State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

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 ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2056-C			07-5329

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20561		

For Department Use Only

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

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bristol Healthcare, Inc. d/b/a Ingraham Manor [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 10/1/2018	To 9/30/2019
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. ***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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Bristol Healthcare, Inc. d/b/a Ingraham Manor	400 North Main Street, Bristol, CT 06010

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2056-C			07-5329

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Ashley Soyka		36.002090

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

Name	License No.:
N/A	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
N/A			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Bristol Healthcare, Inc. d/b/a Ingraham Manor	400 North Main Street, Bristol, CT 06010	CT

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Management Fees & Administrator	Pa. 16 &10/ Line m12		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Medical Malpractice Insurance	Pg. 27/Line 14c3		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Employee Physicals	Pg. 15/Line l9a		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Payroll Deductions	Passthrough from Emp		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Property/Umbrella Insurance	Pg.27/Line14a		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Medical Director/Assistant Medical Director	Pg.13/Line B8		
Bristol Hospital, Inc.	41 Brewster Road, Bristol, CT 06010	○	⊙		Common Pension Plan	Pg.15/Line la7		
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	5	37

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

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

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

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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	9/30/2019	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Ricoh, 100 Pearl Street, CT 06103	○	⊙	Copier	04/01/16	5 years	15,153	15,153
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingrah	2056-C	9/30/2019	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	$
2	$
3	$
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	Telephone Number
1	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	$
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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	128	128			128	128			128	128		
B. On last day of THIS report period	128	128			128	128			128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period												
B. As of midnight of THIS report period												
3. Total Number of Days Care Provided During Period												
A. Medicare	3,991	3,991			3,194	3,194			797	797		
B. Medicaid (Conn.)	27,867	27,867			21,133	21,133			6,734	6,734		
C. Medicaid (other states)												
D. Private Pay	6,377	6,377			4,112	4,112			2,265	2,265		
E. State SSI for RCH												
F. Other (Specify)	5,021	5,021			3,709	3,709			1,312	1,312		
G. Total Care Days During Period (3A thru F)	43,256	43,256			32,148	32,148			11,108	11,108		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	58	58			45	45			13	13		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	43,314	43,314			32,193	32,193			11,121	11,121		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	9	37

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

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

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents								
Per Diem Rate								
a. One bed rm.	Various	241.62		500.00				
b. Two bed rms.	Varios	241.62		419.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,638	6,638		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	125	125		
2. Restorative Treatments				
C. Other	19,417	19,417		
D. ***Total Physical Therapy Treatments***	26,180	26,180		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	591	591		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	43	43		
2. Restorative Treatments				
C. Other	1,347	1,347		
D. ***Total Speech Therapy Treatments***	1,981	1,981		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	6,213	6,213		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	189	189		
2. Restorative Treatments				
C. Other	20,324	20,324		
D. ***Total Occupational Therapy Treatments***	26,726	26,726		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,285	2,006				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	153,975	9,873				
5. Dietary Service						
a. Head Dietitian	46,482	1,304				
b. Food Service Supervisor	38,035	1,446				
c. Dietary Workers	402,568	29,237				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	372,719	23,257				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	35,267	2,053				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	60,997	4,016				
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	171,583	3,851				
b. RN						
1. Direct Care	651,375	13,956				
2. Administrative**	703,509	14,301				
c. LPN						
1. Direct Care	883,154	32,094				
2. Administrative**						
d. Aides and Attendants	1,808,317	124,633				
e. Physical Therapists	54,747	935				
f. Speech Therapists	6,177	155				
g. Occupational Therapists	34,887	874				
h. Recreation Workers	92,890	4,560				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	108,261	4,230				
n. Marketing	59,234	2,100				
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,809,462	274,881				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
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	9/30/2019	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	125,285			Non Discriminatory	Administrator	2,006		N/A		
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	16,080					
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	470,588					
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	77,833					
b. Other						
10. Occupational Therapist						
a. Resident Care	439,589					
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	125					
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,004,215					

