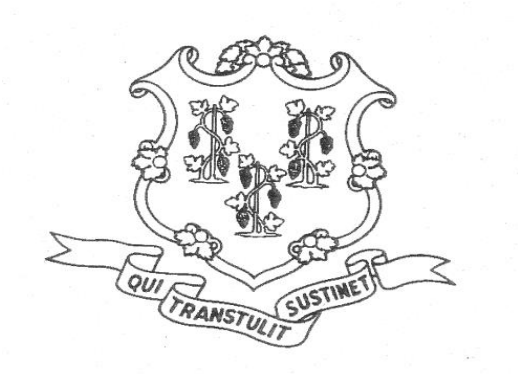
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Bristol Healthcare, Ince. 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 (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

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

Medicaid Provider Numbers:	CCNH / RHNS 20561	(Specify)	(Specify)

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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, Ince. d/b/a Ingraham Manor [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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. 3/2023

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, Ince. d/b/a Ingraham Manor	Period Covered:		From 10/1/2022	To 9/30/2023
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)	(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. 3/2023

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended 9/30/2023	Page 2	of 37

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

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (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.:

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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, Ince. d/b/a Ingraham Mar	2056-C	9/30/2023	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
400 North Main Street, Bristol, CT 06010	CT	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See complete list 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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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	Pg 16 & 10/ Line m12	1,394,254	1,394,254
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	○	⊙		Medical Malpractice Insurance (acct #09.66	Pg 27/Line 14c3		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	○	⊙		Employee Physical	Pg 15/Line 19a	6,200	6,200
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	○	⊙		Property/Umbrella Insurance ((acct #09.660	Pg 27/Line 14a		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	○	⊙		Medical Director/Assistant Medical Director	Pg 13/Line 5A		
Bristol Hospital, Inc	41 Brewster Road, Bristol, CT 06010	○	⊙		Common Pension Plan	Pg 15/Line 1a7	66,326	66,326
		○	⊙					
		○	⊙					
		○	⊙					

* 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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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. 3/2023

General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraha	2056-C	9/30/2023	6	37

Square footage of entire facility.	48,546

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Inc	2056-C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 3/2023

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	128	128			128	128						
B. On last day of THIS report period	128	128							128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	118	118			118	118						
B. As of midnight of THIS report period	118	118							118	118		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,747	5,747			4,368	4,368			1,379	1,379		
B. Medicaid (Conn.)	32,259	32,259			23,904	23,904			8,355	8,355		
C. Medicaid (other states)												
D. Private Pay	4,982	4,982			3,842	3,842			1,140	1,140		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	42,988	42,988			32,114	32,114			10,874	10,874		
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)**	42,988	42,988			32,114	32,114			10,874	10,874		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 3/2023

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(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.

Change in Resident Days	CCNH / RHNS	(Specify)	(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 / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	15	55		7				
Per Diem Rate								
a. One bed rm.		######		575.00				
b. Two bed rms.		######		555.00				
c. Three or more bed rms.		######		525.00				

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	4,721	4,721			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	21,629	21,629			
D. ***Total Physical Therapy Treatments***	26,350	26,350			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	247	247			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	1,479	1,479			
D. ***Total Speech Therapy Treatments***	1,726	1,726			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	4,539	4,539			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	21,298	21,298			
D. ***Total Occupational Therapy Treatments***	25,837	25,837			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	173,613		2,123						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	170,484		8,864						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	67,746		2,104						
c. Dietary Workers	569,314		44,375						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	473,297		27,502						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers									
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	62,244		4,542						
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	131,724		2,101						
b. RN									
1. Direct Care	324,556		11,260						
2. Administrative**	981,486		28,961						
c. LPN									
1. Direct Care	1,581,972		58,580						
2. Administrative**									
d. Aides and Attendants	2,639,313		138,743						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	100,152		6,116						
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	207,769		6,841						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	7,483,670		342,113						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			(Specify)		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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)	(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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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)	(Specify)							
Section III - Administrators* **										
Ashley Soyka	173,613					2,123	A2		2,123	
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. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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									
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	485,199		8,686						
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	78,002		1,399						
b. Other									
10. Occupational Therapist									
a. Resident Care	428,805		7,674						
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	587,437		9,651						
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	1,579,443		27,410						

* 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 in the Adjustment column.

