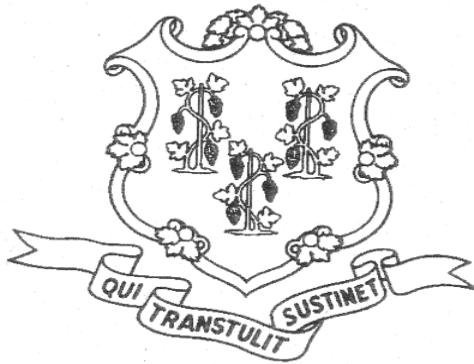


State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2022

Name of Facility (as licensed) Aaron Manor Nursing & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 3 South Wig Hill Road, Chester, CT 06412	
Type of Facility	
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2168-C	RHNS	(Specify)	Medicare Provider 21684
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Medicaid Provider Numbers:	CCNH 21684	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Aaron Manor Nursing & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Kerri Roche		Printed Name (Owner) Martin Sbriglio		
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public				

(Notary Seal)

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State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility Aaron Manor Nursing & Rehabilitation Center	Period Covered:	From 10/1/2021	To 9/30/2022		
Address of Facility 3 South Wig Hill Road, Chester, CT 06412					
Report Prepared By Ryders Health Management	Phone Number 203-381-1327	Date 1/10/2023			
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-381-1327	9/30/2022	2	37

Name of Facility (as shown on license) Aaron Manor Nursing & Rehabilitation Center	Address (No. & Street, City, State, Zip) 3 South Wig Hill Road, Chester, CT 06412		
License Numbers: CCNH 2168-C	RHNS	(Specify)	Medicare Provider No. 21684

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 Kerri Roche	Nursing Home Administrator's License No.:
--------------------------------------	---

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

Name N/A	License No.: N/A

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Aaron Manor Nursing & Rehabilitation Cent	License No. 2168-C	Report for Year Ended 9/30/2022	Page of 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	
Aaron Manor Nursing & Rehabilitation Center	3 South Wig Hill Road, Chester, CT 06412	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
The Dr. Robers Stbiglio 2009 Trust	3 South Wig Hill Road, Chester, CT 06412		2
The Martin Sbriglio Trust	3 South Wig Hill Road, Chester, CT 06412		2
Dr. Robert Sbriglio, MPH, NHA	3 South Wig Hill Road, Chester, CT 06412		48
Mr. Martin Sbriglio, RN, NHA	3 South Wig Hill Road, Chester, CT 06412		48
Names of Stockholders Owning at Least 10% of Shares			
Dr. Robert Sbriglio, MPH, NHA	3 South Wig Hill Road, Chester, CT 06412		48
Mr. Martin Sbriglio, RN, NHA	3 South Wig Hill Road, Chester, CT 06412		48

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Aaron Manor Nursing & Rehabilitation Center	2168-C	9/30/2022	3B	37

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

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022	Page 4	of 37			
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No			If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?			<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
See Attached Schedule		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.

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

Aaron Manor Nursing and Rehabilitation Center
Cost Report 9/30/2022
List of Related Parties
Page 4 Attachment