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 9/2018

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	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	554,405	554,405		
2. Disability Insurance	$	12,279	12,279		
3. Unemployment Insurance	$	10,512	10,512		
4. Social Security (F.I.C.A.)	$	446,594	446,594		
5. Health Insurance	$	1,003,375	1,003,375		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	3,801	3,801		
7. Pensions (Non-Discriminatory)	$	66,113	66,113		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	400,320	400,320		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$	949,064	949,064		
c. Bad Debts*	$	590,000	590,000		
d. Accounting and Auditing	$	13,091	13,091		
e. Legal (*Services should be fully described on Page 7)*	$	305	305		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	11,299	11,299		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,877	26,877		
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	$	826,653	826,653		
Subtotal	$	4,914,688	4,914,688		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Hire Bonus	$ 13,038		
PTO Expense Accrual	$ 337,411		
Employee Physicals	$ 32,962		
EE Satisfaction (Disallowed)	$ 16,509		
Misc Expense	$ 400		
Total	$ 400,320	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		4,914,688	4,914,688		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,826	1,826		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	580	580		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	103	103		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	26,949	26,949		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	11,107	11,107		
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	98,479	98,479		
12. Administrative Management Services**	$	1,295,556	1,295,556		
13. Other (*Specify*) See Attached Schedule	$				
C-14 Total Administrative & General Expenditures	$	6,349,288	6,349,288		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Subs, Books, Etc	$ 306		
Bank Charges	$ 5,723		
Misc Expense (Disallowed)	$ (1,555)		
PT Satisf-OOPS Fund (Disallowed)	$ 21,975		
Survey Expense	$ 500		
Total Dues	$ 26,949	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Total Other Administrative and General	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingraham M	2056-C	9/30/2019	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 #
Marcum LLP 555 Long Wharf Drive, New Haven, CT 06511		Reimbursement Advisory Consulting	Page 15, Line 1d
Crowe Horwath LLP PO Box 71570, Chicago, IL 60694-1570		Annual Audit, Facility Audit	Page 15, Line 1d

*** 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2018

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
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	292,750	292,750		
2. Non-Food Supplies	$	33,274	33,274		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Misc	$	267	267		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	326,291	326,291		

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	141,937	141,937		
c. Other (*Specify*) Supplies	$	16	16		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	141,953	141,953		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2018

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
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	56,662	56,662		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	56,662	56,662		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	132,715	132,715		
b. Medicine Cabinet Drugs		$	222,886	222,886		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	49,898	49,898		
f. X-rays and Related Radiological Procedures***		$	59,904	59,904		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	38,983	38,983		
i. Recreation		$	30,422	30,422		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	318,388	318,388		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	853,196	853,196		

* 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 (Disallow)	$ 911		
X-Ray Fees	$ 32,813		
PT supplies IM	$ 17,927		
MSS-Bed Rental (Disallow)	$ 633		
Special Matt Rent IM (Disallow)	$ 23,530		
Wound Vacuum Supply (Disallow)	$ 17,624		
MSS-IV Sets (Disallow)	$ 7,497		
MM-IV Solutions (Disallow)	$ 31,891		
M&S Supply Misc	$ 635		
Nursing Supplies	$ 171,999		
Nutritional Supp	$ 9,819		
Tube feeding (Disallow)	$ 3,109		
Total Other Resident Care	$ 318,388	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	107,972	107,972		
b. Heat	$	10,350	10,350		
c. Light & Power	$	146,670	146,670		
d. Water	$	41,062	41,062		
e. Equipment Lease (*Provide detail on page 6*)	$	12,803	12,803		
f. Other (*itemize*)	$	172,021	172,021		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	490,878	490,878		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,757	1,757		
b. Building & Building Improvements	$	377,822	377,822		
c. Non-Movable Equipment	$	5,414	5,414		
d. Movable Equipment	$	52,418	52,418		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	437,411	437,411		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	20,040	20,040		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	20,040	20,040		
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	$	164,722	164,722		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	18,684	18,684		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	640,857	640,857		

* 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	$ 7,895		
Snow Removal	$ 16,275		
Maint/Serv Contracts	$ 40,947		
Equip Not Capitalized	$ 68,113		
Rental of Equipment	$ 9,046		
Trash/Recycling Exp	$ 17,590		
Sewage	$ 12,155		
Total Other Repairs and Maintenance	$ 172,021	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	409,631		409,631	401,793	S/L	Various	1,757	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,757
B. **Building and Building Improvements**								
1. Acquired prior to this report period	10,176,507		10,177,261	9,158,972	S/L	Various	377,822	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								377,822
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	56,520		56,520	20,968	S/L	Various	5,414	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								5,414

	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					1,696,997		1,696,997	1,412,958	S/L	Various	52,418	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												52,418
E. ***Total Depreciation***												437,411

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

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

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Mortgage Expense	1	2002	20	473,226	421,316			20,040	
2.									
3.									
B-4. Subtotal									20,040
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***									20,040

* Straight-line method must be used.

