

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Miller Memorial Community	
Address (No. & Street, City, State, Zip Code) 360 Broad St., Meriden, CT 06450	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Other	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

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

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General Information

Name of Facility (as licensed) Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	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, 2016 and ending September 30, 2017, 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)

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 10/1/2016	To 9/30/2017	
Address of Facility 360 Broad St., Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 1/18/2018		
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 9/30/2017		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 Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing 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
Related Parties*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	Page 4	of 37
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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	%**				
President's Office	360 Broad St., Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		James W. Batten, President	16/m12	112,200	112,200
Clifford R. Dreschsler-Martell, MD	360 Broad St., Meriden, CT 06450	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director	13/B8a	23,520	23,520
Edward C. Miller Memorial Trust	360 Broad St., Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Loaning of Funds	34/B4	694,000	694,000
Edward C. Miller Memorial Trust	360 Broad St., Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Donations	30/IV8	41,294	41,294
		<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 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 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2017		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
N/A	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> 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 9/30/2017	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 1 CJLC, LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT
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Services Provided by This Firm (*describe fully*)

1 Audit, Cost Reporting, Tax Services	\$ 24,650
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 24,650

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 1 Shipman & Goodwin 2 Michalik, Bauer, Silvia 3 4 5	Telephone Number (860) 251-5000 (860) 225-8403
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Address (*No. & Street, City, State, Zip Code*)
 1 1 Constitution Plaza, Hartford, CT 06103
 2 35 W Pearl St # 300, New Britain, CT 06051
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Legal advice/litigation	\$ 10,755
2 A/R collection services (disallowed on page 28)	\$ 6,473
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 17,228

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Miller Memorial Community			License No. 992-C			Report for Year Ended 9/30/2017				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	76	76			76	76			77	77		
B. As of midnight of THIS report period	68	68			77	77			68	68		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,298	2,298			1,802	1,802			496	496		
B. Medicaid (Conn.)	21,097	21,097			16,099	16,099			4,998	4,998		
C. Medicaid (other states)												
D. Private Pay	1,924	1,924			1,362	1,362			562	562		
E. State SSI for RCH												
F. Other (Specify) Managed Care	780	780			657	657			123	123		
G. Total Care Days During Period (3A thru F)	26,099	26,099			19,920	19,920			6,179	6,179		
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)	26,099	26,099			19,920	19,920			6,179	6,179		

Schedule of Resident Statistics (Cont'd)

Name of Facility Miller Memorial Community			License No. 992-C			Report for Year Ended 9/30/2017			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	RHNS	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-IID				
No. of Residents	6		55		7								
Per Diem Rate													
a. One bed rm.	Varous RUGS rate		242.71		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
A. Medicare - Part B										3,487	3,487		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Physical Therapy Treatments										3,487	3,487		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										311	311		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Speech Therapy Treatments										311	311		
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										3,326	3,326		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Occupational Therapy Treatments										3,326	3,326		

Report of Expenditures - Salaries & Wages

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	111,493	2,129			1,228	23
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	328,139	2,063			2,779	17
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	404,038	26,948			1,796	120
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	236,871	17,752			107	8
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	65,268	2,072				
b. Other Maintenance Workers						
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	90,635	2,080				
b. RN						
1. Direct Care	542,729	12,734				
2. Administrative**	258,549	6,067				
c. LPN						
1. Direct Care	711,925	25,994				
2. Administrative**						
d. Aides and Attendants	1,416,848	90,356				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	116,302	5,955				
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	60,414	2,541			665	28
n. Marketing						
o. Other (Specify) See Attached Schedule	54,390	2,080				
<i>A-13. Total Salary Expenditures</i>	4,397,602	198,769			6,575	197

* 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)

Position	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
SALARY - ADMISSIONS	\$ 54,390	2,080				
Total	\$ 54,390	2,080	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
Total	\$ -	-	\$ -	-	\$ -	-

**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	
Miller Memorial Community				992-C	9/30/2017			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	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.