Name of Related Individual or Company	Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Services Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%				
Ryders Health Management (RHM)	88 Ryders Lane, Suite 208, Stratford, CT 06614	X			Financial and Managerial Support	16/m12	247,555	247,555
Aaron Manor Realty	3 South Wig Hill Road, Chester, CT 06412	X			Rental of Real Estate	22/9	99,600	99,600
Due from Bel-Air Manor	256 New Britain Ave, Newington, CT 06111	X			Loan to Facility	32/D7, 34/B4	196,757	196,757
Due from Cheshire House	3396 East Main St., Waterbury, CT 06705	X			Loan to Facility	32/D7, 34/B4	135,213	135,213
Due to/from Chamberlain Manor	7003 Main St., Stratford, CT 06614	X			Loan to Facility	32/D7, 34/B4	12,420	12,420
Due to/from Greentree Manor	4 Greentree Drive, Waterford, CT 06385	X			Loan to Facility	32/D7, 34/B4	238,911	238,911
Due to/from Lord Chamberlain	7003 Main St., Stratford, CT 06614	X			Loan to Facility	32/D7, 34/B4	326,489	326,489
Due to/from Mystic Healthcare	475 High St., Mystic, CT 06355	X			Loan to Facility	32/D7, 34/B4	40,589	40,589
Due to/from Ryders Health	88 Ryders Lane, Suite 208, Stratford, CT 06614	X			Loan to Facility	32/D7, 34/B4	122,521	122,521
Due to/from Lighthouse	88 Ryders Lane, Stratford, CT 06614	X			Loan to Facility	32/D7, 34/B4	360,127	360,127
Due to AM Realty	3 South Wig Hill Road, Chester, CT 06412	X			Loan to/from Facility	34/B4	396,759	396,759

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required?	<input checked="" type="radio"/> Yes <input type="radio"/> 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.)		
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.		

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

8,683

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire

Accounting Basis

Name of Facility Aaron Manor Nursing & Rehabilita	License No. 2168-C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this

period the same as for the previous period?

Yes
 No

If "No," explain.

Independent Accounting Firm

Name of Accounting Firm 1 CJLC Consulting, LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St., East Hartford, CT 06108
--	--

Services Provided by This Firm (*describe fully*)

1	Tax Return, year end financial review, consulting	\$ 6,656
2		\$
3		\$
4		\$
		Charge for Services Provided
		\$ 6,656

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

Yes No | Page 15, line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Attached	
2	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

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

⊕ Yes ⊖ No

Page 15, line 1f

Aaron Manor

Legal Fees

9/30/2022

Vendor	Description	Amount	Allowable	
			Yes	No
Karen Cotrona	Notary License Renewal	60.00	60.00	-
Joe D'Agostino	Various	7,691.22	3,845.61	3,845.61
Kainen , Escalera & McHale	Various	20,718.61	-	20,718.61
Laurie Gfeller LLP	Review Probate Court Website	2,737.24	2,737.24	-
Total		<u>\$ 31,207.07</u>	<u>\$ 6,582.85</u>	<u>\$ 24,564.22</u>

Schedule of Resident Statistics

Name of Facility Aaron Manor Nursing & Rehabilitation Center			License No. 2168-C			Report for Year Ended 9/30/2022				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					60	60						
A. On last day of PREVIOUS report period	60	60										
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents					46	46						
A. As of midnight of PREVIOUS report period	46	46										
B. As of midnight of THIS report period	56	56							56	56		
3. Total Number of Days Care Provided During Period					2,026	2,026			691	691		
A. Medicare	2,717	2,717										
B. Medicaid (Conn.)	10,782	10,782			8,171	8,171			2,611	2,611		
C. Medicaid (other states)												
D. Private Pay	3,569	3,569			2,531	2,531			1,038	1,038		
E. State SSI for RCH												
F. Other (Specify) Managed Care	2,312	2,312			1,687	1,687			625	625		
G. Total Care Days During Period (3A thru F)	19,380	19,380			14,415	14,415			4,965	4,965		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					60	60			26	26		
A. Medicaid Bed Reserve Days	86	86										
B. Other Bed Reserve Days	32	32			21	21			11	11		
5. Total Resident Days (3G + 4A + 4B)	19,498	19,498			14,496	14,496			5,002	5,002		

Schedule of Resident Statistics (Cont'd)

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	7	29		16				
Per Diem Rate								
a. One bed rm.	Various	271.82		\$448-\$456				
b. Two bed rms.				\$414-\$422				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	1,521	1,521		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				