*** 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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare Pharamcy, Dept 7811668, PO Box 7800, Detriot, MI 48278-1668	Pharmacist	○	⊙	N/A
Symbria Rehab Services, 28100 Torch Parkway, Suite 600, Warrrenville, IL 60558	Physical, Occupational and Speech Therapy	○	⊙	N/A
Dr. Doris Alher, MD - Bristol Hospital	Medical Director	○	⊙	N/A
Dr. Surendran Varma, MD - Bristol Hospital	Assistant Medical Director	○	⊙	N/A
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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. 3/2023

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	192,759	192,759					
2. Disability Insurance	$	578	578					
3. Unemployment Insurance	$	25,500	25,500					
4. Social Security (F.I.C.A.)	$	554,435	554,435					
5. Health Insurance	$	512,898	512,898					
6. Life Insurance (employees only)								
(not-owners and not-operators)	$	14,023	14,023					
7. Pensions (Non-Discriminatory)	$	66,326	66,326					
(not-owners and not-operators)								
8. Uniform Allowance	$							
9. Other (*Specify*)	$	422,647	440,453	(17,806)				
See Attached Schedule								
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		653,727	(653,727)				
d. Accounting and Auditing	$							
e. Legal (*Services should be fully described on Page 15b)*	$	15,410	15,410					
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	15,779	15,779					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	47,874	64,752	(16,878)				
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	$	528,966	528,966					
Subtotal	$	2,397,195	3,085,606	(688,411)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
09.6643.1992 BHC Employee Benefits PTO Expense Accrual	$ 19,497					
09.6643.2150 BHC Employee Benefits Employee Physicals	$ 6,200					
09.6643.2221 BHC Employee Benefits EE Satisfaction	$ 17,806	$ (17,806)				
09.6643.2510 BHC Employee Benefits Tuition Reimbursemnt	$ 3,760					
09.6643.1920 BHC Employee Benefits Retention	$ -					
09.6643.2491 BHC Employee Benefits Family Med Leave Ins	$ 4,056					
09.6643.2709 BHC Employee Benefits Aetna Benefits - IM	$ 389,114					
09.6643.7999 BHC Employee Benefits Other-Misc	$ 20					
Total	$ 440,453	$ (17,806)	$ -	$ -	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15b Rev. 3/2023

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingra	2056-C	9/30/2023	15b	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 Baker Tilly US, LLP	One Penn Plaza, Ste 3000 New York, NY 10119 United States of America
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audited Financial Statements	$ Included in Bristol Hospital a
2		$ Health Care Group Audit Fe
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	Telephone Number
1 Various	
2	
3	
4	
5	

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	$ 15,410
2	Settlement of claim	$
3		$
4		$
5		$

Charge for Services Provided: $ 15,410

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-16 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		2,397,195	3,085,606	(688,411)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$							
3. Gifts to Staff and Residents	$	(5,766)	(5,766)					
4. Employee Travel	$	1,552	1,552					
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*)	$	82,391	82,391					
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	$							
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$							
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$							
10. Contributions*** See Attached Schedule	$							
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	323,693	323,693					
12. Administrative Management Services**	$	1,394,254	1,394,254					
13. Other (*Specify*) See Attached Schedule	$							
C-14 Total Administrative & General Expenditures	$	4,193,319	4,881,730	(688,411)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
09.6600.7650 BHC Administration EE Dues Licen Mbship	$ -					
Total Dues	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
09.6600.7395 BHC Administration Patient Satisfaction	$ -					
09.6600.2221 BHC Administration EE Satisfaction	$ -					
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, Ince. d/b/a Ingraham M	2056-C	9/30/2023	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	1,394,254	Parent Company chargebacks for administractive 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 3/2023

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	421,520	421,520					
2. Non-Food Supplies	$	103,063	103,063					
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)_____ Dues/Satisfaction Survey/Nutrition Software	$	4,645	4,645					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	529,228	529,228					

		Total	CCNH / RHNS	(Specify)	(Specify)
2E.	Dietary Questionnaire				
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)				Page 30 Line IV. 1 (Acct #09.40
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.	648
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Page 30 Line IV.8. (Acct #09.40
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. 3/2023

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	219,712	219,712					
c. Other (*Specify*)	$							
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	219,712	219,712					

