

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

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 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 460-C	RHNS	(Specify)	Medicare Provider 07-5235
------------------	---------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 4606	RHNS	ICF-IID
----------------------------	--------------	------	---------

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. 460-C	Report for Year Ended 9/30/2021	Page 1	of 37
--	----------------------	------------------------------------	-----------	----------

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, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) 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 - Leases	6
General Information and Questionnaire - Accounting Basis	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
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
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 10/1/2020	To 9/30/2021	
Address of Facility 109 West Lake Avenue, Guilford, CT 06437				
Report Prepared By Tim Dolce	Phone Number 203-488-9142	Date 1/15/2022		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 299,387	299,387		
2. Laundry wages paid	\$ 25,541	25,541		
3. Housekeeping wages paid	\$ 275,398	275,398		
4. Nursing wages paid	\$ 3,398,876	3,398,876		
5. All other wages paid	\$ 1,474,777	1,474,777		
6. Total Wages Paid	\$ 5,473,979	5,473,979		
7. Total salaries paid	\$ 138,285	138,285		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 5,612,264	5,612,264		

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 9/30/2021	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 460-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
Individual Proprietorship**

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	Page 3B	of 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. 460-C	Report for Year Ended 9/30/2021	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 checked="" type="radio"/> Yes <input type="radio"/> No 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 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	135,244	135,244
Patricia Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		RN	Page 10 Line A12B2	189,019	189,019
Jillian(Moffie) DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Admissions	Page 10 Line A12M	98,046	98,046
Nathan Moffie	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		HR Director and Administrator	Page 10 Line A-2	138,285	138,285
Christopher DeGennaro	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Director	Page 10 Line A-7	68,506	68,506
CM 5775, LLC	109 West Lake Avenue, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Owns Building operations is in	Page 22 Line 9	1,299,667	1,299,667
The Suffield House	One Canal Road, Suffield, CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Cash Advance	Page 31 Line A-8	9,220	9,220
Grand Prix Painting	203 Williams Road, Wallingford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Painting of walls and furniture	Page 22 Line 6A		
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	832,595	832,595

* 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. 460-C	Report for Year Ended 9/30/2021	Page 5	of 37
--	----------------------	------------------------------------	-----------	----------

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<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. 460-C	Report for Year Ended 9/30/2021			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 - cost per copy		Monthly	956	956
De Lage Landen	<input type="radio"/>	<input checked="" type="radio"/>	Copier Lease - 5 machines		Monthly	21,374	21,374
Pitney Bowes Global	<input type="radio"/>	<input checked="" type="radio"/>	Potage Meter		Monthly	1,982	1,982
	<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 ***							24,312

* 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. 460-C	Report for Year Ended 9/30/2021	Page 7	of 37
--	----------------------	------------------------------------	-----------	----------

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

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Clifton Larson Allen LLP	300 Crown Colony Drive, Quincy MA 02169
2 Sheptoff Reuber & Company	655 Winding Brook Dr. Glastonbury, CT 06033
3 Medicaid 4U	377 Hubbard Street, Glastonbury, CT 06033
4 Wells Thomas LLC	469 West Main Street, Branford, CT06405

Services Provided by This Firm (*describe fully*)

1 Medicare Cost Report	\$ 3,045
2 Financial Statement Review	\$ 11,500
3 Prepare Medicaid applications for Residents	\$ 5,000
4 401K pension reporting and yearend plan work 5500	\$ 2,818
	Charge for Services Provided
	\$ 22,363

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 Green & Levine LLP	860-677-7004
2 Unemployment Tax Management	781-245-5353
3 Brenner Saltzman & Wallman	203-772-2600
4 Cranmore Fitzgerald & Meaney	860-522-9100
5 Kainen Escalera and Mchale	860-493-0870

Address (*No. & Street, City, State, Zip Code*)
 1 231 Farmington Ave. Farmington, CT
 2 P.O. Box 4074, Wakefield, MA
 3 271 Whitney Avenue, New Haven, CT
 4 1010 Wethersfield Ave. Hartford, CT
 5 21 Oak Street, Hartford, CT

Services Provided by This Firm (*describe fully*)

1 Closing cost for line of credit and general legal issues.	\$ 6,825
2 Advisor for handling unemployment claims by Guilford House employees	\$ 5,060
3 Service for figuring out tax issues	\$ 1,040
4 Banks atty for closing line of credit	\$ 2,889
5 Labor law resource issues hire temp employee	\$ 5,705
	Charge for Services Provided
	\$ 21,519