C. Other

9,150 9,150

D. **Total Physical Therapy Treatments**

10,671 10,671

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	227	227	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	690	690	
D. Total Speech Therapy Treatments	917	917	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,250	1,250	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	10,057	10,057	
D. Total Occupational Therapy Treatments	11,307	11,307	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
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)	138,019	2,580			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	177,265	7,437			
5. Dietary Service					
a. Head Dietitian	34,958	813			
b. Food Service Supervisor	74,512	2,792			
c. Dietary Workers	271,272	13,870			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	140,261	8,851			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	74,680	1,988			
b. Other Maintenance Workers	34,328	2,067			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
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	121,448	1,800			
b. RN					
1. Direct Care	802,982	16,479			
2. Administrative**					
c. LPN					
1. Direct Care	448,443	12,542			
2. Administrative**					
d. Aides and Attendants	816,725	36,156			
e. Physical Therapists	254,964	6,561			
f. Speech Therapists	32,594	560			
g. Occupational Therapists	165,111	3,603			
h. Recreation Workers	93,502	3,896			
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	131,913	4,128			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	1,957	183			
<i>A-13. Total Salary Expenditures</i>	3,814,935	126,307			

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

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center				License No. 2168-C	Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Dr. Robert Sbriglio, MD								Lord Chamberlain, 7003 Main St., Stratford, CT 06614	1,440	133,802
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	3,652	245,192
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
Aaron Manor Nursing & Rehabilitation Center				2168-C		9/30/2022			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***										
Deborah Bradley - 10/1/2021 - 5/31/2022	88,231			Non Discriminatory	Administrative		A2			
Joe Colaci - 6/1/22 - 6/26/22	24,038			Non Discriminatory	Administrative		A2			
Kerri Roche - 6/27/22 - 9/30/22	25,750			Non Discriminatory	Administrative		A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2168-C	9/30/2022		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	2,990				
3. Pharmacist	2,218				
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	(98)				
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	31,200				
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	1,926				
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	98,571	782			
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***	318,729	2,967			
c. Aides	323,903	5,449			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	779,437	9,198			

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center		License No. 2168-C	Report for Year Ended 9/30/2022		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
LTC Management	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
MassTex Imaging	ST	<input type="radio"/>	<input checked="" type="radio"/>			
Peter Dixon MD, 192 Westbrook Road, Essex, CT 06426	Medical Director, Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
ValueRx	Pharmacy Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Timothy Tobin MD, 2 Turnstone Road, Essex, CT 06426	Medical Director, Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
The Nurse Network	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
MAS Medical Staffing Corp	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Fusion Medical Staffing LLC	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
All American Healthcare Services, Inc	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Vertical Staffing Corp	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
AAA Nursing Care	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Solomon Page Group LLC	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
SambaCare	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Headcount Management Inc	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	156,205	156,205		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$	329,560	329,560		
5. Health Insurance	\$	187,028	187,028		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	6,598	6,598		
8. Uniform Allowance	\$	10,072	10,072		
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	78,580	78,580		
d. Accounting and Auditing	\$	6,656	6,656		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	31,207	31,207		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$	11,771	11,771		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	16,319	16,319		
2. Cellular Phones	\$	3,652	3,652		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$	310,360	310,360		
<i>Subtotal</i>	\$	1,148,007	1,148,007		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>	1,148,007	1,148,007		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$	6,823	6,823	
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$	1,851	1,851	
5. Education Expenses Related to Seminars and Conventions	\$	14,237	14,237	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$	696	696	
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	24,149	24,149	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	(2,123)	(2,123)	
4. Fund-Raising***	\$			
5. Medical Records	\$	8,640	8,640	
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$	2,609	2,609	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	4,205	4,205	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	50	50	
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	74,655	74,655	
12. Administrative Management Services**	\$	247,555	247,555	
13. Other (<i>Specify</i>) See Attached Schedule	\$	30,304	30,304	
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,561,659	1,561,659	

* 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)
Meals & Entertainment	\$ 696		
Total Other Travel and Entertainment	\$ 696	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	\$ (2,123)		
Total Other Advertising	\$ (2,123)	\$ -	\$ -

