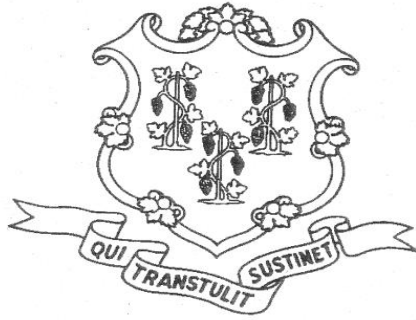


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

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 Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 4606-C	(Specify)	(Specify)	Medicare Provider 07-5235
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Medicaid Provider Numbers:	CCNH / RHNS 4606	(Specify)	(Specify)
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General Information

Name of Facility (as licensed) The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	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, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) 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)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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 10/1/2022	To 9/30/2023
Address of Facility 109 West Lake avenue, Guilford, CT 06437				
Report Prepared By Tim Dolce		Phone Number 203-488-9142	Date 12/31/2023	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$ 357,916	357,916		
2. Laundry wages paid	\$ 19,899	19,899		
3. Housekeeping wages paid	\$ 342,806	342,806		
4. Nursing wages paid	\$ 3,588,999	3,588,999		
5. All other wages paid	\$ 1,566,652	1,566,652		
6. Total Wages Paid	\$ 5,876,272	5,876,272		
7. Total salaries paid	\$ 169,458	169,458		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 6,045,730	6,045,730		

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 9/30/2023	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 / RHNS 4606-C	(Specify)	(Specify)	Medicare Provider No. 07-5235
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <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
Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-C	9/30/2023	3B	37
If this facility is owned or operated as an individual proprietorship, provide the following information:				
Owner(s) of Facility				
West Lake Property, LLC				
109 West Lake Avenue				
Guilford, CT 06437				

**General Information and Questionnaire
 Related Parties***

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	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	%**				
Calvin Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		A & G employee	Page 10 Line A-4	133,654	133,654
Patricia Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		RN	Page 10 Line A12B2	186,666	186,666
Jillian (Moffie) DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Admissions	Page 10 Line A12M	109,830	109,830
Nathan Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Administrator	Page 10 Line A-2	169,458	169,458
Christopher DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Director	Page 10 Line A-7	80,874	80,874
CM 5775, LLC	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Owens Building the operation is in	Page 22 Line 9	1,372,242	1,372,242
Grand Prix Painting	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Painting of walls and furniture	Page 22 Line 6-A	5,718	5,718
The Suffield House	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Cash Advance	Page 31 Line A-8	12,961	12,961
The Rose's at GuilfordHouse & CM 5781, LLC	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Cash Advance	Page 31 Line A-8	1,377,235	1,377,235

* 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 9/30/2023	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
Other Lines of Business

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		43,271		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
Square footage of kitchen				
Number of meals served per week				
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
Amount Reported				
Annual Report page and line				
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		Yes		
<i>If yes, please complete the following:</i>				
0	Square footage of apartments			
0	Square footage of independent living			
17,902	Square footage of assisted living			
Please identify the services provided:				
No services provided by Nursing Ho				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 7	of 37
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Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

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

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

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

Schedule of Resident Statistics

Name of Facility The Guilford House			License No. 4606-C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(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	65	65			65	65						
B. As of midnight of THIS report period	69	69							69	69		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,351	4,351			3,453	3,453			898	898		
B. Medicaid (Conn.)	11,510	11,510			8,066	8,066			3,444	3,444		
C. Medicaid (other states)												
D. Private Pay	4,550	4,550			3,441	3,441			1,109	1,109		
E. State SSI for RCH												
F. Other (Specify) ManagedCare	3,855	3,855			3,015	3,015			840	840		
G. Total Care Days During Period (3A thru F)	24,266	24,266			17,975	17,975			6,291	6,291		
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)	24,266	24,266			17,975	17,975			6,291	6,291		

Schedule of Resident Statistics (Cont'd)

