

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

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 Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input checked="" type="checkbox"/> Supervision only <input checked="" type="checkbox"/> Other (CCNH) (RHNS)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 992-C	RHNS 134-RH	Other	Medicare Provider 07-5295
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Medicaid Provider Numbers:	CCNH 209928	RHNS 91348	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Miller Memorial Community [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Paul Messier			Printed Name (Owner)		
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 10/1/2015	To 9/30/2016	
Address of Facility 360 Broad St., Meriden, CT 06450				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/8/2017		
Item	Total	CCNH	RHNS	Other
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-237-5302		Report for Year Ended 9/30/2016		Page 2	of 37
Name of Facility (as shown on license) Miller Memorial Community			Address (No. & Street, City, State, Zip) 360 Broad St., Meriden, CT 06450		
License Numbers:	CCNH 992-C	RHNS 134-RH	Other	Medicare Provider No. 07-5295	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Other	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator Paul Messier			Nursing Home Administrator's License No.:	1721	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

General Information and Questionnaire
Related Parties*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
President's Office	360 Broad St., Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		James W. Batten, President	16/m12	112,200	112,200
Clifford R. Dreschsler-Martell, MD	360 Broad St., Meriden, CT 06450	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director	13/B8a	24,000	24,000
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2016		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
N/A	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	Total ***

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

General Information and Questionnaire
Accounting Basis

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC, LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT
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Services Provided by This Firm (*describe fully*)

1 Audit, Cost Reporting, Tax Services	\$ 19,000
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 19,000

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Shipman & Goodwin 2 Michalik, Bauer, Silvia 3 Miller Memorial Petty Cash/Probate 4 5	Telephone Number (860) 251-5000 (860) 225-8403
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Address (*No. & Street, City, State, Zip Code*)

1 1 Constitution Plaza, Hartford, CT 06103
2 35 W Pearl St # 300, New Britain, CT 06051
3
4
5

Services Provided by This Firm (*describe fully*)

1 General Matters	\$ 20,573
2 Collections (disallowed pg 28/10)	\$ 3,936
3 Conservatorship (disallowed pg 28/10)	\$ 637
4	\$
5	\$
	Charge for Services Provided
	\$ 25,146

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

Schedule of Resident Statistics

Name of Facility Miller Memorial Community			License No. 992-C			Report for Year Ended 9/30/2016				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	93	85	8		93	85	8		93	85	8	
B. On last day of THIS report period	90	85	5		93	85	8		90	85	5	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	80	76	4		80	76	4		71	69	2	
B. As of midnight of THIS report period	77	73	4		71	69	2		77	73	4	
3. Total Number of Days Care Provided During Period												
A. Medicare	3,025	2,602	423		2,436	2,098	338		589	504	85	
B. Medicaid (Conn.)	21,774	21,534	240		16,107	15,916	191		5,667	5,618	49	
C. Medicaid (other states)												
D. Private Pay	1,815	1,690	125		1,410	1,293	117		405	397	8	
E. State SSI for RCH												
F. Other (Specify) Managed Care	648	447	201		466	310	156		182	137	45	
G. Total Care Days During Period (3A thru F)	27,262	26,273	989		20,419	19,617	802		6,843	6,656	187	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	265	265			216	216			49	49		
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	27,527	26,538	989		20,635	19,833	802		6,892	6,705	187	

Schedule of Resident Statistics (Cont'd)

Name of Facility Miller Memorial Community			License No. 992-C			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	Other	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
3/23/2016		X				3						5	
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-IID					
No. of Residents	2	62	2	5									
Per Diem Rate													
a. One bed rm.	Varous RUGS rate	242.60		465.00	345.00								
b. Two bed rms.				405.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	Other
A. Medicare - Part B										1,725	717	883	125
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments										352	252	100	
C. Other										8,791	7,926	827	38
D. Total Physical Therapy Treatments										10,868	8,895	1,810	163
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										418	367	51	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments										78	74	4	
C. Other										854	746	108	
D. Total Speech Therapy Treatments										1,350	1,187	163	
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										3,105	2,209	810	86
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments										310	207	103	
C. Other										10,543	9,340	1,203	
D. Total Occupational Therapy Treatments										13,958	11,756	2,116	86