Schedule of Dues

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Elevator Renewal	\$ 720		
Physician Care Employees	\$ 7,667		
Bank Charges	\$ 17,247		
Bank Charges - Lease	\$ 479		
Unemployment Tax Management	\$ 963		
AR Consulting - Bookkeeping Services, Not Collections	\$ 193		
HR Consultant	\$ 1,928		
American Express Card Renewal Fee	\$ 50		
CMS Medicare Application	\$ 599		
CLIA Renewal	\$ 180		
Food License	\$ 280		
Total Other Administrative and General	\$ 30,304	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Aaron Manor Nursing & Rehabilitation C	2168-C	9/30/2022	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 #
Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	247,555	Financials and Managerial Support	Page 16, m12

* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

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

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2022		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 140,745	140,745		
2. Non-Food Supplies	\$ 18,687	18,687		
3. Other (Specify) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 159,432	159,432		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
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? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs

(See Note on Page 5)

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2022		Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	59,151	59,151		
c. Other (<i>Specify</i>) Laundry Supplies	\$	37	37		
3D. Total Laundry Expenditures (3a + b + c)	\$	59,188	59,188		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 26,208	26,208		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	26,208	26,208		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from ValueRx	\$	181,146	181,146		
b. Medicine Cabinet Drugs	\$	20,814	20,814		
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$	(282)	(282)		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	12,395	12,395		
f. X-rays and Related Radiological Procedures***	\$	9,729	9,729		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	29,141	29,141		
i. Recreation	\$	10,623	10,623		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	137,983	137,983		
5M. Total Resident Care Expenditures (5a - 5j)	\$	401,549	401,549		

* 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

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

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 135,100	135,100			
b. Heat	\$ 36,584	24,388			12,196
c. Light & Power	\$ 106,760	99,687			7,074
d. Water	\$				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 8,683	8,683			
f. Other (<i>itemize</i>)	\$				
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 287,128	267,857			19,270
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 111,324	111,324			
c. Non-Movable Equipment	\$ 16,356	16,356			
d. Movable Equipment	\$ 20,520	20,520			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 148,200	148,200			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 99,600	99,600			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 65,989	65,989			
c. Personal property taxes	\$ 7,465	7,465			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 321,254	321,254			

* 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

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/9/2022	Well Pump	\$ 2,659	10	\$ 22
6/3/2022	Nurse Call Systemt	\$ 1,403	10	\$ 47
Total additions for Building Improvements		\$ 4,062		\$ 69 *
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:				
11/15/2021	Radiator	\$ 6,571	5	\$ 1,205
12/28/2021	Radiator	\$ 2,190	5	\$ 329
4/13/2022	Nurse Call System	\$ 39,952	10	\$ 1,998
6/29/2022	Wander Guard	\$ 13,294	5	\$ 665
7/31/2022	A/C	\$ 1,792	5	\$ 60
5/16/2022	Freezer Compressor	\$ 3,945	5	\$ 329
Total additions for Non-Movable Equipment		\$ 67,743		\$ 4,584
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	Useful Life		Depreciation
		Movable Category	Cost	Life	
Additions:					
3/4/2022	Electric Beds	Standard Resident	\$ 13,567	5	\$ 1,583
3/18/2022	Electric Beds	Standard Resident	\$ 13,488	5	\$ 225
6/28/2022	Computer	Standard Resident	\$ 1,471	3	\$ 123
8/3/2022	Hoyer Lift	Standard Resident	\$ 3,904	5	\$ 130
9/19/2022	Generator Battery	Standard Resident	\$ 1,382	5	\$ 23
9/2/2022	Generator Battery	Standard Resident	\$ 1,037	5	\$ 17
Total additions for Movable Equipment			\$ 34,849		\$ 2,100 *
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

Amortization Schedule*

Name of Facility Aaron Manor Nursing & Rehabilitation Center			License No. 2168-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

- 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.

