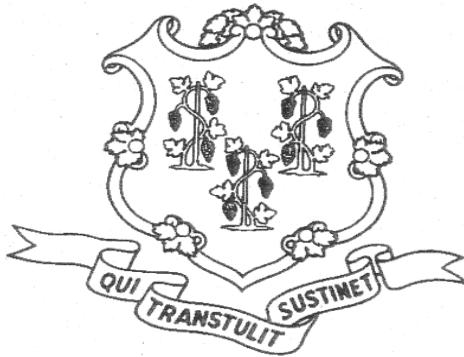


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

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 <input checked="" type="checkbox"/> Nursing Home only (CCNH)	Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Other
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

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

Medicaid Provider Numbers:	CCNH 209928	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	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 Miller Memorial Community [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Edward Baker		Printed Name (Owner) James W. Batten, President		
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Miller Memorial Community	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 360 Broad St. Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/15/2021		
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.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203-237-5302	Report for Year Ended 9/30/2020	Page 2
		of 37	
Name of Facility (as shown on license) Miller Memorial Community		Address (No. & Street, City, State, Zip) 360 Broad St. Meriden, CT 06450	
License Numbers:	CCNH 992-C	RHNS	Other
Medicare Provider No. 07-5295			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Other			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Edward Baker			
		Nursing Home Administrator's License No.:	1721
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

**General Information and Questionnaire
Individual Proprietorship**

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	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 Miller Memorial Community		License No. 992-C	Report for Year Ended 9/30/2020			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input 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	%**				
Presidents Office	360 Broad St, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		James Batten, President	16/m12	112,200	112,200
Clifford Dreschler, Martell, MD	360 Broad St, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Medical Director	13/B8a	21,600	21,600
Edward C Miller Memorial Trust	360 Broad St, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Loaning of Funds	34/B4	1,404,000	1,404,000
		<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"/>					

* 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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	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?	<input checked="" type="radio"/> Yes <input type="radio"/> 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.)		
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.		

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

* 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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2 AR Solutions	4 Pogmore Dr, Wallingford, CT 06492
3	
4	

Services Provided by This Firm (*describe fully*)

1	Controller Services, Tax Preparation and Cost Report Services	\$	64,390
2	Assist with Billing	\$	19,800
3		\$	
4		\$	
		Charge for Services Provided	
		\$	84,190

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 State Marshall Joseph Maranin	
3	
4	
5	

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

1 One Constitution Plaza, Hartford, CT
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	General Legal Matters	\$	470
2	Marshall Services - Disallowed	\$	60
3		\$	
4		\$	
5		\$	
		Charge for Services Provided	
		\$	530

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

Pg 15/1e

Schedule of Resident Statistics

Name of Facility Miller Memorial Community			License No. 992-C				Report for Year Ended 9/30/2020				Page 8 of 37	
	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			68	68		
B. As of midnight of THIS report period	63	63			68	68			63	63		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,504	1,504			1,315	1,315			189	189		
B. Medicaid (Conn.)	21,844	21,844			16,162	16,162			5,682	5,682		
C. Medicaid (other states)												
D. Private Pay	1,973	1,973			1,789	1,789			184	184		
E. State SSI for RCH												
F. Other (Specify) Insurance	425	425			407	407			18	18		
G. Total Care Days During Period (3A thru F)	25,746	25,746			19,673	19,673			6,073	6,073		
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)	25,746	25,746			19,673	19,673			6,073	6,073		

Schedule of Resident Statistics (Cont'd)

Name of Facility Miller Memorial Community			License No. 992-C			Report for Year Ended 9/30/2020			Page 9	of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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		CCNH	RHNS	Other	
(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)			
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.											
Change in Resident Days								CCNH	RHNS	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	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR		
No. of Residents	3	51			9						
Per Diem Rate											
a. One bed rm.		259.22			455.00						
b. Two bed rms.					420.00						
c. Three or more bed rms.											
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	Other
								8,024	8,024		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments											
C. Other											
D. Total Physical Therapy Treatments								8,024	8,024		
8. Total Number of Speech Therapy Treatments								556	556		
								A. Medicare - Part B			
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments											
C. Other											
D. Total Speech Therapy Treatments								556	556		
9. Total Number of Occupational Therapy Treatments								7,525	7,525		
								A. Medicare - Part B			
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments											
C. Other											
D. Total Occupational Therapy Treatments								7,525	7,525		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		992-C	9/30/2020	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Item	CCNH	Hours	RHNS	Hours	Other
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	110,308	2,043			1,984
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	252,883	11,475			3,890
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	432,716	27,579			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	233,543	17,546			295
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	55,314	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	102,285	2,080			
b. RN					
1. Direct Care	704,289	14,630			
2. Administrative**	183,729	5,948			
c. LPN					
1. Direct Care	668,687	21,842			
2. Administrative**					
d. Aides and Attendants	1,314,384	72,869			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	117,477	6,308			
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	60,211	1,940			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	58,227	2,022			
A-13. Total Salary Expenditures	4,294,052	188,362			6,169
					236

* 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)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Miller Memorial Community				License No. 992-C		Report for Year Ended 9/30/2020			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	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.