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Miller Memorial Community	992-C	9/30/2016	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	82,339	1,650	3,253	116	1,011	19
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	299,456	10,150	11,761	399	3,300	112
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	386,865	27,024	14,417	1,007	1,526	107
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	302,213	20,827	11,939	823	3,711	256
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	93,161	1,998	3,472	78		
b. RN						
1. Direct Care	601,222	1,844	22,406	72		
2. Administrative**	292,779	16,706	10,911	623		
c. LPN						
1. Direct Care	682,902	10,586	25,450	395		
2. Administrative**						
d. Aides and Attendants	1,430,776	24,769	53,321	923		
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	86,020	5,199	3,206	194		
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	78,958	3,154	3,119	125	970	39
n. Marketing						
o. Other (Specify) See Attached Schedule	66,610	2,479	2,482	92		
<i>A-13. Total Salary Expenditures</i>	4,403,301	126,387	165,738	4,846	10,518	532

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
SALARY - ADMISSIONS	\$ 66,610	2,479	\$ 2,482	92		
Total	\$ 66,610	2,479	\$ 2,482	92	\$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Miller Memorial Community				992-C	9/30/2016			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** employment worked during the cost year.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Miller Memorial Community				992-C	9/30/2016			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators***										
Paul Messier (11/23/15 to 9/30/16)	82,339	3,253	1,011	Standard	Administrator	1,785	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Miller Memorial Community	992-C	9/30/2016	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Other	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	18,007	462	671	18	71	1
2. Dentist						
3. Pharmacist	5,925	334	221	12		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	189,238		21,549		1,941	
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	23,138	96	862	4		
b. Utilization Review (Title 18 and 19 only) monthly meeting	482	4	18	0		
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	26,712	5	3,668	0		
b. Other						
10. Occupational Therapist						
a. Resident Care	152,525		133,025		1,116	
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	102,553	1,497	3,822	59		
2. Administrative***						
b. LPN						
1. Direct Care	42,057	994	1,567	39		
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	560,636	3,391	165,403	132	3,127	1

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

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

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

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

Name of Facility Miller Memorial Community		License No. 992-C	Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Clifford R. Dreschsler-Martell, MD 324 Ridge Rd, Middletown, CT 06457	Medical Director & Board of Directors	<input checked="" type="radio"/>	<input type="radio"/>		
David Taraskevich, MD 237 Liberty St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
Audrey Lefkowitz, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
Neil Scollan, MD 469 E Main St, Meriden, CT 06450	Medical Staff Meeting	<input type="radio"/>	<input checked="" type="radio"/>		
The Nures Network, Inc. 653 Main St, Plantsville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Ready Nurse Staffing Services 360 Bloomfield Ave #303, Windsor, CT 06095	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Keep Me Home 1340 Worthington Rdg., Berlin, CT 06037	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Nursefinders Hartford, CT	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics LLC 21 Waterville Rd, Avon, CT 06001	ST Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare of Connecticut 525 Knotter Dr, Cheshire, CT 06410	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Foremost Rehab of Connecticut 1157 Highland Ave # 101, Cheshire, CT 06410	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Preferred Therapy Solutions 850 Silas Deane Hwy #2, Wethersfield, CT 06109	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Mitchele Lipka, MS, RD	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Louise Kovacik	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Miller Memorial Community	992-C	9/30/2016		15	37
Item	Total	CCNH	RHNS	Other	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 144,824	139,250	5,241	333	
2. Disability Insurance	\$ 8,864	8,523	321	20	
3. Unemployment Insurance	\$ 40,300	38,749	1,458	93	
4. Social Security (F.I.C.A.)	\$ 353,375	339,774	12,789	812	
5. Health Insurance	\$ 611,238	587,713	22,121	1,404	
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 3,626	3,487	131	8	
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 4,840	4,653	175	11	
8. Uniform Allowance	\$ 1,052	1,012	38	2	
9. Other (<i>Specify</i>) See Attached Schedule	\$ 8,943	8,599	324	21	
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 88,053	84,889	3,164		
d. Accounting and Auditing	\$ 19,000	18,064	714	222	
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 25,146	23,908	944	294	
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 24,629	23,416	925	288	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 22,189	21,097	833	259	
2. Cellular Phones	\$ 2,151	2,045	81	25	
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 492,435	481,060	11,375		
Subtotal	\$ 1,850,665	1,786,239	60,635	3,791	

