State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2016

Name of Facility (as licensed) The Guilford House		
Address (No. & Street, City, State, Zip Code) 109 West Lake Avenue, Guilford, CT 06437		
Type of Facility ☐ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	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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General Information

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) 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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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 10/1/2015	To 9/30/2016
Address of Facility 109 West Lake Avenue, Guilford, CT 06437				
Report Prepared By Tim Dolce	Phone Number 203-488-9142		Date 1/13/2017	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	382,020	382,020		
2. Laundry wages paid	$	20,162	20,162		
3. Housekeeping wages paid	$	255,171	255,171		
4. Nursing wages paid	$	3,141,826	3,141,826		
5. All other wages paid	$	1,554,817	1,554,817		
6. ***Total Wages Paid***	$	5,353,995	5,353,995		
7. Total salaries paid	$	130,714	130,714		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	5,484,709	5,484,709		

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	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Guilford House	109 West Lake Avenue, Guilford, CT 06437

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	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) ☐ (Specify)

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
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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
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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
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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*

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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	130,714	
Patricia Moffie	109 West Lake Avenue, Guilford, CT	○	◉		RN	Page 10 Line A12B2	197,308	
Jillian Moffie	109 West Lake Avenue, Guilford, CT	○	◉		Admissions	Page 10 Line A-4	61,090	
CM 5775, LLC	109 West Lake Avenue, Guilford, CT	○	◉		Owns Building operatings are in	Page 22 Line 9	1,105,862	
Grand Prix Painting	203 Willaims Road, Wallingford, CT	○	◉		Painting of walls and furniture	Page 22 Line 6A	4,330	
		○	○					
		○	○					
		○	○					
		○	○					

* 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

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
ABM Business Systems	○	◉	Copier Maintenance		Monthly	969	969
Pitney Bowes Global	○	◉	Poatage Meter Rental		Monthly	2,329	2,329
De Lage Landen	○	◉	Cost per copy for copier		Monthly	7,609	7,609
GE Capital/Wells Fargo	○	◉	Copier Lease		Monthly	8,720	8,720
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		○ Yes	◉ No		**Total *****		19,627

* 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

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

◉ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Clifton,Larson & Allen LLP	300 Crown Colony Drive, Quincy, MA 02169
2	Craig J. Lubitski Consulting LLC	225 Pitkin Street, East Hartford, CT 06108
3	Sheptoff, Reuber & Company, P.C.	111 New London Turnpike, Glastonbury, CT
4		

Services Provided by This Firm (*describe fully*)

1	Year end review of financial statements and Medicare cost report	$ 10,125
2	Wage and Enhancement program	$ 600
3	Tax work on the sale and purchase of CM 5775 owner of building	$ 6,810
4		$
	Charge for Services Provided	$ 17,535

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

◉ Yes ○ No — Page 15 Line 9D

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		
5		

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 01880
4
5

Services Provided by This Firm (*describe fully*)

1	legal support for business tranactions for the Guilford House	$ 10,800
2	handling age discrimination law suite	$ 5,896
3	Advisor for handling unemployment claims by Guilford House employees	$ 4,270
4		$
5		$
	Charge for Services Provided	$ 20,966

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

◉ Yes ○ No — Page 15 Line 9E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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			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	62	62			62	62			71	71		
B. As of midnight of THIS report period	59	59			66	66			59	59		
3. Total Number of Days Care Provided During Period												
A. Medicare	9,459	9,459			7,475	7,475			1,984	1,984		
B. Medicaid (Conn.)	8,545	8,545			6,121	6,121			2,424	2,424		
C. Medicaid (other states)												
D. Private Pay	2,528	2,528			1,744	1,744			784	784		
E. State SSI for RCH												
F. Other (Specify) ManageCare	4,004	4,004			3,016	3,016			988	988		
G. Total Care Days During Period (3A thru F)	24,536	24,536			18,356	18,356			6,180	6,180		
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)**	24,536	24,536			18,356	18,356			6,180	6,180		

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Schedule of Resident Statistics (Cont'd)

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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ◉ No
If "YES", provide the following information:

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

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

Change in Resident Days	CCNH	RHNS	(Specify)
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	(Specify)	R.C.H.	ICF-MR
No. of Residents	17	22		20				
Per Diem Rate								
a. One bed rm.	607.12	248.10		475.00				
b. Two bed rms.	607.12	248.10		395.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	11,130	11,130		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	506,711	506,711		
D. ***Total Physical Therapy Treatments***	517,841	517,841		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	225	225		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	45,340	45,340		
D. ***Total Speech Therapy Treatments***	45,565	45,565		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	9,761	9,761		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	433,814	433,814		
D. ***Total Occupational Therapy Treatments***	443,575	443,575		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)	130,714	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	225,315	9,242				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	54,447	2,310				
c. Dietary Workers	327,572	21,704				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	255,171	21,148				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	34,325	1,931				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	20,162	1,344				
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	104,987	2,080				
b. RN						
1. Direct Care	476,611	12,139				
2. Administrative**	483,134	10,440				
c. LPN						
1. Direct Care	1,077,367	36,796				
2. Administrative**						
d. Aides and Attendants	999,727	69,640				
e. Physical Therapists	617,954	16,292				
f. Speech Therapists	66,499	1,581				
g. Occupational Therapists	417,883	11,991				
h. Recreation Workers	76,895	4,480				
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	115,946	4,160				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,484,709	229,358				

* 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		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Message Therapy	$ 3,700	148				
Total	$ 3,700	148	$ -	-	$ -	-

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

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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	130,714			Same as other employees	Oversee daily operations of facilty	2,080	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	197,308			Same as other employees	RN, oversee care of residents, cash flow	2,080	A-12B2			
Jillian Moffie	61,090			Same as other employees	Admissions	2,080	A-12M			

* 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
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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* **										
Calvin Moffie	130,714			Same as other employees	Oversee daily operations of facilty	2,080	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
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
***B. Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	5,198	69				
3. Pharmacist	13,888	278				
4. Podiatrist	36	1				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,000	61				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	12,180	106				
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)						
Nursing Consultant	7,710	154				
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***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	3,700	148				
B-13 Total Fees Paid in Lieu of Salaries	72,711	817				

* 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.

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

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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Partner's Pharmacy	Pharmacy, Medical records, Nurse Consultant	○	◉	
Harbor Medical Associates, LLC	Medical Staff	○	◉	
James J. Zumpano, MD	Medical Staff	○	◉	
HealthDrive Dental Group	Dental Services	○	◉	
Channa Perera, M.D.	Medical Director	○	◉	
Celtic Healing Arts	Message Therapy	○	◉	
HealthDrive Prodiatrist	Prodiatrist	○	◉	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	161,553	161,553		
2. Disability Insurance	$				
3. Unemployment Insurance	$	125,297	125,297		
4. Social Security (F.I.C.A.)	$	402,844	402,844		
5. Health Insurance	$	365,406	365,406		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	17,701	17,701		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	60,447	60,447		
d. Accounting and Auditing	$	17,535	17,535		
e. Legal (*Services should be fully described on Page 7)*	$	20,966	20,966		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	15,680	15,680		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	19,506	19,506		
2. Cellular Phones	$	135	135		
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	$	222,112	222,112		
Subtotal	$	1,429,181	1,429,181		

* 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	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,429,181	1,429,181		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,160	2,160		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	803	803		
5. Education Expenses Related to Seminars and Conventions	$	1,802	1,802		
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*)	$	456	456		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	2,226	2,226		
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	$	2,965	2,965		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,468	5,468		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	503	503		
10. Contributions*** See Attached Schedule	$	100	100		
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	$	64,687	64,687		
C-14 Total Administrative & General Expenditures	$	1,510,351	1,510,351		

* 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)
Business Promotion	$ 2,226		
Total Other Advertising	$ 2,226	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,468		
Total Dues	$ 5,468	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Guilford Fire Department	$ 100		
Total Contributions	$ 100	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Printing	$ 3,140		
Ct Back ground check	$ 1,889		
License & Permits	$ 2,881		
Computer Service	$ 25,852		
Payroll Service	$ 17,488		
Late Fee	$ 7,188		
Miscellaneous Administrative	$ 3,793		
Bank Fee	$ 2,456		
Total Other Administrative and General	$ 64,687	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility The Guilford House	License No. 460-C	Report for Year Ended 9/30/2016	Page 17 of 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.**

