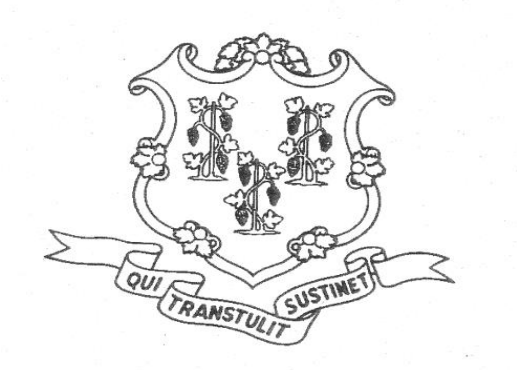
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Miller Memorial Community		
Address (No. & Street, City, State, Zip Code) 360 Broad St. Meriden, CT 06450		
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Other
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider
	992-C			07-5295

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Other
	209928		

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Miller Memorial Community [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Elyse Dent			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
Annual Report of Long-Term Care Facility
CSP-1A Rev. 3/2023

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 10/1/2022	To 9/30/2023
Address of Facility 360 Broad St. Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date	

Item		Total	CCNH / RHNS	(Specify)	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 3/2023

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-237-5302	9/30/2023	2	37

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

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider No.
	992-C			07-5295

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ Other

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Elyse Dent	

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Miller Memorial Community	360 Broad St, Meriden, CT 06450	CT

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Presidents Office	360 Broad St, Meriden, CT 06450	○	⊙		James Batten, President	16/m12	112,200	112,200
Clifford Dreschler, Martell, MD	360 Broad St, Meriden, CT 06450	○	⊙		Medical Director	13/B8a	23,520	23,520
Edward C Miller Memorial Trust	360 Broad St, Meriden, CT 06450	○	⊙		Loaning of Funds	34/B4	1,781,000	1,781,000
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	5	37

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

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

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No

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

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

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

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Com	992-C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

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

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 3/2023

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	Other	Total	CCNH / RHNS	(Specify)	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	90			90	90						
B. On last day of THIS report period	90	90							90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	59	59			59	59						
B. As of midnight of THIS report period	48	48							48	48		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,083	2,083			1,822	1,822			261	261		
B. Medicaid (Conn.)	15,814	15,814			11,940	11,940			3,874	3,874		
C. Medicaid (other states)												
D. Private Pay	1,838	1,838			1,334	1,334			504	504		
E. State SSI for RCH												
F. Other (Specify) Insurance	326	326			294	294			32	32		
G. Total Care Days During Period (3A thru F)	20,061	20,061			15,390	15,390			4,671	4,671		
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)**	20,061	20,061			15,390	15,390			4,671	4,671		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 3/2023

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	9	37

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

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	Other	Lost			Gained			CCNH / RHNS	(Specify)	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	(Specify)	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	(Specify)	CCNH / RHNS	(Specify)	Other	R.C.H.	ICF-MR
No. of Residents	2	44		2				
Per Diem Rate								
a. One bed rm.		303.51		455.00				
b. Two bed rms.				420.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Other
A. Medicare - Part B	4,636	4,636			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Physical Therapy Treatments***	4,636	4,636			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	1,340	1,340			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Speech Therapy Treatments***	1,340	1,340			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,961	1,961			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Occupational Therapy Treatments***	1,961	1,961			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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)	146,988		2,015				1,506		21
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	301,535		4,462				2,540		38
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	517,390		27,949						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	249,291		14,778						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	65,870		2,280						
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	112,664		2,280						
b. RN									
1. Direct Care	538,696		12,189						
2. Administrative**	137,901		5,202						
c. LPN									
1. Direct Care	778,023		22,797						
2. Administrative**									
d. Aides and Attendants	1,502,262		71,864						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	88,271		4,242						
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	65,658		1,971						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	64,985		2,280						
A-13. Total Salary Expenditures	4,569,533		174,309				4,046		59

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			Other		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Admissions	$ 64,985		2,280						
Total	$ 64,985	$ -	2,280	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Other		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	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	9/30/2023	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	(Specify)	Other							
Section III - Administrators* **										
Edward Baker (10/1/22-8/30/23)	141,626		1,451	Standard		1,907	A2			
Elyse Dent (9/11/23-9/30/23)	5,362		55	Standard		129	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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	11,890		245						
2. Dentist									
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	210,914		3,247						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	23,520		460						
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	60,517		829						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other	108,798	(108,798)	1,889						
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	198,150		2,607						
2. Administrative***									
b. LPN									
1. Direct Care	130,264		2,505						
2. Administrative***									
c. Aides	156,991		3,651						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	901,043	(108,798)	15,433						

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed in the Adjustment column.

