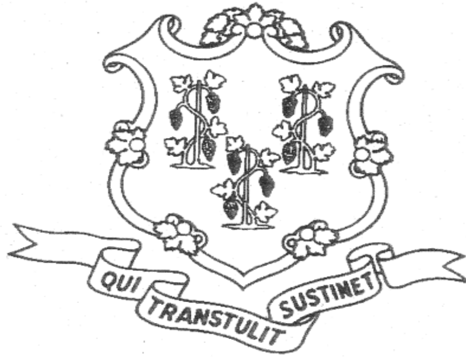
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) Miller Memorial Community		
Address (No. & Street, City, State, Zip Code) 360 Broad St. Meriden, CT 06450		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☑ Rest Home with Nursing Supervision only (RHNS)	☑ Other
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	209928		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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 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, 2020 and ending September 30, 2021, 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 10/1/2020	To 9/30/2021
Address of Facility 360 Broad St. Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date	

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	Report for Year Ended	Page	of
203-237-5302	9/30/2021	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	Other	Medicare Provider No.
	992-C			07-5295

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Edward Baker	1721

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	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
Irene S. Melasky	360 Broad St, Meriden, CT 06450	Director	N/A
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	3B	37

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

Owner(s) of Facility
N/A

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	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	24,960	24,960
Edward C Miller Memorial Trust	360 Broad St, Meriden, CT 06450	○	⦿		Loaning of Funds	34/B4	1,631,000	1,631,000
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	6	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	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	7	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	Pue, Chick, Leibowitz and Blezard	76 South Frontage Rd, Vernon, CT 06066
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Controller Sevices, Tax Preparatin and Cost Report Services	$ 66,000
2	Assit with Billing	$ 15,390
3	Financial Statement Audit	$ 38,000
4		$
	Charge for Services Provided	$ 119,390

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

⊙ Yes ○ No Pg 15/1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Shipman & Goodwin LLP	
2		
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*)

	Service	Amount
1	General Legal Matters	$ 262
2		$
3		$
4		$
5		$
	Charge for Services Provided	$ 262

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

⊙ Yes ○ No Pg 15/1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page 8 of 37
Miller Memorial Community	992-C	9/30/2021	

	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30 Total	CCNH	RHNS	Other	Period 7/1 Thru 9/30 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	63	63			63	63			59	59		
B. As of midnight of THIS report period	61	61			59	59			61	61		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,629	1,629			1,217	1,217			412	412		
B. Medicaid (Conn.)	20,351	20,351			15,372	15,372			4,979	4,979		
C. Medicaid (other states)												
D. Private Pay	856	856			672	672			184	184		
E. State SSI for RCH												
F. Other (Specify) Insurance	234	234			154	154			80	80		
G. Total Care Days During Period (3A thru F)	23,070	23,070			17,415	17,415			5,655	5,655		
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)**	23,070	23,070			17,415	17,415			5,655	5,655		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	Other
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR
No. of Residents	3	51		9				
Per Diem Rate								
a. One bed rm.		259.22		455.00				
b. Two bed rms.				420.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,361	6,361		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	2,014	2,014		
C. Other	3,086	3,086		
D. ***Total Physical Therapy Treatments***	11,461	11,461		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,838	1,838		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	590	590		
C. Other	772	772		
D. ***Total Speech Therapy Treatments***	3,200	3,200		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,691	2,691		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	985	985		
C. Other	2,574	2,574		
D. ***Total Occupational Therapy Treatments***	6,250	6,250		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	10	37

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

Item	Total Cost and Hours					
	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)	122,183	2,043			2,198	37
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	252,301	11,103			3,951	174
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	432,169	26,692				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	232,998	16,981			295	22
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	55,346	2,013				
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	99,642	2,013				
b. RN						
1. Direct Care	574,828	14,159				
2. Administrative**	174,538	5,757				
c. LPN						
1. Direct Care	722,882	21,139				
2. Administrative**						
d. Aides and Attendants	1,318,359	70,525				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	129,380	6,105				
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	59,568	1,878				
n. Marketing						
o. Other (Specify) See Attached Schedule	59,767	1,957				
A-13. Total Salary Expenditures	4,233,960	182,365			6,444	233

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Admissions	$ 59,767	1,957				
Total	$ 59,767	1,957	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	12	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: Other	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
Section III - Administrators* **										
Edward Baker	122,183		2,198	standard		2,080	10/a2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
** Include **all** other employment worked during the cost year.
*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	13	37

Item	CCNH	Hours	RHNS	Hours	Other	Hours
	Total Cost and 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	10,060	252				
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	273,758	4,455				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	24,960	483				
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	78,591	1,137				
b. Other						
10. Occupational Therapist						
a. Resident Care	149,285	2,592				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	32,493	426				
2. Administrative***						
b. LPN						
1. Direct Care	9,347	180				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	578,495	9,525				

