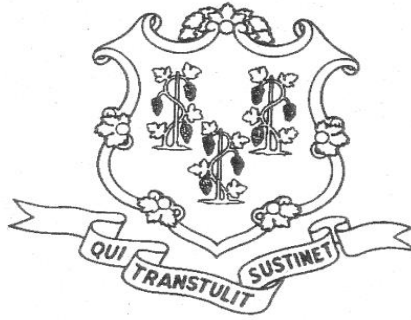


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2024

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 (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024

License Numbers:	CCNH / RHNS 2168-C	(Specify)	(Specify)	Medicare Provider 07-5410
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Medicaid Provider Numbers:	CCNH / RHNS 21684	(Specify)	(Specify)
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### General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Aaron Manor Nursing & Rehabilitation Center	2168-C	9/30/2024	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 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, 2023 and ending September 30, 2024, 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) Frank Raccio			Printed Name (Owner) Martin Sbriglio		
Subscribed and Sworn to before me:	State of	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 10/1/2023	To 9/30/2024
Address of Facility 3 South Wig Hill Road, Chester, CT 06412				
Report Prepared By Ryders Health Management		Phone Number 203-381-1327	Date 2/1/2025	
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility 203-381-1327		Report for Year Ended 9/30/2024	Page 2	of 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 / RHNS 2168-C	(Specify)	(Specify)	Medicare Provider No. 07-5410
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input checked="" type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Frank Raccio		Nursing Home Administrator's License No.:	2019	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

[illegible]

## General Information and Questionnaire

### Corporate Owners

Name of Facility Aaron Manor Nursing & Rehabilitation Cent	License No. 2168-C	Report for Year Ended 9/30/2024	Page 3A	of 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. Robert Sbriglio 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	

N/A



## Related Parties\*

[illegible]

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2024	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.) ☒ Yes ☐ No If "No," explain fully why such allocation was not made.

## General Information and Questionnaire

### Other Lines of Business

Name of Facility Aaron Manor Nursing & Rehabilitati	License No. 2168-C	Report for Year Ended 9/30/2024	Page 6	of 37
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Square footage of entire facility.	37,223
------------------------------------	--------

**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?
	<i>If yes, please state where costs are reported.</i>
No	Are drivers for the program included in the facility's payroll?
	<i>If yes, please complete the following:</i>
	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:

**General Information and Questionnaire**  
**Other Lines of Business (Continued)**

Name of Facility	License No.	Report for Year Ended	Page	of
Aaron Manor Nursing	2168-C	9/30/2024	7	37

**Child Day Care**

Does the Facility provide Child Day Care?

*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?

*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:

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

CSP-8 Rev. 3/2023

**Schedule of Resident Statistics**

Name of Facility Aaron Manor Nursing & Rehabilitation Center			License No. 2168-C		Report for Year Ended 9/30/2024				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	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	60	60			60	60						
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	58	58			58	58						
B. As of midnight of THIS report period	58	58							58	58		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,070	2,070			1,566	1,566			504	504		
B. Medicaid (Conn.)	11,961	11,961			8,973	8,973			2,988	2,988		
C. Medicaid (other states)												
D. Private Pay	4,081	4,081			3,100	3,100			981	981		
E. State SSI for RCH												
F. Other (Specify) Managed Care	2,592	2,592			1,835	1,835			757	757		
G. Total Care Days During Period (3A thru F)	20,704	20,704			15,474	15,474			5,230	5,230		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	20,704	20,704			15,474	15,474			5,230	5,230		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Aaron Manor Nursing & Rehabilitation Center				License No. 2168-C		Report for Year Ended 9/30/2024				Page 9		of 37	
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span> 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)	(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	6	30		22				
Per Diem Rate								
a. One bed rm.	Various	#####		\$466/\$474				
b. Two bed rms.				\$431/\$439				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B				3,139	3,139			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments				13	13			
2. Restorative Treatments								
C. Other				7,801	7,801			
<b>D. Total Physical Therapy Treatments</b>				10,953	10,953			

8. Total Number of Speech Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B				218	218			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments								
2. Restorative Treatments								
C. Other				668	668			
<b>D. Total Speech Therapy Treatments</b>				886	886			

9. Total Number of Occupational Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B				2,573	2,573			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments								
2. Restorative Treatments								
C. Other				7,731	7,731			
<b>D. Total Occupational Therapy Treatments</b>				10,304	10,304			

## Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

## Report of Expenditures - Salaries &amp; Wages

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2024	Page 10	of 37					
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No									
	Total Cost and Hours								
Item	CCNH / 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)	105,384		1,951						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	204,368		8,327						
5. Dietary Service									
a. Head Dietitian	32,767		720						
b. Food Service Supervisor	68,581		2,590						
c. Dietary Workers	276,904		15,139						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	138,213		8,598						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	77,714		2,067						
b. Other Maintenance Workers	38,804		2,170						
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	103,276		1,619						
b. RN									
1. Direct Care	1,038,883		21,646						
2. Administrative**									
c. LPN									
1. Direct Care	515,885		13,503						
2. Administrative**									
d. Aides and Attendants	1,178,684		46,536						
e. Physical Therapists	271,713		5,645						
f. Speech Therapists	34,754		579						
g. Occupational Therapists	92,738		1,951						
h. Recreation Workers	89,823		3,468						
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	142,380		4,230						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	4,410,870		140,737						

\* 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.

[illegible]

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Celtic Consulting-Clinical Consulting	\$ 30,861		98						
<b>Total</b>	\$ 30,861	\$ -	98	\$ -	\$ -	-	\$ -	\$ -	-



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
Aaron Manor Nursing & Rehabilitation Center				2168-C		9/30/2024			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)							
<b>Section I - Operators/Owners</b>										
Dr. Robert Sbriglio, MD								Lord Chamberlain, 7003 Main St., Stratford, CT 06614	2,125	130,341
Mr. Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	2,080	254,808
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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		9/30/2024			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)							
<b>Section III - Administrators***</b>										
Kerri Roche	105,384			Non Discriminatory	Administrative	1,951	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C			Report for Year Ended 9/30/2024				Page 13	of 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	2,138	(2,138)							
3. Pharmacist	1,656		33						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	30,000		103						
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	552		4						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	51,199		558						
2. Administrative***									
b. LPN									
1. Direct Care	155,890		2,324						
2. Administrative***									
c. Aides	441,255		10,467						
d. Other									
12. Other (Specify) See Attached Schedule									
	30,861		98						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	713,550	(2,138)	13,586						

\* 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.

**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 9/30/2024	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
MassTex Imaging	ST	<input type="radio"/>	<input checked="" type="radio"/>			
ValueRx	Pharmacy Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Yeboah, Benjamin MD, 47 Waterbury Road, Suite 155, Prospect, CT 06712	Medical Director, Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
All American Healthcare Services, Inc	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
AAA Nursing Care	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"/>			
Norton & Associates	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Amidon Nursing Staffing	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Mindseeker Professional Services	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Delta-T Group	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Pro MedStaff	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"/>			
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		<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
Aaron Manor Nursing & Rehabilitation Center	2168-C	9/30/2024					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 71,338	71,338						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 353,839	353,839						
5. Health Insurance	\$ 277,959	277,959						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 161,194	161,194						
8. Uniform Allowance	\$ 12,074	12,074						
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 11,924	11,924						
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$	85,897	(85,897)					
d. Accounting and Auditing	\$ 27,504	27,504						
e. Legal ( <i>Services should be fully described on Page 15b</i> )	\$ 9,050	12,710	(3,661)					
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$							
g. Office Supplies	\$ 10,186	10,186						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 21,344	21,344						
2. Cellular Phones	\$ 2,800	2,884	(84)					
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	\$ 348,008	348,008						
<b>Subtotal</b>	\$ 1,307,219	1,396,860	(89,641)					

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

(Carry Subtotals forward to next page)



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Aaron Manor Nursing & Rehabilita	License No. 2168-C	Report for Year Ended 9/30/2024	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

☒ Accrual    ☐ Cash    ☐ Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC Consulting, LLC	225 Pitkin St., East Hartford, CT 06108
2 Marcum, LLP	555 Long Warf Dr., New Haven, CT 06511
3 Smith & Howard	17th St. NW, Suite 1600, Atlanta, GA 30363
4	

Services Provided by This Firm (*describe fully*)

1 Tax Return, year end financial review, consulting	\$ 10,008
2 Consulting	\$ 11,495
3 Prepare Payroll Tax Forms	\$ 6,000
4	\$
	Charge for Services Provided
	\$ 27,504

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 See Attached	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