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

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

Miller Memorial Community
9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
PRE-EMP SERVICES	\$ 8,599	\$ 324	\$ 21
Total	\$ 8,599	\$ 324	\$ 21

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Miller Memorial Community	992-C	9/30/2016		16	37
Item	Total	CCNH	RHNS	Other	
<i>Subtotals Brought Forward:</i>	1,850,665	1,786,239	60,635	3,791	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 215	205	8	3	
3. Gifts to Staff and Residents	\$ 8,414	7,999	316	98	
4. Employee Travel	\$ 249	237	9	3	
5. Education Expenses Related to Seminars and Conventions	\$ 4,409	4,192	166	51	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 9,138	8,688	343	107	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 15,890	15,107	597	186	
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	\$ 5,400	5,134	203	63	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 8,238	7,833	309	96	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 45	43	2	1	
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 45,075	42,856	1,693	526	
12. Administrative Management Services**	\$ 112,200	106,675	4,214	1,310	
13. Other (<i>Specify</i>) See Attached Schedule	\$ 28,382	23,393	922	4,067	
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,088,320	2,008,601	69,418	10,301	

* Do not include Subscriptions, which should go in item 9.

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

*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Other
ADVERTISING - MARKETING	\$ 13,499	\$ 533	\$ 166
ADVERTISING - TELEPHONE - MARKET	\$ 826	\$ 33	\$ 10
FUN/EVENTS/PROGRAMS - MARKETING	\$ 782	\$ 31	\$ 10
Total Other Advertising	\$ 15,107	\$ 597	\$ 186

Schedule of Dues

Description	CCNH	RHNS	Other
DUES & MEMBERSHIPS	\$ 7,833	\$ 309	\$ 96
Total Dues	\$ 7,833	\$ 309	\$ 96

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
BANK CHARGES-ADMIN	\$ 7,229	\$ 286	\$ 89
LICENSES & FEES	\$ 1,721	\$ 68	\$ 21
QUARTERLY FEDERAL EXCISE TAX	\$ 87	\$ 3	\$ 1
FINES AND PENALTIES	\$ 13,360	\$ 528	\$ 164
LICENSES - DINING SERVICES	\$ 96	\$ 4	\$ 0
SOFTWARE CONTRACTS - DININ	\$ 758	\$ 28	\$ 3
LICENSES - MAINTENANCE	\$ -	\$ -	\$ -
LICENSES - NURSING ADMINISTRATI	\$ 143	\$ 6	\$ 2
EQUIPMENT RENTAL - RLC	\$ -	\$ -	\$ 3,673
RECREATIONAL MATERIALS - RLC	\$ -	\$ -	\$ 35
SPECIFIC FUN/EVENTS/PROGRAMS -	\$ -	\$ -	\$ 78
Total Other Administrative and General	\$ 23,393	\$ 922	\$ 4,067

Schedule C-1 - Management Services*

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Miller Memorial Community, President's Office, James Batten	112,200	Management Oversight of Operations, President, Legal Counsel, VP Compliance	16/m12