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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)	(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)	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	37		13				
Per Diem Rate								
a. One bed rm.	722.76	#####		520.00				
b. Two bed rms.	723.00	#####		490.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	18,108	18,108			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	4,930	4,930			
2. Restorative Treatments					
C. Other	#####	243,187			
D. Total Physical Therapy Treatments	#####	266,225			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	75	75			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	5,225	5,225			
D. Total Speech Therapy Treatments	5,300	5,300			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	17,915	17,915			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	4,355	4,355			
2. Restorative Treatments					
C. Other	#####	222,613			
D. Total Occupational Therapy Treatments	#####	244,883			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	169,458		1,946						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	410,001		8,142	Cal Moffie	(133,654)	-122			
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	79,937		1,790						
c. Dietary Workers	277,979		12,827						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	342,806		17,146						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	80,874		1,872						
b. Other Maintenance Workers									
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	19,899		1,216						
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	110,399		2,080						
b. RN									
1. Direct Care	1,021,899		14,888						
2. Administrative**	329,909		3,765	P. Moffie	(186,666)				
c. LPN									
1. Direct Care	1,038,601		21,084						
2. Administrative**									
d. Aides and Attendants	1,088,191		31,315						
e. Physical Therapists	350,189		7,170						
f. Speech Therapists	128,177		1,912						
g. Occupational Therapists	308,798		6,836						
h. Recreation Workers	104,196		3,020						
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	184,417		4,032						
n. Marketing									
o. Other (Specify) See Attached Schedule									
<i>A-13. Total Salary Expenditures</i>	6,045,730		141,041		(320,320)	-122			

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Total	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Swallow Therapy	\$ 1,080		3						
Dietary Consultant	\$ 7,150		286						
Nurse Consultant	\$ 4,590		102						
Physical Therapy Consultant	\$ 4,000		15						
Employee Consultant	\$ 3,000		47						
Total	\$ 19,820	\$ -	453	\$ -	\$ -	-	\$ -	\$ -	-

**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	9/30/2023			11	37		
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section I - Operators/Owners										
Calvin Moffie	133,654			Same as other employees	Owner	122	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	169,458			Same as other employees	Administrator	1,946	Line A-2			
Patricia Moffie	186,666			Same as other employees	RN	zero	Line A-12-B			
Jillian DeGennaro	109,830			Same as other employees	Admissions	2,080	Line A-12-M			
Christopher DeGennaro	80,874			Same as other employees	Maintenance Director	1,872	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		9/30/2023			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section III - Administrators***										
Nathan Moffie	169,458			Same as other employees	Administrator	1,946	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	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist	5,670		64						
3. Pharmacist									
4. Podiatrist	50		2						
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	36,000		152						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	12,000		161						
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	41,406		401						
2. Administrative***									
b. LPN									
1. Direct Care	114,299		1,962						
2. Administrative***									
c. Aides	393,158		11,211						
d. Other									
12. Other (Specify)									
See Attached Schedule	19,820		453						
B-13 Total Fees Paid in Lieu of Salaries	622,403		14,406						

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

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

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

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 9/30/2023	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 Health LLC	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
All American Healthcare LLC/AllShifts	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
ClipBoard Health	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Connect RN	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
AA Northeast LLC	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Isaias Arce II	Dietary Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Valerie Harrington, RN	Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Quality Rehab Management	Therapy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Terrance Brennan	Employee Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
HealthDrive Podiatry	Foot Care	<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	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 106,127	106,127						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 46,883	46,883						
4. Social Security (F.I.C.A.)	\$ 466,873	466,873						
5. Health Insurance	\$ 365,930	365,930						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 24,909	24,909						
8. Uniform Allowance	\$ 2,117	2,117						
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*	\$	149,273	(149,273)	disallowed				
d. Accounting and Auditing	\$ 27,721	27,721						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 30,024	39,794	(9,770)	Atty Bonito				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 16,840	16,840						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 22,642	22,642						
2. Cellular Phones	\$							
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	\$ 329,647	329,647						
Subtotal	\$ 1,439,713	1,598,756	(159,043)					