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

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	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	○	⦿	
Preferred Therapy Solutions 850 Silas Deane Hwy #2, Wethersfield, CT 06109	Therapy Services	○	⦿	
The Nures Network, Inc. 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⦿	
Swallowing Diagnostics LLC 21 Waterville Rd, Avon, CT 06001	ST Consultant	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	74,370	74,257		113
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	329,506	329,006		501
5. Health Insurance	$	547,414	546,582		832
6. Life Insurance (employees only) (not-owners and not-operators)	$	8,452	8,439		13
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	22,058	22,024		34
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	36,000	36,000		
d. Accounting and Auditing	$	119,390	117,280		2,110
e. Legal (*Services should be fully described on Page 7)*	$	262	257		5
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	23,509	23,116		393
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,781	20,414		367
2. Cellular Phones	$	547	537		10
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	$	255	255		
3. Resident Day User Fee	$	446,107	446,107		
Subtotal	$	1,628,652	1,624,275		4,377

* 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 Attachment Page 15
9/30/2021

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
Pre-Employment Services	$ 22,024		$ 34
Total	$ 22,024	$ -	$ 34

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Quarterly Federal Excise Tax	$ 255		
Total	$ 255	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		1,628,652	1,624,275		4,377
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	675	675		
3. Gifts to Staff and Residents	$	7,774	7,774		
4. Employee Travel	$	313	307		6
5. Education Expenses Related to Seminars and Conventions	$	200	200		
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*)	$	384	384		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	7,588	7,454		134
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	$				
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	180	177		3
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	599	588		11
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	36,422	35,797		625
12. Administrative Management Services**	$	112,200	110,217		1,983
13. Other (*Specify*) See Attached Schedule	$	12,930	12,902		28
C-14 Total Administrative & General Expenditures	$	1,807,916	1,800,751		7,166

* Do not include Subscriptions, which should go in item 9.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Other
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Marketing	$ 7,454		$ 134
Total Other Advertising	$ 7,454	$ -	$ 134

Schedule of Dues

Description	CCNH	RHNS	Other
CAHCF	$ 177		$ 3
Total Dues	$ 177	$ -	$ 3

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Licenses & Fees	$ 1,577		$ 28
Fines and Penalties	$ 3,687		
Temp Labor-Service-Admin	$ 1,093		
Bank Charges-Admin	$ 7,969		
Meetings-Admin	$ 1,000		
Prior Year Expense	$ (2,423)		
Total Other Administrative and General	$ 12,902	$ -	$ 28

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Miller Memorial Community, Presidents Office, James Batten	112,200	Management, Oversight of Operations, President, Legal, Counsel, VP Compliance	16/m12

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	191,906	191,906		
2. Non-Food Supplies	$	29,094	29,094		
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)	$	221,000	221,000		

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

	Question	Yes	No	
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.

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	9/30/2021	19 | 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. $				
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)*	$	52,676	52,676		
c. Other (*Specify*) Supplies	$	117	117		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	52,793	52,793		

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.

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	9/30/2021	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping						
a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	33,349	33,307		42
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)		$	33,349	33,307		42
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	125,741	125,741		
b. Medicine Cabinet Drugs		$	26,075	26,075		
c. Medical and Therapeutic Supplies		$	182,847	182,847		
d. Ambulance/Limousine***		$	55,281	55,281		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	3,257	3,257		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	13,703	13,703		
h. Laboratory***		$	18,827	18,827		
i. Recreation		$	22,563	19,246		3,317
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	51,179	51,179		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	499,474	496,157		3,317

* 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
MED A Physician Fees	$ 1,709		
Prof Serv.-Mis-Ancillary Serv	$ 5,555		
Nutritional Supplements - Nursing	$ 30,617		
Equipment Rental - Rehab	$ 20		
Accelerated Care Plus	$ 13,059		
Physical Therapy Supplies	$ 221		
Total Other Resident Care	$ 51,179	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Other	Pg	Line
Unitex	565 Taxter Road, Elmsford NY	○	⦿		Laundry Services				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).