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

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 18	of 37
Item	Total	CCNH	RHNS	Other
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 215,215	206,697	7,703	815
2. Non-Food Supplies	\$ 25,131	24,136	899	95
3. Other (<i>Specify</i>) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services (Complete Schedule C-2 att. Page 21)</i>)	\$			
c. Management Services**	\$			
d. Other (<i>Specify</i>) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 240,346	230,833	8,603	910
2F. Dietary Questionnaire	Total	CCNH	RHNS	Other
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt. \$2,981				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30/IV1
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Miller Memorial Community		992-C	9/30/2016		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. \$	722	687	27	8
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)		\$	62,476	59,400	2,347	729
c. Management Services**		\$				
d. Other (Specify)		\$				
3E. Total Laundry Expenditures (3a + b + c + d)		\$	63,198	60,086	2,374	738
3F. Laundry Questionnaire						
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility Miller Memorial Community			License No. 992-C	Report for Year Ended 9/30/2016	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Other	Pg	Line
See Attachment		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Miller Memorial Community	992-C	9/30/2016			22	37
Item		Total	CCNH	RHNS	Other	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	53,577	44,279	2,439	6,859	
b. Heat	\$	85,855	82,751	3,087	17	
c. Light & Power	\$	161,481	132,216	5,190	24,075	
d. Water	\$	34,966	24,892	1,874	8,200	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$	149,962	131,179	6,326	12,458	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	485,841	415,316	18,916	51,608	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$	2,158	1,537	116	506	
b. Building & Building Improvements	\$	204,678	194,600	7,688	2,390	
c. Non-Movable Equipment	\$	25,506	24,250	958	298	
d. Movable Equipment	\$	46,892	44,583	1,761	548	
*7e. Total Depreciation Costs (7a + b + c + d)	\$	279,234	264,970	10,523	3,741	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	194	138	10	45	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	279,428	265,108	10,533	3,787	

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

Miller Memorial Community
9/30/2016

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:				
11/3/2015	New Roof-Memory Care EP	\$ 50,697	20	\$ 2,324
8/31/2016	Sprinkler Dry System Accelerator	\$ 1,850	10	\$ 31
9/1/2016	Gliding Doors in dining room	\$ 3,339	10	\$ 28
9/7/2016	Gliding Doors	\$ 10,407	15	\$ 58
Prior Year	Carpeting (Cottages - Not for Fair Rent)	\$ 1,965	5	\$ 459
Total additions for Building Improvements		\$ 68,258		\$ 2,899 *
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:				
6/8/2016	Fan A/C	\$ 8,289	5	\$ 553
Total additions for Non-Movable Equipment		\$ 8,289		\$ 553 *
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:				
1/25/2016	Wheel chair scale - EP	\$ 738	5	\$ 111
1/28/2016	Repair Sarita Lift	\$ 932	3	\$ 233
9/7/2016	Defibrillator	\$ 1,275	3	\$ 35
Total additions for Movable Equipment		\$ 2,945		\$ 379 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Miller Memorial Community			License No. 992-C		Report for Year Ended 9/30/2016			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	Prior to 1844				
2. Date Structure Completed	10/1/1976				
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure	10/1/1976				
5. Total Licensed Bed Capacity	90				
6. Square Footage	53,896				
7. Acquisition Cost					
a. Land	Unknown				
b. Building	Unknown				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Miller Memorial Community		992-C	9/30/2016		26	37
Item			Total	CCNH	RHNS	Other
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page	of
Miller Memorial Community		992-C		9/30/2016			27	37
Item				Total	CCNH	RHNS	Other	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (<i>Specify</i>)				\$				
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 (<i>Specify</i>) Interest & Late Fees				\$	4,824	4,586	181	56
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	4,824	4,586	181	56
14. Insurance								
a. Insurance on Property (buildings only)				\$	36,758	26,168	1,970	8,620
b. Insurance on Automobiles				\$	3,492	2,486	187	819
c. Insurance other than Property (as specified above)								
1. Umbrella (<i>Blanket Coverage</i>)				\$	102,738	97,680	3,859	1,200
2. Fire and Extended Coverage				\$				
3. Other (<i>Specify</i>) Surety Bond \$517; D&O \$15,390; Cyber \$5,712				\$	21,619	20,555	812	252
14d. Total Insurance Expenditures (14a + b + c)				\$	164,607	146,888	6,828	10,891
15. Total All Expenditures (A-13 thru C-14)				\$	9,165,860	8,606,435	467,137	92,288

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Miller Memorial Community			992-C	9/30/2016	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	10a	Occupational Therapy	\$ 286,665	152,525	133,025	1,116
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 88,053	84,889	3,164	
10.	15	1e	Accounting & Legal	\$ 4,573	4,348	172	53
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 1,071	1,018	40	13
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 *	\$ 15,890	15,108	597	186
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 14,937	14,201	561	174
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)				\$ 411,189	272,089	137,558	1,542

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16	m13	FINES AND PENALTIES	\$ 13,360	\$ 528	\$ 164
16	13	STAFF GIFTS	\$ 842	\$ 33	\$ 10
Total Other A&G Adjustments			\$ 14,201	\$ 561	\$ 174