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

General Information and Questionnaire Accounting Basis

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 15b	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 Drive, Glastonbury, CT 06033
3 Wells Thimas 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	\$ 3,413
2 Financial and Tax Consultants	\$ 16,125
3 401K Pension reporting and yearend pain work form 5500	\$ 3,123
4 Advisor for handling unemployment claims by Guilford House employees	\$ 5,060
Charge for Services Provided	
\$ 27,720	

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 and Dana, LLP	203-498-4400
2 Green and Levine LLP	860-677-7004
3 Kainen, Escalera and McHale	860-493-0870
4 Weinstein & Wisser	860-881-2732
5 Atty. Frank Bonito	203-458-7288

Address (*No. & Street, City, State, Zip Code*)

- 1 One Centry Tower, New Haven, CT 06508
- 2 231 Farmington Ave. Farmington, CT 06032
- 3 21 Oak Street, Hartford, CT 06106
- 4 29 South Main St. West Hartford, CT 06107
- 5 1139 Boston Post RD. Guilford, CT 06437

Services Provided by This Firm (*describe fully*)

1 Legal Advice on Medicare Fine	\$ 8,207
2 Legal fee for bank loan closing	\$ 505
3 CHRO Complaint by Guilford House employee	\$ 7,680
4 Legal advice for HUD Rent default	\$ 2,990
5 Clollection work and Medicaid application work	\$ 9,770
Charge for Services Provided	
\$ 29,152	

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

- Yes No Medicaid4You - \$2,500 Medicaid application and Celtic Consulting - \$8,142 Advice on Medicare and ManageCare request for medical records.

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	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:	1,439,713	1,598,756	(159,043)				
l. Travel and Entertainment							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$	644	644					
3. Gifts to Staff and Residents \$		4,857	(4,857)	disallowed			
4. Employee Travel \$	1,672	4,043	(2,371)	disallowed			
5. Education Expenses Related to Seminars and Conventions \$	10,523	10,523					
6. Automobile Expense (not purchase or depreciation) \$							
7. Other (Specify) \$ See Attached Schedule							
m. Other Administrative and General Expenses							
1. Advertising Help Wanted (all such expenses) \$	31,841	31,841					
2. Advertising Telephone Directory (all such expenses)*** \$							
3. Advertising Other (Specify)*** \$ 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 \$	4,768	4,768					
* 8. Dues and Membership Fees to Professional Associations (Specify) \$ See Attached Schedule	576	576					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$							
9. Subscriptions \$							
10. Contributions*** \$ See Attached Schedule							
11. Services Provided by Contract (Specify and Complete Schedule C-2, Page 21 for each firm or individual) \$							
12. Administrative Management Services** \$							
13. Other (Specify) \$ See Attached Schedule	105,619	119,665	(14,046)				
C-14 Total Administrative & General Expenditures	1,595,356	1,775,673	(180,317)				

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 350					
Med Pass	\$ 226					
Total Dues	\$ 576	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Printing	\$ 5,110					
Truck Expense	\$ 2,875					
Business Promotion	\$ 3,637	\$ (3,637)	disallow			
CT Background Check	\$ 3,935					
Fees & Registration	\$ 9,240					
License & Permits	\$ 815					
Computer Service	\$ 57,441					
Payroll Service	\$ 19,535					
Late Fee	\$ 5,818	\$ (5,818)	disallow			
Miscellaneous Administration	\$ 4,591	\$ (4,591)	disallow			
Bank Charges	\$ 6,668					
Total Other Administrative and General	\$ 119,665	\$ (14,046)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	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	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 237,454	237,454						
2. Non-Food Supplies	\$ 44,975	44,975						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____ Dietary Service Maintenance	\$ 4,868	4,868						
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 287,297	287,297						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(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 9/30/2023				Page 19	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*		Lbs.						
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$						
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.						
		Amt. \$						
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.						
		Amt. \$						
4. Repair and/or purchase of linens.***		Lbs.						
		Amt. \$	87	87				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	91,610	91,610				
c. Other (Specify)		\$						
3D. Total Laundry Expenditures (3a + b + c)		\$	91,697	91,697				
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	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping							
	a. In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	42,470	42,470				
	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)	\$	42,470	42,470				
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Partners Pharmacy	\$	177,347	355,495	(178,148)	Med A		
	b. Medicine Cabinet Drugs	\$						
	c. Medical and Therapeutic Supplies	\$	214,756	214,756				
	d. Ambulance/Limousine***	\$						
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$	35,844	35,844				
	f. X-rays and Related Radiological Procedures***	\$		13,615	(13,615)	Med A		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
	h. Laboratory***	\$		54,057	(54,057)	Med A		
	i. Recreation	\$	26,949	26,949				
	j. Direct Management Services*	\$						
	k. Indirect Management Services*	\$						
	l. Cable TV	\$						
	m. Other (Specify)**** See Attached Schedule	\$	43,832	51,580	(7,748)			
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	498,728	752,296	(253,568)			