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. 3/2023

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	20	37

Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel								
a. In-House Care									
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	2,366	2,366					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel								
	Amt.	$							
C. Other (*Specify*)		$	31,042	31,042					
Covid Exp and Other Supplies									
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	33,408	33,408					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from		$	47,767	47,767					
Nursing Services									
b. Medicine Cabinet Drugs		$	323,961	323,961					
c. Medical and Therapeutic Supplies		$	248,461	248,461					
d. Ambulance/Limousine***		$							
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$							
f. X-rays and Related Radiological Procedures***		$							
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$							
i. Recreation		$	16,137	16,137					
j. Direct Management Services*		$							
k. Indirect Management Services*		$							
l. Cable TV		$							
m. Other (Specify)****		$	26,148	26,148					
See Attached Schedule									
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	662,474	662,474					

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense in the Adjustment column.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
09.6022.5320 BHC Nrsg Pool & Serv Nursing-Supplies	$ 1,580					
09.6022.5330 BHC Nrsg Pool & Serv Food & Nutri supp	$ 10,382					
09.6022.7052 BHC Nrsg Pool & Serv COVID Expenses	$ 9,605					
09.6022.6010 BHC Nrsg Pool & Serv Drugs - Charge	$ 4,581					
Total Other Resident Care	$ 26,148	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 3/2023

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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)	(Specify)	Pg	Line
CWPM	PO Box 415 Plainville, CT	○	⊙		Waste Removal - Acct #09.6692.7760	54,479			22	6f
Martin Laviero	PO Bnox 1659 Bristol, CT	○	⊙		Snow Removal - Acct #09.6692.3521	19,385			22	6f
Unitex	420Ledyard St., Hartford, CT	○	⊙		Laundry Services/Linens - Acct #09.6691.3760	219,712			19	3b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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. 3/2023

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

Name of Facility	License No.	Report for Year Ended					Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Mano	2056-C	9/30/2023					22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	61,669	61,669					
b. Heat	$	44,438	44,438					
c. Light & Power	$	53,412	53,412					
d. Water	$	26,866	26,866					
e. Equipment Lease (*Provide detail on page 22b*)	$							
f. Other (*itemize*)	$	225,527	225,527					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	411,912	411,912					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	333	333					
b. Building & Building Improvements	$	82,640	82,640					
c. Non-Movable Equipment	$	12,259	12,259					
d. Movable Equipment	$	31,515	31,515					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	126,747	126,747					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$							
d. Other (*Specify*)	$							
*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	$	161,333	161,333					
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$	18,905	18,905					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	306,985	306,985					

* 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	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
09.6692.3520 BHC Operation Of Plant Prop Maint	$ 23,454					
09.6692.3521 BHC Operation Of Plant Prop Maint-Snw remov	$ 19,385					
09.6692.5180 BHC Operation Of Plant Facility Supplies	$ 78,837					
09.6692.7280 BHC Operation Of Plant Maint/Serv Contracts	$ 46,774					
09.6692.7760 BHC Operation Of Plant Trash/Recycle/Sewage	$ 54,479					
09.6692.4000 BHC Operation Of Plant Pat Med Supp/Equip	$ 2,598					
Total Other Repairs and Maintenance	$ 225,527	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22b Rev. 3/2023

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	○	⊙					
	⊙	○					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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	407,993	S/L	Various	333	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								333
B. **Building and Building Improvements**								
1. Acquired prior to this report period	10,264,180		10,303,800	9,787,337	S/L	Various	81,456	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	39,620						1,184	
B-4. Subtotal								82,640
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	207,524		207,524	30,725	S/L	Various	12,259	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								12,259

	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					1,795,524		1,797,220	1,644,140	S/L	Various	31,232	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					1,696						283	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					1,696						283	
D-3. Subtotal												31,515
E. ***Total Depreciation***												126,747

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/1/2023	Electronic Mixing Valve	$ 7,718	10	$ 386	
9/1/2023	Skylight repair	$ 12,400	20	$ 310	
9/1/2023	Backflow Preventers	$ 19,502	20	$ 488	
Total additions for Building Improvements		$ 39,620		$ 1,184	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
9/1/2023	IM Computers/Tablets/Laptops for use w new MealSuite program	Administrative	$ 1,696	3	$ 283	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 1,696		$ 283	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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, Ince. d/b/a Ingraham Manor	2056-C	9/30/2023	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.									
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:

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, Ince. d/b/a Ingraha	2056-C	9/30/2023	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. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraha	2056-C	9/30/2023	26	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingra	2056-C	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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*) $ Interest Expense	2,850	2,850					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	2,850	2,850					
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)*** $	15,423,001	16,111,412	(688,411)				