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

Name of Facility Aaron Manor Nursing & Rehabilitation	License No. 2168-C	Report for Year Ended 9/30/2022	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

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

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

Description	Total			
1. Date Land Purchased	04/01/51			
2. Date Structure Completed	1971 (SNF) 1951 (RCH)			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	60 (SNF) 18 (RCH)			
6. Square Footage	37,223			
7. Acquisition Cost				
a. Land	13,428			
b. Building	219,006			

Part B - Owner and Related Parties

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

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

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	2,095	2,095		
Interest Expense						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	2,095	2,095		
14. Insurance						
a. Insurance on Property (buildings only)		\$	10,916	10,916		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)		\$	60,940	60,940		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	71,856	71,856		
15. Total All Expenditures (A-13 thru C-14)		\$	7,484,740	7,465,470		19,270

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Aaron Manor Nursing & Rehabilitation Center			2168-C	9/30/2022		28 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
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	\$			
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$				

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other A&G Adjustments			\$ -	\$ -	\$ -

State of Connecticut

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.		2168-C	9/30/2022	29	37
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$			
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
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	\$			
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)				\$			

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

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$	4,265,361	4,265,361			
b. Medicaid Room and Board Contractual Allowance **	\$	(1,334,481)	(1,334,481)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$	1,372,662	1,372,662			
b. Medicare Room and Board Contractual Allowance **	\$	414,137	414,137			
4. a. Private-Pay Residents and Other	\$	2,347,895	2,347,895			
b. Private-Pay Room and Board Contractual Allowance **	\$	(300,796)	(300,796)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	173,222	173,222			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(173,222)	(173,222)			
c. Prescription Drugs - Non-Medicare	\$	28,991	28,991			
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	\$	181,469	181,469			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(181,469)	(181,469)			
c. Physical Therapy - Non-Medicare	\$	216,522	216,522			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$	33,096	33,096			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(33,096)	(33,096)			
c. Speech Therapy - Non-Medicare	\$	44,714	44,714			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$	210,559	210,559			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(210,559)	(210,559)			
c. Occupational Therapy - Non-Medicare	\$	217,917	217,917			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$	(0)	(0)			
b. Other (<i>Specify</i>) - Non-Medicare	\$	1,717	1,717			
III. Total Resident Revenue (Section I. thru Section II.)		\$	7,274,640	7,274,640		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$	242	242			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$	723	723			
V. Total Other Revenue (1 thru 8)		\$	965	965		
VI. Total All Revenue (III +V)		\$	7,275,605	7,275,605		

* 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)
	Oxygen	\$ 365		
	X-Ray	\$ 8,653		
	Lab	\$ 21,566		
	Contractuals	\$ (30,584)		
	Total Other Resident Revenue - Medicare	\$ (0)	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	X-Ray Managed Care	\$ 253		
	Lab Managed Care	\$ 1,464		
	Total Other Resident Revenue	\$ 1,717	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	\$ 242			
	Total Interest Income	\$ 242	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc Revenue	\$ 723		
	Total Other Revenue	\$ 723	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of		
		9/30/2022	31	37		
Account			Amount			
Assets						
A. Current Assets						
1. Cash (<i>on hand and in banks</i>)			\$ 512,508			
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 744,980			
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$			
4. Inventories			\$			
5. Prepaid Expenses			\$ 4,059			
a. Prepaid Expenses 2,201						
b. Prepaid Insurance 1,858						
c. _____						
d. See Schedule						
6. Interest Receivable			\$			
7. Medicare Final Settlement Receivable			\$			
8. Other Current Assets (<i>itemize</i>)			\$ (331,925)			
Loans & Exchanges (350,152)						
Refunds 18,226						
See Schedule						
A-9. Total Current Assets (Lines A1 thru 8)			\$ 929,622			
B. Fixed Assets						
1. Land			\$			
2. Land Improvements *Historical Cost 127,074			\$ 1,452			
Accum. Depreciation 125,622 Net						
3. Buildings *Historical Cost 3,466,408			\$ 1,181,427			
Accum. Depreciation 2,284,981 Net						
4. Leasehold Improvements *Historical Cost _____			\$			
Accum. Depreciation _____ Net						
5. Non-Movable Equipment *Historical Cost 573,913			\$ 139,462			
Accum. Depreciation 434,451 Net						
6. Movable Equipment *Historical Cost 670,666			\$ 63,839			
Accum. Depreciation 606,827 Net						
7. Motor Vehicles *Historical Cost 33,275			\$			
Accum. Depreciation 33,275 Net						
8. Minor Equipment-Not Depreciable			\$			
9. Other Fixed Assets (<i>itemize</i>)			\$ 410,552			
Work in Progress 410,552						
See Schedule						
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 1,796,732			

