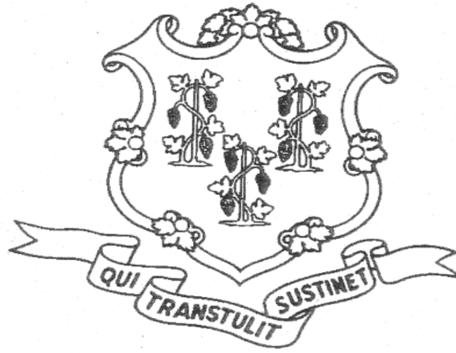
State of Connecticut



Annual Report of Long-Term Care Facility
Cost Year 2018

Name of Facility (as licensed)		
The Guilford House		
Address (No. & Street, City, State, Zip Code)		
109 West Lake Avenue, Guilford, CT		
Type of Facility		
☐ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Other
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	Other	Medicare Provider
	460-C			07-5235

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4606		

For Department Use Only

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

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Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Guilford House [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Calvin Moffie			Printed Name (Owner) Calvin Moffie	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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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 10/1/2017	To 9/30/2018
Address of Facility 109 West Lake Avenue, Guilford, CT					
Report Prepared By Tim Dolce		Phone Number 203-488-9142		Date 2/1/2019	

Item		Total	CCNH	RHNS	Other
1. Dietary wages paid	$	388,580	388,580		
2. Laundry wages paid	$	16,223	16,223		
3. Housekeeping wages paid	$	265,254	265,254		
4. Nursing wages paid	$	3,412,564	3,412,564		
5. All other wages paid	$	1,703,845	1,703,845		
6. ***Total Wages Paid***	$	5,786,466	5,786,466		
7. Total salaries paid	$	130,019	130,019		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	5,916,485	5,916,485		

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-488-9142	9/30/2018	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Guilford House	109 West Lake Avenue, Guilford, CT

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.
	460-C			07-5235

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Calvin Moffie	000738

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	○	⦿		Administrator	Page 10 Line A-2	126,019	126,019
Patricia Moffie	109 West Lake Avenue, Guilford, CT	○	⦿		RN	Page 10 Line A12B2	190,000	190,000
Jillian (Moffie) DeGennaro	109 West Lake Avenue, Guilford, CT	○	⦿		Admissions	Page 10 Line A12M	77,006	77,006
Nathan Moffie	109 West Lake Avenue, Guilford, CT	○	⦿		HR Director	Page 10 Line A-4	92,231	92,231
Christopher DeGennaro	109 West Lake Avenue, Guilford, CT	○	⦿		Maintenance Director	Page 10 Line A-7	15,000	15,000
CM 5775, LLC	109 West Lake Avenue, Guilford, CT	○	⦿		Owns building operations is in	Page 22 Line 9	654,303	654,303
Grand Prix Painting	203 Williams Road, Wallingford, CT	○	⦿		Painting of walls and furniture	Page 22 Line 6A	4,145	4,145
		○	⦿					
		○	⦿					

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	5	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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
ABM Business Systems	○	⦿	Copier Maintenance - cost per copy		Monthly	1,190	1,190
Pitney Bowes Global	○	⦿	Postage Meter		Monthly	1,868	1,868
De Lage landen	○	⦿	Copier Lease		Monthly	14,323	14,323
Wells Fargo	○	⦿	Copier Lease		Monthly	3,654	3,654
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

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

Total *** 21,035

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	7	37

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

⦿ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⦿ Yes ○ No

If "No," explain.

