

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) The Guilford House	
Address (No. & Street, City, State, Zip Code) 109 West Lake Avenue, Guilford, CT 06437	
Type of Facility <input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 4606-c	RHNS	(Specify)	Medicare Provider 07-5235
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Medicaid Provider Numbers:	CCNH 4606	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	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 The Guilford House [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Nathan Moffie			Printed Name (Owner) Calvin Moffie		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Guilford House	Period Covered:	From 10/1/2021	To 9/30/2022	
Address of Facility 109 West Lake Avenue, Guilford, CT 06437				
Report Prepared By Tim Dolce	Phone Number 203-488-9142 ext.4004	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 317,061	317,061		
2. Laundry wages paid	\$ 24,201	24,201		
3. Housekeeping wages paid	\$ 320,190	320,190		
4. Nursing wages paid	\$ 3,439,927	3,439,927		
5. All other wages paid	\$ 1,462,572	1,462,572		
6. Total Wages Paid	\$ 5,563,951	5,563,951		
7. Total salaries paid	\$ 156,221	156,221		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 5,720,172	5,720,172		

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 203-488-9142		Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) The Guilford House		Address (No. & Street, City, State, Zip) 109 West Lake Avenue, Guilford, CT 06437		
License Numbers:	CCNH 4606-c	RHNS	(Specify)	Medicare Provider No. 07-5235
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input checked="" type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input 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 Nathan Moffie		Nursing Home Administrator's License No.:	002119	
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 The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 4	of 37				
<p>Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p style="text-align: right;">If "Yes," provide the Name/Address and complete the information on Page 11 of the report.</p>								
<p>Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p style="text-align: right;">If "Yes," provide the following information:</p>								
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	%**				
Calvin Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Office	Page 10 Line A-4	31,154	31,154
Patricia Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		RN	Page 10 Line A12B2	122,257	122,257
Jillian (Moffie) DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Admissions	Page 10 Line A12M	103,949	103,949
Nathan Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Administrator and HR Director	Page 10 Line A-2	150,475	150,475
Christopher DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Director	Page 10 Line A-7	74,223	74,223
CM 5775, LLC	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Owns Building the operations is in	Page 22 Line 9	1,295,392	1,295,392
Grand Prix Painting	203 Williams Road, Wallingford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Painting of walls and furniture	Page 22 Line 6-A	2,190	2,190
The Suffield House	One Canal Road, Suffield, CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Cash Advance	Page 31 Line A-8	12,961	12,961
The Rose's at Guilford House & CM 5781	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Cash Advance	Page 31 Line A-8	1,029,107	1,029,107

* 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 The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	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 The Guilford House		License No. 4606-c	Report for Year Ended 9/30/2022			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					
ABM Business Systems	<input type="radio"/>	<input checked="" type="radio"/>	Copier maintenance and equipment rental - cost per copy		Monthly	1,438	1,438
De Lage Landen	<input type="radio"/>	<input checked="" type="radio"/>	Copier Lease - 5 machines		Monthly	20,573	20,573
Pitney Bowes Global	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter		Quarterly	2,083	2,083
	<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"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input checked="" type="radio"/> No
Total ***						24,094	

* 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 The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Clifton Larson Allen LLP	300 Crown Colony Drive, Quincy MA 02169
2 SRC & Company	655 Winding Brook Dr. Glastonbury, CT 06033
3 Wells Thomas LLC	469 West Main Street, Branford, CT 06405
4 Unemployment Tax Management	P.O. Box 4074, Wakefield, MA

Services Provided by This Firm (*describe fully*)

1 Medicare Cost Report	\$ 3,255
2 Financial Statement and Tax Returns	\$ 17,850
3 401K pension reporting and yearend plan work Form 5500	\$ 3,933
4 Advisor for handling unemployment claims by Guilford House employees	\$ 5,060
	Charge for Services Provided
	\$ 30,098

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Wiggins & Dana LLP	203-498-4400
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
 1 One Century Tower, New Haven CT 06508
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Legal advise on a Medicare Fine	\$ 1,390
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 1,390

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

Schedule of Resident Statistics

Name of Facility The Guilford House		License No. 4606-c			Report for Year Ended 9/30/2022				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	75	75			75	75						
B. On last day of THIS report period	75	75							75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	69	69			69	69						
B. As of midnight of THIS report period	65	65							65	65		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,525	5,525			3,888	3,888			1,637	1,637		
B. Medicaid (Conn.)	9,089	9,089			6,917	6,917			2,172	2,172		
C. Medicaid (other states)												
D. Private Pay	4,706	4,706			3,427	3,427			1,279	1,279		
E. State SSI for RCH												
F. Other (Specify) ManageCare	4,352	4,352			3,405	3,405			947	947		
G. Total Care Days During Period (3A thru F)	23,672	23,672			17,637	17,637			6,035	6,035		
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)	23,672	23,672			17,637	17,637			6,035	6,035		

