

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Bristol Healthcare, Inc. d/b/a ingraham Manor	
Address (No. & Street, City, State, Zip Code) 400 North Main Street, Bristol, CT 06010	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2056-C	RHNS	(Specify)	Medicare Provider 07-5329
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Medicaid Provider Numbers:	CCNH 20561	RHNS	ICF-IID
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### For Department Use Only

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

## General Information

Name of Facility (as licensed) Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bristol Healthcare, Inc. d/b/a ingraham Manor [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Ashley Soyka		Printed Name (Owner)		
Subscribed and Sworn to before me:	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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 400 North Main Street, Bristol, CT 06010				
Report Prepared By	Phone Number	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

	Phone No. of Facility	Report for Year Ended 9/30/2020	Page 2	of 37
Name of Facility (as shown on license) Bristol Healthcare, Inc. d/b/a ingraham Manor	Address (No. & Street, City, State, Zip ) 400 North Main Street, Bristol, CT 06010			
License Numbers: CCNH 2056-C	RHNS	(Specify)	Medicare Provider No. 07-5329	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Ashley Soyka		Nursing Home Administrator's License No.:	36.002090	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

## **General Information and Questionnaire Partners/Members**

# **General Information and Questionnaire**

## **Corporate Owners**

# **General Information and Questionnaire**

## **Individual Proprietorship**

## General Information and Questionnaire

### Related Parties\*

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No 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?				<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Management Fees & Administrator	Pg 16 & 10/ Line m12	1,833,842	1,833,842
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Medical Malpractice Insurance	Pg 27/Line 14c3		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Employee Physical	Pg 15/Line 19a	34,830	34,830
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Deductions	Pass through from Emp		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Property/Umbrella Insurance	Pg 27/Line 14a		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Medical Director/Assistant Medical Director	Pg 13/Line B8	21,400	21,400
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Common Pension Plan	Pg 15/Line 1a7	49,140	49,140
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

\*\* Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

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

## **General Information and Questionnaire**

### **Leases (Excluding Real Property)**

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

Name of Facility		License No.		Report for Year Ended			Page	of
Bristol Healthcare, Inc. d/b/a ingraham Manor		2056-C		9/30/2020			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						
Ricoh, 100 Pearl Street, CT 06103	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/01/16	5 years	15,153	15,153	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		<b>Total ***</b>	15,153	

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

## General Information and Questionnaire

### Accounting Basis

Name of Facility Bristol Healthcare, Inc. d/b/a ingra	License No. 2056-C	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

Is the accounting basis for this

period the same as for the     Yes    If "No," explain.  
previous period?     No

#### Independent Accounting Firm

Name of Accounting Firm 1   Baker Tilly US, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) One Penn Plaza, Ste 3000 New York, NY 10119 United States of America
---	---

Services Provided by This Firm (*describe fully*)

1   Audited Financial Statements	\$ Included in Bristol Hospital a
2	\$ Health Care Group Audit Fee
3   Billing Service Fees	\$ \$150
4	\$
	Charge for Services Provided \$

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

Yes     No

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1   Pullman & Comley, LLC 2 3 4 5	Telephone Number
---	------------------

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

1   850 Main St, PO Box 7006, Bridgeport, CT 06601-7006 2 3 4 5
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Services Provided by This Firm (*describe fully*)