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Clifford R. Dreschsler-Martell, MD, 324 Ridge Rd, Middletown, CT 06457	Medical Director	○	⊙	Member of Board of Directors
Mitchele Lipka, MS, RD	Dietician	○	⊙	
Partners Pharmacy, 6 Thompson Rd, East Windsor CT	Pharmacy Services	○	⊙	
The Nures Network, Inc., 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
Swallowing Diagnostics LLC, 21 Waterville Rd, Avon, CT 06001	ST Consultant	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 3/2023

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	80,482	80,411				71	
2. Disability Insurance	$							
3. Unemployment Insurance	$							
4. Social Security (F.I.C.A.)	$	351,652	351,341				311	
5. Health Insurance	$	569,124	568,621				504	
6. Life Insurance (employees only)								
(not-owners and not-operators)	$	5,364	5,359				5	
7. Pensions (Non-Discriminatory)	$							
(not-owners and not-operators)								
8. Uniform Allowance	$							
9. Other (*Specify*)	$	17,729	17,714				15	
See Attached Schedule								
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$	60,000	60,000	(60,000)				
d. Accounting and Auditing	$	84,750	83,890				860	
e. Legal (*Services should be fully described on Page 15b)*	$	85,403	84,537	(84,537)			866	
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	19,733	19,555				179	
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	20,059	19,855				203	
2. Cellular Phones	$	469	464				5	
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	$	372,558	372,558					
Subtotal	$	1,667,324	1,664,305	(144,537)			3,019	

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Pre-Employment Services	$ 17,714				$ 15	
Total	$ 17,714	$ -	$ -	$ -	$ 15	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15b Rev. 3/2023

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	15b	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 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 Sevices, Tax Preparatin and Cost Report Services	$ 66,000
2	Assit with Billing	$ 18,750
3		$
4		$
		Charge for Services Provided $ 84,750

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

⊙ Yes ○ No 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman & Goodwin LLP	
2	
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	$ 85,403
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 85,403

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

⊙ Yes ○ No 15/1e

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 3/2023

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	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:		1,667,324	1,664,305	(144,537)			3,019	
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	4,660	4,660					
3. Gifts to Staff and Residents	$	2,274	2,274					
4. Employee Travel	$	2,024	2,003				21	
5. Education Expenses Related to Seminars and Conventions	$							
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$							
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	1,742	1,724	(1,724)			18	
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$							
7. Postage	$	2,506	2,481				25	
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	645	638				7	
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	599	593				6	
9. Subscriptions	$	105	105					
10. Contributions***	$							
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	20,167	19,962				205	
12. Administrative Management Services**	$	112,200	111,061				1,138	
13. Other (*Specify*)	$	45,269	45,265	(24,290)			4	
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	1,859,514	1,855,072	(170,551)			4,443	

* Do not include Subscriptions, which should go in item 9.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** Facility should self-disallow the expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total Other Travel and Entertainment	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Marketing	$ 1,724	$ (1,724)			$ 18	
Total Other Advertising	$ 1,724	$ (1,724)	$ -	$ -	$ 18	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Experience Care	$ 638				$ 7	
Total Dues	$ 638	$ -	$ -	$ -	$ 7	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total Contributions	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Licenses & Fees	$ 721				$ 4	
Fines and Penalties	$ 24,290	$ (24,290)				
Temp Labor-Service-Admin	$ 11,566					
Bank Charges-Admin	$ 8,688					
Total Other Administrative and General	$ 45,265	$ (24,290)	$ -	$ -	$ 4	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2023	Page 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 3/2023

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	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	230,368	230,368					
2. Non-Food Supplies	$	36,710	36,710					
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	267,078	267,078					

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	Other
F. Resident Meals: Total no. of meals served per day:*				

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	49,137	49,137					
c. Other (*Specify*)	$							
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	49,137	49,137					