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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	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	54,213	42,394	1,791	10,028
b. Heat	$	110,790	110,491	11	288
c. Light & Power	$	155,705	126,521	119	29,065
d. Water	$	32,855	21,598	410	10,847
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	153,824	136,967	3,066	13,791
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	507,387	437,971	5,397	64,018
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,790	1,691	99	
b. Building & Building Improvements	$	65,335	53,821	3,166	8,348
c. Non-Movable Equipment	$	34,461	32,278	1,899	284
d. Movable Equipment	$	23,954	21,920	1,289	745
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	125,540	109,709	6,453	9,378
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)	$	125,540	109,709	6,453	9,378

* 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
Generator Service/Stand by Pwr	$ 363	$ 21	
Fire Prot. Maint Simplex	$ 9,605		
Elevator Service Baystate	$ 9,917	$ 583	
Exterminator Service - Maint	$ 3,136		
Grounds Service	$ 35,382	$ 2,081	$ 11,655
Hvac Service	$ 48,688		
Plowing & Sanding	$ 6,483	$ 381	$ 2,136
Refuse Removal	$ 20,465		
Medical Waste Removal - Nursing	$ 1,200		
Minor Equipment	$ 1,729		
Total Other Repairs and Maintenance	$ 136,967	$ 3,066	$ 13,791

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	1,459,099		1,459,099	1,449,029	SL	VAR	1,435	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	7,100						355	
A-4. Subtotal								1,790
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,327,274		8,327,274	7,035,207	SL	VAR	65,335	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								65,335
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,296,445		1,296,445	1,139,312	SL	Var	32,777	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	33,243						1,684	
C-4. Subtotal								34,461

	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	1,998,301		1,998,301	1,932,512	SL	VAR	23,954	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												23,954
E. ***Total Depreciation***												125,540

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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/29/2021	Parking Lot Repairs	$ 7,100	10	$ 355	
Total additions for Land Improvements		$ 7,100		$ 355	*
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:					
Total additions for Building Improvements		$ -		$ -	*
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:					
11/20/2020	Boiler Repairs	$ 7,059	10	$ 706	
3/15/2021	Boiler Repairs	$ 6,395	10	$ 320	
7/1/2021	HVAC Unit	$ 11,832	10	$ 592	
9/16/2021	HVAC Repairs	$ 7,957	10	$ 66	
Total additions for Non-Movable Equipment		$ 33,243		$ 1,684	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
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**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition		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	License No.	Report for Year Ended	Page of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	Prior to 1844
2. Date Structure Completed	10/01/76
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	10/01/76
5. Total Licensed Bed Capacity	90
6. Square Footage	53,896
7. Acquisition Cost	
a. Land	Unknown
b. Building	Unknown

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of ___________				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	Other
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
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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*) $			164	164		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $			164	164		
14. Insurance a. Insurance on Property (buildings only) $			58,141	57,113		1,027
b. Insurance on Automobiles $			3,130	3,075		55
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $			142,327	139,812		2,515
2. Fire and Extended Coverage $						
3. Other (*Specify*) $ Surety Bond			300	295		5
14d. ***Total Insurance Expenditures (14a + b + c)*** $			203,898	200,295		3,603
15. ***Total All Expenditures (A-13 thru C-14)*** $			8,270,420	8,164,601	11,851	93,968

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$	149,285	149,285		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	36,000	36,000		
10.			Accounting	$				
10a.			Legal	$				
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 *	$	7,454	7,454		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	1,264	1,264		
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)	$	194,003	194,003		

* 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	Prior Year Expenses	$ (2,423)		
16	m13	Fines & Penalties	$ 3,687		
Total Other A&G Adjustments			$ 1,264	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward	$	194,003	194,003		
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	125,741	125,741		
28.	20	5d	Ambulance/Limousine	$	55,281	55,281		
29.	20	5f	X-rays, etc	$	3,257	3,257		
30.	20	5h	Laboratory	$	18,827	18,827		
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	1,929	1,929		
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	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.			***Total Amount of Decrease (Items 1 - 48)***	$	399,039	399,039		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Miller Memorial Community
9/30/2021

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
	20/5j	PT Supplies	$ 221		
	20/5j	MED A Physician Fees	$ 1,709		
Total Other Ancillary Costs			$ 1,929	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,946,293	8,946,293		
b. Medicaid Room and Board Contractual Allowance **	$	(3,763,723)	(3,763,723)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	743,520	743,520		
b. Medicare Room and Board Contractual Allowance **	$	298,778	298,778		
4. a. Private-Pay Residents and Other	$	674,598	545,945		128,653
b. Private-Pay Room and Board Contractual Allowance **	$	(14,877)	(14,877)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	73,326	73,326		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(73,326)	(73,326)		
c. Prescription Drugs - Non-Medicare	$	10,566	10,566		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(10,566)	(10,566)		
2. a. Medical Supplies - Medicare	$	3,327	3,327		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	(1,640)	(1,640)		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	197,600	197,600		
b. Physical Therapy - Medicare Contractual Allowance **	$	(103,322)	(103,322)		
c. Physical Therapy - Non-Medicare	$	39,814	39,814		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(38,907)	(38,907)		
4. a. Speech Therapy - Medicare	$	129,951	129,951		
b. Speech Therapy - Medicare Contractual Allowance **	$	(29,196)	(29,196)		
c. Speech Therapy - Non-Medicare	$	17,057	17,057		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(17,057)	(17,057)		
5. a. Occupational Therapy - Medicare	$	354,363	354,363		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(149,863)	(149,863)		
c. Occupational Therapy - Non-Medicare	$	92,044	92,044		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(90,444)	(90,444)		
6. a. Other *(Specify)* - Medicare	$	121,165	121,165		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,409,480	7,280,827		128,653
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*)	$	680	680		
V. Total Other Revenue (1 thru 8)	$	680	680		
VI. Total All Revenue (III +V)	$	7,410,160	7,281,507		128,653