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 ** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
 *** Facility should self-disallow the expense in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Social Service Expense	\$ 14,250					
Physical Therapy Expense	\$ 5,843	\$ (5,843)	Med A			
IV - House	\$ 15,730					
Complex Med Equipmet	\$ 343	\$ (343)	Med A			
Medicare A transportation	\$ 1,562	\$ (1,562)	Med A			
Mattress Rental	\$ 9,329					
COVID 19 Supplies	\$ 4,523					
Total Other Resident Care	\$ 51,580	\$ (7,748)	\$ -	\$ -	\$ -	\$ -

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 9/30/2023				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)	(Specify)	Pg	Line
BioServ	10 Graman Avenue, Prospect, CT 06712	<input type="radio"/>	<input checked="" type="radio"/>		Remove Harazed Waste Material	763	Page 22	6-F		
Facilities Compliance Fire Protection	1492 Berlin Turnpike, Berlin, CT 06037	<input type="radio"/>	<input checked="" type="radio"/>		Fire Systems and Sprinklers Maintenance	24,447	Page 22	6-F		
Gavlak Contingency Water Company	P.O. Box 418 Somerville, CT 06072	<input type="radio"/>	<input checked="" type="radio"/>		Back up Water for Emergencies	2,100	Page 22	6-F		
Gentech Power Systems, Inc	63 Indian Ledge Road, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Generator Maintenance	9,090	Page 22	6-F		
John's Refuse & Recycling, LLC	P.o. Box 520, Northford, CT 06472	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	38,537	Page 22	6-F		
Proshred Security	801 North Main Street, Wallingford,CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Shred Documents	2,737	Page 22	6-F		
Sarracco Mechanical Services, LLC	P.O. Box 986500, Boston, MA 02298	<input type="radio"/>	<input checked="" type="radio"/>		HVAC Maintenance	8,521	Page 22	6-F		
Yale Termite & Pest Elimination Corp	69 Mott Street, Ansonia, CT 06401	<input type="radio"/>	<input checked="" type="radio"/>		Pest Control	5,732	Page 22	6-F		
Richard Finn & Associates	310 Kenyon Road, Morris, CT 06763	<input type="radio"/>	<input checked="" type="radio"/>		Septic System Maintenance	23,750	Page 22	6-F		
Commerical Kitchens Inc.	290 Bic Drive, Milford, CT 06461	<input type="radio"/>	<input checked="" type="radio"/>		Kitchen Equipment Maintenance	4,868	Page 22	6-F		
Iron Mountain Inc.	2 Sun Court, Norcross, GA, 30092	<input type="radio"/>	<input checked="" type="radio"/>		Medical Records Storage	9,399	Page 22	6-F		
ShoreHaven Landscaping, LLC	127 Crestwood Drive, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Yard Maintenance and Snow Removal	22,880	Page 22	6-F		
Rinaldi Linen Service	47 Commons Court, Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	91,471	Page 22	6-F		
		<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 The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023					Page 22	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 140,655	140,655						
b. Heat	\$ 28,731	28,731						
c. Light & Power	\$ 123,813	123,813						
d. Water	\$ 16,102	16,102						
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 30,590	30,590						
f. Other (<i>itemize</i>)	\$ 197,442	211,332	(13,890)					
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 537,333	551,223	(13,890)					
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$ 18,051	18,051						
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 18,051	18,051						
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$ 5,826	5,826						
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)	\$ 5,826	5,826						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,193,221	1,193,221						
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$ 179,021	179,021						
c. Personal property taxes	\$ 4,651	4,651						
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,400,770	1,400,770						

