorial Community	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 360 Broad St. Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date 2/13/2019	

Item		Total	CCNH	RHNS	Other
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
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Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Miller Memorial Community	360 Broad St. Meriden, CT 06450

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.
	992-C			07-5295

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☑ Other

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.:
Edward Baker	1721

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Miller Memorial Community	360 Broad St, Meriden, CT 06450	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
James W. Batten	360 Broad St, Meriden, CT 06450	ent Secretary Di	N/A
George C. Carabetta	360 Broad St, Meriden, CT 06450	Director	N/A
Clifford R. Dreschler-Martell, MD	360 Broad St, Meriden, CT 06450	Director	N/A
Irene S. Melasky	360 Broad St, Meriden, CT 06450	Director	N/A
Peter B. Viering	360 Broad St, Meriden, CT 06450	reasurer, Directo	N/A
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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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
#REF!

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Presients Office	360 Broad St, Meriden, CT 06450	○	⊙		James Batten, President	16/m12	112,200	112,200
Clifford Dreschler, Martell, MD	360 Broad St, Meriden, CT 06450	○	⊙		Medical Director	13/B8a	21,600	21,600
Edward C Miller Memorial Trust	360 Broad St, Meriden, CT 06450	○	⊙		Loaning of Funds	34/B4	769,000	769,000
Edward C Miller Memorial Trust	360 Broad St, Meriden, CT 06450	○	⊙		Donations	30/IV8	528,206	528,206
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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.

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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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
N/A	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total *** |

* 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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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit, Tax, Cost Report Services	$ 21,200
2		$
3		$
4		$
		Charge for Services Provided $ 21,200

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

⊙ Yes ○ No Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman & Goodwin LLP	
2 Michalik, Bauer, Silvia & Ciccarillo	
3	
4	
5	

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

1 One Constitution Plaza, Hartford, CT
2 35 Pearl St, New Britain, CT
3
4
5

Services Provided by This Firm (*describe fully*)

1	General Legal Matters	$ 917
2	AR Collections - Disallowed	$ 1,215
3		$
4		$
5		$
		Charge for Services Provided $ 2,132

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

⊙ Yes ○ No Pg 15/1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	85	5		90	85	5		90	85	5	
B. On last day of THIS report period	90	85	5		90	85	5		90	85	5	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	68	68			68	68			72	72		
B. As of midnight of THIS report period	73	73			72	72			73	73		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,583	2,583			2,052	2,052			531	531		
B. Medicaid (Conn.)	21,195	21,195			15,460	15,460			5,735	5,735		
C. Medicaid (other states)												
D. Private Pay	2,346	2,346			1,964	1,964			382	382		
E. State SSI for RCH												
F. Other (Specify)	624	624			474	474			150	150		
G. Total Care Days During Period (3A thru F)	26,748	26,748			19,950	19,950			6,798	6,798		
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												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	26,748	26,748			19,950	19,950			6,798	6,798		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

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	Other
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	Other	R.C.H.	ICF-MR
No. of Residents	5	64		4				
Per Diem Rate								
a. One bed rm.		243.11		455.00				
b. Two bed rms.				420.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,724	3,724		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***	3,724	3,724		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	368	368		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	368	368		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,859	2,859		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***	2,859	2,859		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	110,314	2,062			1,044	18
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	288,051	14,311			2,367	135
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	410,046	30,224			807	60
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	206,857	14,177			262	21
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	58,304	2,080				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	96,249	2,080				
b. RN						
1. Direct Care	589,875	13,212				
2. Administrative**	178,382	6,227				
c. LPN						
1. Direct Care	724,790	26,136				
2. Administrative**						
d. Aides and Attendants	1,350,595	82,880				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	127,586	7,381				
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	77,311	2,595				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	53,971	2,080				
A-13. Total Salary Expenditures	4,272,330	205,445			4,480	234

* 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)

	CCNH		RHNS		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Admissions	$ 53,971	2,080				
Total	$ 53,971	2,080	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**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
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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	Other							
Section I - Operators/Owners										
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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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
Miller Memorial Community	992-C	9/30/2018	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	Other							
Section III - Administrators* **										
Edward Baker (10/1/17-9/30/18))	110,314		1,044	standard		2,080	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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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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	14,102	353			28	1
2. Dentist						
3. Pharmacist	5,940	Flat Fee				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	219,331	4,023				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,600	342				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Medical Staff	205	1				
9. Speech Therapist						
a. Resident Care	44,035	687				
b. Other						
10. Occupational Therapist						
a. Resident Care	192,682	4,302				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	20,198	270				
2. Administrative***						
b. LPN						
1. Direct Care	12,408	255				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	530,501	10,233			28	1

* 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.