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Clifton Larson Allen LLP	300 Crown Colony Drive, Quincy, MA 02169
2	Sheptoff Reuber & Company	111 New London Turnpike, Glastonbury CT
3	Wells Thomas LLC	568 East Main Street, Branford, CT 06405
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Medicare Cost Report	$ 2,750
2	Yearend Financial Review	$ 8,590
3	401K Audit and Management	$ 1,179
4		$
	Charge for Services Provided	$ 12,519

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

⦿ Yes ○ No — Page 15 Line 9-D Accounting

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Green & Levine LLP	860-677-7004
2	Kainen, Escalera and McHale	860-493-0870
3	Unemployment Tax Management	781-245-5353
4	Wiggins and Dana	860-297-3723
5	See Attached Schedule	

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

1 231 Farmington Avenue, Farmington, CT
2 21 Oak Street Suite 601 Hartford, CT
3 P.O.Box 4074 Wakefield, MA
4 20 Church Street, Hartford, CT
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Legal support for business transactions fot The Guilford House	$ 7,843
2	Handle age discrimination law suite	$ 256
3	Advisor for handling unemployment claims by Guilford House employees	$ 4,770
4	handle legal defense againist claims for resident care	$ 9,918
5	See Attached Schedule	$ 12,984
	Charge for Services Provided	$ 35,771

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

⦿ Yes ○ No — Page 15 Line 9-E Legal

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	75	75			75	75			75	75		
B. On last day of THIS report period	75	75			75	75			75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	67	67			67	67			75	75		
B. As of midnight of THIS report period	73	73			75	75			73	73		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,026	8,026			6,307	6,307			1,719	1,719		
B. Medicaid (Conn.)	8,717	8,717			6,186	6,186			2,531	2,531		
C. Medicaid (other states)												
D. Private Pay	3,484	3,484			2,413	2,413			1,071	1,071		
E. State SSI for RCH												
F. Other (Specify) Managed Medicare	4,396	4,396			3,297	3,297			1,099	1,099		
G. Total Care Days During Period (3A thru F)	24,623	24,623			18,203	18,203			6,420	6,420		
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)**	24,623	24,623			18,203	18,203			6,420	6,420		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR
No. of Residents	25	24		24				
Per Diem Rate								
a. One bed rm.	640.67	248.10		395.00				
b. Two bed rms.	640.67	248.00		440.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	17,955	17,955		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	478,431	478,431		
D. ***Total Physical Therapy Treatments***	496,386	496,386		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	805	805		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	32,935	32,935		
D. ***Total Speech Therapy Treatments***	33,740	33,740		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	13,794	13,794		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	418,634	418,634		
D. ***Total Occupational Therapy Treatments***	432,428	432,428		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	126,019	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	313,667	10,224				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	66,128	2,196				
c. Dietary Workers	322,452	17,851				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	265,254	19,269				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	48,846	2,302				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	16,223	1,099				
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	106,136	2,080				
b. RN						
1. Direct Care	570,657	13,416				
2. Administrative**	496,112	10,029				
c. LPN						
1. Direct Care	1,142,404	39,221				
2. Administrative**						
d. Aides and Attendants	1,097,254	71,626				
e. Physical Therapists	608,871	15,231				
f. Speech Therapists	78,710	1,646				
g. Occupational Therapists	429,138	11,343				
h. Recreation Workers	62,224	3,405				
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	150,359	4,424				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,900,455	227,442				

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Massage Therapy	$ 725	29				
Total	$ 725	29	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	11	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: Other	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I - Operators/Owners										
Calvin Moffie	126,019			Same as other Employees	oversee daily operations of facility	2,080	Line A-2			
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	190,000			Same as other Employees	RN oversee care of residents	2,080	Line 12-B-2			
Jillian DeGennaro(moffie)	77,006			Same as other Employees	Admissions	2,080	A-12-M			
Nathan Moffie	92,231			Same as other Employees	HR Director	2,080	A-4			
Christopher DeGennaro	15,000			Same as other Employees	Maintenance Supervisor	480	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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators* **										
Calvin Moffie	126,019			Same as other Employees	oversee daily operations of facility	2,080	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	13	37

Item	CCNH	Hours	RHNS	Hours	Other	Hours
	Total Cost and Hours					
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	5,462	75				
3. Pharmacist	24,210	476				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,000	68				
b. Utilization Review (Title 18 and 19 only) monthly meeting	12,907	105				
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) Swallow Therapy	4,320	48				
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						
2. Administrative***	375	4				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	725	29				
B-13 Total Fees Paid in Lieu of Salaries	77,999	805				