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bulk Cable TV	\$ 13,890	\$ (13,890)	Disallowed			
Record Storage	\$ 9,399					
Maintenance Service Contracts	\$ 92,268					
Septic System Upkeep	\$ 66,988					
Yard Maintenance	\$ 28,787					
Total Other Repairs and Maintenance	\$ 211,332	\$ (13,890)	\$ -	\$ -	\$ -	\$ -

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
The Guilford House			4606-C	9/30/2023			22b	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 1200 Village Walk, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>	Copier maintenance and equipment rental - cost per copy		Monthly	4,958		4,958
De Lage Landen P.O. Box 41602, Philadelphia, PA 19101	<input checked="" type="radio"/>	<input type="radio"/>	Copier Leases for 5 copiers		Monthly	23,516		23,516
Pitney Bowes Global P.O. Box 981022 Boston, MA 02298	<input type="radio"/>	<input checked="" type="radio"/>	Postage meter rental		Quarterly	2,116		2,116
	<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"/>						
							Total ***	30,590

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes No

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

Depreciation Schedule

Name of Facility The Guilford House			License No. 4606-C		Report for Year Ended 9/30/2023			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						447,094		447,094	413,129	SL	Various	17,650	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative						4,242		4,242		SL	5	401	
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period						4,242		4,242				401	
D-3. Subtotal													18,051
E. Total Depreciation													18,051

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:				
Total additions for Building Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
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:					
3/8/2023	4 Dell Laptops	Administrative	\$ 2,909	5	\$ 290
4/8/2023	2 Dell Laptops	Administrative	\$ 1,333	5	\$ 111
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 4,242		\$ 401 *
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
7/12/2023	Blusky Restoration Contractors	\$ 8,883	15	\$ 295
9/18/2023	Blusky Restoration Contractors	\$ 8,884	15	\$ -
Total additions for Leasehold Improvement		\$ 17,767		\$ 295 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility The Guilford House			License No. 4606-C		Report for Year Ended 9/30/2023			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	61,381			5,531	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				17,767				295	
C-4. Subtotal									5,826
D. Total Amortization									5,826

* 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 9/30/2023	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		18,492,058			
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 The Guilford House		License No. 4606-C	Report for Year Ended 9/30/2023				Page 26	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$						

(Carry Subtotals forward to next page)

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		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment										
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$ 42,952	42,952					
A. Item		Rate	Amount							
Webster Bank - Peoples Bank I			42,952							
Lender										
Address of Lender										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 42,952	42,952					
12. D. Other Interest Expense (Specify)				\$ 6,604	6,604					
Dell Computers Partners Pharmacy										
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 49,556	49,556					
14. Insurance										
a. Insurance on Property (buildings only)				\$ 912	912					
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$						
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$						
14d. Total Insurance Expenditures (14a + b + c)				\$ 912	912					
15. Total All Expenditures (A-13 thru C-14)				\$ 10,851,932	11,620,027	(447,775)		(320,320)		