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev. 3/2023

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Healthcare, Ince. d/b/a Ingraham M	2056-C	9/30/2023	30	37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	15,259,316	15,259,316		
b. Medicaid Room and Board Contractual Allowance **	$	(6,867,614)	(6,867,614)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,696,746	1,696,746		
b. Medicare Room and Board Contractual Allowance **	$	291,345	291,345		
4. a. Private-Pay Residents and Other	$	3,993,474	3,993,474		
b. Private-Pay Room and Board Contractual Allowance **	$	(14,271)	(14,271)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	124,912	124,912		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	137,685	137,685		
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	$	377,912	377,912		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	800,790	800,790		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	69,210	69,210		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	106,279	106,279		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	383,139	383,139		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	796,958	796,958		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(2,585,541)	(2,585,541)		
b. Other *(Specify)* - Non-Medicare	$	(5,405)	(5,405)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,564,935	14,564,935		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	1,223	1,223		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	12,516	12,516		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	23,343	23,343		
V. Total Other Revenue (1 thru 8)	$	37,082	37,082		
VI. Total All Revenue (III +V)	$	14,602,017	14,602,017		

* *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)	(Specify)
	09.3120.1011 BHC Diagnostic X-Ray REV IP MCR	$ 9,205		
	09.3120.1012 BHC Diagnostic X-Ray REV IP MCR MGD	$ 10,000		
	09.3140.1011 BHC Laboratory REV IP MCR	$ 16,325		
	09.3140.1012 BHC Laboratory REV IP MCR MGD	$ 7,956		
	09.3154.1011 BHC Respiratory Care REV IP MCR	$ 7,743		
	09.3154.1012 BHC Respiratory Care REV IP MCR MGD	$ 6,662		
	09.5003.1011 BHC Allow. Ancillary IP Medicare	$ (650,263)		
	09.5003.1012 BHC Allow. Ancillary IP Medicare Mgd	$ (1,770,686)		
	09.5003.1021 BHC Allow. Ancillary IP Medicaid	$ (112,858)		
	09.5003.1043 BHC Allow. Ancillary Medicare Part B	$ (86,401)		
	09.5000.4821 BHC Cont-Adj Medicaid Settlements	$ -		
	09.4000.4127 BHC Other Op Revenue-Adm Other Operating Rev	$ (22,530)		
	09.4000.5602 BHC Other Op Revenue-Adm Int Inc-Misc	$ 48		
	09.4027.5999 BHC OOR-HR Misc Income	$ (85)		
	09.4033.5500 BHC OOR-MatMgmt Purchase Discounts	$ (9)		
	09.4035.5997 BHC OOR-Food & Nutrition Counceling CTR INC	$ (648)		
Total Other Resident Revenue - Medicare		$ (2,585,541)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	09.3010.1021 BHC MSS REV IP Medicaid	$ (25,413)		
	09.3120.1021 BHC Diagnostic X-Ray REV IP Medicaid	$ 1,037		
	09.3120.1033 BHC Diagnostic X-Ray REV IP Commercial	$ -		
	09.3140.1021 BHC Laboratory REV IP Medicaid	$ (782)		
	09.3140.1033 BHC Laboratory REV IP Commercial	$ -		
	09.3154.1021 BHC Respiratory Care REV IP Medicaid	$ 15,722		
	09.3154.1033 BHC Respiratory Care REV IP Commercial	$ -		
	09.3120.1041 BHC Diagnostic X-Ray REV IP Selfpay Via Hlth	$ 871		
	09.3140.1041 BHC Laboratory REV IP Selfpay Via Hlth	$ 1,083		
	09.3154.1041 BHC Respiratory Care REV IP Selfpay Via Hlth	$ 2,077		
Total Other Resident Revenue		$ (5,405)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	09.4200.5604 BHC Other Non-Oper REV Int Inc-Misc Invest		$ 12,516		
Total Interest Income			$ 12,516	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	09.4000.4127 BHC Other Op Revenue-Adm Other Operating Rev	$ 22,530		
	09.4000.5255 BHC Other Op Revenue-Adm COVID-19 INCENTIVE	$ -		
	09.4000.5602 BHC Other Op Revenue-Adm Int Inc-Misc	$ (48)		
	09.4000.5998 BHC Other Op Revenue-Adm Misc Non-Oper Rev	$ 81		
	09.4027.5999 BHC OOR-HR Misc Income	$ 85		
	09.4033.5500 BHC OOR-MatMgmt Purchase Discounts	$ 9		
	09.4035.5997 BHC OOR-Food & Nutrition Counceling CTR INC	$ 648		
	09.4000.5623 BHC Other Op Revenue-Adm Net Assets Released	$ 38		
Total Other Revenue		$ 23,343	$ -	$ -