* 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	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Partners Pharmacy	Pharmacy, Medical records, Pharmacy Consultant	○	⦿	
Healthmed Urgent Care LLC	Medical Staff	○	⦿	
Lori Griffin RN	Nurse Consultant	○	⦿	
James J Zumpano, MD	Medical Staff	○	⦿	
Healthdrive Dental Group	Dental Service	○	⦿	
Channa Perera, MD	Medical Director	○	⦿	
Celtic Healing Arts	Message Therapy	○	⦿	
SDX Swallowing Diag	Swallowing Consultant	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	115,274	115,274		
2. Disability Insurance	$				
3. Unemployment Insurance	$	74,500	74,500		
4. Social Security (F.I.C.A.)	$	430,305	430,305		
5. Health Insurance	$	385,818	385,818		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	18,134	18,134		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	129,472	129,472		
d. Accounting and Auditing	$	12,519	12,519		
e. Legal (*Services should be fully described on Page 7)*	$	35,771	35,771		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	21,481	21,481		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,834	20,834		
2. Cellular Phones	$	1,747	1,747		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	263,569	263,569		
Subtotal	$	1,509,425	1,509,425		

* 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	Other
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		1,509,425	1,509,425		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,936	1,936		
4. Employee Travel	$	702	702		
5. Education Expenses Related to Seminars and Conventions	$	13,958	13,958		
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*)	$	3,903	3,903		
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	$	2,453	2,453		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,982	5,982		
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	$	104,121	104,121		
C-14 Total Administrative & General Expenditures	$	1,642,480	1,642,480		

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Other
CAHCF	$ 5,818		
MED*PASS	$ 164		
Total Dues	$ 5,982	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Printing	$ 2,880		
Business Promotion	$ 12,779		
CT Back Ground Checks	$ 2,944		
Fees & Registration	$ 338		
License & Permits	$ 2,650		
Computer Services	$ 60,725		
Payroll Services	$ 19,129		
Bank Fees	$ 2,676		
Total Other Administrative and General	$ 104,121	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2018	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	460-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	251,396	251,396		
2. Non-Food Supplies	$	36,111	36,111		
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)	$	287,507	287,507		

2F. Dietary Questionnaire	Total	CCNH	RHNS	Other
G. Resident Meals: Total no. of meals served per day:*	73,869	73,869		

	Question	Yes	No	
H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	Other
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	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. $	968	968		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	88,520	88,520		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	89,488	89,488		

3F. Laundry Questionnaire

	Question			
G.	Is cost of employee laundry included in 3E?	○ Yes	⦿ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⦿ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⦿ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

*** 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	9/30/2018	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	42,964	42,964		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	42,964	42,964		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	585,662	585,662		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	215,763	215,763		
d. Ambulance/Limousine***		$				
e. Oxygen 1. For Emergency Use		$				
2. Other***		$	23,969	23,969		
f. X-rays and Related Radiological Procedures***		$	26,626	26,626		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	60,491	60,491		
i. Recreation		$	23,203	23,203		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	119,762	119,762		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,055,474	1,055,474		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
*** Facility should self-disallow the expense on Page 29 of the Cost Report.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	Other
Social Service Expense	$ 1,256		
Physical Therapy Supplies A	$ 554		
Physical Therapy Supplies B	$ 507		
IV House	$ 156		
Complex Medical Equipment	$ 2,640		
Medicare Non-Billable	$ 100,589		
Medicare Transportation	$ 9,316		
Mattress Rental	$ 4,744		
Total Other Resident Care	$ 119,762	$ -	$ -