**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	9/30/2017			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***										
Paul Messier (10/1/16 to 12/15/16)	21,039			Standard	Administrator of Facility	433	A2	None	N/A	N/A
Edward Baker (12/5/16 to 9/30/17)	91,682			Standard	Administrator of Facility	1,719	A2	None	N/A	N/A
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	License No.	Report for Year Ended	Page	of		
Miller Memorial Community	992-C	9/30/2017	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	17,590	410			78	2
2. Dentist						
3. Pharmacist	5,940	Flat Fee				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	202,240	3,592				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	23,520	321				
b. Utilization Review (Title 18 and 19 only) monthly meeting	375	3				
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	39,277	592				
b. Other						
10. Occupational Therapist						
a. Resident Care	187,892	4,594				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	66,051	969				
2. Administrative***						
b. LPN						
1. Direct Care	34,985	861				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	577,869	11,341			78	2

* 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*

Name of Facility Miller Memorial Community		License No. 992-C	Report for Year Ended 9/30/2017	Page 14	of 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 & Board of Directors	<input checked="" type="radio"/>	<input type="radio"/>		
David Taraskevich, MD 237 Liberty St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
Audrey Lefkowitz, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
Neil Scollan, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
The Nures Network, Inc. 653 Main St, Plantsville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Ready Nurse Staffing Services 360 Bloomfield Ave #303, Windsor, CT 06095	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Keep Me Home 1340 Worthington Rdg., Berlin, CT 06037	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Nursefinders Hartford, CT	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics LLC 21 Waterville Rd, Avon, CT 06001	ST Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare of Connecticut 525 Knotter Dr, Cheshire, CT 06410	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Foremost Rehab of Connecticut 1157 Highland Ave # 101, Cheshire, CT 06410	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Preferred Therapy Solutions 850 Silas Deane Hwy #2, Wethersfield, CT 06109	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Mitchele Lipka, MS, RD	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Louise Kovacik	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	Other
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 123,564	123,380		184
2. Disability Insurance	\$ 9,196	9,182		14
3. Unemployment Insurance	\$ 25,831	25,792		39
4. Social Security (F.I.C.A.)	\$ 341,651	341,141		510
5. Health Insurance	\$ 571,068	570,215		853
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 4,573	4,566		7
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 5,915	5,906		9
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 10,842	10,826		16
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 106,600	106,600		
d. Accounting and Auditing	\$ 24,650	24,381		269
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 17,228	17,040		188
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 23,049	22,806		242
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 23,185	22,933		253
2. Cellular Phones	\$ 884	874		10
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 485,414	485,414		
Subtotal	\$ 1,773,649	1,771,057		2,592

* 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
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
PRE-EMP SERVICES	\$ 10,826		\$ 16
Total	\$ 10,826	\$ -	\$ 16

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Miller Memorial Community	992-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	Other	
<i>Subtotals Brought Forward:</i>	1,773,649	1,771,057		2,592	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 1,198	1,184		13	
3. Gifts to Staff and Residents	\$ 6,572	6,500		72	
4. Employee Travel	\$ 55	55		1	
5. Education Expenses Related to Seminars and Conventions	\$ 1,935	1,914		21	
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>)	\$ 2,340	2,315		25	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 20,745	20,519		226	
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	\$ 4,773	4,721		52	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 480	475		5	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 584	578		6	
9. Subscriptions	\$ 45	44		0	
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>)	\$ 33,242	32,880		362	
12. Administrative Management Services**	\$ 112,200	110,977		1,222	
13. Other (<i>Specify</i>) See Attached Schedule	\$ 40,733	35,737		4,996	
<i>C-14 Total Administrative & General Expenditures</i>	\$ 1,998,550	1,988,956		9,594	