1   Patient Conservator failure of fiduciary duties.	\$ \$560
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$

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

Yes     No

## Schedule of Resident Statistics

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor			License No. 2056-C				Report for Year Ended 9/30/2020				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					128	128						
A. On last day of PREVIOUS report period	128	128										
B. On last day of THIS report period	128	128							128	128		
2. Number of Residents					128	128						
A. As of midnight of PREVIOUS report period	128	128							128	128		
B. As of midnight of THIS report period	128	128							128	128		
3. Total Number of Days Care Provided During Period					2,867	2,867			1,249	1,249		
A. Medicare	4,116	4,116										
B. Medicaid (Conn.)	26,978	26,978			20,152	20,152			6,826	6,826		
C. Medicaid (other states)												
D. Private Pay	4,990	4,990			3,847	3,847			1,143	1,143		
E. State SSI for RCH												
F. Other (Specify)	5,407	5,407			4,063	4,063			1,344	1,344		
G. Total Care Days During Period (3A thru F)	41,491	41,491			30,929	30,929			10,562	10,562		
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. <b>Total Resident Days (3G + 4A + 4B)</b>	41,491	41,491			30,929	30,929			10,562	10,562		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
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	11	74		28				
Per Diem Rate								
a. One bed rm.	Various	246.85		433.00				
b. Two bed rms.	Various	246.85		419.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B		6,589	6,589	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		348	348	
2. Restorative Treatments				
C. Other		19,976	19,976	
<b>D. Total Physical Therapy Treatments</b>		26,913	26,913	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		714	714	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		10	10	
2. Restorative Treatments				
C. Other		1,473	1,473	
<b>D. Total Speech Therapy Treatments</b>		2,197	2,197	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		5,150	5,150	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		139	139	
2. Restorative Treatments				
C. Other		19,306	19,306	
<b>D. Total Occupational Therapy Treatments</b>		24,595	24,595	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		9/30/2020		10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No							
Total Cost and Hours							
Item	CCNH	Hours	RHNS	Hours	(Specify)		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,001	2,085					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	166,039	9,545					
5. Dietary Service							
a. Head Dietitian	12,500	1,337					
b. Food Service Supervisor	52,380	1,895					
c. Dietary Workers	488,264	30,365					
6. Housekeeping Service							
a. Head Housekeeper							
b. Other Housekeeping Workers	431,060	22,610					
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance							
b. Other Maintenance Workers	37,183	2,618					
8. Laundry Service							
a. Supervisor							
b. Other Laundry Workers	60,952	3,826					
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	209,356	4,317					
b. RN							
1. Direct Care	607,629	10,738					
2. Administrative**	644,679	13,815					
c. LPN							
1. Direct Care	943,396	33,438					
2. Administrative**							
d. Aides and Attendants	1,947,532	127,348					
e. Physical Therapists	36,104	817					
f. Speech Therapists	8,776	199					
g. Occupational Therapists	47,139	1,066					
h. Recreation Workers	99,780	5,134					
i. Physicians							
1. Medical Director							
2. Utilization Review							
3. Resident Care***							
j. Dentists							
k. Pharmacists							
l. Podiatrists							
m. Social Workers/Case Management	118,382	4,156					
n. Marketing	64,664	2,080					
o. Other (Specify) See Attached Schedule	119,818	3,728					
<i>A-13. Total Salary Expenditures</i>	6,220,634	281,117					

\* 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)**

**Schedule of Other Fees (Page 13)**

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-11 Rev. 10/2005

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor			License No. 2056-C		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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.

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-12 Rev. 10/2005

**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
Bristol Healthcare, Inc. d/b/a ingraham Manor				2056-C		9/30/2020			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Ashley Soyka	125,001					2,085		N/A	2,085	
<b>Section IV - Assistant Administrators</b>										

\*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

\*\* Include all other employment worked during the cost year.

\*\*\* If more than one Administrator is reported, include dates of employment for each.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended		Page	of
	2056-C	9/30/2020		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist					
3. Pharmacist	14,821	232			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	398,779	4,752			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	21,400	107			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	96,940	1,439			
b. Other					
10. Occupational Therapist					
a. Resident Care	520,661	2,503			
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	31,559	946			
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,084,160	9,979			

\* 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\***

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 324	324			
2. Disability Insurance	\$ 3,706	3,706			
3. Unemployment Insurance	\$ 22,000	22,000			
4. Social Security (F.I.C.A.)	\$ 471,131	471,131			
5. Health Insurance	\$ 109,452	109,452			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 10,907	10,907			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 49,140	49,140			
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$ 235,665	235,665			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$ 983,542	983,542			
c. Bad Debts*	\$ 1,141,035	1,141,035			
d. Accounting and Auditing	\$ 150	150			
e. Legal (Services should be fully described on Page 7)	\$ 560	560			
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 13,954	13,954			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 48,737	48,737			
2. Cellular Phones	\$				
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	\$ 785,623	785,623			
<b>Subtotal</b>	\$ 3,875,926	3,875,926			

