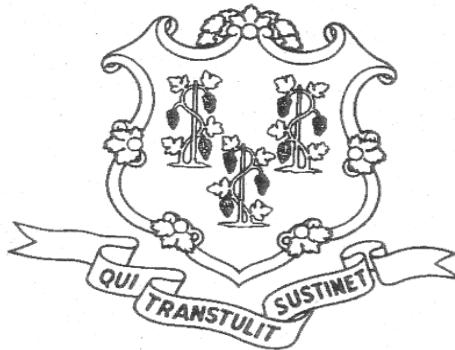


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

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 checked="" 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 10/1/2020	Report for Year Ending 9/30/2021

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 9/30/2021	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, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 400 North Main Street, Bristol, CT 06010				
Report Prepared By Marc Levy	Phone Number 207-791-7174	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. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (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	Page	of
		9/30/2021	2	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"/> Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only (CCNH) <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.	
Administrator				
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 9/30/2021			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	1,613,225	1,613,225
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	5,542	5,542
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 5A	17,200	17,200
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	<input type="radio"/>	<input checked="" type="radio"/>		Common Pension Plan	Pg 15/Line 1a7	94,004	94,004
		<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 9/30/2021	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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

* 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 9/30/2021	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 (Acct #09.6600.3250)	\$
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 Various 2 3 4 5	Telephone Number
---	------------------

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

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1 Probate fees, marshal fees, OSHA fine	\$ 6,938
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 6,938

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 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					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					105	105						
A. As of midnight of PREVIOUS report period	105	105										
B. As of midnight of THIS report period	113	113							113	113		
3. Total Number of Days Care Provided During Period					3,790	3,790			1,223	1,223		
A. Medicare	5,013	5,013										
B. Medicaid (Conn.)	24,574	24,574			18,058	18,058			6,516	6,516		
C. Medicaid (other states)												
D. Private Pay	5,436	5,436			3,943	3,943			1,493	1,493		
E. State SSI for RCH												
F. Other (Specify)	3,764	3,764			2,668	2,668			1,096	1,096		
G. Total Care Days During Period (3A thru F)	38,787	38,787			28,459	28,459			10,328	10,328		
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)	38,787	38,787			28,459	28,459			10,328	10,328		

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 9/30/2021	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)
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	14	72		12				
Per Diem Rate								
a. One bed rm.	Various	288.63		476.00				
b. Two bed rms.	Various	288.63		460.00				
c. Three or more bed rms.		288.63		456.00				

7. Total Number of Physical Therapy Treatments	TOTAL		CCNH	RHNS	(Specify)
	8,021		8,021		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		468	468		
C. Other		19,986	19,986		
D. Total Physical Therapy Treatments		28,475	28,475		
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B		568	568		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		1,166	1,166		
D. Total Speech Therapy Treatments		1,734	1,734		
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B		6,562	6,562		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		252	252		
C. Other		20,004	20,004		
D. Total Occupational Therapy Treatments		26,818	26,818		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		9/30/2021		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)	136,932	2,086					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	206,642	12,364					
5. Dietary Service							
a. Head Dietitian							
b. Food Service Supervisor	61,803	2,102					
c. Dietary Workers	473,135	41,536					
6. Housekeeping Service							
a. Head Housekeeper							
b. Other Housekeeping Workers	450,804	30,641					
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance							
b. Other Maintenance Workers	19,562	1,263					
8. Laundry Service							
a. Supervisor							
b. Other Laundry Workers	32,569	2,467					
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	129,645	2,312					
b. RN							
1. Direct Care	498,452	22,483					
2. Administrative**	908,524	28,928					
c. LPN							
1. Direct Care	1,145,001	58,940					
2. Administrative**							
d. Aides and Attendants	2,285,079	173,013					
e. Physical Therapists							
f. Speech Therapists							
g. Occupational Therapists							
h. Recreation Workers	125,766	8,772					
i. Physicians							
1. Medical Director							
2. Utilization Review							
3. Resident Care***							
j. Dentists							
k. Pharmacists							
l. Podiatrists							
m. Social Workers/Case Management	192,552	6,726					
n. Marketing							
o. Other (Specify)							
See Attached Schedule							
<i>A-13. Total Salary Expenditures</i>	6,666,466	393,633					

* 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 9/30/2021			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)							
Section I - Operators/Owners										
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).										