* 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
ADVERTISING - MARKETING	\$ 18,099		\$ 199
ADVERTISING - TELEPHONE - MARKE	\$ 1,047		\$ 12
FUN/EVENTS/PROGRAMS - MARKETING	\$ 1,373		\$ 15
Total Other Advertising	\$ 20,519	\$ -	\$ 226

Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM	\$ 45		\$ 0
CAHCF	\$ 84		\$ 1
Briggs	\$ 347		\$ 4
Total Dues	\$ 475	\$ -	\$ 5

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
BANK CHARGES-ADMIN	\$ 6,729		\$ 74
LICENSES & FEES	\$ 8,360		\$ 92
ADMIN-FRGT/SALE TAX	\$ 168		\$ 2
FINES AND PENALTIES	\$ 18,556		\$ 204
LICENSES - DINING SERVICES	\$ 100		\$ 0
SOFTWARE CONTRACTS - DININ	\$ 787		\$ 3
LICENSES - MAINTENANCE	\$ 460		\$ 5
EQUIPMENT RENTAL - RLC	\$ -		\$ 3,375
EQUIPMENT MAINT & REPAIR - RLC	\$ -		\$ 515
MINOR EQUIPMENT & FURNITURE - RLC	\$ -		\$ 387
SPECIFIC FUN/EVENTS/PROGRAMS -	\$ -		\$ 331
Chamber of Commerce	\$ 578		\$ 6
Total Other Administrative and General	\$ 35,737	\$ -	\$ 4,996

Schedule C-1 - Management Services*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	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, President's 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	License No.	Report for Year Ended		Page	of
Miller Memorial Community	992-C	9/30/2017		18	37
Item	Total	CCNH	RHNS	Other	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 209,507	208,580			927
2. Non-Food Supplies	\$ 24,184	24,077			107
3. Other (<i>Specify</i>) _____	\$				
b. Purchased Services (<i>by contract other than through Management Services (Complete Schedule C-2 att. Page 21)</i>)	\$				
c. Management Services**	\$				
d. Other (<i>Specify</i>) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 233,691	232,657			1,034
2F. Dietary Questionnaire	Total	CCNH	RHNS	Other	
G. Resident Meals: Total no. of meals served per day:*	3	3			
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 checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt. \$4,002					
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? <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.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	Other
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	975	975	
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)	\$	58,212	58,212	
c.	Management Services**	\$			
d.	Other (Specify)	\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	59,187	59,187	
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.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Miller Memorial Community	992-C	9/30/2017	20	37	
Item		Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	21,926	21,916		10
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	21,926	21,916		10
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	165,805	165,805		
b. Medicine Cabinet Drugs	\$	26,097	26,097		
c. Medical and Therapeutic Supplies	\$	33,046	33,046		
d. Ambulance/Limousine***	\$	32,720	32,720		
e. Oxygen					
1. For Emergency Use	\$	26,402	26,402		
2. Other***	\$	8,199	8,199		
f. X-rays and Related Radiological Procedures***	\$	6,803	6,803		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$	10,100	10,100		
h. Laboratory***	\$	5,300	5,300		
i. Recreation	\$	16,759	16,759		
j. Other (Specify)**** See Attached Schedule	\$	188,430	188,430		
5K. Total Resident Care Expenditures (5a - 5j)	\$	519,661	519,661		

* 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	\$ 963		
MEDICAL SUPPLIES	\$ 98,494		
M/S - DISPOSABLE INCONTINENCE	\$ 38,415		
MIN EQUIP&FURN-NURSING	\$ 175		
NUTRITIONAL SUPPLEMENTS - NURSI	\$ 37,273		
ACCELERATED CARE PLUS	\$ 13,110		
Total Other Resident Care	\$ 188,430	\$ -	\$ -