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. 460-C			Report for Year Ended 9/30/2021				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	62	62			62	62						
B. As of midnight of THIS report period	69	69							69	69		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,094	5,094			3,774	3,774			1,320	1,320		
B. Medicaid (Conn.)	8,444	8,444			5,890	5,890			2,554	2,554		
C. Medicaid (other states)												
D. Private Pay	3,403	3,403			2,598	2,598			805	805		
E. State SSI for RCH												
F. Other (Specify) ManageCare	4,143	4,143			3,066	3,066			1,077	1,077		
G. Total Care Days During Period (3A thru F)	21,084	21,084			15,328	15,328			5,756	5,756		
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)	21,084	21,084			15,328	15,328			5,756	5,756		

Schedule of Resident Statistics (Cont'd)

Name of Facility The Guilford House			License No. 460-C			Report for Year Ended 9/30/2021			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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	19		29		21								
Per Diem Rate													
a. One bed rm.	460.00		295.70		460.00								
b. Two bed rms.	435.00		295.70		435.00								
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)					1,480	1,480							
1. Maintenance Treatments					5,330	5,330							
2. Restorative Treatments													
C. Other					236,625	236,625							
D. Total Physical Therapy Treatments					243,435	243,435							
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments					155	155							
2. Restorative Treatments													
C. Other					6,455	6,455							
D. Total Speech Therapy Treatments					6,610	6,610							
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B					1,960	1,960							
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments					4,365	4,365							
2. Restorative Treatments													
C. Other					222,236	222,236							
D. Total Occupational Therapy Treatments					228,561	228,561							

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	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)	138,285	1,984				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	365,404	7,567				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	64,597	2,064				
c. Dietary Workers	234,790	14,192				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	275,398	18,325				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	68,506	2,032				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	25,541	1,596				
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	111,212	2,080				
b. RN						
1. Direct Care	729,920	15,208				
2. Administrative**	429,031	8,974				
c. LPN						
1. Direct Care	1,092,005	32,626				
2. Administrative**						
d. Aides and Attendants	1,036,708	60,325				
e. Physical Therapists	325,966	8,178				
f. Speech Therapists	110,309	2,266				
g. Occupational Therapists	378,606	9,873				
h. Recreation Workers	53,886	2,677				
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	172,101	4,080				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	5,612,264	194,048				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Total	\$ -	-	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended				Page	of
The Guilford House				460-C	9/30/2021				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Calvin Moffie	135,244			same as other employees	Customer Relations		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).										
Patricia Moffie	189,019			same as other employees	RN oversee care of residents	1,680	Line 12-B2			
Jillian(Moffie) DeGennaro	98,046			same as other employees	Admissions	2,080	Line A-12-M			
Nathan Moffie	138,285			same as other employees	Administrator	1,992	Line A-2			
Christopher DeGennaro	68,506			same as other employees	Maintenance Director	2,032	Line A-7-A			

* 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				460-C		9/30/2021			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	138,285			same as other employees	Administrator	1,992	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	460-C	9/30/2021	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	6,190	78				
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	196				
b. Utilization Review (Title 18 and 19 only) monthly meeting	10,521	112				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,742	24				
2. Administrative***						
b. LPN						
1. Direct Care	8,358	167				
2. Administrative***						
c. Aides	1,000	32				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	63,810	610				

* 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. 460-C	Report for Year Ended 9/30/2021	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"/>		
		<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"/>		
		<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	460-C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 55,318	55,318		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 50,161	50,161		
4. Social Security (F.I.C.A.)	\$ 415,304	415,304		
5. Health Insurance	\$ 310,789	310,789		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 19,423	19,423		
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*	\$ 69,095	69,095		
d. Accounting and Auditing	\$ 22,363	22,363		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 21,519	21,519		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 24,321	24,321		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 21,199	21,199		
2. Cellular Phones	\$ 423	423		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ (36,810)	(36,810)		
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	\$ 241,501	241,501		
Subtotal	\$ 1,214,606	1,214,606		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
The Guilford House	460-C	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<i>Subtotals Brought Forward:</i>	1,214,606	1,214,606			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 4,760	4,760			
4. Employee Travel	\$ 1,464	1,464			
5. Education Expenses Related to Seminars and Conventions	\$ 1,821	1,821			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 2,261	2,261			
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 14,414	14,414			
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	\$ 4,568	4,568			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 5,647	5,647			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 108,425	108,425			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 1,357,966	1,357,966			