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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
Miller Memorial Community	992-C	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Clifford R. Dreschsler-Martell, MD 324 Ridge Rd, Middletown, CT 06457	Medical Director	⊙	○	Member of Board of Directors
David Taraskevich, MD 237 Liberty St, Meriden, CT 06450	Medical Staff Meeting	○	⊙	
Audrey Lefkowitz, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	○	⊙	
Neil Scollan, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	○	⊙	
The Nures Network, Inc. 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
Ready Nurse Staffing Services 360 Bloomfield Ave #303, Windsor, CT 06095	Nurse Pool	○	⊙	
Keep Me Home 1340 Worthington Rdg., Berlin, CT 06037	Nurse Pool	○	⊙	
Nursefinders Hartford, CT	Nurse Pool	○	⊙	
Swallowing Diagnostics LLC 21 Waterville Rd, Avon, CT 06001	ST Consultant	○	⊙	
Omnicare of Connecticut 525 Knotter Dr, Cheshire, CT 06410	Pharmacist	○	⊙	
Foremost Rehab of Connecticut 1157 Highland Ave # 101, Cheshire, CT 06410	Therapy Services	○	⊙	
Foremost Rehab of Connecticut 1157 Highland Ave # 101, Cheshire, CT 06410	Therapy Services	○	⊙	
Mitchele Lipka, MS, RD	Dietician	○	⊙	
Louise Kovacik	Dietician	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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
Miller Memorial Community	992-C	9/30/2018	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	137,989	137,844		145
2. Disability Insurance	$	8,064	8,056		8
3. Unemployment Insurance	$	12,204	12,191		13
4. Social Security (F.I.C.A.)	$	331,310	330,963		347
5. Health Insurance	$	572,510	571,910		600
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	3,988	3,984		4
7. Pensions (Non-Discriminatory)	$	2,500	2,497		3
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	7,875	7,867		8
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	123,443	123,443		
d. Accounting and Auditing	$	25,380	25,142		238
e. Legal (*Services should be fully described on Page 7)*	$	2,132	2,112		20
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	20,454	20,269		185
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	25,038	24,803		235
2. Cellular Phones	$	983	974		9
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	$	497,627	497,627		
Subtotal	$	1,771,496	1,769,682		1,814

* 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**

Miller Memorial Community
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Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
EAP	$ 350		
Pre-Employment Services	$ 7,517		$ 8
Total	$ 7,867	$ -	$ 8

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

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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
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Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		1,771,496	1,769,682		1,814
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	270	270		
3. Gifts to Staff and Residents	$	7,427	7,373		53
4. Employee Travel	$	169	168		2
5. Education Expenses Related to Seminars and Conventions	$	5,696	5,647		49
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*)	$	1,955	1,937		18
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	17,330	17,181		149
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,385	4,344		41
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	785	778		7
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	850	842		8
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	55,370	54,860		511
12. Administrative Management Services**	$	112,200	111,147		1,052
13. Other (*Specify*)	$	28,621	22,254		6,367
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,006,554	1,996,483		10,071

* 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	Other
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Marketing	$ 17,181		$ 149
Total Other Advertising	$ 17,181	$ -	$ 149

Schedule of Dues

Description	CCNH	RHNS	Other
CAHCF	$ 693		$ 7
ALTCFM	$ 85		
Total Dues	$ 778	$ -	$ 7

Schedule of Contributions

Description	CCNH	RHNS	Other
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Bank Charges-Admin	$ 9,173		$ 87
Licenses & Fees	$ 6,687		$ 14
RTA Fund	$ 108		
Fines and Penalties	$ 50		
Licenses - Dining Services	$ 818		$ 2
Licenses - Maintenance	$ 480		
Licenses - Nursing Admin	$ 150		
Equipment Rental - Rlc			$ 3,573
Equipment Maint & Repair - Rlc			$ 483
Minor Equipment & Furniture - Rlc			$ 2,096
Specific Fun/Events/Programs -			$ 112
Gain/Loss of Disposal of Equipment	$ 4,788		
Total Other Administrative and General	$ 22,254	$ -	$ 6,367