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Schedule of Resident Statistics (Cont'd)

Name of Facility The Guilford House		License No. 4606-c		Report for Year Ended 9/30/2022			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	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	16		25			24							
Per Diem Rate													
a. One bed rm.	645.34		288.82			490.00							
b. Two bed rms.	645.00		288.82			460.00							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments													
A. Medicare - Part B						TOTAL	CCNH	RHNS	(Specify)				
B. Medicaid (Exclusive of Part B)						5,690	5,690						
1. Maintenance Treatments						1,820	1,820						
2. Restorative Treatments													
C. Other						266,431	266,431						
D. Total Physical Therapy Treatments						273,941	273,941						
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B						145	145						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other						6,569	6,569						
D. Total Speech Therapy Treatments						6,714	6,714						
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B						5,186	5,186						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						1,705	1,705						
2. Restorative Treatments													
C. Other						251,183	251,183						
D. Total Occupational Therapy Treatments						258,074	258,074						

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CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	156,221	1,984				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	327,121	9,644				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	69,589	2,119				
c. Dietary Workers	247,472	19,094				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	320,190	20,522				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	78,224	2,032				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	24,201	1,542				
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	115,994	2,080				
b. RN						
1. Direct Care	913,597	18,047				
2. Administrative**	305,966	5,850				
c. LPN						
1. Direct Care	1,069,390	31,631				
2. Administrative**						
d. Aides and Attendants	1,034,980	52,233				
e. Physical Therapists	346,748	8,515				
f. Speech Therapists	113,369	2,080				
g. Occupational Therapists	343,469	9,167				
h. Recreation Workers	71,460	3,352				
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	182,181	4,809				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	5,720,172	194,701				

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

Name of Facility				License No.	Report for Year Ended				Page	of
The Guilford House				4606-c	9/30/2022				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Calvin Moffie	31,154			same as other employees	Owner		Line A-4			
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).										
Nathan Moffie	156,221			same as other employees	Administrator	1,984	Line A-2			
Patricia Moffie	122,257			same as other employees	RN	1,376	Line A12B2			
Jillian DeGennaro	103,949			same as other employees	Admissions	2,080	Line A12M			
Christopher DeGennaro	78,224			same as other employees	Maintenance Director	2,032	Line A-7			

* 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	
The Guilford House				4606-c	9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Nathan Moffie	156,221			same as other employees	Administrator	1,984	Line A-2			
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		
The Guilford House	4606-c	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	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						
2. Dentist	5,670	64				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	197				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	14,000	172				
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						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	31,563	335				
2. Administrative***						
b. LPN						
1. Direct Care	99,437	1,654				
2. Administrative***						
c. Aides	216,174	6,129				
d. Other						
12. Other (Specify) See Attached Schedule	13,974	208				
B-13 Total Fees Paid in Lieu of Salaries	416,818	8,759				

* 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 The Guilford House		License No. 4606-c	Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Partners Pharmacy	Pharmacy, Medical records, Consulting	<input type="radio"/>	<input checked="" type="radio"/>		
Shahzad Zaki M.D.	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
James J. Zumpano M.D.	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
HealthDrive Dental Group	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Channa Perera M.D.	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Swallowing Diag	Swallowing Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Harmony Home Healthcare LLC	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
All American Healthcare Services	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Clipboard Health	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Connect RN Inc	Nursing Pool	<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 checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" 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
The Guilford House	4606-c	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 87,732	87,732		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 56,570	56,570		
4. Social Security (F.I.C.A.)	\$ 434,114	434,114		
5. Health Insurance	\$ 344,008	344,008		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 19,248	19,248		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 106,545	106,545		
d. Accounting and Auditing	\$ 30,098	30,098		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 1,390	1,390		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 21,296	21,296		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 21,090	21,090		
2. Cellular Phones	\$			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 173	173		
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	\$ 282,509	282,509		
Subtotal	\$ 1,404,773	1,404,773		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
The Guilford House	4606-c	9/30/2022		16	37
Item	Total	CCNH	RHNS	(Specify)	
<i>Subtotals Brought Forward:</i>	1,404,773	1,404,773			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 4,269	4,269			
4. Employee Travel	\$ 3,912	3,912			
5. Education Expenses Related to Seminars and Conventions	\$ 13,293	13,293			
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>)	\$ 27,402	27,402			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$				
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 4,781	4,781			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 967	967			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 800	800			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 104,031	104,031			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 1,564,228	1,564,228			