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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 9/30/2018	Page 21 of 37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers: Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***: CCNH	RHNS	Other	Pg	Line
Paulo Landscaping LLC		○	⦿		Landscaping and snow plowing	27,031				
Whitewater Inc		○	⦿		Sewer Treatment consultant	71,169				
Anderson Brothers Sanitation		○	⦿		Grease Trap and sewer line service	7,299				
All State Fire Equipment		○	⦿		Fire Equipment	296				
Bioserv		○	⦿		Medical waste	830				
Brand Services		○	⦿		Fire Door Consultants	1,595				
Facilies Compliance Services LLC		○	⦿		of care, Emergency management	1,329				
Gentech Power Systems Inc		○	⦿		Generator service	6,581				
Guaranty Pest Elimination		○	⦿		Pest Control	2,446				
John's Refuse & Recycling LLC		○	⦿		Trash Service	25,072				
Johnson Controls Security Solutions		○	⦿		Door Security for employees	211				
Mack Fire Protection LLC		○	⦿		Fire Sprinkler Service	1,079				
Proshred Security		○	⦿		Paper Shredding	1,930				
Schedule Attached		○	⦿		see attached	12,615				

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

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

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2018	Page of 22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	67,511	67,511		
b. Heat	$	27,301	27,301		
c. Light & Power	$	96,776	96,776		
d. Water	$	12,111	12,111		
e. Equipment Lease (*Provide detail on page 6*)	$	21,035	21,035		
f. Other (*itemize*)	$	196,754	196,754		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	421,487	421,487		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	26,264	26,264		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	26,264	26,264		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	3,392	3,392		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,392	3,392		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	654,303	654,303		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	6,103	6,103		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	690,062	690,062		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Other
Generator Fuel	$ 2,776		
Bulk Cable TV	$ 34,496		
Record Storage	$ 2,024		
Maintenance Service Contracts	$ 53,563		
Septic System Service	$ 76,865		
Yard Maintenance	$ 27,031		
Total Other Repairs and Maintenance	$ 196,754	$ -	$ -

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Depreciation Schedule

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2018	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? Yes	No	Date of Acquisition Month	Year	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
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					538,488		538,488	435,702	SL	5 to 7 year	23,460	
b. Disposals (attach schedule)					(26,165)							
c. Acquired during this report period (attach schedule)					54,837						2,804	
D-3. Subtotal												26,264
E. ***Total Depreciation***												26,264

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 peri

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/26/2018	Wheel Chair	$ 1,851	5	$ 247	
2/28/2018	Chart & Carts top shelf	$ 417	5	$ 49	
2/28/2018	Dell Computers	$ 6,657	5	$ 777	
5/9/2018	Jm Edwards Circuit Breaker	$ 1,270	5	$ 85	
5/31/2018	Call systems parts	$ 4,864	5	$ 324	
5/31/2018	Printer Kitchen	$ 784	5	$ 52	
6/26/2018	Sandwich Prep Frig	$ 4,936	5	$ 247	
7/10/2018	Avaya Phone system	$ 20,102	5	$ 671	
7/31/2018	Air Conditioner Compressor	$ 8,153	5	$ 272	
8/16/2018	Ice Machine	$ 4,871	5	$ 81	
9/12/2018	Optiples 3050 Computer	$ 933	5	$ -	
Total additions for Movable Equipmen		$ 54,837		$ 2,804	*
Deletions:					
10/1/2017	Mattress	$ (26,165)	7		
Total deletions for Movable Equipmen		$ (26,165)		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
7/6/2018	Automatic Door Bottom Glide	$ 1,153	10	$ 19	
7/27/2018	Red Hawk CT2 & SIGA module	$ 2,297	10	$ 38	
9/14/2018	ABC-LERS Curbs	6976.56	10	0	
Total additions for Leasehold Improvemen		$ 10,426		$ 57	*
Deletions:					
Total deletions for Leasehold Improvemen		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2018	Page 24	of 37

Item	Date of Acquisition Month	Date of Acquisition Year	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
A. **Organization Expense**									
1.									
2.									
3. Spaulding Loan Origination Fees		2013		17,000	17,000				
A-4. Subtotal									
B. **Mortgage Expense**									
1. Refinance Fees		2015		8,810	8,810				
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				131,479	38,775			3,335	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				10,426				57	
C-4. Subtotal									3,392
D. ***Total Amortization***									3,392

* Straight-line method must be used.
** Specify which of the following bases were used:
A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	25 | 37

11. Property Questionnaire

Part A

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

⦿ Yes　　○ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	75
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)	HUD			
b. Date Mortgage Obtained	01/01/13			
c. Interest Rate for the Cost Year	377.00%			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	10,500,000			
f. Principal balance outstanding as of ___________	10,082,562			
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	9/30/2018	26 | 37