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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 #
Miller Memorial Community, Presidents Office, James Batten	112,200	Management, Oversight of Operations, President, Legal, Counsel, VP Compliance	16/m12

*** 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
Miller Memorial Community	992-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	223,400	222,961		439
2. Non-Food Supplies	$	25,567	25,517		50
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	248,967	248,478		489

		Total	CCNH	RHNS	Other
2F. Dietary Questionnaire					
G. Resident Meals:	Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No		
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.	
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	⊙ Yes	○ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt.	$1,812
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				30/IV1
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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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
Miller Memorial Community	992-C	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	Other
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	57,379	57,379		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	57,379	57,379		

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

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

*** 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
Miller Memorial Community	992-C	9/30/2018	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,289	24,258		31
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	24,289	24,258		31
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	187,049	187,049		
b. Medicine Cabinet Drugs		$	21,235	21,235		
c. Medical and Therapeutic Supplies		$	174,802	174,802		
d. Ambulance/Limousine***		$	37,696	37,696		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	41,974	41,974		
f. X-rays and Related Radiological Procedures***		$	8,715	8,715		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	10,100	10,100		
h. Laboratory***		$	11,968	11,968		
i. Recreation		$	15,412	15,412		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	45,974	45,974		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	554,923	554,923		

* 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	Other
PROF SERV.-MIS-ANCILLARY SERV	$ 913		
NUTRITIONAL SUPPLEMENTS - NURSING	$ 31,610		
ACCELERATED CARE PLUS	$ 11,799		
PHYSICAL THERAPY SUPPLIES	$ 1,652		
Total Other Resident Care	$ 45,974	$ -	$ -

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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
Miller Memorial Community	992-C	9/30/2018	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	Other	Pg	Line
Unitex	565 Taxter Road, Elmsford NY	○	⊙		Laundry Services	57,379			16	3b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2018			Page 22 | of 37
Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	52,291	41,703	1,595	8,993
b. Heat	$	96,389	95,786	22	581
c. Light & Power	$	151,083	134,959	421	15,704
d. Water	$	36,579	24,046	457	12,076
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	130,571	123,031	1,142	6,398
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	466,913	419,525	3,637	43,751
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,488	1,072	63	353
b. Building & Building Improvements	$	213,208	152,143	8,950	52,116
c. Non-Movable Equipment	$	28,918	26,846	1,579	493
d. Movable Equipment	$	37,031	32,086	1,887	3,057
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	280,645	212,147	12,479	56,019
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)	$	280,645	212,147	12,479	56,019

* 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	Other
Exterminator Serv-Dining Serv	$ 2,167		$ 4
Fire Prot. Maint Simplex	$ 5,503		
Elevator Service Baystate	$ 11,351		
Exterminator Service - Maint	$ 1,483		
Grounds Service	$ 19,409	$ 1,142	$ 6,394
Hvac Service	$ 33,929		
Plowing & Sanding	$ 16,500		
Refuse Removal	$ 18,080		
Medical Waste Removal - Nursing	$ 3,374		
Cable Tv - Plant Operations	$ 11,235		
Total Other Repairs and Maintenance	$ 123,031	$ 1,142	$ 6,398

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	1,459,099		1,459,099	1,444,671	SL	VAR	1,488	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,488
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,743,290		7,743,290	6,486,895	SL	VAR	205,675	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	582,117						7,533	
B-4. Subtotal								213,208
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,201,237		1,201,237	1,047,933	SL	Var	26,428	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	37,167						2,490	
C-4. Subtotal								28,918

	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. Fully Depreciated Vehicles	x		Var		146,817		146,817	146,817				
b. 2001 Dodge Ram	x		9	2017	2,000		2,000	56			667	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			var	var	1,978,559		1,978,559	1,839,282	SL	VAR	34,407	
b. Disposals (attach schedule)					(15,120)			(10,332)				
c. Acquired during this report period (attach schedule)					34,067						1,957	
D-3. Subtotal												37,031
E. ***Total Depreciation***												280,645