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

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2017			Page of 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
See Attachment		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* 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	License No.	Report for Year Ended			Page	of
Miller Memorial Community	992-C	9/30/2017			22	37
Item		Total	CCNH	RHNS	Other	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	55,400	42,144	2,004	11,252	
b. Heat	\$	83,309	77,056	5,745	508	
c. Light & Power	\$	145,945	126,573	134	19,239	
d. Water	\$	31,272	20,557	391	10,324	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$	96,391	94,047	323	2,020	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	412,317	360,377	8,597	43,343	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$	2,065	1,488	88	490	
b. Building & Building Improvements	\$	205,931	142,828	10,750	52,352	
c. Non-Movable Equipment	\$	25,754	23,450	1,760	544	
d. Movable Equipment	\$	42,446	36,572	2,589	3,285	
*7e. Total Depreciation Costs (7a + b + c + d)	\$	276,196	204,337	15,187	56,672	
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	\$	37	37		0	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	276,233	204,374	15,187	56,672	

* 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	\$ 2,216	\$ -	\$ 10
FIRE PROT. MAINT SIMPLEX	\$ 5,005	\$ -	\$ -
ELEVATOR SERVICE BAYSTATE	\$ 9,710	\$ -	\$ -
GENERATOR SERVICE /STAND BY PWR	\$ 3,556	\$ -	\$ -
EXTERMINATOR SERVICE - MAINT	\$ 1,364	\$ -	\$ -
GROUNDS SERVICE	\$ 4,450	\$ 262	\$ 1,466
HVAC SERVICE	\$ 31,640	\$ -	\$ -
PLOWING & SANDING	\$ 1,049	\$ 62	\$ 345
REFUSE REMOVAL	\$ 18,074	\$ -	\$ 199
MEDICAL WASTE REMOVAL - NURSING	\$ 4,450	\$ -	\$ -
CABLE TV - PLANT OPERATIONS	\$ 12,535	\$ -	\$ -
Total Other Repairs and Maintenance	\$ 94,047	\$ 323	\$ 2,020

Miller Memorial Community
9/30/2017

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:				
10/11/2016	Window Replacmenet	\$ 1,960	20	\$ 98
10/26/2016	Window Replacmenet	\$ 4,900	20	\$ 245
1/9/2017	Window Replacmenet	\$ 10,290	20	\$ 386
2/14/2017	Window Replacmenet	\$ 3,500	20	\$ 117
3/1/2017	Window Replacmenet	\$ 4,320	20	\$ 126
5/30/2017	Floor Tile	\$ 2,291	10	\$ 95
9/22/2017	Relace HVAC Pump	\$ 6,527	10	\$ 54
Total additions for Building Improvements		\$ 33,789		\$ 1,121 *
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:				
10/26/2016	Curculator Pump	\$ 1,308	10	\$ 131
1/24/2017	Pump Replacmenet	\$ 4,638	10	\$ 348
5/10/2017	Compressors	\$ 23,114	10	\$ 963
Total additions for Non-Movable Equipment		\$ 29,060		\$ 1,442 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/17/2016	Beds	\$ 13,500	10	\$ 1,238
10/5/2016	Tractor	\$ 14,999	10	\$ 1,500
Total additions for Movable Equipment		\$ 28,499		\$ 2,737 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2017			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 9/30/2017	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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.					
Description	Total				
1. Date Land Purchased	Prior to 1844				
2. Date Structure Completed	10/1/1976				
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure	10/1/1976				
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		License No.	Report for Year Ended			Page	of
Miller Memorial Community		992-C	9/30/2017			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)

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		9/30/2017		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) Interest & Late Fees				\$	3,946	3,946	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	3,946	3,946	
14. Insurance							
a. Insurance on Property (buildings only)				\$	39,135	28,190	1,658
b. Insurance on Automobiles				\$	3,613	3,574	39
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	100,742	99,645	1,098
2. Fire and Extended Coverage				\$			
3. Other (Specify) Surety Bond \$517; D&O \$15,390; Cyber \$5,750				\$	21,657	21,421	236
14d. Total Insurance Expenditures (14a + b + c)				\$	165,147	152,830	1,658
15. Total All Expenditures (A-13 thru C-14)				\$	8,672,783	8,519,375	25,443