\* 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**

Attachment Page 15

## **Schedule of Other Employee Benefits**

## Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>		3,875,926	3,875,926		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,259	1,259		
5. Education Expenses Related to Seminars and Conventions	\$				
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	11,204	11,204		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	103	103		
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	\$				
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	10,908	10,908		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract ( <i>Specify and Complete         Schedule C-2, Page 21 for each firm or individual</i> )	\$	134,296	134,296		
12. Administrative Management Services**	\$	1,708,841	1,708,841		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	25,820	25,820		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	5,768,357	5,768,357		

\* 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)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promotional Expense	\$ 103		
<b>Total Other Advertising</b>	<b>\$ 103</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
Member Dues & Fees	\$ 10,908		
<b>Total Dues</b>	<b>\$ 10,908</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 5,330		
Misc Expense (Disallowed)	\$ 6,739		
PT Satisf OPPS Fund (Disallowed)	\$ 1,215		
COVID-19	\$ 12,536		
<b>Total Other Administrative and General</b>	<b>\$ 25,820</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule C-1 - Management Services\***

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham M	License No. 2056-C	Report for Year Ended 9/30/2020	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 #
Bristol Hospital, Inc., 41 Brewster Road, Bristol, CT 06010	1,708,841	Parent Company chargebacks for administrative costs	Pg. 16 Line m12

**\* 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
	2056-C	9/30/2020		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 276,581	276,581		
2. Non-Food Supplies	\$ 26,626	26,626		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ _____			
c. Other (Specify) _____	\$ 7,359	7,359		
COVID-19				
Misc				
2D. <b>Total Dietary Expenditures</b> (2a + b + c + d)	\$ 310,566	310,566		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$2,050
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Page 30 Line IV. 1
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?				
J. <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify cost.	\$1,666
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	\$1,666
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Page 30 Line IV.8.
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	License No. 2056-C	Report for Year Ended 9/30/2020		Page of 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$	1,514	1,514	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	127,778	127,778	
c. Other (Specify)	\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	129,292	129,292	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care**  
**Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 64,291	64,291		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other ( <i>Specify</i> )		\$ 2,174	2,174		
COVID-19					
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>		\$ 66,465	66,465		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from West River Pharmacy	\$	140,189	140,189		
b. Medicine Cabinet Drugs	\$	260,942	260,942		
c. Medical and Therapeutic Supplies	\$	1,488	1,488		
d. Ambulance/Limousine***	\$	4,062	4,062		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	34,558	34,558		
f. X-rays and Related Radiological Procedures***	\$				
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	115,598	115,598		
i. Recreation	\$	32,503	32,503		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )****	\$	296,262	296,262		
See Attached Schedule					
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>		\$ 885,602	885,602		

\* 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)
Med A Md Off vst-IM (Disallowed)	\$ 380		
MMS-Bed Rental (Disallowed)	\$ 4,652		
Special Matt Rent IM (Disallowed)	\$ 16,564		
Wound Vacuum Supply (Disallowed)	\$ 15,665		
MMS-IV Solutions (Disallowed)	\$ 58		
Nursing-Supplies	\$ 197,268		
Nutritional Supp	\$ 8,572		
Other Supplies	\$ 40		
Tube Feeding	\$ 442		
COVID-19	\$ 16,902		
PT Supplies IM	\$ 16,922		
MSS-IV Sets (Disallowed)	\$ 4,954		
MMS_ IV Solutions (Disallowed)	\$ 13,843		
<b>Total Other Resident Care</b>	<b>\$ 296,262</b>	<b>\$ -</b>	<b>\$ -</b>