Item		Total	CCNH	RHNS	Other
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	27 | 37

Item				Total	CCNH	RHNS	Other
		Subtotals Brought Forward:					
12. C. Movable Equipment 1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$	79,407	79,407		
A. Item Working Capital Loans	Rate	Amount 58,239					
Lender TD bank,1st Nat bank, Spaulding Capital,							
Address of Lender							
B. Item Vendor Accounts Payable Loans	Rate	Amount 21,168					
Lender Omni, Partners, Dell, Tyco, Avaya							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$	79,407	79,407		
12. D. Other Interest Expense (*Specify*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	79,407	79,407		
14. Insurance a. Insurance on Property (buildings only)			$	4,752	4,752		
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)***			$	4,752	4,752		
15. ***Total All Expenditures (A-13 thru C-14)***			$	10,292,074	10,292,074		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	9-C	Bad Debts	$	129,472	129,472		
10.			Accounting	$				
10a.			Legal	$				
11.			Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.	16	M-13	Unallowable Advertising *	$	12,779	12,779		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	1,936	1,936		
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)	$	144,187	144,187		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16	L-3	Employee Relation	$ 1,936		
Total Other A&G Adjustments			$ 1,936	$ -	$ -

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CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward	$	144,187	144,187		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$				
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.			Laboratory	$				
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	567,194	567,194		
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	$	34,496	34,496		
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)***	$	745,877	745,877		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5-L	PT Expense A	$ 554		
20	5-L	PT Expense B	$ 507		
20	5-A-2	Pharmacy Medicare A	$ 366,472		
20	5-H	Lab Med A	$ 60,491		
20	5-F	Radiology Med A	$ 26,626		
20	5-L	Complex Medical Equipment A	$ 2,640		
20	5-L	Medicare Non-Billable	$ 100,589		
20	5-L	Medicare A Transportation	$ 9,316		
Total Other Ancillary Costs			$ 567,194	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	6-F	Bulk Cable TV	$ 34,496		
Total Other Property Adjustments			$ 34,496	$ -	$ -

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2018	Page 30 of 37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,420,485	3,420,485		
b. Medicaid Room and Board Contractual Allowance **	$	(1,274,396)	(1,274,396)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,258,330	3,258,330		
b. Medicare Room and Board Contractual Allowance **	$	1,743,004	1,743,004		
4. a. Private-Pay Residents and Other	$	3,100,089	3,100,089		
b. Private-Pay Room and Board Contractual Allowance **	$	103,512	103,512		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	347,611	347,611		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(347,611)	(347,611)		
c. Prescription Drugs - Non-Medicare	$	200,421	200,421		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(200,421)	(200,421)		
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	$	1,454,355	1,454,355		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,420,686)	(1,420,686)		
c. Physical Therapy - Non-Medicare	$	597,260	597,260		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(591,597)	(591,597)		
4. a. Speech Therapy - Medicare	$	113,495	113,495		
b. Speech Therapy - Medicare Contractual Allowance **	$	(108,962)	(108,962)		
c. Speech Therapy - Non-Medicare	$	64,900	64,900		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(64,900)	(64,900)		
5. a. Occupational Therapy - Medicare	$	1,289,129	1,289,129		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,261,178)	(1,261,178)		
c. Occupational Therapy - Non-Medicare	$	466,917	466,917		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(466,917)	(466,917)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,422,839	10,422,839		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	130	130		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	130	130		
VI. Total All Revenue (III +V)	$	10,422,969	10,422,969		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab Med A	$ 24,397		
	Radiology Med A	$ 51,144		
	Lab Med A	$ (24,397)		
	Radiology Med A	$ (51,144)		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab Medicaid	$ 106		
	Lab Other	$ 12,991		
	Radiology Medicaid	$ 150		
	Radiology Other	$ 16,914		
	Lab Medicaid	$ (106)		
	Lab Other	$ (12,991)		
	Radiology Medicaid	$ (150)		
	Radiology Other	$ (16,914)		
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	Other
	Interest on old ManageCare claims	-	$ 130		
Total Interest Income			$ 130	$ -	$ -