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CSP-18 Rev. 9/2002

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	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	264,986	264,986		
2. Non-Food Supplies	$	35,328	35,328		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	300,314	300,314		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				

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

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CSP-19 Rev. 9/2002

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 9/30/2016	Page 19 of 37

Item		Total	CCNH	RHNS	(Specify)
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. $	1,124	1,124		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	81,787	81,787		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	82,911	82,911		

3F.	Laundry Questionnaire			
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.

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

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

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CSP-20 Rev. 9/2002

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	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	41,684	41,684		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	41,684	41,684		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	626,190	626,190		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	199,975	199,975		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	33,199	33,199		
f. X-rays and Related Radiological Procedures***		$	27,366	27,366		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	58,102	58,102		
i. Recreation		$	25,954	25,954		
j. Other (Specify)**** See Attached Schedule		$	33,303	33,303		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,004,088	1,004,088		

* 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	$ 731		
Physical Therapy Expense	$ 524		
Physical Therapy Expense	$ 1,778		
IV House	$ 169		
Complex Med Equipment	$ 22,128		
Medicare Non-Billable	$ 4,414		
Medicare Transportation	$ 1,842		
Flu Vaccine	$ 748		
Mattress Rental	$ 968		
Total Other Resident Care	$ 33,303	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	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
New England Water utility Service		○	⊙		Sewer treatment plant maintenance	153			22	6-F
Whitewater Inc		○	⊙		Sewer treatment plant maintenance	67,188			22	6-F
McVac Enviromental Services, Inc		○	⊙		Sewer treatment plant maintenance	4,992			22	6-F
Paulo Landscaping LLC		○	⊙		Yard maintenance and snow plowing	23,850			22	6-F
Brand Services		⊙	○		exhaust Hood Cleaning	1,685			22	6-F
All State Fire Equipment		○	⊙		Fire equipment	504			22	6-F
Anderson Brothers Sanitation		○	⊙		Sewer treatment plant maintenance	3,456			22	6-F
ArjoHuntleigh		○	⊙		equipment power service	1,010			22	6-F
Comcast		○	⊙		cable TV	22,583			22	6-F
E.N.T. Heating & Cooling		○	⊙		HVAC	7,232			22	6-F
Gentech Power Systems, Inc		○	⊙		Generator Service	9,695			22	6-F
Guaranty Pest Elimination		○	⊙		Pest control	2,446			22	6-F
John's Refuse & Recycling		○	⊙		trash service	23,703			22	6-F
Mack Fire Protection		○	⊙		Fire Sprinklers	1,571			22	6-F

* 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 9/30/2016			Page 22 of 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	49,310	49,310		
b. Heat	$	781	781		
c. Light & Power	$	97,472	97,472		
d. Water	$	9,130	9,130		
e. Equipment Lease (*Provide detail on page 6*)	$	19,627	19,627		
f. Other (*itemize*)	$	214,279	214,279		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	390,600	390,600		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	38,396	38,396		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	38,396	38,396		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	5,405	5,405		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	3,461	3,461		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	8,866	8,866		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,105,862	1,105,862		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	5,684	5,684		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,158,808	1,158,808		

* 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)
Gas	$ 23,936		
Maintenance Service Contracts	$ 88,386		
Septic System Upkeep	$ 68,976		
Yard Maintenace	$ 24,331		
Equipment Rental Comcast	$ 8,650		
Total Other Repairs and Maintenance	$ 214,279	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	23	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					451,060		451,060	376,229	SL	5YRS TO	35,307	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					49,470						3,090	
D-3. Subtotal												38,396
E. ***Total Depreciation***												38,396