F. Statement of Revenue

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023		Page 30	of 37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,192,810	5,192,810			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,949,054)	(1,949,054)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,073,245	2,073,245			
b. Medicare Room and Board Contractual Allowance **	\$ 869,078	869,078			
4. a. Private-Pay Residents and Other	\$ 4,077,890	4,077,890			
b. Private-Pay Room and Board Contractual Allowance **	\$ 225,906	225,906			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 172,440	172,440			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (172,440)	(172,440)			
c. Prescription Drugs - Non-Medicare	\$ 141,111	141,111			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (141,111)	(141,111)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 564,960	564,960			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (552,884)	(552,884)			
c. Physical Therapy - Non-Medicare	\$ 562,267	562,267			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (544,014)	(544,014)			
4. a. Speech Therapy - Medicare	\$ 15,950	15,950			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (15,576)	(15,576)			
c. Speech Therapy - Non-Medicare	\$ 18,900	18,900			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (10,253)	(10,253)			
5. a. Occupational Therapy - Medicare	\$ 515,996	515,996			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (502,625)	(502,625)			
c. Occupational Therapy - Non-Medicare	\$ 505,487	505,487			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (492,679)	(492,679)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,555,404	10,555,404			
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>)	\$ 11	11			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$				
V. Total Other Revenue (1 thru 8)	\$ 11	11			
VI. Total All Revenue (III +V)	\$ 10,555,415	10,555,415			

* 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)	(Specify)
	Lab Medicare A	\$ 25,368		
	Radiology Medicare A	\$ 7,856		
	Lab Medicare A	\$ (25,368)		
	Radiology Medicare A	\$ (7,856)		
	Lab Other	\$ 21,089		
	Radiology Other	\$ 5,937		
	Lab Other	\$ (21,089)		
	Radiology Other	\$ (5,937)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
16 line 13	Webster Bank	237,654	\$ 11		
Total Interest Income			\$ 11	\$ -	\$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	324,229
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,229,713
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	8,834
5. Prepaid Expenses			\$	10,000
a. Retention deposit with Lawyer	10,000			
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	1,364,274

See Schedule	1,364,274			
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,937,050
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>177,522</u>		\$	110,315
	Accum. Depreciation <u>67,207</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>451,336</u>		\$	20,156
	Accum. Depreciation <u>431,180</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)			\$	130,471

* 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 (Itemize) Page 31 Line A8

Page Ref	Line Ref	Description	
		Loan due to Suffield House	\$ (12,961)
		Loan due from The Roses at Guilford House	\$ 1,370,750
		Loan due from CM 5781 LLC	\$ 6,485
Total Other Current Assets (Itemize)			\$ 1,364,274

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Webster Bank Note Payable	\$ 641,160
Total Notes Payable			\$ 641,160

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

Page Ref	Line Ref	Description	
		Due to Solamor Hospice	\$ 24,223
		Due to CM 5775, LLC	\$ 2,116,661
Total Other Current Liabilities (Itemize)			\$ 2,140,884

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	3,067,521
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>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,067,521

* 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 The Guilford House		License No. 4606-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	822,559
2. Notes Payable (<i>itemize</i>)				\$	641,160

See Schedule					641,160
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>)				\$	247,367
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	19,227
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>)				\$	2,856,917
Payroll Exchange		(792) Accrued Pension Expense	24,926		
Employee Loan		(2,109) Accrued Provider Tax	251,580		
Vacation Accrual		334,319			
Accrued Medicare Expense		108,110 See Schedule	2,140,884		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	4,587,230

* 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 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				4,587,230	
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>)				\$	

See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,587,230	

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	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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			\$	(455,097)
6. Gain or Loss for Period			\$	(1,064,612)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	(1,519,709)
C. Total Reserves and Net Worth			\$	(1,519,709)
D. Total Liabilities, Reserves, and Net Worth			\$	3,067,521

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	4606-C	9/30/2023	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	(514,702)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,555,415
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	11,620,027
D. Net Income or Deficit			\$	(1,064,612)
E. Balance			\$	(1,579,314)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Calvin Moffie Capital Contribution	61,000			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	61,000
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	1,395
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
Calvin Moffie	Onwer	1,395		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	1,395
H. Balance at End of Period			\$	(1,519,709)
09/30/23				

I. Preparer's/Reviewer's Certification

Name of Facility The Guilford House	License No. 4606-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input type="checkbox"/> (Specify)	<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 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		
Contact Email Address				
Tim@tsh.necoxmail.com				