* 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	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 427		
MED*PASS	\$ 191		
CAHCF - Mutual Aid	\$ 350		
Total Dues	\$ 967	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Yale New Haven Hospital - Cancer Dinner	\$ 800		
Total Contributions	\$ 800	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Printing	\$ 3,056		
Truck Expense	\$ 3,496		
CT Background Checks	\$ 4,998		
Fees & Registration	\$ 10,461		
License & Permits	\$ 2,033		
Computer Service	\$ 50,894		
Payroll Service	\$ 20,343		
Late Fees	\$ 706		
Miscellaneous Administrative	\$ 2,015		
Bank Fees	\$ 6,029		
Total Other Administrative and General	\$ 104,031	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	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 #

*** 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
The Guilford House	4606-c	9/30/2022	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 218,351	218,351		
2. Non-Food Supplies	\$ 39,100	39,100		
3. Other (<i>Specify</i>) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$ _____			
c. Other (<i>Specify</i>) _____ Dietary Service Maintenance	\$ 2,688	2,688		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 260,139	260,139		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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 The Guilford House		License No. 4606-c	Report for Year Ended 9/30/2022		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)	
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. \$	368	368		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)		\$	85,074	85,074		
c. Other (<i>Specify</i>)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	85,442	85,442		
3E. Laundry Questionnaire						
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> 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?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> 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
The Guilford House		4606-c	9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	39,665	39,665		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	39,665	39,665		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Partners Pharmacy	\$	418,317	418,317		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	296,530	296,530		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	27,567	27,567		
f.	X-rays and Related Radiological Procedures***	\$	15,322	15,322		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	74,494	74,494		
i.	Recreation	\$	14,270	14,270		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	32,408	32,408		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	878,908	878,908		

* 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	(Specify)
Social Service Expense	\$ 259		
PT Supplies	\$ 2,603		
IV House	\$ 4,764		
Medicare non-Billable	\$ 95		
Flu Vaccine	\$ 3,975		
Mattress Rental	\$ 20,087		
Medicare A Transportation	\$ 625		
Total Other Resident Care	\$ 32,408	\$ -	\$ -

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

Name of Facility The Guilford House			License No. 4606-c		Report for Year Ended 9/30/2022			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	(Specify)	Pg	Line
Point Click Care Technologies	P.O. Box 674802, Detroit, MI	<input type="radio"/>	<input checked="" type="radio"/>		Computer software for nursing home	27,673				
SLG Technology	34 Ric Court, Branford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Computer maintenance and email hosting	14,210				
Paychex	1175 John Street, Henrietta, NY	<input type="radio"/>	<input checked="" type="radio"/>		Payroll service for bi-weekly payroll	21,310				
Assisted Living Allocation	Assisted Living Allocation	<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living Allocation	-967				
Facilities Compliance Fire Protection, LLC	360 Capital Lewis Drive Unit B, Southington, CT	<input type="radio"/>	<input checked="" type="radio"/>		service on Fire sprinkler systems, alarms and	24,681				
John's Refuse & Recycling, LLC	P.O. Box 387, Guilford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Trash and recycle services	33,872				
Paulo Landscaping LLC	235 Old Tavern Road, Orange, CT	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping and snow plowing	38,432				
Assisted Living Allocation	Assisted Living Allocation	<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living Allocation	-13,027				
Sarracco Mechanical Services, LLC	Dept 2500, P.O. Box 986500, Boston, MA	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance of HVAC system	23,730				
Frank Katkauskas	110 Maple Avenue, Higganum, CT	<input type="radio"/>	<input checked="" type="radio"/>		Septic System UpKeep	12,813				
Richard Finn & Associates	310 Kenyon Road, Morris, CT	<input type="radio"/>	<input checked="" type="radio"/>		Septic System UpKeep	37,478				
Assisted Living Allocation	Assisted Living Allocation	<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living Allocation	-16,796				
Rinaldi Lien Service	47 Common Court, Waterbury, CT	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	84,993				
		<input type="radio"/>	<input checked="" 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
The Guilford House	4606-c	9/30/2022			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 63,066	63,066				
b. Heat	\$ 27,272	27,272				
c. Light & Power	\$ 85,402	85,402				
d. Water	\$ 12,211	12,211				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$ 24,094	24,094				
f. Other <i>(itemize)</i>	\$ 191,434	191,434				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 403,479	403,479				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 24,149	24,149				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 24,149	24,149				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 5,531	5,531				
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 5,531	5,531				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,079,202	1,079,202				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 216,190	216,190				
c. Personal property taxes	\$ 6,657	6,657				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,331,729	1,331,729				