☒ Yes    ☐ No

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

Name of Facility	License No.	Report for Year Ended					Page	of
Aaron Manor Nursing & Rehabilitation Center	2168-C	9/30/2024					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>	1,307,219	1,396,860	(89,641)					
1. Travel and Entertainment								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	6,818	6,818						
3. Gifts to Staff and Residents \$								
4. Employee Travel \$	2,753	2,753						
5. Education Expenses Related to Seminars and Conventions \$	3,487	3,487						
6. Automobile Expense ( <i>not purchase or depreciation</i> ) \$								
7. Other ( <i>Specify</i> ) \$		3,763	(3,763)					
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted ( <i>all such expenses</i> ) \$	41,652	41,652						
2. Advertising Telephone Directory ( <i>all such expenses</i> )*** \$								
3. Advertising Other ( <i>Specify</i> )*** \$		2,906	(2,906)					
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 \$	3,932	3,932						
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) \$	4,502	4,502						
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$	(300)	(300)						
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> ) \$	103,152	103,152						
12. Administrative Management Services** \$	179,544	179,544						
13. Other ( <i>Specify</i> ) \$	26,098	40,486	(14,388)					
See Attached Schedule								
<b>C-14 Total Administrative &amp; General Expenditures</b> \$	1,678,856	1,789,554	(110,698)					

\* 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 in the Adjustment column.



## Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Meals & Entertainment	\$ 3,763	\$ (3,763)				
<b>Total Other Travel and Entertainment</b>	<b>\$ 3,763</b>	<b>\$ (3,763)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Adv & Pub Relations Donations	\$ 2,906	\$ (2,906)				
<b>Total Other Advertising</b>	<b>\$ 2,906</b>	<b>\$ (2,906)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 4,502					
<b>Total Dues</b>	<b>\$ 4,502</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Contributions

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

## Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank Charges	\$ 17,816					
Donations	\$ 250	\$ (250)				
Fines & Penalties	\$ 14,138	\$ (14,138)				
Unemployment Tax Management	\$ 1,062					
AR Consulting - Bookkeeping Services	\$ 3,200					
American Express Renewal	\$ 50					
Zoom Renewal	\$ 463					
Elevator Renewal	\$ 480					
CT River Area Renewal	\$ 480					
Medical Director License Renewal	\$ 888					
Facility License Renewal	\$ 740					
CLIA Laboratory Program Renewal	\$ 248					
Administrator License Renewal	\$ 205					
Secretary of the State	\$ 450					
CT Middletown Renewal	\$ 16					
<b>Total Other Administrative and General</b>	<b>\$ 40,486</b>	<b>\$ (14,388)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended	Page of
Aaron Manor Nursing & Rehabilitation C	2168-C	9/30/2024	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	179,544	Financials and Managerial Support	Page 16, m12
Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	42,536	Management Fees-Direct Care	Page 20 j

**\* 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 Aaron Manor Nursing & Rehabilitation Center		License No. 2168-C		Report for Year Ended 9/30/2024			Page 18	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food		\$ 149,811	149,811					
2. Non-Food Supplies		\$ 26,510	26,510					
3. Other (Specify) _____		\$						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$						
c. Other (Specify) _____		\$						
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 176,321	176,321					
2E. Dietary Questionnaire		Total	CCNH / RHNS	(Specify)		(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 9/30/2024				Page 19	of 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)		\$ 71,271	71,271					
c. Other (Specify) Laundry Equipment		\$ 550	550					
3D. <b>Total Laundry Expenditures</b> (3a + b + c )		\$ 71,821	71,821					
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 Aaron Manor Nursing & Rehabilitation Center		License No. 2168-C	Report for Year Ended 9/30/2024				Page 20	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care	Amt.	\$ 25,603	25,603					
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. <b>Total Housekeeping Expenditures</b> (4a + b + c )		\$ 25,603	25,603					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy		\$						
2. Purchased from ValueRx		\$	186,349	(186,349)				
b. Medicine Cabinet Drugs		\$ 24,306	24,306					
c. Medical and Therapeutic Supplies		\$						
d. Ambulance/Limousine***		\$						
e. Oxygen								
1. For Emergency Use		\$						
2. Other***		\$	7,535	(7,535)				
f. X-rays and Related Radiological Procedures***		\$	11,259	(11,259)				
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$						
h. Laboratory***		\$	23,997	(23,997)				
i. Recreation		\$ 10,734	10,734					
j. Direct Management Services*		\$ 42,536	42,536					
k. Indirect Management Services*		\$						
l. Cable TV		\$						
m. Other (Specify)**** See Attached Schedule		\$ 176,260	187,987	(11,727)				
n. Physical Therapy Expense		\$	15,345	(15,345)				
o. Speech Therapy Expense		\$						
5P. <b>Total Resident Care Expenditures</b> (5a - 5o)		\$ 253,836	510,050	(256,214)				