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

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Mand	License No. 2056-C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	56,144	56,144			
b. Heat	\$	46,020	46,020			
c. Light & Power	\$	105,694	105,694			
d. Water	\$	37,067	37,067			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	111,846	111,846			
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	356,771	356,771			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	1,758	1,758			
b. Building & Building Improvements	\$	84,604	84,604			
c. Non-Movable Equipment	\$	7,131	7,131			
d. Movable Equipment	\$	52,115	52,115			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	145,608	145,608			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$	168,943	168,943			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	18,557	18,557			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	333,108	333,108			

\* 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)
Landscaping	\$ 6,385		
Snow Removal	\$ 13,018		
COVID-19	\$ 7,459		
Maint/Serv contracts	\$ 38,435		
Equip not Capitalized	\$ 6,213		
Rental of Equipment	\$ 13,883		
Trash/Recycling	\$ 20,901		
Plant Sewage	\$ 5,552		
<b>Total Other Repairs and Maintenance</b>	<b>\$ 111,846</b>	<b>\$ -</b>	<b>\$ -</b>

## Depreciation Schedule

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor				License No. 2056-C			Report for Year Ended 9/30/2020				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	
<b>A. Land Improvements</b>												
1. Acquired prior to this report period				409,631		409,631	403,550	S/L	Various	1,758		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
<b>A-4. Subtotal</b>											1,758	
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period				10,176,507		10,146,091	9,536,793	S/L	Various	84,604		
2. Disposals (attach schedule)				(229,246)								
3. Acquired during this report period (attach schedule)				198,830								
<b>B-4. Subtotal</b>											84,604	
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period				56,520		85,474	21,990	S/L	Various	7,131		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				28,954								
<b>C-4. Subtotal</b>											7,131	
	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								
<b>D. Movable Equipment</b>												
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					1,696,997		1,755,512	1,470,522	S/L	Various	52,115	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					58,515							
<b>D-3. Subtotal</b>											52,115	
<b>E. Total Depreciation</b>											145,608	

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

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

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

**Schedule of Movable Equipment Acquired during this report period**

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

**Schedule of Leasehold Improvements Acquired during this report period**

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

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor			License No. 2056-C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1. Mortgage Expense									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- Actual Life if owned by Related Party.

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingrahm	License No. 2056-C	Report for Year Ended 9/30/2020	Page 25	of 37
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#### 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	02/01/88			
2. Date Structure Completed	12/01/89			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	12/08/89			
5. Total Licensed Bed Capacity	128			
6. Square Footage				
7. Acquisition Cost				
a. Land	343,035			
b. Building	9,229,206			

##### Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing
  - a. Type of Financing (e.g., fixed, variable)
  - b. Date Mortgage Obtained
  - c. Interest Rate for the Cost Year
  - d. Term of Mortgage (number of years)
  - e. Amount of Principal Borrowed
  - f. Principal balance outstanding as of \_\_\_\_\_

##### Complete if Mortgage was Refinanced

##### During Current Cost Year

- g. Type of Financing (e.g., fixed, variable)
- 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 9/30/2020			Page 26	of 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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page )

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingra	License No. 2056-C	Report for Year Ended 9/30/2020			Page 27	of 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)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$				
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)		\$				
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$				
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$	15,154,955	15,154,955		

## **D. Adjustments to Statement of Expenditures**

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2056-C	9/30/2020	28   37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 119,818	119,818		
<b><i>Page 13 - Professional Fees</i></b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$ 520,661	520,661		
7.			Other - See attached Schedule	\$			
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$ 9,310	9,310		
9.			Bad Debts	\$ 1,141,035	1,141,035		
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.			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	\$ 15,069	15,069		
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 1,805,893	1,805,893			

\* All except "Help Wanted".