* 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		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Ashley Soyka	136,932					2,086	A12A			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2056-C	9/30/2021		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
*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		(1,086)			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	424,114	8,307			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)					
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	66,552	1,303			
b. Other					
10. Occupational Therapist					
a. Resident Care	361,104	6,898			
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	30,657				
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	881,341	16,508			

* 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
Bristol Healthcare, Inc. d/b/a ingraham Manor	2056-C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 291,458	291,458		
2. Disability Insurance	\$ 584	584		
3. Unemployment Insurance	\$ 40,376	40,376		
4. Social Security (F.I.C.A.)	\$ 495,716	495,716		
5. Health Insurance	\$ 506,964	506,964		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 13,113	13,113		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 94,004	94,004		
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 356,751	356,751		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 227,719	227,719		
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$ 6,938	6,938		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 4,003	4,003		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 62,086	62,086		
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	\$ 720,691	720,691		
Subtotal	\$ 2,820,403	2,820,403		

* 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

Description	CCNH	RHNS	(Specify)
BHC Human Resources COVID Expenses	\$ 394		
BHC Employee Benefits Severance	\$ 22,790		
BHC Employee Benefits Hire Bonus	\$ 317,296		
BHC Employee Benefits PTO Expense Accrual	\$ (4,501)		
BHC Employee Benefits Employee Physicals	\$ 5,542		
BHC Employee Benefits EE Satisfaction	\$ 12,979		
BHC Employee Benefits Tuition Reimbursement	\$ 2,250		
Total	\$ 356,751	\$ -	\$ -

Schedule of Other Taxes

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

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 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		2,820,403	2,820,403		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	6,126	6,126		
4. Employee Travel	\$	1,347	1,347		
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>)	\$	76,860	76,860		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	79	79		
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	\$	13,199	13,199		
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>)	\$	59,050	59,050		
12. Administrative Management Services**	\$	1,613,225	1,613,225		
13. Other (<i>Specify</i>) See Attached Schedule	\$	19,010	19,010		
<i>C-14 Total Administrative & General Expenditures</i>	\$	4,609,299	4,609,299		

* 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)
BHC Administration Mktg & Advertising	\$ 79		
Total Other Advertising	\$ 79	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
BHC Administration EE Dues Licens Mbship	\$ 13,199		
Total Dues	\$ 13,199	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
BHC Administration Billing Service Fees	\$ -		
BHC Administration COVID-19	\$ -		
BHC Administration Bank Charges	\$ -		
BHC Administration Misc Expense	\$ 7,545		
BHC Administration Patient Satisfaction	\$ 4,308		
BHC Administration Survey Expense	\$ 7,158		
Total Other Administrative and General	\$ 19,010	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham M	License No. 2056-C	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Bristol Hospital, Inc., 41 Brewster Road, Bristol, CT 06010	1,613,225	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	9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 292,463	292,463		
2. Non-Food Supplies	\$ 71,611	71,611		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____ Dietary Covid, Misc, and Dues	\$ 9,766	9,766		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 373,840	373,840		
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.	\$400
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.	
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	\$858
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 9/30/2021		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. \$	182,010	182,010	
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$ 182,010	182,010		
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
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 53,785	53,785		
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>)		\$ 437	437		
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 54,222	54,222		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	128,154	128,154		
b. Medicine Cabinet Drugs	\$	459,486	459,486		
c. Medical and Therapeutic Supplies	\$	83,188	83,188		
d. Ambulance/Limousine***	\$	(716)	(716)		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	30,066	30,066		
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	34,968	34,968		
i. Recreation	\$	8,918	8,918		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)****	\$	254,060	254,060		
See Attached Schedule					
5M. Total Resident Care Expenditures (5a - 5j)		\$ 998,124	998,124		