* 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			\$ <u> </u>

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Due from Chamberlain Manor	\$ 12,420
		Due from Greentree Manor	\$ 238,911
		Due from Lord Chamberlain	\$ 326,489
		Due from Mystic Manor	\$ 40,589
		Due from Ryder Health Management	\$ 122,521
		Due from Lighthouse Home Care	\$ 107,022
		Due from Lighthouse Home Healthcare	\$ 253,105
Total Other Assets			\$ 1,101,057

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Schedule of Other Long Term Liabilities (Itemize) Page 34 Line R4

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Aaron Manor Nursing & Rehabilitation	2168-C	9/30/2022	32 37
Account			Amount
Total Brought Forward:			\$ 2,726,354
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net \$
3. Buildings	*Historical Cost	Accum. Depreciation	Net \$
4. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net \$
5. Movable Equipment	*Historical Cost	Accum. Depreciation	Net \$
6. Motor Vehicles	*Historical Cost	Accum. Depreciation	Net \$
7. Minor Equipment-Not Depreciable			\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net \$
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care (<i>itemize</i>)			\$
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$
Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$ 1,433,027
Due from Bel-Air Manor		196,757	
Due from Cheshire House		135,213	
See Schedule		1,101,057	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 1,433,027
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 4,159,381

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
		Account	Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 800,734
2. Notes Payable (<i>itemize</i>)				\$
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 64,019
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable (<i>Current Portion</i>)				\$
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities (<i>itemize</i>)				\$ 747,820
Aflac - Individual	6,478	Accrued PTO	95,401	
Patient Fund	28,630			
Accrued Expenses	136,636			
Accrued User Fee	480,674	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,612,573

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Aaron Manor Nursing & Rehabilitation Cen	License No. 2168-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				1,612,573
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 850,445
Due from/to Officers				453,687
Due to AM Realty				396,759
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 850,445
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,463,018

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Aaron Manor Nursing & Rehabilitatio	License No. 2168-C	Report for Year Ended 9/30/2022	Page 35	of 37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
B. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$ 1,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 1,904,495
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ (209,134)
7. Total Net Worth				\$ 1,696,362
C. Total Reserves and Net Worth				\$ 1,696,362
D. Total Liabilities, Reserves, and Net Worth				\$ 4,159,380

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Aaron Manor Nursing & Rehabilitation C	2168-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 1,916,050		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 7,275,605		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 7,484,740		
D. Net Income or Deficit				\$ (209,135)		
E. Balance				\$ 1,706,915		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
Out of period adj			\$ (10,553)			
F-3. Total Additions				\$ (10,553)		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawals (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 1,696,362		

I. Preparer's/Reviewer's Certification

Name of Facility Aaron Manor Nursing & Rehabilitation	License No. 2168-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Printed Name of Preparer Ryders Health Management		
Address 88 Ryders Lane, Stratford, CT 06614		Phone Number 203-381-1327
Contacted Person Regarding Additional Information Needed Regarding This Report Elizabeth Maglio		Phone Number 203-381-1327
Contact Email Address emaglio@rydershealth.com		