* *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
	HHS Stimulus Funds	$ 121,165		
Total Other Resident Revenue - Medicare		$ 121,165	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	Other Income	$ 680		
Total Other Revenue		$ 680	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 447,875
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 608,277
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 12,275
4 Inventories				$
5. Prepaid Expenses				$ 200,512
a.				
b.				
c.				
d. See Schedule		200,512		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,268,939
B. Fixed Assets				
1. Land				$ 301,065
2. Land Improvements	*Historical Cost	1,466,199		$ 15,380
	Accum. Depreciation	1,450,819	Net	
3. Buildings	*Historical Cost	8,327,274		$ 1,226,732
	Accum. Depreciation	7,100,542	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,329,688		$ 155,915
	Accum. Depreciation	1,173,773	Net	
6. Movable Equipment	*Historical Cost	1,998,301		$ 41,835
	Accum. Depreciation	1,956,466	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (392,827)
See Schedule		(392,827)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,348,099

* 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	$ 157,017
		Prepaid Expenses	$ 43,494
Total Prepaid Expenses			$ 200,512

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

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

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

Page Ref	Line Ref	Description	
		Book Vs Cost Report	$ (392,827)
Total Other Other Fixed Assets (Itemize)			$ (392,827)

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Lease Payable - US Bank	$ 136
		Loan Payable - First Insurance	$ 13,249
		Worker's Comp Trust	$ 81,539
		The Hartford	$ 508
Total Notes Payable			$ 95,432

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

Page Ref	Line Ref	Description	
		Lease Payable	$ 8,345
		DSS Rate Advance	$ 90,000
		Resident Trust Fund	$ 54,577
Total Other Current Liabilities (Itemize)			$ 152,922

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

Page Ref	Line Ref	Description	
		Note Payable - E. Miller Memorial Trust	$ 1,631,000
		Rounding	$ (2)
Total Other Current Liabilities (Itemize)			$ 1,630,998

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2021	32 | 37

Account				Amount
			Total Brought Forward:	$ 2,617,038
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)				$ 2,617,038

* 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	9/30/2021	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 566,830
2. Notes Payable (*itemize*)				$ 95,432
See Schedule		95,432		
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*)				$ 146,596
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 92,393
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*)				$ 152,922
		See Schedule	152,922	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,054,173

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	34	37

Account	Amount
Total Brought Forward:	1,054,173
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 1,630,998
See Schedule	1,630,998	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,630,998
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,685,171

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

Name of Facility	License No.	Report for Year Ended	Page of
Miller Memorial Community	992-C	9/30/2021	35 | 37

Account				Amount
A. **Reserves**				
1. Reserve for value of leased land				$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$
3. Reserve for depreciation value of leased personal property (*Equity)*				$
4. Reserve for leasehold real properties on which fair rental value is based				$
5. Reserve for funds set aside as donor restricted				$
6. Total Reserves				$
B. **Net Worth**				
1. Owner's Capital				$ 4,445,353
2. Capital Stock				$
3. Paid-in Surplus				$
4. Treasury Stock				$
5. Cumulated Earnings				$ (3,653,226)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	$ (860,260)
7. Total Net Worth				$ (68,133)
C. ***Total Reserves and Net Worth***				$ (68,133)
D. ***Total Liabilities, Reserves, and Net Worth***				$ 2,617,038

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020	$ 1,477,718
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 7,410,160
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 8,270,420
D.	Net Income or Deficit	$ (860,260)
E.	Balance	$ 617,458
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

			Amount
	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/21	$ 617,458

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
CJLC LLC	
Addres Address	**Phone Number**
225 Pitkin Street, East Hartford, CT 06108	860-610-9009
Annual Report Contact	**Phone Number**
CJLC	860-610-9009
Annual Report Contact Email Address	
annualreports@cjlc.com	