\* 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
Medical Supplies	\$ 163,425					
Medical Supplements	\$ 9,323					
Medical Waste	\$ 482					
Medical Equipment	\$ 2,605					
Medical Equipment - Rental	\$ 11,727	\$ (11,727)				
Physician Care - Patients	\$ 425					
<b>Total Other Resident Care</b>	<b>\$ 187,987</b>	<b>\$ (11,727)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center				License No. 2168-C	Report for Year Ended 9/30/2024				Page 21	of 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
Unitex	Parkway, Mt. Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	59,763			19	3b
Med-Apparel Services	Parkway South, Mt. Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	11,507			19	3b
All Waste	PO Box 4272, Hartford, CT 06146	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	17,314			22	6a
In Full Bloom	51 Old Chester Road, Haddam, CT 06438	<input type="radio"/>	<input checked="" type="radio"/>		Lawn Services	11,635			22	6a
Point Click Care	PO Box 8500, Philadelphia, PA 19178	<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Support Services	33,203			16	m11
ADP	1 ADP Plaza, Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing Services	18,023			16	m11
Sourcepass	Suite 1400, Melville, NY 11747	<input type="radio"/>	<input checked="" type="radio"/>		Computer Support Services	19,017			16	m11
SLC Landscaping	56 Stanwoll Hill Road , Deep River, CT 06417	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	17,981			22	6a
		<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"/>							

\* 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 Aaron Manor Nursing & Rehabilitation Center	License No. 2168-C	Report for Year Ended 9/30/2024					Page 22	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 143,151	143,151						
b. Heat	\$ 34,253	34,253						
c. Light & Power	\$ 150,655	150,655						
d. Water	\$							
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$ 10,184	10,184						
f. Other ( <i>itemize</i> )	\$							
See Attached Schedule								
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 338,244	338,244						
7. Depreciation ( <i>complete schedule page 23*</i> )								
a. Land Improvements	\$							
b. Building & Building Improvements	\$ 110,400	110,400						
c. Non-Movable Equipment	\$ 9,684	9,684						
d. Movable Equipment	\$ 20,520	20,520						
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 140,604	140,604						
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$							
d. Other ( <i>Specify</i> )	\$							
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$							
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 99,600	99,600						
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$ 54,128	54,128						
c. Personal property taxes	\$ 6,955	6,955						
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 301,287	301,287						

\* 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
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## 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 Aaron Manor Nursing & Rehabilitation Center			License No. 2168-C		Report for Year Ended 9/30/2024		Page 22b of 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						
LEAF	<input type="radio"/>	<input checked="" type="radio"/>	Copier			4,446	4,446	
BBI Technologies	<input type="radio"/>	<input checked="" type="radio"/>	Copier			5,738	5,738	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	
<b>Total ***</b>							10,184	

\* 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.

[illegible]

## Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
3/22/2024	Chlorination Treatment Plant Upgrade	\$ 25,279	10	\$ 1,264
<b>Total additions for Building Improvements</b>		\$ 25,279		\$ 1,264 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
5/29/2024	Dishwasher	\$ 13,476	10	\$ 449
7/16/2024	Kitchen Ductless Split Replacement	\$ 2,084	10	\$ 52
<b>Total additions for Non-Movable Equipment</b>		\$ 15,561		\$ 501 *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
		PICK A CATEGORY			
5/22/2024	UITRSD Bladder Scanner	Standard Resident	\$ 2,601	5	\$ 217
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 2,601		\$ 217 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility Aaron Manor Nursing & Rehabilitation Center			License No. 2168-C		Report for Year Ended 9/30/2024			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* 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 9/30/2024	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 <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	60				
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 _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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 Aaron Manor Nursing & Rehabilitatio		License No. 2168-C	Report for Year Ended 9/30/2024				Page 26	of 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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

(Carry Subtotals forward to next page )