** Specify which of the following bases were used:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham	2056-C	9/30/2019	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingrahar	2056-C	9/30/2019	26 | 37

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

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingrah	2056-C	9/30/2019	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
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*) $	19,469	19,469		
Interest Expense				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	19,469	19,469		
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*) $	(17,191)	(17,191)		
Malpractice				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	(17,191)	(17,191)		
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,675,080	15,675,080		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	59,234	59,234		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $	439,589	439,589		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $	25,305	25,305		
9.			Bad Debts $	590,000	590,000		
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 $	36,929	36,929		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	1,151,057	1,151,057		

* 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	12n	Marketing Salaries	$ 59,234		
Total Other Salaries Adjustment			$ 59,234	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a9	Employee Satisfaction (Disallowed)	$ 16,509		
16	M13	Misc, Expense (Disallowed)	$ (1,555)		
16	M13	Patient Satisfaction (Disallowed)	$ 21,975		
Total Other A&G Adjustments			$ 36,929	$ -	$ -

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	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,151,057	1,151,057		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	132,715	132,715		
28.			Ambulance/Limousine $				
29.			X-rays, etc $	59,904	59,904		
30.			Laboratory $	38,983	38,983		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $	49,898	49,898		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	101,335	101,335		
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 $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	48,684	48,684		
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)*** $	1,582,576	1,582,576		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Med A Md Off vist-IM	$ 911		
20	5i	Mss-Bed Rental	$ 633		
20	5i	Special Matt Rent IM	$ 23,530		
20	5i	Wound Vacuum Supply	$ 17,624		
20	5i	Tube feeding	$ 3,109		
20	5i	Mss-IV Sets	$ 7,497		
20	5i	MM-IV Solutions	$ 31,891		
20	5i	Cable (see attached)	$ 16,140		
Total Other Ancillary Costs			$ 101,335	$ -	$ -

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	Other Operating Income	$ 45,056		
30	IV8	Purchase Discounts	$ 8		
30	IV8	Misc. Income	$ 304		
30	IV8	Medical Records Fees	$ 566		
30	IV8	HR Misc. Income	$ 30		
30	IV8	Vending Machine Income	$ 1,148		
30	IV8	Counseling Center Income	$ 1,572		
30	IV8	Meals sold to Guests	$ -		
Total Other Adjustments			$ 48,684	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham	M 2056-C	9/30/2019	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,652,152	11,652,152		
b. Medicaid Room and Board Contractual Allowance **	$	(4,923,348)	(4,923,348)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,683,268	1,683,268		
b. Medicare Room and Board Contractual Allowance **	$	435,752	435,752		
4. a. Private-Pay Residents and Other	$	4,755,214	4,755,214		
b. Private-Pay Room and Board Contractual Allowance **	$	(112,769)	(112,769)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	132,709	132,709		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	194,144	194,144		
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	$	479,117	479,117		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	581,237	581,237		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	82,450	82,450		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	102,026	102,026		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	429,598	429,598		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	654,354	654,354		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(2,040,916)	(2,040,916)		
b. Other *(Specify)* - Non-Medicare	$	214,253	214,253		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,319,241	14,319,241		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	3,048	3,048		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	(15,092)	(15,092)		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	56,301	56,301		
V. Total Other Revenue (1 thru 8)	$	44,257	44,257		
VI. Total All Revenue (III +V)	$	14,363,498	14,363,498		