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	
Miller Memorial Community			992-C		9/30/2020			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators***										
Edward Baker	110,308		1,984	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.

B. Report of Expenditures - Professional Fees

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 13	of 37
Item	CCNH	Hours	RHNS	Hours	Other
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	10,220	256			
2. Dentist					
3. Pharmacist	528	Flat Fee			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	154,479	2,514			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	21,600	418			
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)					
9. Speech Therapist					
a. Resident Care	12,498	186			
b. Other					
10. Occupational Therapist					
a. Resident Care	144,877	2,515			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	4,649	61			
2. Administrative***					
b. LPN					
1. Direct Care	5,473	112			
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	354,324	6,062			

* 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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 15	of 37
Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	105,917	105,765		152
2. Disability Insurance	\$	1,367	1,365		2
3. Unemployment Insurance	\$	13,000	12,981		19
4. Social Security (F.I.C.A.)	\$	334,386	333,906		480
5. Health Insurance	\$	478,459	477,773		686
6. Life Insurance (employees only) (not-owners and not-operators)	\$	11,140	11,124		16
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	1,454	1,452		2
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$	4,285	4,279		6
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	36,000	36,000		
d. Accounting and Auditing	\$	84,190	82,702		1,488
e. Legal (Services should be fully described on Page 7)	\$	530	520		9
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	21,998	21,650		348
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	21,229	20,854		375
2. Cellular Phones	\$	594	584		11
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	\$	501,999	501,999		
Subtotal	\$	1,616,549	1,612,954		3,594

* 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
9/30/2020

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
Pre-Employment Services	\$ 4,279		\$ 6
Total	\$ 4,279	\$ -	\$ 6

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	\$ -	\$ -	\$ -

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	Other
	<i>Subtotals Brought Forward:</i>	1,616,549	1,612,954		3,594
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,027	1,027		
3. Gifts to Staff and Residents	\$	6,539	6,539		
4. Employee Travel	\$	28	28		0
5. Education Expenses Related to Seminars and Conventions	\$	964	964		
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>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	8,117	7,974		143
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	\$	4,418	4,339		78
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	530	530		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	700	688		12
9. Subscriptions	\$				
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>)	\$	34,839	34,238		600
12. Administrative Management Services**	\$	112,200	110,217		1,983
13. Other (<i>Specify</i>) See Attached Schedule	\$	5,521	5,493		28
C-14 Total Administrative & General Expenditures	\$	1,791,431	1,784,991		6,440

* 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	\$ 7,974		\$ 143
Total Other Advertising	\$ 7,974	\$ -	\$ 143

Schedule of Dues

Description	CCNH	RHNS	Other
CAHCF	\$ 350		
CLIA	\$ 180		
Total Dues	\$ 530	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Licenses & Fees	\$ 1,547		\$ 28
Fines and Penalties	\$ 2,042		
Allscripts/Navihealth	\$ 1,904		
Total Other Administrative and General	\$ 5,493	\$ -	\$ 28

Schedule C-1 - Management Services*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
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.

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 18 of 37
Item	Total	CCNH	RHNS	Other
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 231,562	231,562		
2. Non-Food Supplies	\$ 35,020	35,020		
3. Other (Specify) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 266,582	266,582		
2F. Dietary Questionnaire	Total	CCNH	RHNS	Other
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 19	of 37
Item		Total	CCNH	RHNS	Other
3. Laundry	Lbs.				
a. In-House Processing*					
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.***					
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
4. Repair and/or purchase of linens.***	Lbs.				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	48,852	48,852		
c. Other (Specify) Supplies	\$	1,425	1,425		
3D. Total Laundry Expenditures (3a + b + c)	\$	50,277	50,277		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 32,657	32,616		41
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
(Amt.)	Amt.	\$			
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	32,657	32,616		41
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	134,054	134,054		
b. Medicine Cabinet Drugs	\$	37,573	37,573		
c. Medical and Therapeutic Supplies	\$	200,749	200,749		
d. Ambulance/Limousine***	\$	11,283	11,283		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	2,167	2,167		
f. X-rays and Related Radiological Procedures***	\$	11,083	11,083		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$	8,417	8,417		
h. Laboratory***	\$	23,837	23,837		
i. Recreation	\$	26,501	21,668		4,833
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	55,620	55,620		
5M. Total Resident Care Expenditures (5a - 5j)	\$	511,284	506,451		4,833

* 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.