Schedule of Other Revenue

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

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	31 | 37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 435,247
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,039,332
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 17,154
5. Prepaid Expenses			$ 11,525
a. Prepaid Other - Lawyer Retainers		11,525	
b.			
c.			
d. See Schedule			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 1,040
Employee Loar		1,040	
See Schedule			
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 1,504,299
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	141,905	$ 99,738
	Accum. Depreciation	42,167 Net	
5. Non-Movable Equipment	*Historical Cost		$
	Accum. Depreciation	Net	
6. Movable Equipment	*Historical Cost	567,161	$ 106,756
	Accum. Depreciation	460,405 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$
See Schedule			
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 206,494

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	32 | 37

Account				Amount
			Total Brought Forward:	$ 1,710,793
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	17,000		
	Accum. Depreciation	17,000	Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ 52,906
Name and Address	Amount	Loan Date		
Rose's@Guilford House	52,906	9/30/18		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 52,906
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,763,699

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
		Loan Origination Fee	$ 25,810
		Accum Amort Loan Origination Fee	$ (25,810)
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	
		First National Bank of Suffield - Working Capital Loan	$ 731,188
		TD Bank - Working Capital Loan	$ 38,498
		Spaulding Capital - Working Capital Loan	$ 176,973
		Global Financial - Security System Loan	$ 875
		OmniCare - Accounts Payable Note	$ 67,833
		Partners Pharmacy - Accounts Payable Note	$ 148,320
		Note Payable - Avaya Phone System	$ 19,002
		Note Payable - Dell Computer	$ 14,489
Total Notes Payable			$ 1,197,178

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 921,589
2. Notes Payable (*itemize*)				$ 1,197,178
See Schedule		1,197,178		
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 129,226
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 9,964
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$ 4,441
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 517,432
Accrued Pension	18,066	Patient Exchange	(1,180)	
Accrued Vacation	314,586	Payroll Exchange	(2,035)	
Accrued Porvider Tax	74,852	Patient Refunds	(2,456)	
Accrued Medicare A Consolidated E	115,598	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,779,830

* 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	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	34	37

Account	Amount
Total Brought Forward:	2,779,830
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 501,578

Name and Address of Lender	Amount	Loan Date
CM 5775, LLC	501,578	9/30/18

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 24,223
Due to Solamor Hospice	24,223	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 525,801
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 3,305,631

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	9/30/2018	35	37

Account					Amount
A. **Reserves**					
1. Reserve for value of leased land					$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized					$
3. Reserve for depreciation value of leased personal property (*Equity)*					$
4. Reserve for leasehold real properties on which fair rental value is based					$
5. Reserve for funds set aside as donor restricted					$
6. Total Reserves					$
B. **Net Worth**					
1. Owner's Capital					$
2. Capital Stock					$
3. Paid-in Surplus					$
4. Treasury Stock					$
5. Cumulated Earnings					$ (1,672,827)
6. Gain or Loss for Period	10/1/2017	thru	9/30/2018		$ 130,895
7. Total Net Worth					$ (1,541,932)
C. ***Total Reserves and Net Worth***					$ (1,541,932)
D. ***Total Liabilities, Reserves, and Net Worth***					$ 1,763,699

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2018	36 | 37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017	$ (1,475,099)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 10,422,969
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 10,292,074
D.	Net Income or Deficit	$ 130,895
E.	Balance	$ (1,344,204)
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$ 197,728

Name and Address (*No., City, State, Zip*)	Title	Amount
Calvin Moffie	Owner	197,728

	Account	Amount
	2. Other Withdrawings (*Specify*)	$

Purpose	Amount

	Account	Amount
	3. Total Deductions	$ 197,728
H.	***Balance at End of Period*** 09/30/18	$ (1,541,932)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2018	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Tim Dolce

Addres Address	Phone Number
109 West Lake Avenue, Guilford, CT 06437	203-488-9142