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 3/2023

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	9/30/2023	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	20,936	20,909				26	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $							
C. Other (*Specify*)	$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)	$	20,936	20,909				26	
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from	$	151,622	151,622	(151,622)				
b. Medicine Cabinet Drugs	$	30,228	30,228					
c. Medical and Therapeutic Supplies	$	119,304	119,304					
d. Ambulance/Limousine***	$	10,938	10,938	(10,938)				
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$	3,475	3,475	(3,475)				
f. X-rays and Related Radiological Procedures***	$	7,224	7,224	(7,224)				
g. Dental (*Not dentists who should be included under salaries or fees*)	$	10,941	10,941					
h. Laboratory***	$	23,049	23,049	(23,049)				
i. Recreation	$	9,361	8,058				1,303	
j. Direct Management Services*	$							
k. Indirect Management Services*	$							
l. Cable TV	$	14,116	14,116					
m. Other (Specify)**** See Attached Schedule	$	49,590	49,590					
n. Physical Therapy Expense	$	224	224					
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	430,072	428,769	(196,308)			1,303	

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

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

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Prof Serv-Mis-Anncillary Serv	$ 1,286					
Nutritional Supplements	$ 32,616					
Accelerated Care Plus	$ 15,688					
Total Other Resident Care	$ 49,590	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	Other	Pg	Line
Unitex	565 Taxter Road, Elmsford NY	○	⊙		Laundry Service	49,137			19	3b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 3/2023

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	9/30/2023					22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	49,493	38,527				10,966	
b. Heat	$	132,774	132,580				194	
c. Light & Power	$	208,434	170,693				37,741	
d. Water	$	12,909	8,647				4,262	
e. Equipment Lease (*Provide detail on page 22b*)	$							
f. Other (*itemize*)	$	172,364	159,120				13,244	
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	575,973	509,567				66,406	
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	2,099	2,099					
b. Building & Building Improvements	$	64,650	53,819				10,830	
c. Non-Movable Equipment	$	24,669	24,646				22	
d. Movable Equipment	$	15,470	14,799				671	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	106,888	95,364				11,524	
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$							
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$							
9. Rental payments on leased real property less real estate taxes included in item 10b	$							
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$							
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	106,888	95,364				11,524	

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Exterminator Service - Dinning Serv	$ 172					
Fire Prot. Maint Simplex	$ 13,466					
Elevator Service Baystate	$ 11,040					
Generator Service/Stand by Pwr	$ 1,842					
Exterminator Service - Maint	$ 3,762					
Grounds Service	$ 42,571				$ 13,244	
Hvac Service	$ 59,853					
Refuse Removal	$ 24,974					
Medical Waste Removal - Nursing	$ 972					
Minor Equipment	$ 468					
Total Other Repairs and Maintenance	$ 159,120	$ -	$ -	$ -	$ 13,244	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22b Rev. 3/2023

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	22b	37

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

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

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	1,466,199		1,466,199	1,452,933	SL	Var	2,099	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								2,099
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,327,274		8,327,274	7,163,967	SL	Var	62,000	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	26,500						2,650	
B-4. Subtotal								64,650
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,362,630		1,362,630	1,208,327	SL	Var	24,669	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								24,669

	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.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	2,005,921		2,005,921	1,975,795	SL	Var	15,470	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period												
D-3. Subtotal												15,470
E. ***Total Depreciation***												106,888

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:					
9/30/2023	Plumbing and Water Damage Repair (Cottages)	$ 26,500	10	$ 2,650	
Total additions for Building Improvements		$ 26,500		$ 2,650	*
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:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ -		$ -	*
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**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2023	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	26	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage $							
Name of Lender / Rate							
Address of Lender							
2. Second Mortgage $							
Name of Lender / Rate							
Address of Lender							
3. Third Mortgage $							
Name of Lender / Rate							
Address of Lender							
4. Fourth Mortgage $							
Name of Lender / Rate							
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount $							
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $							

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 3/2023

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	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment $							
A. Item / Rate / Amount							
Lender							
Address of Lender							
2. Other (*Specify*) $							
A. Item / Rate / Amount							
Lender							
Address of Lender							
B. Item / Rate / Amount							
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $							
12. D. Other Interest Expense (*Specify*) $	9,794	9,794	(9,794)				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	9,794	9,794	(9,794)				
14. Insurance							
a. Insurance on Property (buildings only) $	61,383	60,760				623	
b. Insurance on Automobiles $	942	932				10	
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $	167,380	165,682				1,698	
2. Fire and Extended Coverage $							
3. Other (*Specify*) $	300	297				3	
Surety Bond							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	230,005	227,672				2,333	
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,024,020	8,933,938	(485,451)			90,082	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev. 3/2023