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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
5/30/2018	Eectrical Project	$ 582,117	30	$ 7,533	
Total additions for Building Improvements		$ 582,117		$ 7,533	*
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:					
12/28/2017	Expansion Tank	$ 8,696	10	$ 725	
1/18/2018	Replace Relief Valve	$ 2,330	10	$ 175	
2/16/2018	Replace Compressor	$ 6,922	10	$ 461	
2/19/2018	Freezer Repairs	$ 1,381	5	$ 184	
2/22/2018	Freezer Repairs	$ 1,853	5	$ 247	
2/27/2018	Boiler Repair	$ 1,800	5	$ 240	
4/6/2018	Bearing Assembly	$ 2,749	10	$ 137	
4/17/2018	Bearing Assembly	$ 1,386	10	$ 69	
7/13/2018	Boiler Work	$ 10,050	10	$ 251	
Total additions for Non-Movable Equipment		$ 37,167		$ 2,490	*
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	Cost	Useful Life	Depreciation	
Additions:					
3/7/2018	Chair Sofa Loveseats	$ 12,143	5	$ 1,417	
6/13/2018	Server	$ 3,962	3	$ 440	
7/31/2018	Canon Copier	$ 17,962	5	$ 100	
Total additions for Movable Equipment		$ 34,067		$ 1,957	*
Deletions:					
	Copier	$ (15,120)			
Total deletions for Movable Equipment		$ (15,120)		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report perioc

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 Month	Date of Acquisition Year	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
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	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	Prior to 1844
2. Date Structure Completed	10/01/76
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	10/01/76
5. Total Licensed Bed Capacity	90
6. Square Footage	53,896
7. Acquisition Cost	
a. Land	Unknown
b. Building	Unknown

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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2018	26 | 37

Item		Total	CCNH	RHNS	Other
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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2018	27 | 37

Item	Total	CCNH	RHNS	Other
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*) $	5,164	5,164		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	5,164	5,164		
14. Insurance				
a. Insurance on Property (buildings only) $	43,521	31,350	1,844	10,327
b. Insurance on Automobiles $	4,718	4,674		44
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	5,805	5,750		54
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	118,420	117,310		1,110
14d. ***Total Insurance Expenditures (14a + b + c)*** $	172,464	159,084	1,844	11,536
15. ***Total All Expenditures (A-13 thru C-14)*** $	8,624,637	8,480,272	17,960	126,406

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2018	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	192,682	192,682		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	123,443	123,443		
10.			Accounting $				
10a.			Legal $	1,214	1,203		11
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.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	17,330	17,181		149
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	5,688	5,680		8
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $	1,812	1,812		
Page 19 - Laundry Expenditures							
25.	30	IV8	Laundry services to employees, guests and others who are not residents $	1,647	1,647		
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	343,816	343,648		168

* 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	Other
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16	m8a	Chamber of Commerce	$ 842		$ 8
16	m13	Fines & Penalties	$ 50		
16	m13	Loss on Disposal of Equipment	$ 4,788		
Total Other A&G Adjustments			$ 5,680	$ -	$ 8

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward $	343,816	343,648		168
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	187,049	187,049		
28.	20	5d	Ambulance/Limousine $	37,696	37,696		
29.	20	5f	X-rays, etc $	8,715	8,715		
30.	20	5h	Laboratory $	11,968	11,968		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	41,974	41,974		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
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 $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.	30	IV4	Other - Miscellaneous Administrative $	3,831	3,831		
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	635,049	634,881		168

*** 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.

Attachment Page 29

Miller Memorial Community
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	30	37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,467,415	9,467,415		
b. Medicaid Room and Board Contractual Allowance **	$	(4,318,592)	(4,318,592)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,160,367	1,160,367		
b. Medicare Room and Board Contractual Allowance **	$	253,242	253,242		
4. a. Private-Pay Residents and Other	$	1,521,141	1,297,490		223,651
b. Private-Pay Room and Board Contractual Allowance **	$	(55,696)	(55,696)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	111,748	111,748		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(111,748)	(111,748)		
c. Prescription Drugs - Non-Medicare	$	25,218	25,218		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(24,104)	(24,104)		
2. a. Medical Supplies - Medicare	$	9,049	9,049		
b. Medical Supplies - Medicare Contractual Allowance **	$	(9,049)	(9,049)		
c. Medical Supplies - Non-Medicare	$	1,473	1,473		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(2,512)	(2,512)		
3. a. Physical Therapy - Medicare	$	325,703	325,703		
b. Physical Therapy - Medicare Contractual Allowance **	$	(218,198)	(218,198)		
c. Physical Therapy - Non-Medicare	$	81,099	81,099		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(78,272)	(78,272)		
4. a. Speech Therapy - Medicare	$	63,289	63,289		
b. Speech Therapy - Medicare Contractual Allowance **	$	(29,237)	(29,237)		
c. Speech Therapy - Non-Medicare	$	15,427	15,427		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(12,619)	(12,619)		
5. a. Occupational Therapy - Medicare	$	318,410	317,827		583
b. Occupational Therapy - Medicare Contractual Allowance **	$	(235,995)	(235,905)		(90)
c. Occupational Therapy - Non-Medicare	$	71,112	71,112		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(66,383)	(66,383)		
6. a. Other *(Specify)* - Medicare	$	990	990		
b. Other *(Specify)* - Non-Medicare	$	49	49		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	8,263,325	8,039,182		224,143
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	1,812	1,812		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$	3,831	3,831		
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	537,128	536,975		153
V. Total Other Revenue (1 thru 8)	$	542,771	542,618		153
VI. Total All Revenue (III +V)	$	8,806,096	8,581,799		224,296