* 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)
BHC Nrsg Pool & Serv Med A Md Off vst-IM	\$ -		
BHC Nrsg Pool & Serv X-Ray Fees	\$ (21,344)		
BHC Nrsg Pool & Serv MSS-Bed Rental	\$ -		
BHC Nrsg Pool & Serv Special Matt Rent IM	\$ -		
BHC Nrsg Pool & Serv Wound Vacuum Supply	\$ -		
BHC Nrsg Pool & Serv MSS-IV Solutions	\$ -		
BHC Nrsg Pool & Serv Nursing-Supplies	\$ 156,826		
BHC Nrsg Pool & Serv Food & Nutri supp	\$ 8,178		
BHC Nrsg Pool & Serv Other Supplies	\$ -		
BHC Nrsg Pool & Serv Tube feeding	\$ 1,079		
BHC Nrsg Pool & Serv COVID Expenses	\$ 108,626		
BHC Physical Therapy PT supplies IM	\$ (11)		
BHC Pharmacy MSS-IV Sets	\$ 308		
BHC Pharmacy MSS-IV Solutions	\$ 398		
Total Other Resident Care	\$ 254,060	\$ -	\$ -

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 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	83,468	83,468			
b. Heat	\$	31,215	31,215			
c. Light & Power	\$	78,538	78,538			
d. Water	\$	53,205	53,205			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	112,984	112,984			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	359,410	359,410			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	1,758	1,758			
b. Building & Building Improvements	\$	80,508	80,508			
c. Non-Movable Equipment	\$	8,849	8,849			
d. Movable Equipment	\$	54,482	54,482			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	145,597	145,597			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (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	\$	169,940	169,940			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	18,753	18,753			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	334,290	334,290			

* 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)
BHC Operation Of Plant Prop Maint	\$ (1,705)		
BHC Operation Of Plant Prop Maint-Snw remov	\$ 5,544		
BHC Operation Of Plant Facility Supplies	\$ 17,371		
BHC Operation Of Plant COVID Expenses	\$ 6,293		
BHC Operation Of Plant Maint/Serv Contracts	\$ 58,622		
BHC Operation Of Plant Equip Not Capitalizd	\$ 2,050		
BHC Operation Of Plant Rental Of Equipment	\$ -		
BHC Operation Of Plant Trash/Recycle/Sewage	\$ 24,810		
BHC Operation Of Plant Sewage	\$ -		
Total Other Repairs and Maintenance	\$ 112,984	\$ -	\$ -

Depreciation Schedule

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor				License No. 2056-C			Report for Year Ended 9/30/2021				Page 23	of 37
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period				409,631		409,631	405,308	S/L	Various	1,758		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal											1,758	
B. Building and Building Improvements												
1. Acquired prior to this report period				9,947,261		10,205,074	9,621,012	S/L	Various	71,385		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				257,813		248,690		S/L	Various	9,123		
B-4. Subtotal											80,508	
C. Non-Movable Equipment												
1. Acquired prior to this report period				85,474		85,474	23,011	S/L	Various	8,849		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal											8,849	
	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					1,755,512		1,782,116	1,529,132	S/L	Various	52,212	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					26,604				S/L	Various	2,270	
D-3. Subtotal											54,482	
E. Total Depreciation											145,597	