(Carry Subtotal forward to next page )

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12 n	Marketing	\$ 119,818		
<b>Total Other Salaries Adjustment</b>			\$ 119,818	\$ -	\$ -

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**Schedule of Fees Adjustments**

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

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**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a9	EE Satisfaction (Disallowed)	\$ 7,115		
16	m13	Misc Expense (Disallowed)	\$ 6,739		
16	m13	PT Satisf OPPS Fund (Disallowed)	\$ 1,215		
<b>Total Other A&amp;G Adjustments</b>			\$ 15,069	\$ -	\$ -

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State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of	
Bristol Healthcare, Inc. d/b/a ingraham Manor			2056-C	9/30/2020		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,805,893	1,805,893		
<b><i>Page 20 - Resident Care Supplies***</i></b>							
27.			Prescription Drugs	\$ 140,189	140,189		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$ 115,598	115,598		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 34,558	34,558		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 74,302	74,302		
<b><i>Page 22 - Maintenance and Property</i></b>							
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	\$			
<b><i>Page 27 - Insurance</i></b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b><i>Other - Miscellaneous</i></b>							
42.			Other - Indirect	\$ 27,963	27,963		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b><i>Not For Profit Providers Only</i></b>							
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,198,503	2,198,503		

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

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	MMS-Bed Rental (Disallowed)	\$ 4,652		
20	5i	Special Matt Rent IM (Disallowed)	\$ 16,564		
20	5i	Wound Vacuum Supply (Disallowed)	\$ 15,665		
20	5i	MMS-IV Solutions (Disallowed)	\$ 58		
20	5i	MSS-IV Sets (Disallowed)	\$ 4,954		
20	5i	MMS IV Solutions (Disallowed)	\$ 13,843		
20	5i	Med A Md Off vst-IM (Disallowed)	\$ 380		
20	5i	Cable TV	\$ 18,186		
<b>Total Other Ancillary Costs</b>			\$ 74,302	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Adm Other Operating Rev	\$ 24,861		
30	IV 8	Adm Int Inc-Misc	\$ 44		
30	IV 8	Admin Medical Record Fees	\$ 50		
30	IV 8	HR Misc Income	\$ 30		
30	IV 8	MatMgmt Purchase Discounts	\$ 62		
30	IV 8	Food & Nutrition Vend Machime	\$ 1,250		
30	IV 8	Food & Nutrition Counceling CTR INC	\$ 1,666		
<b>Total Other Adjustments</b>			\$ 27,963	\$ -	\$ -

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## Schedule of Unallowable Building Interest

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 11,548,407	11,548,407				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,646,367)	(4,646,367)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,723,472	1,723,472				
b. Medicare Room and Board Contractual Allowance **	\$ 917,507	917,507				
4. a. Private-Pay Residents and Other	\$ 4,059,430	4,059,430				
b. Private-Pay Room and Board Contractual Allowance **	\$ (55,316)	(55,316)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 130,465	130,465				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 212,971	212,971				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
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	\$ 430,318	430,318				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 654,055	654,055				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 68,096	68,096				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 90,014	90,014				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 406,577	406,577				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 586,914	586,914				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (2,095,269)	(2,095,269)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 16,799	16,799				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,048,073	14,048,073				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 2,050	2,050				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 811,951	811,951				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 814,001	814,001				
<b>VI. Total All Revenue</b> (III +V)	\$ 14,862,074	14,862,074				

\* 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)
30 II6a	Diagnostic X-Ray	\$ 28,341		
30 II6a	Diagnostic X-Ray Managed Care	\$ 24,534		
30 II6a	Laboratory	\$ 24,028		
30 II6a	Laboratory Managed Care	\$ 22,001		
30 II6a	Respiratory	\$ 12,043		
30 II6a	Ancillary Allowance - Medicare	\$ (2,206,216)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (2,095,269)	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 II6b	MMS - Medicaid	\$ (35)		
31 II6b	Diagnostic X-Ray Medicaid	\$ 2,170		
32 II6b	Laboratory Medicaid	\$ 8,527		
33 II6b	Respiratory Care Medicaid	\$ 5,953		
34 II6b	Respiratory Care Commercial	\$ 184		
<b>Total Other Resident Revenue</b>		\$ 16,799	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
<b>Total Interest Income</b>		\$ -	\$ -	\$ -	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30	Adm Other Operating Rev	\$ 24,861		
30	Adm COVID-19 STIMULUS	\$ 851,988		
30	Adm Int Inc-Misc	\$ 44		
30	Admin Medical Record Fees	\$ 50		
30	HR Misc Income	\$ 30		
30	MatMgmt Purchase Discounts	\$ 62		
30	Food & Nutrition Vend Machine	\$ 1,250		
30	Food & Nutrition Counceling CTR INC	\$ 1,666		
30	Oper REV Misc Non-Oper Rev	\$ (68,000)		
<b>Total Other Revenue</b>		\$ 811,951	\$ -	\$ -