The Guilford House
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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/1/2015	Chart & Carts	$ 2,566	5	$ 470	
10/15/2015	TV	$ 374	5	$ 69	
11/20/2015	Computer & Printer	$ 1,383	5	$ 253	
4/6/2016	TV	$ 450	5	$ 38	
5/18/2016	HVAC Software	$ 2,917	5	$ 194	
6/30/2016	Nursing Call System Software	$ 9,625	5	$ 481	
7/18/2016	Ipad	542	5	$ 18	
9/14/2016	Ice machine	1,249	5	0	
9/30/2016	Website design	3,500	5	0	
4/19/2016	50 Mattress	26,165	7	1,557	
8/31/2016	Chair	700	7	8	
Total additions for Movable Equipment		$ 49,470		$ 3,090	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	1	2013		17,000	12,143			3,643	
A-4. Subtotal									3,643
B. **Mortgage Expense**									
1. Refinances Fee		2015		8,810				1,762	
2.									
3.									
B-4. Subtotal									1,762
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				131,479	31,570			3,461	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									3,461
D. ***Total Amortization***									8,866

* 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.

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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	9/30/2016	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	
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	01/01/10			
c. Interest Rate for the Cost Year	3.98%			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	10,500,000			
f. Principal balance outstanding as of	10,192,983			
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
The Guilford House	460-C	9/30/2016	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)

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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	9/30/2016	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*) $	100,684	100,684		
A. Item / Rate / Amount Working Capital Lines / 5.60% / 61,483				
Lender TD Bank, 1st National Bank, Spaulding Capital				
Address of Lender				
B. Item / Rate / Amount Vendor Acoount payable Loans / 5.00% / 39,201				
Lender OmniCare, Partners Pharmacy				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $	100,684	100,684		
12. D. Other Interest Expense (*Specify*) $ Demm Computers equipment purchase 24 months	861	861		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	101,545	101,545		
14. Insurance				
a. Insurance on Property (buildings only) $				
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ Bond Insurance 200 Risk Management 2,425	2,625	2,625		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	2,625	2,625		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,150,344	10,150,344		

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D. Adjustments to Statement of Expenditures

Name of Facility: The Guilford House	License No. 460-C	Report for Year Ended 9/30/2016	Page 28 of 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
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 $	60,447	60,447		
10.			Accounting & 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.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	21,539	21,539		
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) $	81,986	81,986		

* 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 Fee	$ 7,188		
16	M-13	Miscellaneous Administrative Expense	$ 3,793		
16	l-2	Employee Relations	$ 1,421		
16	M-3	Business Promotion	$ 2,226		
15	9-D	Sheptoff, Reuber & Company Professional Fees	$ 6,810		
16	M-10	Donations	$ 100		
Total Other A&G Adjustments			$ 21,539	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	81,986	81,986		
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 $	540,164	540,164		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.	23	D-2	Unallowable Property and Real Estate Taxes $	106	106		
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	622,256	622,256		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	2-J	PT Expense A	$ 524		
20	2-J	PT Expense B	$ 1,778		
20	5-A-2	Pharmacy Med A	$ 439,060		
20	5-2-H	Lab Med A	$ 51,147		
20	5-2-F	Radiology Med A	$ 19,270		
20	2-J	Complex Equipment Med A	$ 22,128		
20	2-J	Medicare Non Billable	$ 4,414		
20	2-J	Medicare A transportation	$ 1,842		
Total Other Ancillary Costs			$ 540,164	$ -	$ -

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)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other 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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,387,900	3,387,900		
b. Medicaid Room and Board Contractual Allowance **	$	(1,283,690)	(1,283,690)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,844,115	3,844,115		
b. Medicare Room and Board Contractual Allowance **	$	1,956,745	1,956,745		
4. a. Private-Pay Residents and Other	$	2,574,658	2,574,658		
b. Private-Pay Room and Board Contractual Allowance **	$	(22,748)	(22,748)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	454,137	454,137		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(454,137)	(454,137)		
c. Prescription Drugs - Non-Medicare	$	160,026	160,026		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(159,032)	(159,032)		
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	$	1,656,306	1,656,306		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,634,678)	(1,634,678)		
c. Physical Therapy - Non-Medicare	$	538,768	538,768		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(529,886)	(529,886)		
4. a. Speech Therapy - Medicare	$	213,825	213,825		
b. Speech Therapy - Medicare Contractual Allowance **	$	(213,233)	(213,233)		
c. Speech Therapy - Non-Medicare	$	61,400	61,400		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(59,987)	(59,987)		
5. a. Occupational Therapy - Medicare	$	1,431,710	1,431,710		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,413,316)	(1,413,316)		
c. Occupational Therapy - Non-Medicare	$	410,960	410,960		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(409,911)	(409,911)		
6. a. Other *(Specify)* - Medicare	$	0	0		
b. Other *(Specify)* - Non-Medicare	$	(0)	(0)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,509,932	10,509,932		
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)*	$	371	371		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	371	371		
VI. Total All Revenue (III +V)	$	10,510,303	10,510,303		