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

Total deletions for Non-Movable Equipment	\$ -		\$ -	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

ttachment Pages 23 24

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/1/2021	IM - Computers	\$ 2,308	3	\$ 385
8/1/2021	IM Computer	\$ 1,152	3	\$ 192
8/1/2021	IM Computers	\$ 1,735	3	\$ 289
8/1/2021	IM Computer	\$ 1,152	3	\$ 192
8/1/2021	IM Computer	\$ 1,702	3	\$ 284
8/1/2021	IM Moveable Ice Machine	\$ 11,556	10	\$ 578
8/1/2021	IM Moveable Refrigerator	\$ 6,999	10	\$ 350
Total additions for Movable Equipment		\$ 26,604		\$ 2,270 *
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 Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*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 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* 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 9/30/2021	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 9/30/2021			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. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingra	License No. 2056-C	Report for Year Ended 9/30/2021			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. Total All Interest Expense (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. Total Insurance Expenditures (14a + b + c)		\$				
15. Total All Expenditures (A-13 thru C-14)		\$	14,459,001	14,459,001		

D. Adjustments to Statement of Expenditures

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Manor			License No. 2056-C	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$	382,765	382,765	
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$	227,719	227,719	
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	\$	20,524	20,524	
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$	631,008	631,008		

* 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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a9	EE Satisfaction (Disallowed)	\$ 12,979		
16	m13	Misc Expense (Disallowed)	\$ 7,545		
Total Other A&G Adjustments			\$ 20,524	\$ -	\$ -

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	9/30/2021		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 631,008	631,008		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ (1,309)	(1,309)		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$ 34,968	34,968		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 30,066	30,066		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 706	706		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation	\$			
			See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$ 34,154	34,154		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation	\$			
			Unallowable Building Interest -	\$			
			See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 729,593	729,593		

*** 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	51	MMS-Bed Rental (Disallowed)	\$ -		
20	51	Special Matt Rent IM (Disallowed)	\$ -		
20	51	Wound Vacuum Supply (Disallowed)	\$ -		
20	51	MMS-IV Solutions (Disallowed)	\$ -		
20	51	MSS-IV Sets (Disallowed)	\$ 308		
20	51	MMS IV Solutions (Disallowed)	\$ 398		
20	51	Med A Md Off vst-IM (Disallowed)	\$ -		
20	51	Cable TV	\$ -		
Total Other Ancillary Costs			\$ 706	\$ -	\$ -

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 - Indirect Adjustments

Attachment Page 29

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Adm Other Operating Rev	\$ 32,622		
30	IV 8	Adm Int Inc-Misc	\$ 38		
30	IV 8	Admin Medical Record Fees	\$ -		
30	IV 8	HR Misc Income	\$ 50		
30	IV 8	MatMgmt Purchase Discounts	\$ 186		
30	IV 8	Food & Nutrition Vend Machime	\$ 400		
30	IV 8	Food & Nutrition Counceling CTR INC	\$ 858		
Total Other Adjustments			\$ 34,154	\$ -	\$ -

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		Page of	
		9/30/2021		30 37	
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 10,463,117	10,463,117			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,224,745)	(4,224,745)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,944,612	1,944,612			
b. Medicare Room and Board Contractual Allowance **	\$ 844,996	844,996			
4. a. Private-Pay Residents and Other	\$ 3,966,833	3,966,833			
b. Private-Pay Room and Board Contractual Allowance **	\$ 59,995	59,995			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 181,881	181,881			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 254,061	254,061			
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	\$ 502,399	502,399			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 572,466	572,466			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 70,952	70,952			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 100,214	100,214			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 463,807	463,807			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 534,771	534,771			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (1,903,394)	(1,903,394)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 44,547	44,547			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,876,512	13,876,512			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 819	819			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 4,581	4,581			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 132,540	132,540			
V. Total Other Revenue (1 thru 8)	\$ 137,941	137,941			
VI. Total All Revenue (III +V)	\$ 14,014,453	14,014,453			