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

Name of Facility Aaron Manor Nursing & Rehabilita			License No. 2168-C		Report for Year Ended 9/30/2024			Page 27	of 37
Item					Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment (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) Interest Expense						56,480	(56,480)		
13. Total All Interest Expense (12B7 + 12C3 + 12D)						56,480	(56,480)		
14. Insurance									
a. Insurance on Property (buildings only)					\$ 15,696	15,696			
b. Insurance on Automobiles									
c. Insurance other than Property (as specified above)									
1. Umbrella (Blanket Coverage)					\$ 53,906	53,906			
2. Fire and Extended Coverage									
3. Other (Specify)									
14d. Total Insurance Expenditures (14a + b + c)					\$ 69,602	69,602			
15. Total All Expenditures (A-13 thru C-14)					\$ 8,037,851	8,463,380	(425,529)		

### F. Statement of Revenue

Name of Facility Aaron Manor Nursing & Rehabilitation C 2168-C		License No. C 2168-C		Report for Year Ended 9/30/2024		Page 30	of 37
Item		Total	CCNH / RHNS	(Specify)	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>							
1. a. Medicaid Residents ( <i>CT only</i> )	\$	5,280,111	5,280,111				
b. Medicaid Room and Board Contractual Allowance **	\$	(1,285,919)	(1,285,919)				
2. a. Medicaid ( <i>All other states</i> )	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents ( <i>all inclusive</i> )	\$	1,092,687	1,092,687				
b. Medicare Room and Board Contractual Allowance **	\$	274,714	274,714				
4. a. Private-Pay Residents and Other	\$	2,842,446	2,842,446				
b. Private-Pay Room and Board Contractual Allowance **	\$	(427,134)	(427,134)				
<b>II. Other Resident Revenue</b>							
1. a. Prescription Drugs - Medicare	\$	183,340	183,340				
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(183,340)	(183,340)				
c. Prescription Drugs - Non-Medicare	\$	19,694	19,694				
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	\$	136,318	136,318				
b. Physical Therapy - Medicare Contractual Allowance **	\$	(136,318)	(136,318)				
c. Physical Therapy - Non-Medicare	\$	262,362	262,362				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$						
4. a. Speech Therapy - Medicare	\$	31,584	31,584				
b. Speech Therapy - Medicare Contractual Allowance **	\$	(31,584)	(31,584)				
c. Speech Therapy - Non-Medicare	\$	52,409	52,409				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$						
5. a. Occupational Therapy - Medicare	\$	142,774	142,774				
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(142,774)	(142,774)				
c. Occupational Therapy - Non-Medicare	\$	251,480	251,480				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$						
6. a. Other ( <i>Specify</i> ) - Medicare	\$						
b. Other ( <i>Specify</i> ) - Non-Medicare	\$	1,016	1,016				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)		\$ 8,363,865	8,363,865				
<b>IV. Other Revenue*</b>							
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> )	\$	22	22				
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other ( <i>Specify</i> )	\$	247,736	247,736				
<b>V. Total Other Revenue</b> (1 thru 8)		\$ 247,758	247,758				
<b>VI. Total All Revenue</b> (III + V)		\$ 8,611,624	8,611,624				

\* 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)
	Oxygen	\$ 86		
	X-Ray	\$ 10,788		
	Lab	\$ 21,159		
	Contractuals Allowances	\$ (32,032)		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Non-Medicare Resident Revenue

## Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	X-Ray Managed Care	\$ 395		
	Lab Managed Care	\$ 621		
	<b>Total Other Resident Revenue</b>	<b>\$ 1,016</b>	<b>\$ -</b>	<b>\$ -</b>

## Interest Income

## Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest Income		\$ 22		
	<b>Total Interest Income</b>		<b>\$ 22</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Misc Income	\$ 584		
	COVID Relief Revenue Recognition	\$ 247,152		
	<b>Total Other Revenue</b>	<b>\$ 247,736</b>	<b>\$ -</b>	<b>\$ -</b>