* 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	\$ 5,647		
Total Dues	\$ 5,647	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Printing	\$ 2,641		
Ct Background Checks	\$ 4,148		
Fees & Registration	\$ 3,381		
License & Permits	\$ 955		
Computer Services	\$ 55,059		
Payroll Services	\$ 26,602		
Late Fees	\$ 9,847		
Miscellaneous Administrative Fees	\$ 2,893		
Bank Fees	\$ 2,899		
Total Other Administrative and General	\$ 108,425	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	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 The Guilford House		License No. 460-C	Report for Year Ended 9/30/2021	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	163,021	163,021		
2. Non-Food Supplies	\$	28,626	28,626		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____					
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 191,647	191,647		
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. 460-C	Report for Year Ended 9/30/2021	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. \$	41	41		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	87,472	87,472		
c. Other (<i>Specify</i>)	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	87,513	87,513		
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		460-C	9/30/2021		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. \$	29,802	29,802		
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)	\$	29,802	29,802		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Partners Pharmacy	\$	397,575	397,575		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	278,731	278,731		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	27,868	27,868		
f.	X-rays and Related Radiological Procedures***	\$	14,406	14,406		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	42,211	42,211		
i.	Recreation	\$	11,194	11,194		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	540	540		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	772,525	772,525		

* 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	\$ 6,518		
PT Supplies	\$ 48		
IV House	\$ 1,186		
Complex Medical Equipment	\$ 343		
Medicare Non-Billable	\$ (17,978)		
Medicare Transportation	\$ 1,335		
Flu Vaccine	\$ 3,581		
Mattress Rental	\$ 5,507		
Total Other Resident Care	\$ 540	\$ -	\$ -

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

Name of Facility The Guilford House			License No. 460-C		Report for Year Ended 9/30/2021			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	25,884				
SLG Technology	34 Ric Court, Branford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Computer Maintenance Services	22,146				
Paychex, Inc	1175 John Street, west Henrietta, NY	<input type="radio"/>	<input checked="" type="radio"/>		Process Bi weekly Payroll	27,884				
Assisted Living Allocation for Paychex Inc		<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living allocation	-1,281				
Facilities Compliance Services, LLC	221 West Main Street, Plantsville, CT	<input type="radio"/>	<input checked="" type="radio"/>		Fire Sprinklers, Fire Alarm	34,676				
John's Refuse & Recycling, LLC	P.O. Box 387, Guilford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Trash and Recycle Service	34,779				
Sarracco Mechanical Services, LLC	Dept 2500, P.O. Box 986500, Boston, MA	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance on HVAC	10,727				
Rinaldi Linen Services	47 Common Court, Waterbury, CT	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	87,472				
Paulo Landscaping LLC	235 Old Tavern Road, Orange, CT	<input type="radio"/>	<input checked="" type="radio"/>		landscaping and Snow Plowing	34,956				
Assisted Living Allocation for Paulo Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living allocation	-11,641				
Frank Katkauskas	110 Maple Avenue, Higganum, CT	<input type="radio"/>	<input checked="" type="radio"/>		Septic System Upkeep Consultant	13,825				
Richard Finn & Associates	310 Kenyon Road, Morris, CT	<input type="radio"/>	<input checked="" type="radio"/>		Septic System Upkeep Consultant	38,754				
Assisted Living Allocation for Septic Upkeep		<input type="radio"/>	<input checked="" type="radio"/>		Assisted Living allocation	-15,634				
		<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	460-C	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 63,683	63,683				
b. Heat	\$ 22,375	22,375				
c. Light & Power	\$ 75,525	75,525				
d. Water	\$ 10,747	10,747				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$ 24,312	24,312				
f. Other <i>(itemize)</i>	\$ 186,326	186,326				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 382,968	382,968				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 27,889	27,889				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 27,889	27,889				
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	\$ 869,818	869,818				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 213,105	213,105				
c. Personal property taxes	\$ 6,687	6,687				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,123,030	1,123,030				

* 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	(Specify)
Bulk Cable TV	\$ 37,185		
Record Storage	\$ 5,420		
Maintenance Service Contracts	\$ 76,708		
Septic System Upkeep	\$ 38,795		
Yard Maintenance	\$ 28,218		
Total Other Repairs and Maintenance	\$ 186,326	\$ -	\$ -