* 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	BHC Diagnostic X-Ray REV IP MCR	09.3120.1011	\$ 15,881	
30 II6a	BHC Diagnostic X-Ray REV IP MCR MGD	09.3120.1012	\$ 15,967	
30 II6a	BHC Laboratory REV IP MCR	09.3140.1011	\$ 15,623	
30 II6a	BHC Laboratory REV IP MCR MGD	09.3140.1012	\$ 12,124	
30 II6a	BHC Respiratory Care REV IP MCR	09.3154.1011	\$ 4,384	
30 II6a	BHC Respiratory Care REV IP MCR MGD	09.3154.1012	\$ 6,591	
30 II6a	BHC Allow. Ancillary IP Medicare	09.5003.1011	\$ (997,673)	
30 II6a	BHC Allow. Ancillary IP Medicare Mgd	09.5003.1012	\$ (818,717)	
30 II6a	BHC Allow. Ancillary IP Medicaid	09.5003.1021	\$ (100,273)	
30 II6a	BHC Allow. Ancillary Medicare Part B	09.5003.1043	\$ (57,300)	
30 II6a	BHC Oxygen allowance IP Medicare	09.5154.1011	\$ -	
Total Other Resident Revenue - Medicare		\$ (1,903,394)	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
31 II6b	BHC MSS REV IP Medicaid	09.3010.1021	\$ -	
31 II6b	BHC Diagnostic X-Ray REV IP Medicaid	09.3120.1021	\$ 138	
31 II6b	BHC Diagnostic X-Ray REV IP Commercial	09.3120.1033	\$ 15	
31 II6b	BHC Laboratory REV IP Medicaid	09.3140.1021	\$ 27,278	
31 II6b	BHC Laboratory REV IP Commercial	09.3140.1033	\$ 587	
31 II6b	BHC Respiratory Care REV IP Medicaid	09.3154.1021	\$ 15,331	
31 II6b	BHC Respiratory Care REV IP Commercial	09.3154.1033	\$ 955	
31 II6b	BHC Oxygen allowance IP Medicaid	09.5154.1021	\$ 243	
Total Other Resident Revenue		\$ 44,547	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	BHC Other Non-Oper REV Int Inc-Misc Invest - Acct #09.4200.5604		\$ 4,581		
Total Interest Income		\$ 4,581	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Adm Other Operating Rev	09.4000.4127	\$ 32,622	
30	BHC Other Op Revenue-Adm COVID-19 INCENTIVE	09.4000.5255	\$ 75,432	
30	Adm Int Inc-Misc	09.4000.5602	\$ 38	
30	Admin Medical Record Fees	09.4002.5511	\$ -	
30	HR Misc Income	09.4027.5999	\$ 50	
30	MatMgmt Purchase Discounts	09.4033.5500	\$ 186	
30	Food & Nutrition Vend Machime	09.4035.5535	\$ 400	
30	Food & Nutrition Counceling CTR INC	09.4035.5997	\$ 858	
30	Oper REV Misc Non-Oper Rev	09.4200.5998	\$ 22,935	
30	BHC Other Op Revenue-Adm Misc Non-Oper Rev	09.4000.5998	\$ 20	
Total Other Revenue		\$ 132,540	\$ -	\$ -

G. Balance Sheet

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham	License No. 2056-C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 79,168	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 4,002,435	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 68,137	
5. Prepaid Expenses			\$ 49,240	
a. BHC Prepaid Expense		49,240		
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 315,040	
BHC Due From HomecareHos		295,776		
BHC Inv in BHDF		19,264		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 4,514,020	
B. Fixed Assets				
1. Land			\$ 343,035	
2. Land Improvements	*Historical Cost	409,631	\$ 2,565	
	Accum. Depreciation	407,066	Net	
3. Buildings	*Historical Cost	10,205,074	\$ 503,554	
	Accum. Depreciation	9,701,520	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	85,474	\$ 53,614	
	Accum. Depreciation	31,860	Net	
6. Movable Equipment	*Historical Cost	1,782,116	\$ 198,502	
	Accum. Depreciation	1,583,614	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 1,101,270	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description		
Total Prepaid Expenses			\$	-