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Miller Memorial Community			992-C	9/30/2017	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	10a	Occupational Therapy	\$ 187,892	187,892		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 106,600	106,600		
10.	15	1e	Accounting & Legal	\$ 6,473	6,402		71
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 *	\$ 20,745	20,519		226
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 19,344	19,133		211
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)				\$ 341,054	340,546		507

* 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	m13	FINES AND PENALTIES	\$ 18,556		\$ 204
16	m8a	Chamber of Commerce	\$ 578		\$ 6
Total Other A&G Adjustments			\$ 19,133	\$ -	\$ 211

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Miller Memorial Community			992-C	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 341,054	340,546		507
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 165,805	165,805		
28.	20	5d	Ambulance/Limousine	\$ 32,720	32,720		
29.	20	6f	X-rays, etc	\$ 6,803	6,803		
30.	20	5h	Laboratory	\$ 5,300	5,300		
31.			Medical Supplies	\$			
32.	20	5e	Oxygen (non emergency)	\$ 8,199	8,199		
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.	27	14b	Property Insurance	\$ 3,613	3,574		39
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.	30	IV4	Radio and Television Revenue	\$ 4,337	4,337		
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 52,271			52,271
51.	Total Amount of Decrease (Items 1 - 50)			\$ 620,101	567,283		52,818

*** 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
9/30/2017

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			\$ -	\$ -	\$ -

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7b	Depreciation on Cottages	\$ -	\$ -	\$ 52,271
Total Unallowable Building Interest			\$ -	\$ -	\$ 52,271

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Miller Memorial Community	992-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	Other		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,481,430	9,481,430				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,293,465)	(4,293,465)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,015,290	1,015,290				
b. Medicare Room and Board Contractual Allowance **	\$ 217,775	217,775				
4. a. Private-Pay Residents and Other	\$ 1,299,411	1,107,380		192,031		
b. Private-Pay Room and Board Contractual Allowance **	\$ (76,876)	(76,876)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 99,728	99,728				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (99,728)	(99,728)				
c. Prescription Drugs - Non-Medicare	\$ 37,049	37,049				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (36,463)	(36,463)				
2. a. Medical Supplies - Medicare	\$ 4,368	4,368				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (4,368)	(4,368)				
c. Medical Supplies - Non-Medicare	\$ 3,270	3,270				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (3,270)	(3,270)				
3. a. Physical Therapy - Medicare	\$ 290,060	289,390		671		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (174,919)	(174,919)				
c. Physical Therapy - Non-Medicare	\$ 77,548	77,548				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (83,278)	(83,278)				
4. a. Speech Therapy - Medicare	\$ 52,427	52,427				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (23,913)	(23,913)				
c. Speech Therapy - Non-Medicare	\$ 7,660	7,660				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (7,660)	(7,660)				
5. a. Occupational Therapy - Medicare	\$ 314,814	313,281		1,533		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (202,976)	(202,976)				
c. Occupational Therapy - Non-Medicare	\$ 85,304	85,304				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (84,238)	(84,238)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 120	120				
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 7,895,099	7,700,865		194,234		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 4,002	4,002				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$ 4,337	4,337				
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 66,062	65,570		492		
V. Total Other Revenue (1 thru 8)	\$ 74,401	73,909		492		
VI. Total All Revenue (III +V)	\$ 7,969,500	7,774,774		194,726		

