



CITY OF MERIDEN OFFICE OF THE ASSESSOR
Skilled Nursing Facility
Income and Expense Survey for Calendar Year 2019

Information provided is CONFIDENTIAL, in accordance with Connecticut General Statutes

Owner of Record: _____
Property Address: _____
Name of Facility: _____ Property ID# _____
Form Preparer/Position: _____
Telephone Number: _____ Email _____

GENERAL INSTRUCTIONS: This form should be completed using the annual information for calendar year 2019, for all rented or leased commercial, retail, industrial or combination property. Identify the property and address; provide all income derived from this property, all expenses related to this property and any vacant space. The vacant space information should contain the terms you are marketing for this space. Complete Verification of Purchase price information if purchased within the last twenty-four months.

Each summary page should reflect information for a single property for the year of 2019. If you own more than one rental property, a separate report/form must be filed for each property in this jurisdiction. An income and expense report summary page and the appropriate income schedule must be completed for each rental property.

General Data

Name of Facility : _____
Year Built _____ Year of last Renovation: _____
Description of work: _____ Cost: _____
Number of Rooms (or Units) _____
Number of Licensed Beds _____
Annual Occupancy _____

Facility Operations

Which best describes your facility? Please check all that apply.

- Long Term Care Short Term Care Out Patient Services
 Independent Living Assisted Living Other (Define) _____



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Annual Gross Income

Potential Gross Income (At 100% Occupancy):

Type of Patient		Daily Reimbursement Rates	Census (# Patient Days)	Annual Income
Private Pay	Private			
	Semi-private			
	Wards			
VA	Skilled			
	Intermediate			
HMO	Semi-private			
Medicare	Semi-private			
Medicaid	Semi-private			
Total Income from Rooms				

Total Income from Rooms (see table above) _____

Out Patient Services _____

Medical Equipment/Supplies _____

Food and Beverage _____

Telephone, Cable, WiFi _____

Minor Operated Departments(Define) _____

Miscellaneous Rentals (Define) _____

Other (Define) _____

Total Annual Revenue \$ _____

Annual Cost of Goods Sold

Medical Equipment/Supplies _____

Food and Beverage _____

Minor Operated Departments _____

Other (Define) _____

Cost of Goods Sold \$ _____

Effective Annual Income \$ _____

(Total income – Cost of Goods Sold)



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Annual Operating Expenses

Advertising	_____
Administrative	_____
Electric	_____
Exterminating	_____
Heat	_____
Housekeeping and Laundry	_____
Insurance	_____
Janitorial/Cleaning	_____
Management	_____
Nursing and Personal Care	_____
Payroll	_____
Repair and Maint: Building	_____
Repair and Maint: Grounds	_____
Reserves for Replacement (Attach Detail)	_____
Rubbish Removal	_____
Security	_____
Sewer	_____
Snow Removal	_____
Supplies (Office, Cleaning,)	_____
Water	_____
Other (Define)_____	_____
Other (Define)_____	_____
Other (Define)_____	_____
Other (Define)_____	_____

Total Operating Expenses \$ _____

Net Operating Income \$ _____
(Effective Annual Income – Total Operating Expenses)

Please include a copy of your year-end Income Summary.

Do any of the figures include capital expenditures or extraordinary costs which vary from typical operating expenses? Yes No

If yes, explain: _____



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