**G. Balance Sheet**

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham	License No. 2056-C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	7,281,711
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,785,583
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	71,313
5. Prepaid Expenses			\$	48,927
a. Prepaid Expenses ( <i>itemize</i> )		48,927		
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	248,356
Due from Affiliates		233,674		
Assets Whose Use is Limited		14,682		
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	10,435,890
B. Fixed Assets				
1. Land			\$	343,035
2. Land Improvements	*Historical Cost	409,631	\$	4,323
	Accum. Depreciation	405,308	Net	
3. Buildings	*Historical Cost	10,146,091	\$	524,694
	Accum. Depreciation	9,621,397	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	85,474	\$	56,353
	Accum. Depreciation	29,121	Net	
6. Movable Equipment	*Historical Cost	1,755,512	\$	232,875
	Accum. Depreciation	1,522,637	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,161,280

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

(Carry Total forward to next page)

## Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

<b>Total Prepaid Expenses</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Assets (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Other Fixed Assets (Itemize)</b>		\$ -

## Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

<b>Total Other Assets</b>		\$ -

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

<b>Total Notes Payable</b>		\$ -

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

Page Ref Line Ref Description

33	12	Benefit Plus Payable	\$ (913)
33	12	Health Savings	\$ 330
33	12	FVOL FCO Vol. Deduct	\$ 1,679
33	12	PR ded-Misc	2952
33	12	Accrued Expenses-PO	14694
<b>Total Other Current Liabilities (Itemize)</b>			\$ 18,742

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

## G. Balance Sheet (cont'd)

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham	License No. 2056-C	Report for Year Ended 9/30/2020	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 11,597,170
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)				\$
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost _____ Accum. Depreciation _____	Net		\$
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care ( <i>itemize</i> )				\$
6. Loans to Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )				\$
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)				\$
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)				\$ 11,597,170

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

## **G. Balance Sheet (cont'd)**

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Mano	License No. 2056-C	Report for Year Ended 9/30/2020	Page 33	of 37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	254,952
2. Notes Payable ( <i>itemize</i> )			\$	
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	431,020
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	203,191
7. Medicare Final Settlement Payable			\$	529,358
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$	6,277,940
A/R Credit Balances		449,673	Due to BHI	4,608,967
Accrued Expenses		298,469	Self-Workers Comp	654,204
Due to CT Hosp Tax		195,759	Self Insurance Claim	33,539
Due to EMS LLC		18,587	See Schedule	18,742
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$	7,696,461

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

**G. Balance Sheet (cont'd)**

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Mar	License No. 2056-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			7,696,461	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$	
			7,696,461	

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a ingraha	2056-C	9/30/2020	35	37
Account				Amount
<b>A. Reserves</b>				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
<b>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 4,193,590
6. Gain or Loss for Period 10/1/2019 thru 9/30/2020				\$ (292,881)
7. Total Net Worth				\$ 3,900,709
<b>C. Total Reserves and Net Worth</b>				\$ 3,900,709
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 11,597,170

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Bristol Healthcare, Inc. d/b/a ingraham	2056-C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ 3,210,049		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 14,862,074		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 15,154,956		
D. Net Income or Deficit				\$ (292,882)		
E. Balance				\$ 2,917,167		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Transfer from Hospital				983,542		
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ 983,542		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$		
Name and Address (No., City, State, Zip )		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ 3,900,709		
Report for Year Ended 09/30/2020						

## I. Preparer's/Reviewer's Certification

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham	License No. 2056-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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		
Address		Phone Number
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Contact Email Address		