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Miller Memorial Community			992-C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 411,189	272,089	137,558	1,542
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 156,360	150,743	5,618	
28.	20	5d	Ambulance/Limousine	\$ 24,324	23,451	874	
29.	20	5f	X-rays, etc	\$ 10,325	9,954	371	
30.	20	5h	Laboratory	\$ 9,457	9,117	340	
31.			Medical Supplies	\$			
32.	20	5e	Oxygen (non emergency)	\$ 8,643	8,333	311	
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b/1	Property Insurance	\$ 3,492	2,486	187	819
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.	30	IV4	Radio and Television Revenue	\$ 4,011	3,532	478	
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 52,319	49,743	1,965	611
51.	Total Amount of Decrease (Items 1 - 50)			\$ 680,121	529,448	147,702	2,972

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

Miller Memorial Community
9/30/2016

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7b	Depreciation on Cottages	\$ 49,743	\$ 1,965	\$ 611
Total Unallowable Building Interest			\$ 49,743	\$ 1,965	\$ 611

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Miller Memorial Community	992-C	9/30/2016			30	37
Item	Total	CCNH	RHNS	Other		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,725,915	9,445,550	280,365			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,509,188)	(4,377,414)	(131,774)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,384,185	284,890	1,099,295			
b. Medicare Room and Board Contractual Allowance **	\$ 394,880		394,880			
4. a. Private-Pay Residents and Other	\$ 1,292,398	502,510	622,320	167,568		
b. Private-Pay Room and Board Contractual Allowance **	\$ (20,952)	4,948	(25,900)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 146,822	20,132	126,690			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (146,822)	(20,132)	(126,690)			
c. Prescription Drugs - Non-Medicare	\$ 24,212	912	23,450	(150)		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (22,950)	(186)	(22,764)			
2. a. Medical Supplies - Medicare	\$ 4,786	573	4,213			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (4,786)	(573)	(4,213)			
c. Medical Supplies - Non-Medicare	\$ 3,857		3,857			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (3,481)		(3,481)			
3. a. Physical Therapy - Medicare	\$ 346,443	90,767	255,676			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (261,263)	(39,078)	(222,185)			
c. Physical Therapy - Non-Medicare	\$ 69,224	10,148	59,077			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (70,342)	(8,852)	(61,490)			
4. a. Speech Therapy - Medicare	\$ 94,732	43,998	50,734			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (56,193)	(9,973)	(46,220)			
c. Speech Therapy - Non-Medicare	\$ 20,499	6,877	13,622			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (18,091)	(6,877)	(11,214)			
5. a. Occupational Therapy - Medicare	\$ 444,618	132,551	312,067			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (342,072)	(58,127)	(283,944)			
c. Occupational Therapy - Non-Medicare	\$ 77,646	9,251	68,395			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (74,980)	(8,276)	(66,704)			
6. a. Other (<i>Specify</i>) - Medicare	\$ (0)	(3,239)	3,239			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 356	344	13			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,499,453	6,020,722	2,311,312	167,418		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 2,981			2,981		
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$ 4,011	3,532	478			
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 9,655	8,000	298	1,357		
V. Total Other Revenue (1 thru 8)	\$ 16,647	11,532	777	4,338		
VI. Total All Revenue (III +V)	\$ 8,516,099	6,032,254	2,312,089	171,756		