## G. Balance Sheet

Name of Facility Aaron Manor Nursing & Rehabilitation	License No. 2168-C	Report for Year Ended 9/30/2024	Page 31 of 37
Account			Amount
<b>Assets</b>			
A. Current Assets			
1. Cash ( <i>on hand and in banks</i> )			\$ 90,334
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,049,544
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$
4 Inventories			\$
5. Prepaid Expenses			\$ 2,269
a. Prepaid Insurance 2,269			
b. _____			
c. _____			
d. See Schedule			
6. Interest Receivable			\$
7. Medicare Final Settlement Receivable			\$
8. Other Current Assets ( <i>itemize</i> )			\$ 7,768
Refunds 7,768			
_____			
_____			
See Schedule			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 1,149,916
B. Fixed Assets			
1. Land			\$
2. Land Improvements			
*Historical Cost 127,479			\$
Accum. Depreciation 127,479 Net			
3. Buildings			\$ 959,981
*Historical Cost 3,499,888			
Accum. Depreciation 2,539,907 Net			
4. Leasehold Improvements			\$
*Historical Cost _____			
Accum. Depreciation _____ Net			
5. Non-Movable Equipment			\$ 158,694
*Historical Cost 641,079			
Accum. Depreciation 482,385 Net			
6. Movable Equipment			\$ 35,611
*Historical Cost 686,404			
Accum. Depreciation 650,793 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> )			\$ 476,606
Work in Progress 476,606			
See Schedule			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 1,630,892

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

(Carry Total forward to next page)



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

Name of Facility		License No.	Report for Year Ended	Page	of
Aaron Manor Nursing & Rehabilitation		2168-C	9/30/2024	32	37
Account			Amount		
Total Brought Forward:			\$ 2,780,808		
C. Leasehold or like property recorded for Equity Purposes.					
1. Land			\$		
2. Land Improvements		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
3. Buildings		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
4. Non-Movable Equipment		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
5. Movable Equipment		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
6. Motor Vehicles		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
7. Minor Equipment-Not Depreciable			\$		
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$		
D. Investment and Other Assets					
1. Deferred Deposits			\$		
2. Escrow Deposits			\$		
3. Organization Expense		*Historical Cost _____			
		Accum. Depreciation _____ Net	\$		
4. Goodwill (Purchased Only)			\$		
5. Investments Related to Resident Care ( <i>itemize</i> )			\$		
_____					
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$		
Name and Address		Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$ 1,980,395		
_____					
See Schedule			1,980,395		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ 1,980,395		
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 4,761,204		

\* 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 Aaron Manor Nursing & Rehabilitation Center		License No. 2168-C	Report for Year Ended 9/30/2024	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	925,653
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> )				\$	108,872
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> )				\$	1,112,099
Patient Fund		35,918	AFLAC	4,913	
Accrued Expenses		109,317			
Accrued User Fee		865,589			
Accrued PTO		96,363	See Schedule		
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	2,146,625

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

(Carry Total forward to next page)

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

CSP-34 Rev. 6/95

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

Name of Facility Aaron Manor Nursing & Rehabilitation Center		License No. 2168-C	Report for Year Ended 9/30/2024		Page 34	of 37
Account					Amount	
Total Brought Forward:					2,146,625	
<b>Liabilities (cont'd)</b>						
B. Long-Term Liabilities						
1. Loans Payable-Equipment ( <i>itemize</i> )					\$	
Name of Lender	Purpose	Amount	Date Due			
2. Mortgages Payable					\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )					\$	
Name and Address of Lender	Amount	Loan Date				
4. Other Long-Term Liabilities ( <i>itemize</i> )					\$ 1,155,934	
Due from/to Officers		453,687				
Due to R. Sbriglio, MD		18,995				
Due to M. Sbriglio, MD		18,995				
See Schedule		664,258				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)					\$ 1,155,934	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)					\$ 3,302,559	



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

Name of Facility Aaron Manor Nursing & Rehabilitatio	License No. 2168-C	Report for Year Ended 9/30/2024	Page 35	of 37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,309,401
6. Gain or Loss for Period			\$	148,244
7. Total Net Worth			\$	1,458,645
<b>C. Total Reserves and Net Worth</b>			\$	1,458,645
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	4,761,204

## H. Changes in Total Net Worth

Name of Facility Aaron Manor Nursing & Rehabilitation C	License No. 2168-C	Report for Year Ended 9/30/2024	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2023			\$	1,310,401
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	8,611,624
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	8,463,380
D. Net Income or Deficit			\$	148,244
E. Balance			\$	1,458,645
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions				
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>		09/30/24	\$	1,458,645

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

Name of Facility Aaron Manor Nursing & Rehabilitation	License No. 2168-C	Report for Year Ended 9/30/2024	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>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 in the Adjustments columns. Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer  Gennaro Evangelista				
Address Address		Phone Number		
88 Ryders Lane, Stratford, CT 06614		203-381-1327		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Gennaro Evangelista		203-381-1327		
Contact Email Address				
gevangelista@rydershealth.com				