* 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
30/II6a	IV -MEDA-SNF	\$ 6,749		
30/II6a	IV -MEDA-ICF	\$ 10,372		
30/II6a	LAB -MEDA-SNF	\$ 318		
30/II6a	LAB -MEDA-ICF	\$ 4,579		
30/II6a	X-RAY -MEDA-SNF	\$ 191		
30/II6a	X-RAY -MEDA-ICF	\$ 3,266		
30/II6a	ANC ALLOW-IV-MEDA-SNF	\$ (6,749)		
30/II6a	ANC ALLOW-IV-MEDA-ICF	\$ (10,372)		
30/II6a	ANC ALLOW-LAB-MEDA-SNF	\$ (318)		
30/II6a	ANC ALLOW-LAB-MEDA-SNF	\$ (4,579)		
30/II6a	ANC ALLOW-X-RAY-MEDA-SNF	\$ (71)		
30/II6a	ANC ALLOW-X-RAY-MEDA-ICF	\$ (3,266)		
Total Other Resident Revenue - Medicare		\$ 120	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30/II6b	IV -MCAID-SNF	\$ 645		
30/II6b	IV -MGED CARE-ICF	\$ 1,120		
30/II6b	LAB -MGED/C-ICF	\$ 1,488		
30/II6b	X-RAY -MGED CARE-ICF	\$ 1,585		
30/II6b	ANC ALLOWIV-MCAID-SNF	\$ (645)		
30/II6b	ANC ALLOW-IV-MGED/CARE-ICF	\$ (1,120)		
30/II6b	ANC ALLOW-LAB-MGED/C-ICF	\$ (1,488)		
30/II6b	ANC ALLOW-X-RAY-MGED/C-ICF	\$ (1,585)		
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30/IV8	HKPING -PRIV-COTTAGES	\$ -		\$ 474
30/IV8	LAUNDRY -PRIV-SNF	\$ 288		\$ -
30/IV8	LAUNDRY -PRIV-ICF	\$ 288		\$ -
30/IV8	LAUNDRY -PRIV-COTTAGES	\$ -		\$ 18
30/IV8	CONTRIB-UNRESTRICTED	\$ 44,822		\$ -
30/IV8	OTHER INCOME	\$ 20,172		\$ -
Total Other Revenue		\$ 65,570	\$ -	\$ 492

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	62,708
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	812,321
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	50
4. Inventories			\$	
5. Prepaid Expenses			\$	221,673
a. Prepaid Insurance	162,281			
b. Prepaid Expenses	59,391			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,096,752
B. Fixed Assets				
1. Land			\$	301,065
2. Land Improvements	*Historical Cost	1,459,099	\$	14,425
	Accum. Depreciation	1,444,674		Net
3. Buildings	*Historical Cost	7,743,288	\$	1,256,393
	Accum. Depreciation	6,486,895		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	1,201,237	\$	153,303
	Accum. Depreciation	1,047,933		Net
6. Movable Equipment	*Historical Cost	1,978,559	\$	139,277
	Accum. Depreciation	1,839,282		Net
7. Motor Vehicles	*Historical Cost	148,817	\$	1,944
	Accum. Depreciation	146,873		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	(324,910)
C.I.P. - Electrical/Generator R		56,745		
Book vs Cost Report		(381,655)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,541,497

* 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 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	2,638,249
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>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,638,249	

* 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	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2017	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	788,478
2. Notes Payable (<i>itemize</i>)			\$	26,619
NOTES & LEASES PAYABLE-US Bank			8,400	
LOAN PAYABLE - FIRST INS FUND C			18,219	
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>)			\$	56,653
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	79,091
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>)			\$	54,171
LEASE PAYABLE - GE CAPITAL			280	
ACCRUED PENSION CONTRIBU'			30,765	
RESIDENT TRUST FUND			23,127	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	1,005,013

* 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 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				1,005,013
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>)				\$ 694,000
NOTE PAYABLE - E. MILLER MEM. T		694,000		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 694,000
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,699,013

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	9/30/2017	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 (<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			\$	4,445,353
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,803,417)
6. Gain or Loss for Period			\$	(703,283)
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	938,652
C. Total Reserves and Net Worth			\$	938,652
D. Total Liabilities, Reserves, and Net Worth			\$	2,637,665

H. Changes in Total Net Worth

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	2,023,591
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	7,969,500
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	8,672,783
D. Net Income or Deficit			\$	(703,283)
E. Balance			\$	1,320,308
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 (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	1,320,308
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	