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30/IIba	IV -MEDA-SNF	\$ 590	\$ -	\$ -
30/IIba	IV -MEDA-ICF	\$ -	\$ 9,157	\$ -
30/IIba	LAB -MEDA-SNF	\$ 617	\$ -	\$ -
30/IIba	LAB -MEDA-ICF	\$ -	\$ 3,239	\$ -
30/IIba	X-RAY -MEDA-SNF	\$ 525	\$ -	\$ -
30/IIba	X-RAY -MEDA-ICF	\$ -	\$ 4,097	\$ -
30/IIba	ANC ALLOW-IV-MEDA-SNF	\$ (590)	\$ -	\$ -
30/IIba	ANC ALLOW-IV-MEDA-ICF	\$ -	\$ (9,157)	\$ -
30/IIba	ANC ALLOW-LAB-MEDA-SNF	\$ (617)	\$ -	\$ -
30/IIba	ANC ALLOW-LAB-MEDA-ICF	\$ (3,239)	\$ -	\$ -
30/IIba	ANC ALLOW-X-RAY-MEDA-SNF	\$ (525)	\$ -	\$ -
30/IIba	ANC ALLOW-X-RAY-MEDA-ICF	\$ -	\$ (4,097)	\$ -
Total Other Resident Revenue - Medicare		\$ (3,239)	\$ 3,239	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30/II/6b	LAB -MGED/C-ICF	\$ -	\$ 590	\$ -
30/II/6b	X-RAY REV_MCAID	\$ 347	\$ 13	\$ -
30/II/6b	X-RAY -MGED CARE-ICF	\$ -	\$ 2,208	\$ -
30/II/6b	ANC ALLOW-LAB-MGED/C-ICF	\$ -	\$ (590)	\$ -
30/II/6b	A ALLOW XRAY_MCAID	\$ (3)	\$ (0)	\$ -
30/II/6b	ANC ALLOW-X-RAY-MGED/C-ICF	\$ -	\$ (2,208)	\$ -
Total Other Resident Revenue		\$ 344	\$ 13	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30/IV8	HKPING -PRIV-COTTAGES			\$ 1,477
30/IV8	COTTAGE ENERGY REBATE			\$ (120)
30/IV8	CONTRIB-UNRESTRICTED	\$ 5,170	\$ 193	\$ -
30/IV8	OTHER INCOME	\$ 2,829	\$ 105	\$ -
Total Other Revenue		\$ 8,000	\$ 298	\$ 1,357

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Miller Memorial Community	992-C	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	116,963
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	719,342
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	220,371
a. Prepaid Insurance	144,728			
b. Prepaid Expenses	75,643			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,056,677
B. Fixed Assets				
1. Land			\$	301,065
2. Land Improvements	*Historical Cost	1,459,099	\$	16,490
	Accum. Depreciation	1,442,609		Net
3. Buildings	*Historical Cost	7,709,499	\$	1,428,535
	Accum. Depreciation	6,280,964		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	1,172,176	\$	149,997
	Accum. Depreciation	1,022,179		Net
6. Movable Equipment	*Historical Cost	1,950,060	\$	153,168
	Accum. Depreciation	1,796,892		Net
7. Motor Vehicles	*Historical Cost	146,817	\$	
	Accum. Depreciation	146,817		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	(322,348)
C.I.P. - Electrical/Generator R		38,294		
Book vs Cost Report		(360,642)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,726,908

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,783,585	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
3. Buildings			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
4. Non-Movable Equipment			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
5. Movable Equipment			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
6. Motor Vehicles			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,783,585	

* 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	9/30/2016	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	586,566
2. Notes Payable (<i>itemize</i>)				\$	32,281
NOTES & LEASES PAYABLE-NTT DATA				2,255	
NOTES & LEASES PAYABLE-US Bank				11,280	
LOAN PAYABLE - FIRST INS FUND C				18,746	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	90,249
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	49,854
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	57,687
LEASE PAYABLE - GE CAPITAL				3,640	
ACCRUED PENSION CONTRIBU'				30,765	
RESIDENT TRUST FUND				23,282	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	816,636

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				816,636
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
NOTE PAYABLE - E. MILLER MEM. T		304,000		304,000
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 304,000
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,120,636

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	9/30/2016	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	4,445,353
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,132,643)
6. Gain or Loss for Period			\$	(649,761)
	10/1/2015	thru	9/30/2016	
7. Total Net Worth			\$	1,662,949
C. Total Reserves and Net Worth			\$	1,662,949
D. Total Liabilities, Reserves, and Net Worth			\$	2,783,585

H. Changes in Total Net Worth

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	2,673,352
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	8,516,099
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	9,165,860
D. Net Income or Deficit			\$	(649,761)
E. Balance			\$	2,023,591
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	2,023,591
				09/30/16

I. Preparer's/Reviewer's Certification

Name of Facility Miller Memorial Community	License No. 992-C	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	