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

Depreciation Schedule

Name of Facility The Guilford House			License No. 4606-c			Report for Year Ended 9/30/2022			Page 23	of 37		
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
		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					437,059		437,059	388,980	SL	Various	22,835	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					10,035		10,035		SL	5	1,314	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					10,035		10,035				1,314	
D-3. Subtotal												24,149
E. Total Depreciation										24,149		

Schedule of Land Improvements Acquired during this report period

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

*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 Improvement		\$ -		\$ -
Deletions:				
Total deletions for Building Improvement		\$ -		\$ -

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ -
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
10/8/2021	Dell Computers	Administrative	\$ 3,060	5	\$ 561
10/21/2021	Dell Laptops	Administrative	\$ 1,711	5	\$ 314
3/15/2022	Samsung Galaxy Tablets	Administrative	\$ 5,264	5	\$ 439
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipmen			\$ 10,035		\$ 1,314
Deletions:					
Total deletions for Movable Equipmen			\$ -		\$ -

*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
Total additions for Leasehold Improvemen		\$ -		\$ -
Deletions:				
Total deletions for Leasehold Improvemen		\$ -		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility The Guilford House			License No. 4606-c		Report for Year Ended 9/30/2022			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				159,755	55,850			5,531	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									5,531
D. Total Amortization									5,531

* 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 The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	10/01/02				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	75				
6. Square Footage	43,271				
7. Acquisition Cost					
a. Land					
b. Building					
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)	Fixed				
h. Date of Refinancing	01/01/22				
i. New Interest Rate	"3.20%				
j. Term of Mortgage (number of years)	35				
k. Amount of Principal Borrowed	18,891,200				
l. Principal Outstanding on Note Paid-Off	18,718,666				
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
The Guilford House		4606-c	9/30/2022			26	37
Item		Total	CCNH	RHNS	(Specify)		
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
The Guilford House	4606-c	9/30/2022			27	37
Item	Total	CCNH	RHNS	(Specify)		
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment	\$					
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)	\$	32,533	32,533			
A. Item	Rate	Amount				
People's Bank Line of Credit		32,533				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$	32,533	32,533			
12. D. Other Interest Expense (Specify)	\$	11,530	11,530			
Partner's Pharmacy and Dell Computers						
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$	44,063	44,063			
14. Insurance						
a. Insurance on Property (buildings only)	\$					
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)	\$	100	100			
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$					
14d. Total Insurance Expenditures (14a + b + c)	\$	100	100			
15. Total All Expenditures (A-13 thru C-14)	\$	10,744,743	10,744,743			

D. Adjustments to Statement of Expenditures

Name of Facility The Guilford House				License No. 4606-c	Report for Year Ended 9/30/2022	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 31,154	31,154		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-C	Bad Debts	\$ 106,545	106,545		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L-3	Gifts, flowers and coffee shops	\$ 4,269	4,269		
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.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 13,102	13,102		
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)				\$ 155,070	155,070		

* 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	(Specify)
10	A-4	Office Salaries - Calvin Moffie	\$ 31,154		
Total Other Salaries Adjustment			\$ 31,154	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M-13	Late Fees	\$ 706		
16	M-13	Miscellaneous Admin Expense	\$ 2,015		
16	M-13	Fees & Registration	\$ 10,381		
Total Other A&G Adjustments			\$ 13,102	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
The Guilford House				4606-c	9/30/2022	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 155,070	155,070		
Page 20 - Resident Care Supplies***							
27.	20	5-A-2	Prescription Drugs	\$ 196,777	196,777		
28.			Ambulance/Limousine	\$			
29.	20	2-F	X-rays, etc	\$ 15,322	15,322		
30.	20	2-H	Laboratory	\$ 74,494	74,494		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 3,323	3,323		
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	\$ 22,968	22,968		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			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)				\$ 467,954	467,954		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	2-L	PT Supplies	\$ 2,603		
20	2-L	Medicare Non-Billable	\$ 95		
20	2-L	Medicare Transportation	\$ 625		
Total Other Ancillary Costs			\$ 3,323	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6-F	Bulk Cable Expense	\$ 22,968		
Total Other Property Adjustments			\$ 22,968	\$ -	\$ -