* *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)
20	Lab Medicare A	$ 22,939		
20	Radiology Medicare A	$ 18,160		
20	Lab Medicare A	$ (22,939)		
20	Radiology Medicare A	$ (18,160)		
Total Other Resident Revenue - Medicare		$ 0	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
20	Lab Other	$ 10,732		
20	Radiology Other	$ 6,203		
20	Lab Other	$ (10,732)		
20	Radiology Other	$ (6,203)		
Total Other Resident Revenue		$ (0)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income from insurance company late payments		$ 371		
Total Interest Income			$ 371	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
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	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 351,763
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 809,414
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 17,154
5. Prepaid Expenses				$ 47,049
a. PREPAID INTEREST		640		
b. WORKERS COMP REFUND		46,410		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 439,579
Construction in Progress		439,579		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,664,959
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	131,479		$ 96,449
	Accum. Depreciation	35,031	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	500,529		$ 85,904
	Accum. Depreciation	414,625	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 7,048
Loan Origination Fee		25,810		
Accum Amrt Loan Origination Fee		(18,762)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 189,401

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

(*Carry Total forward to next page*)

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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	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 1,854,360
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,854,360

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 866,248
	2. Notes Payable (*itemize*)				$ 822,914
	1st National Bank of Suffield		50,174		
	TD Bank		95,987		
	Spaulding Capital		391,484		
	OmniCare inc		285,270		
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$ 343,563
	Name of Lender	Purpose	Amount	Date Due	
	Partner's Pharmacy	A/P Loan	339,022		
	Dell Computer's	Equipment	4,541		
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 90,500
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 7,050
	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*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 275,537
	Patient Exchange	(600) Accrued Pension	17,701		
	Payroll Exchange	(840) Acrued Vacation	206,559		
	Employee Loan	(250) Accrued User Fee	67,285		
	Patient Refund	(14,319)			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,405,812

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

(Carry Total forward to next page)

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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	9/30/2016	34	37

Account				Amount
		Total Brought Forward:		2,405,812
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 1,436,234
Due to Solamor Hospice	24,223			
Due to CM 5775 LLC	1,412,012			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 1,436,234
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,842,047

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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	9/30/2016	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$
3. Reserve for depreciation value of leased personal property (*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		$ 1,000
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ (2,671,074)
6. Gain or Loss for Period	10/1/2015 thru 9/30/2016	$ 359,959
7. Total Net Worth		$ (2,310,115)
C. ***Total Reserves and Net Worth***		$ (2,310,115)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 1,531,932

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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	9/30/2016	36	37

Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2015				$ (2,671,074)
B. Total Revenue (*From Statement of Revenue Page 30*)				$ 10,510,303
C. Total Expenditures (*From Statement of Expenditures Page 27*)				$ 10,150,344
D. Net Income or Deficit				$ 359,959
E. Balance				$ (2,311,115)
F. Additions				
1. Additional Capital Contributed (*itemize*)				
Calvin Moffie		372,020		
2. Other (*itemize*)				
F-3. Total Additions				$ 372,020
G. Deductions				
1. Drawings of Owners/Operators/Partners (*Specify*)				$ 49,592
Name and Address (*No., City, State, Zip*)		Title	Amount	
Calvin Moffie		Onwer	49,592	
2. Other Withdrawings *(Specify)*				$
Purpose		Amount		
3. Total Deductions				$ 49,592
H. ***Balance at End of Period***	09/30/16			$ (1,988,687)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Guilford House	460-C	9/30/2016	37	37

Check appropriate category

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

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 ext. 4014

Level	Item	Reported as