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

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

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

Schedule of Other Assets Page 32 Line D7

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description			
33	12	BHC Accrued Receipt Liab	09.2100.0020	\$ (271	
33	12	BHC A/R Credit Balances	09.2100.0080	\$ 237,828	
33	12	BHC Patient Trust Pay	09.2100.0086	\$ 68,845	
33	12	BHC SS&SSI deposits	09.2100.0088	\$ 3,181	
33	12	BHC Patient Refunds	09.2100.0090	\$ (100	
33	12	BHC Due To EMS LLC	09.2110.0010	\$ 24,960	
33	12	BHC Due To/From BHI	09.2110.0020	\$ (1,510,515	
33	12	BHC Benefit Plus Payable	09.2300.0014	\$ (10	
33	12	BHC Health Savings	09.2300.0022	\$ 173	
33	12	BHC FVOL FCO Vol. Deduct	09.2300.0023	\$ 1,679	
33	12	BHC PR ded-Misc	09.2300.0026	\$ 800	
33	12	BHC Accrued Expenses	09.2400.0030	\$ 171,886	
33	12	BHC Accrued Expenses-PO	09.2400.0032	\$ 23,012	
33	12	BHC Self-Insurance Claim	09.2400.0050	\$ 64,600	
33	12	BHC Self-Workers Comp	09.2400.0052	\$ 724,978	
33	12	BHC Medicare Adv' Pmt	09.2500.0011	\$ 275,410	
33	12	BHC Medicaid Advance Pay	09.2500.0021	\$ 125,000	
33	12	BHC Due to CT Hosp Tax	09.2500.0060	\$ 192,536	
Total Other Current Liabilities (Itemize)					\$ 403,992

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a ingraham	2056-C	9/30/2021	32 37
Account			Amount
Total Brought Forward:			\$ 5,615,290
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost _____	Accum. Depreciation _____	Net \$
3. Buildings	*Historical Cost _____	Accum. Depreciation _____	Net \$
4. Non-Movable Equipment	*Historical Cost _____	Accum. Depreciation _____	Net \$
5. Movable Equipment	*Historical Cost _____	Accum. Depreciation _____	Net \$
6. Motor Vehicles	*Historical Cost _____	Accum. Depreciation _____	Net \$
7. Minor Equipment-Not Depreciable			\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost _____	Accum. Depreciation _____	Net \$
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care (<i>itemize</i>)			\$
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$
Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 5,615,290

* 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 9/30/2021	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 733,224
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>)				\$ 753,286
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable (<i>Current Portion</i>)				\$
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities (<i>itemize</i>)				\$ 403,992
See Schedule				403,992
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,890,502

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham Mar	License No. 2056-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,890,502	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,890,502

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

Name of Facility Bristol Healthcare, Inc. d/b/a ingrahan	License No. 2056-C	Report for Year Ended 9/30/2021	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,710,995
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 13,793
7. Total Net Worth			\$	3,724,788
C. Total Reserves and Net Worth			\$	3,724,788
D. Total Liabilities, Reserves, and Net Worth			\$	5,615,290

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	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 3,900,709		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 14,014,571		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 14,459,000		
D. Net Income or Deficit				\$ (444,429)		
E. Balance				\$ 3,456,280		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
Transfer from Hospital (Acct 09.4000.5630)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
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. Balance at End of Period				\$ 3,456,280		

I. Preparer's/Reviewer's Certification

Name of Facility Bristol Healthcare, Inc. d/b/a ingraham	License No. 2056-C	Report for Year Ended 9/30/2021	Page of 37 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		
Marc Levy		
Address Address 280 Fore Street Portland Maine 04101		Phone Number 207-791-7174
Contacted Person Regarding Additional Information Needed Regarding This Report Marc Levy		Phone Number 207-791-7174
Contact Email Address mlevy@bnncpa.com		