* *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	Other
	Lab Med A	$ 990		
Total Other Resident Revenue - Medicare		$ 990	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab Mgd Care	$ 49		
Total Other Resident Revenue		$ 49	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	HKPING -PRIV-COTTAGES			$ 153
	LAUNDRY -PRIV-SNF	$ 1,647		
	CONTRIB-UNRESTRICTED	$ 528,206		
	OTHER INCOME	$ 7,122		
Total Other Revenue		$ 536,975	$ -	$ 153

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 80,033
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,160,476
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 247,423
a.				
b.				
c.				
d. See Schedule		247,423		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,487,932
B. Fixed Assets				
1. Land				$ 301,065
2. Land Improvements	*Historical Cost	1,459,099		$ 12,937
	Accum. Depreciation	1,446,162	Net	
3. Buildings	*Historical Cost	8,325,405		$ 1,625,303
	Accum. Depreciation	6,700,103	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,238,403		$ 161,552
	Accum. Depreciation	1,076,851	Net	
6. Movable Equipment	*Historical Cost	1,997,505		$ 132,191
	Accum. Depreciation	1,865,314	Net	
7. Motor Vehicles	*Historical Cost	148,817		$ 1,278
	Accum. Depreciation	147,539	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (402,668)
See Schedule		(402,668)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,831,657

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 3,319,589
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)				$ 3,319,589

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 183,832
		Prepaid Health Insurance	$ 49,962
		Prepaid Expenses	$ 13,629
Total Prepaid Expenses			$ 247,423

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

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

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

Page Ref	Line Ref	Description	
		Book Vs Cost Report	$ (402,668)
Total Other Other Fixed Assets (Itemize)			$ (402,668)

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	
		Lease Payable - US Bank	$ 7,077
		Loan Payable - First Insurance	$ 17,054
Total Notes Payable			$ 24,131

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

Page Ref	Line Ref	Description	
		Lease Payable	$ 17,064
		Accrued Pension	$ 30,765
		Due to Resident Trust Fund	$ 22,194
Total Other Current Liabilities (Itemize)			$ 70,023

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

Page Ref	Line Ref	Description	
		Note Payable - E. Miller Memorial Trust	$ 769,000
Total Other Current Liabilities (Itemize)			$ 769,000

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,194,778
2. Notes Payable (*itemize*)					$ 24,131
See Schedule			24,131		
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*)					$ 102,663
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 59,312
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*)					$ 70,023
See Schedule			70,023		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,450,907

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	34	37

Account				Amount
			Total Brought Forward:	1,450,907
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 769,000
See Schedule	769,000			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 769,000
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 2,219,907

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	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	$ 4,445,353
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (3,527,129)
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ 181,458
	7. Total Net Worth	$ 1,099,682
C.	***Total Reserves and Net Worth***	$ 1,099,682
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,319,589

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ 1,320,308
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,806,096
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 8,624,637
D.	Net Income or Deficit			$ 181,458
E.	Balance			$ 1,501,766
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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*** 09/30/18			$ 1,501,766

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2018	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☑ Rest Home with Nursing Supervision only (RHNS)	☑ Other

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
CJLC LLC

Addres Address	Phone Number
225 Pitkin Street, East Hartford, CT 06108	860-610-9009

Annual Report Contact	Phone Number
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