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,048,655	7,048,655		
b. Medicaid Room and Board Contractual Allowance **	$	(2,517,426)	(2,517,426)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	926,611	926,611		
b. Medicare Room and Board Contractual Allowance **	$	484,360	484,360		
4. a. Private-Pay Residents and Other	$	1,065,205	895,583		169,621
b. Private-Pay Room and Board Contractual Allowance **	$	(34,219)	(34,219)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	14,095	14,095		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(14,095)	(14,095)		
c. Prescription Drugs - Non-Medicare	$	3,325	3,325		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(3,325)	(3,325)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	159,995	159,995		
b. Physical Therapy - Medicare Contractual Allowance **	$	(91,686)	(91,686)		
c. Physical Therapy - Non-Medicare	$	56,598	56,598		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(34,765)	(34,765)		
4. a. Speech Therapy - Medicare	$	73,587	73,587		
b. Speech Therapy - Medicare Contractual Allowance **	$	(39,481)	(39,481)		
c. Speech Therapy - Non-Medicare	$	29,643	29,643		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(16,322)	(16,322)		
5. a. Occupational Therapy - Medicare	$	160,369	160,369		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(100,880)	(100,880)		
c. Occupational Therapy - Non-Medicare	$	72,909	72,909		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(52,587)	(52,587)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,190,563	7,020,942		169,621
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 *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,088,461	1,088,461		
V. Total Other Revenue (1 thru 8)	$	1,088,461	1,088,461		
VI. Total All Revenue (III +V)	$	8,279,024	8,109,403		169,621

* *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	(Specify)	Other
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Other
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Other
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	Contributions-Unrestricted	$ 1,066,556		
	Other Income	$ 21,905		
Total Other Revenue		$ 1,088,461	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 186,770
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,248,074
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 30,580
4 Inventories				$
5. Prepaid Expenses				$ 2,059
a.				
b.				
c.				
d. See Schedule		2,059		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,467,484
B. Fixed Assets				
1. Land				$ 301,065
2. Land Improvements	*Historical Cost	1,466,199		$ 11,167
	Accum. Depreciation	1,455,032	Net	
3. Buildings	*Historical Cost	8,353,774		$ 1,125,157
	Accum. Depreciation	7,228,617	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,362,630		$ 129,634
	Accum. Depreciation	1,232,996	Net	
6. Movable Equipment	*Historical Cost	2,005,921		$ 14,656
	Accum. Depreciation	1,991,265	Net	
7. Motor Vehicles	*Historical Cost			$ (0)
	Accum. Depreciation	0	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (390,580)
Book vs Cost Report		(390,580)		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,191,099

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 3,447
		Prepaid Postage	$ 500
		Prepaid Baystate	$ 2,648
		Prepaid Tuxis Fuel	$ (4,474)
		Prepaid Basset Maint.	$ (61)
Total Prepaid Expenses			$ 2,059

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Notes & Leases Payable-US Bank	$ (1,466)
		Loan Payable - First Ins Fund Corp	$ (68,187)
		Note Payable - Workers Comp Trust	$ (49,558)
		Note Payable - The Hartford	$ (4,111)
		Notes Payable Signature Staffing	$ 38,608
Total Notes Payable			$ (84,714)

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

Page Ref	Line Ref	Description	
		Lease Payable-Copier	$ (3,353)
		Resident Trust Fund	$ 54,847
Total Other Current Liabilities (Itemize)			$ 51,494

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

Page Ref	Line Ref	Description	
		Note Payable - E. Miller Mem. Trust	$ 1,781,000
Total Other Current Liabilities (Itemize)			$ 1,781,000

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 2,658,583
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,658,583

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,443,745
	2. Notes Payable (*itemize*)				$ (84,714)
	See Schedule			(84,714)	
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 71,719
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 374,996
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 51,494
	See Schedule			51,494	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,857,241

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	34	37

Account				Amount
			Total Brought Forward:	1,857,241
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 1,781,000
See Schedule	1,781,000			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 1,781,000
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,638,241

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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	9/30/2023	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (234,662)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (744,995)
	7. Total Net Worth	$ (979,657)
C.	***Total Reserves and Net Worth***	$ (979,657)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,658,583

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ 450,979
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,279,024
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,024,020
D.	Net Income or Deficit			$ (744,995)
E.	Balance			$ (294,016)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/23		$ (294,016)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Other

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
CJLC LLC

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

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
CJLC	860-610-9009

Contact Email Address
annualreports@cjlc.com