Depreciation Schedule

Name of Facility The Guilford House			License No. 460-C			Report for Year Ended 9/30/2021			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												
447,337												
b. Disposals (attach schedule)												
20,135												
c. Acquired during this report period (attach schedule)												
9,857												
D-3. Subtotal												
27,890												
E. Total Depreciation												
27,890												

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	Cost	Useful Life	Depreciation
Additions:				
11/19/2020	Cheftop Oven	\$ 7,942	5	\$ 1,324
9/7/2021	ABM MX-B355W Printer/Copier	\$ 1,914	5	\$ -
Total additions for Movable Equipmen		\$ 9,857		\$ 1,324 *
Deletions:				
10/6/2010	Dell Optiplex 380 Mini tower	\$1,463	5	\$0
1/27/2011	LCD HDTV's 2	\$564	5	\$0
2/6/2011	Dell Optiplex 380 Base	\$634	5	\$0
6/1/2011	Longhall Telephone	\$15,300	5	\$0
6/27/2011	Gas Grill Sears	\$514	5	\$0
3/15/2012	TV's 2	\$518	5	\$0
6/20/2014	Vizio TVs	\$542	5	\$0
11/27/2014	Telephones	\$600	5	\$0
Total deletions for Movable Equipmen		\$ 20,135		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility The Guilford House			License No. 460-C		Report for Year Ended 9/30/2021			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	50,319			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. 460-C	Report for Year Ended 9/30/2021	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description		Total			
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity					
6. Square Footage					
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)	Fixed				
b. Date Mortgage Obtained	04/17/19				
c. Interest Rate for the Cost Year	"3.77%				
d. Term of Mortgage (number of years)	40				
e. Amount of Principal Borrowed	18,891,200				
f. Principal balance outstanding as of 9-30-2021	18,040,814				
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
The Guilford House		460-C	9/30/2021			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	460-C	9/30/2021	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)	\$		18,683	18,683		
A. Item	Rate	Amount				
People's Bank line of Credit		36,113				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Vendor Accounts Payable Loan		(17,430)				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$		18,683	18,683		
12. D. Other Interest Expense (Specify)	\$		918	918		
Dell Computers & Avaya Phone System						
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$		19,601	19,601		
14. Insurance						
a. Insurance on Property (buildings only)	\$		243,119	243,119		
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)	\$					
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$		2	2		
Rounding						
14d. Total Insurance Expenditures (14a + b + c)	\$		243,121	243,121		
15. Total All Expenditures (A-13 thru C-14)	\$		9,884,247	9,884,247		

D. Adjustments to Statement of Expenditures

Name of Facility The Guilford House				License No. 460-C	Report for Year Ended 9/30/2021	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.	10	A-4	Salaries not related to Resident Care	\$ 135,244	135,244		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
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	1A-9c	Bad Debts	\$ 69,095	69,095		
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	\$ 4,760	4,760		
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.	15	1-9-j	Income Tax / Corporate Business Tax	\$ (36,810)	(36,810)		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 12,740	12,740		
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)				\$ 185,029	185,029		

* 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)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

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	\$ 9,847		
16	M-13	Miscellaneous Administrative Fees	\$ 2,893		
Total Other A&G Adjustments			\$ 12,740	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
The Guilford House				460-C	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 185,029	185,029		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 194,770	194,770		
28.			Ambulance/Limousine	\$			
29.	20	2-F	X-rays, etc	\$ 14,406	14,406		
30.	20	2-H	Laboratory	\$ 42,211	42,211		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (16,595)	(16,595)		
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	\$ 37,185	37,185		
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)				\$ 457,006	457,006		

*** 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	Medicare Non Billable	\$ (17,978)		
20	2-L	Medicare Transportation	\$ 1,335		
20	2-L	PT Expense	\$ 48		
Total Other Ancillary Costs			\$ (16,595)	\$ -	\$ -

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 TV	\$ 37,185		
Total Other Property Adjustments			\$ 37,185	\$ -	\$ -