* *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 II 6 a	Respiratory	$ 12,749		
30 II 6 a	Laboratory	$ 16,500		
30 II 6 a	Diagnostic X-Ray	$ 26,485		
30 II 6 a	Ancillary Allowance - Medicare	$ (2,141,211)		
30 II 6 a	Laboratory - Managaged Care	$ 12,942		
30 II 6 a	Diagnostic X-Ray Managed Care	$ 31,619		
Total Other Resident Revenue - Medicare		$ (2,040,916)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 6 b	Laboratory/X-Ray - Commerical	$ 867		
30 II 6 b	Laboratory/X-Ray - Medicaid	$ 1,456		
30 II 6 b	Respiratory Care - Medicaid	$ 763		
30 II 6 b	Ancillary Allowance - Medicaid	$ (40,046)		
30 II 6 b		$ -		
30 II 6 b	MSS - Medicaid	$ 251,213		
Total Other Resident Revenue		$ 214,253	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest Income - Misc Investment		$ 16,099		
30 IV 5	Interest Income - Other Non-operating		$ 16,938		
30 IV 5	Unrealized Gain		$ (48,129)		
Total Interest Income			$ (15,092)	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Admin Misc Income	$ 304		
30 IV 8	Food & Nutrition Counceling	$ 1,572		
30 IV 8	Medical Reocrds Fees	$ 566		
30 IV 8	HR Misc Income	$ 30		
30 IV 8	Admin Other Operating Revenue	$ 45,056		
30 IV 8	Material Management Purchase Discounts	$ 8		
30 IV 8	Vending Machine Income	$ 1,148		
30 IV 8	Extraordinary Event	$ (31,871)		
30 IV 8	Net Assets Released	$ 31,350		
30 IV 8	Misc Non-Operating Income	$ 8,138		
Total Other Revenue		$ 56,301	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham	2056-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 3,164,079
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,564,867
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 100,000
4 Inventories				$ 28,980
5. Prepaid Expenses				$ 50,010
a. Prepaid Expenses (itemize)		50,010		
b.				
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 49,448
Due to Affiliates		34,765		
Assets whos use is Limited		14,683		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 6,957,384
B. Fixed Assets				
1. Land				$ 343,035
2. Land Improvements	*Historical Cost	409,631		$ 6,081
	Accum. Depreciation	403,550	Net	
3. Buildings	*Historical Cost	10,176,507		$ 639,713
	Accum. Depreciation	9,536,794	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	56,520		$ 30,138
	Accum. Depreciation	26,382	Net	
6. Movable Equipment	*Historical Cost	1,696,997		$ 231,621
	Accum. Depreciation	1,465,376	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,250,588

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	PR ded-Misc	$ 2,296
33	A12	Self-Insurnace Claim	$ 102,831
33	A12	Self-Insurance Comp	$ 786,281
33	A12	SS & SSI deposits	$ 8,046
Total Other Current Liabilities (Itemize)			$ 899,454

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

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	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 8,207,972
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 8,207,972

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manor	2056-C	9/30/2019	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 534,839
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 339,096
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 4,115,552
A/R Credit Balances	444,368	Due To/From BHI	2,329,951	
Accrued Expenses	181,036	Patient Refunds	(11,620)	
Due to CT Hosp Tax	217,011	Patient Trust Pay	39,633	
Due to EMS LLC	15,719	See Schedule	899,454	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,989,487

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham Manc	2056-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	4,989,487
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 4,989,487

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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 Ingraham	2056-C	9/30/2019	35	37

Account					Amount	
A.	**Reserves**					
	1. Reserve for value of leased land				$	
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$	
	3. Reserve for depreciation value of leased personal property (*Equity)*				$	
	4. Reserve for leasehold real properties on which fair rental value is based				$	
	5. Reserve for funds set aside as donor restricted				$	
	6. Total Reserves				$	
B.	**Net Worth**					
	1. Owner's Capital				$	
	2. Capital Stock				$	
	3. Paid-in Surplus				$	
	4. Treasury Stock				$	
	5. Cumulated Earnings				$	3,204,692
	6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	$	13,793
	7. Total Net Worth				$	3,218,485
C.	***Total Reserves and Net Worth***				$	3,218,485
D.	***Total Liabilities, Reserves, and Net Worth***				$	8,207,972

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham M	2056-C	9/30/2019	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018	$ 3,642,245
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 14,363,498
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 15,666,644
D. Net Income or Deficit	$ (1,303,146)
E. Balance	$ 2,395,761
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$
Purpose	Amount
3. Total Deductions	$
H. ***Balance at End of Period*** 09/30/19	$ 2,395,761

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc. d/b/a Ingraham	2056-C	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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

Addres Address	Phone Number

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number

Contact Email Address