Miller Memorial Community

Attachment Page 20

Schedule of Other Resident Care

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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	Other	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 59,971	47,375	1,909		10,688	
b. Heat	\$ 99,119	98,736	14		369	
c. Light & Power	\$ 138,660	114,779	485		23,395	
d. Water	\$ 28,643	18,829	358		9,456	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 130,651	114,189	2,976		13,486	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 457,044	393,908	5,742		57,394	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 1,435	1,034	61		340	
b. Building & Building Improvements	\$ 125,421	110,260	6,486		8,676	
c. Non-Movable Equipment	\$ 32,781	30,692	1,805		284	
d. Movable Equipment	\$ 32,615	29,050	1,709		1,857	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 192,253	171,035	10,061		11,157	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 192,253	171,035	10,061		11,157	

* 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	\$ 92		
Fire Prot. Maint Simplex	\$ 1,134		
Elevator Service Baystate	\$ 9,664	\$ 568	
Exterminator Service - Maint	\$ 3,835		
Grounds Service	\$ 37,795	\$ 2,223	\$ 12,450
Hvac Service	\$ 32,850		
Plowing & Sanding	\$ 3,145	\$ 185	\$ 1,036
Refuse Removal	\$ 19,909		
Medical Waste Removal - Nursing	\$ 3,548		
Minor Equipment	\$ 2,217		
Total Other Repairs and Maintenance	\$ 114,189	\$ 2,976	\$ 13,486

Depreciation Schedule

Name of Facility Miller Memorial Community				License No. 992-C			Report for Year Ended 9/30/2020				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements													
1. Acquired prior to this report period				1,459,099		1,459,099	1,447,594	SL	VAR	1,435			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal											1,435		
B. Building and Building Improvements													
1. Acquired prior to this report period				8,327,274		8,327,274	6,909,786	SL	VAR	125,421			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal											125,421		
C. Non-Movable Equipment													
1. Acquired prior to this report period				1,256,858		1,256,858	1,108,778	SL	Var	30,534			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				39,587						2,247			
C-4. Subtotal											32,781		
	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	1,390			610		
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
D-3. Subtotal											32,615		
E. Total Depreciation											192,253		

Miller Memorial Community
9/30/2020

Schedule of Land Improvements Acquired during this report period

*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 C2

Schedule of Movable Equipment Acquired during this report period

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2020			Page 24		of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals	
	Month	Year								
A. Organization Expense										
1.										
2.										
3.										
A-4. Subtotal										
B. Mortgage Expense										
1.										
2.										
3.										
B-4. Subtotal										
C. Leasehold Improvements and Other										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)										
C-4. Subtotal										
D. Total Amortization										

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 25	of 37																				
11. Property Questionnaire																								
Part A																								
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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.																								
<table border="1"> <thead> <tr> <th>Description</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>1. Date Land Purchased</td> <td>Prior to 1844</td> </tr> <tr> <td>2. Date Structure Completed</td> <td>10/01/76</td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td></td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td>10/01/76</td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>90</td> </tr> <tr> <td>6. Square Footage</td> <td>53,896</td> </tr> <tr> <td>7. Acquisition Cost</td> <td></td> </tr> <tr> <td> a. Land</td> <td>Unknown</td> </tr> <tr> <td> b. Building</td> <td>Unknown</td> </tr> </tbody> </table>		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			
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.

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020			Page 26	of 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)

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020			Page 27	of 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)		\$	35,113	35,113		
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	35,113	35,113		
14. Insurance						
a. Insurance on Property (buildings only)		\$	54,893	53,922		970
b. Insurance on Automobiles		\$	947	930		17
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)		\$	116,750	114,687		2,063
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$	300	295		5
Surety Bond						
14d. Total Insurance Expenditures (14a + b + c)		\$	172,890	169,835		3,055
15. Total All Expenditures (A-13 thru C-14)		\$	8,164,077	8,059,184	15,803	89,090

D. Adjustments to Statement of Expenditures

Name of Facility Miller Memorial Community			License No. 992-C	Report for Year Ended 9/30/2020		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	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	\$ 144,877	144,877		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 36,000	36,000		
10.			Accounting	\$			
10a.			Legal	\$ 60	59		1
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 *	\$ 8,117	7,974		143
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,742	2,730		12
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 191,796	191,639			156

* 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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16	m8a	Chamber of Commerce	\$ 688		\$ 12
16	m13	Fines & Penalties	\$ 2,042		
Total Other A&G Adjustments			\$ 2,730	\$ -	\$ 12