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. 460-C	Report for Year Ended 9/30/2021		Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 3,465,080	3,465,080			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,329,512)	(1,329,512)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,278,230	2,278,230			
b. Medicare Room and Board Contractual Allowance **	\$ 1,126,936	1,126,936			
4. a. Private-Pay Residents and Other	\$ 3,427,286	3,427,286			
b. Private-Pay Room and Board Contractual Allowance **	\$ 285,031	285,031			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 188,674	188,674			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (188,674)	(188,674)			
c. Prescription Drugs - Non-Medicare	\$ 175,572	175,572			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (175,572)	(175,572)			
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	\$ 524,645	524,645			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (522,658)	(522,658)			
c. Physical Therapy - Non-Medicare	\$ 468,760	468,760			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (466,286)	(466,286)			
4. a. Speech Therapy - Medicare	\$ 20,975	20,975			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (20,975)	(20,975)			
c. Speech Therapy - Non-Medicare	\$ 19,550	19,550			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (18,850)	(18,850)			
5. a. Occupational Therapy - Medicare	\$ 492,632	492,632			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (488,691)	(488,691)			
c. Occupational Therapy - Non-Medicare	\$ 430,570	430,570			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (427,786)	(427,786)			
6. a. Other (<i>Specify</i>) - Medicare	\$ (0)	(0)			
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,264,937	9,264,937			
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>)	\$ 112	112			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 1,400,628	1,400,628			
V. Total Other Revenue (1 thru 8)	\$ 1,400,740	1,400,740			
VI. Total All Revenue (III +V)	\$ 10,665,677	10,665,677			

* 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 - Medicare A	\$ 14,375		
	Radiology Medicare A	\$ 6,021		
	Lab - Medicare A Contractual	\$ (14,375)		
	Radiology Medicare A Contractual	\$ (6,021)		
	Total Other Resident Revenue - Medicare	\$ (0)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicaid	\$ 25		
	Lab Other	\$ 11,691		
	Radiology Other	\$ 5,770		
	Lab Medicaid Contractual	\$ (25)		
	Lab Other Contractual	\$ (11,691)		
	Radiology Other Contractual	\$ (5,770)		
	Total Other Resident Revenue	\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest on PPP loan	-	\$ 112		
	Total Interest Income		\$ 112	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	PPP Loan	\$ 1,324,000		
	COVID Tax Credit	\$ 66,141		
	COVID Education Credit	\$ 6,000		
	Old bank checks never cashed	\$ 4,487		
	Total Other Revenue	\$ 1,400,628	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2021	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	664,282
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,023,369
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	10,454
5. Prepaid Expenses			\$	
a. _____				
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	823,375

See Schedule		823,375		
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,521,480
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>		\$	103,905
	Accum. Depreciation <u>55,850</u> Net			
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____ Net			
6. Movable Equipment	*Historical Cost <u>437,059</u>		\$	48,079
	Accum. Depreciation <u>388,980</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)			\$	151,984

* 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	
		The Suffield House	\$ (9,220)
		The Rose's at Guilford House	\$ 825,270
		CM 5781 LLC	\$ 7,325
Total Other Current Assets (Itemize)			\$ 823,375

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	
Total Other Assets			\$ -

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	
		Accrued Vacation Time	\$ 414,849
		Accrued Medicare A Expenses	\$ 108,110
		Accrued Pension	\$ 20,000
		Accrued Provider Tax	\$ 68,925
		Patient and Payroll Exchange	\$ (4,839)
		Employee Loans	\$ (4,200)
Total Other Current Liabilities (Itemize)			\$ 602,845

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 The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	2,673,464
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)			\$ 2,673,464	

* 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. 460-C	Report for Year Ended 9/30/2021	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	677,968
2. Notes Payable (<i>itemize</i>)				\$	623,644
People's Bank line of credit				611,419	
People's Bank Note Payable				9,363	
Dell Financial				2,862	
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>)				\$	199,664
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	15,517
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>)				\$	602,845
				See Schedule	602,845
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,119,638

* 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. 460-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,119,638	
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>)				\$ 869,205
CM 5775 LLC		844,982		
Due to Solamor Hospice		24,223		
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 869,205
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,988,843

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2021	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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			\$	
6. Gain or Loss for Period			\$	781,430
	10/1/2020	thru 9/30/2021		
7. Total Net Worth			\$	781,430
C. Total Reserves and Net Worth			\$	781,430
D. Total Liabilities, Reserves, and Net Worth			\$	3,770,273

H. Changes in Total Net Worth

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	(1,198,402)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,665,677
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	9,884,247
D. Net Income or Deficit			\$	781,430
E. Balance			\$	(416,972)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Calvin and Patricia Moffie	206,464			
Calvin and Patricia Moffie	37,301			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	243,765
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	142,172
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
Calvin Moffie	Owner	142,172		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	142,172
H. Balance at End of Period			\$	(315,379)

I. Preparer's/Reviewer's Certification

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2021	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 ext. 4004	
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				