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, Ince. d/b/a Ingraham	2056-C	9/30/2023	31	37

Account					Amount
Assets					
A. Current Assets					
1. Cash (*on hand and in banks*)					$ 5,954
2. Resident Accounts Receivable (Less Allowance for Bad Debts)					$ 2,478,871
3. Other Accounts Receivable (Excluding Owners or Related Parties)					$
4 Inventories					$ 73,227
5. Prepaid Expenses					$ 39,556
a. 09.1400.0002 BHC Prepaid Expense		39,556			
b.					
c.					
d. See Schedule					
6. Interest Receivable					$
7. Medicare Final Settlement Receivable					$
8. Other Current Assets (*itemize*)					$ 1,033,158
09.1220.0017 BHC Due From HomecareHos		1,001,788			
09.1600.0004 BHC Inv in BHDF		31,370			
See Schedule					
A-9. ***Total Current Assets*** (Lines A1 thru 8)					$ 3,630,766
B. Fixed Assets					
1. Land					$ 343,035
2. Land Improvements	*Historical Cost	409,631			$ 1,305
	Accum. Depreciation	408,326	Net		
3. Buildings	*Historical Cost	10,303,800			$ 433,823
	Accum. Depreciation	9,869,977	Net		
4. Leasehold Improvements	*Historical Cost				$
	Accum. Depreciation		Net		
5. Non-Movable Equipment	*Historical Cost	207,524			$ 164,540
	Accum. Depreciation	42,984	Net		
6. Movable Equipment	*Historical Cost	1,797,220			$ 121,565
	Accum. Depreciation	1,675,655	Net		
7. Motor Vehicles	*Historical Cost				$
	Accum. Depreciation		Net		
8. Minor Equipment-Not Depreciable					$
9. Other Fixed Assets (*itemize*)					$ 77,374
09.1900.1900 BHC CONSTRUCT IN PROGRES		77,374			
See Schedule					
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)					$ 1,141,642

* 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	
		09.2100.0080 BHC A/R Credit Balances	480,389
		09.2100.0086 BHC Patient Trust Pay	46,251
		09.2100.0088 BHC SS&SSI deposits	5,969
		09.2100.0090 BHC Patient Refunds	(56,372)
		09.2110.0010 BHC Due To EMS LLC	36,616
		09.2110.0020 BHC Due To/From BHI	2,625,169
		09.2300.0014 BHC Benefit Plus Payable	260
		09.2400.0030 BHC Accrued Expenses	212,791
		09.2400.0032 BHC Accrued Expenses-PO	74,941
		09.2400.0050 BHC Self-Insurance Claim	65,800
		09.2400.0052 BHC Self-Workers Comp	813,191
		09.2500.0060 BHC Due to CT Hosp Tax	199,584
		09.2110.0015 BHC Due to BHMSG	1,799
		09.2500.0020 BHC Due to MCD	269,268
Total Other Current Liabilities (Itemize)			$ 4,775,656

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, Ince. d/b/a Ingraham	2056-C	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 4,772,408
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)				$ 4,772,408

* 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, Ince. d/b/a Ingraham Mano	2056-C	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,275,616
	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*)				$ 541,140
	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*)				$ 4,775,656
	See Schedule		4,775,656		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,592,412

* 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, Ince. d/b/a Ingraham Ma	2056-C	9/30/2023	34	37

Account	Amount
Total Brought Forward:	6,592,412
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)	$ 6,592,412

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, Ince. d/b/a Ingraha	2056-C	9/30/2023	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (1,833,797)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 13,793
	7. Total Net Worth	$ (1,820,004)
C.	***Total Reserves and Net Worth***	$ (1,820,004)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,772,408

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, Ince. d/b/a Ingraham	2056-C	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
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*** 09/30/23			$

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, Ince. d/b/a Ingraham	2056-C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (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

Addres Address	Phone Number
Baker Newman Noyes 280 Fore Street Portland Maine 04101	207-791-7174

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Marc Levy	207-791-7174

Contact Email Address
mlevy@bnncpa.com