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022		Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 3,912,395	3,912,395			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,314,538)	(1,314,538)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,458,725	2,458,725			
b. Medicare Room and Board Contractual Allowance **	\$ 1,101,783	1,101,783			
4. a. Private-Pay Residents and Other	\$ 4,087,536	4,087,536			
b. Private-Pay Room and Board Contractual Allowance **	\$ 361,976	361,976			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 202,370	202,370			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (202,370)	(202,370)			
c. Prescription Drugs - Non-Medicare	\$ 188,721	188,721			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (188,721)	(188,721)			
2. a. Medical Supplies - Medicare	\$ 1,050	1,050			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,050)	(1,050)			
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 613,980	613,980			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (608,981)	(608,981)			
c. Physical Therapy - Non-Medicare	\$ 509,290	509,290			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (503,339)	(503,339)			
4. a. Speech Therapy - Medicare	\$ 24,475	24,475			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (24,475)	(24,475)			
c. Speech Therapy - Non-Medicare	\$ 18,275	18,275			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (18,041)	(18,041)			
5. a. Occupational Therapy - Medicare	\$ 569,595	569,595			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (564,980)	(564,980)			
c. Occupational Therapy - Non-Medicare	\$ 474,927	474,927			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (469,442)	(469,442)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,629,161	10,629,161			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 18	18			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ (17,295)	(17,295)			
V. Total Other Revenue (1 thru 8)	\$ (17,277)	(17,277)			
VI. Total All Revenue (III +V)	\$ 10,611,884	10,611,884			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicaid	\$ 15		
	Lab Medicaid	\$ (15)		
	Lab Medicare	\$ 27,371		
	Lab Medicare	\$ (27,371)		
	Radiology Medicare	\$ 9,238		
	Radiology Medicare	\$ (9,238)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Other	\$ 23,622		
	Lab Other	\$ (23,622)		
	Radiology Other	\$ 6,290		
	Radiology Other	\$ (6,290)		
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Savings account	52,000	\$ 18		
Total Interest Income			\$ 18	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medicaid Grant	\$ 18,772		
	Medicaid Recoupment	\$ (37,000)		
	COVID 19 Tax credit	\$ 508		
	AMR Ambulance refund	\$ 425		
Total Other Revenue		\$ (17,295)	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-c	9/30/2022	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	173,948
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,242,490
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	10,690
5. Prepaid Expenses			\$	
a. _____				
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,427,128
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>159,755</u>		\$	98,374
	Accum. Depreciation <u>61,381</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>447,094</u>		\$	33,965
	Accum. Depreciation <u>413,129</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	132,339

* 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	
Total Prepaid Expenses			\$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Due to Suffield House	\$ (12,961)
		Due from The Roses at Guilford House	\$ 1,021,702
		Due from CM 5781 LLC	\$ 7,405
Total Other Assets			\$ 1,016,146

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

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

Page Ref	Line Ref	Description	
Total Other Long-Term Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	1,559,467
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>)			\$	1,016,146

See Schedule				1,016,146
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,016,146
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,575,613

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

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G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
The Guilford House		4606-c	9/30/2022	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	839,036
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
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>)				\$	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	214,930
6. Accrued Payroll Taxes Payable				\$	16,613
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>)				\$	592,701
Payroll Exchange		(1,805)	Accrued Pension Expens	20,118	
Employee Loan		(3,353)	Accrued Nursing Home l	69,051	
Accrued Vacation Expense		400,580			
Accrued Medicare A Expense		108,110	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,663,280

* 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 The Guilford House		License No. 4606-c	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,663,280	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)				\$ 463,880	
Name of Lender	Purpose	Amount	Date Due		
People's Bank	Line of Credit	463,880	5/18/25		
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>)				\$ 963,155	
Due to Solamor Hospice		24,222			
Due to CM 5775 LLC		938,933			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,427,035	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,090,315	

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-c	9/30/2022	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			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(381,843)
6. Gain or Loss for Period			\$	(132,859)
	10/1/2021	thru 9/30/2022		
7. Total Net Worth			\$	(514,702)
C. Total Reserves and Net Worth			\$	(514,702)
D. Total Liabilities, Reserves, and Net Worth			\$	2,575,613

H. Changes in Total Net Worth

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	(315,379)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,611,884
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	10,744,743
D. Net Income or Deficit			\$	(132,859)
E. Balance			\$	(448,238)
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>			\$	66,464
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
Calvin Moffie		Owner	66,464	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	66,464
H. Balance at End of Period			\$	(514,702)

I. Preparer's/Reviewer's Certification

Name of Facility The Guilford House	License No. 4606-c	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
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				
Tim Dolce				
Address			Phone Number	
109 West Lake Avenue, Guilford, CT 06437			203-488-9142	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Tim Dolce			203-488-9142 ext. 4004	
Contact Email Address				
Tim@tsh.necoxmail.com				