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 10/2006

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

Name of Facility Miller Memorial Community				License No. 992-C	Report for Year Ended 9/30/2020		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other	
				Subtotals Brought Forward	\$ 191,796	191,639	156	
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	\$ 134,054	134,054			
28.	20	5d	Ambulance/Limousine	\$ 11,283	11,283			
29.	20	5f	X-rays, etc	\$ 11,083	11,083			
30.	20	5h	Laboratory	\$ 23,837	23,837			
31.			Medical Supplies	\$				
32.	20	5e2	Oxygen (non emergency)	\$ 2,167	2,167			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 2,299	2,299			
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.	27	14b	Property Insurance	\$ 947	930			17
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
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)			\$ 377,466	377,293			173

*** 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.

Miller Memorial Community
9/30/2020

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020			Page 30 37
Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,609,275	9,609,275			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,023,853)	(4,023,853)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 694,782	694,782			
b. Medicare Room and Board Contractual Allowance **	\$ 273,226	273,226			
4. a. Private-Pay Residents and Other	\$ 1,145,936	999,980			145,956
b. Private-Pay Room and Board Contractual Allowance **	\$ (22,083)	(22,083)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 54,029	54,029			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (54,029)	(54,029)			
c. Prescription Drugs - Non-Medicare	\$ 22,151	22,151			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (21,569)	(21,569)			
2. a. Medical Supplies - Medicare	\$ 177	177			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (177)	(177)			
c. Medical Supplies - Non-Medicare	\$ 271	271			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (271)	(271)			
3. a. Physical Therapy - Medicare	\$ 188,903	188,766			138
b. Physical Therapy - Medicare Contractual Allowance **	\$ (121,790)	(121,790)			
c. Physical Therapy - Non-Medicare	\$ 66,682	66,682			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (61,418)	(61,399)			(18)
4. a. Speech Therapy - Medicare	\$ 84,306	84,306			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (37,210)	(37,210)			
c. Speech Therapy - Non-Medicare	\$ 36,251	36,251			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (31,831)	(31,831)			
5. a. Occupational Therapy - Medicare	\$ 174,137	174,137			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (118,909)	(118,909)			
c. Occupational Therapy - Non-Medicare	\$ 55,991	55,991			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (53,731)	(53,731)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 599,460	599,460			
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,458,706	8,312,630			146,075
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 29,107	29,107			
V. Total Other Revenue (1 thru 8)	\$ 29,107	29,107			
VI. Total All Revenue (III +V)	\$ 8,487,813	8,341,737			146,075

* 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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

G. Balance Sheet

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 1,246,603	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,499,301	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 28,247	
4. Inventories			\$	
5. Prepaid Expenses			\$ 263,572	
a. _____				
b. _____				
c. _____				
d. See Schedule		263,572		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 3,037,722	
B. Fixed Assets				
1. Land			\$ 301,065	
2. Land Improvements	*Historical Cost	1,459,099	\$ 10,070	
	Accum. Depreciation	1,449,029	Net	
3. Buildings	*Historical Cost	8,327,274	\$ 1,292,067	
	Accum. Depreciation	7,035,207	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	1,296,445	\$ 154,886	
	Accum. Depreciation	1,141,559	Net	
6. Movable Equipment	*Historical Cost	1,998,301	\$ 66,399	
	Accum. Depreciation	1,931,902	Net	
7. Motor Vehicles	*Historical Cost	148,817	\$	
	Accum. Depreciation	148,817	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$ (452,952)	
See Schedule		(452,952)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 1,371,534	

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,409,256
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 (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,409,256

* 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 Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 340,288	
2. Notes Payable (<i>itemize</i>)			\$ 69,831	
See Schedule			69,831	
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>)			\$ 125,330	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$ 51,093	
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>)			\$ 1,162,345	
See Schedule			1,162,345	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 1,748,887	

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				1,748,887
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 1,404,000
See Schedule	1,404,000			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,404,000
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,152,887

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 35	of 37
Account		Amount		
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	4,672,353
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(3,739,720)
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 323,736
7. Total Net Worth			\$	1,256,369
C. Total Reserves and Net Worth			\$	1,256,369
D. Total Liabilities, Reserves, and Net Worth			\$	4,409,256

H. Changes in Total Net Worth

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 36	of 37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ 1,153,982		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 8,487,813		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 8,164,077		
D. Net Income or Deficit				\$ 323,736		
E. Balance				\$ 1,477,718		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawals (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 1,477,718		

I. Preparer's/Reviewer's Certification

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> 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		
Address Address 225 Pitkin Street, East Hartford, CT 06108		Phone Number 860-610-9009
Annual Report Contact CJLC		Phone Number 860-610-9009
Annual Report Contact Email Address annualreports@cjlc.com		