



***CITY OF MERIDEN OFFICE OF THE ASSESSOR***  
**Skilled Nursing /Assisted Living Facility/ Residential Care Home**  
**Income and Expense Survey for Calendar Year 2021**

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 2021, 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 2021. 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			
<b>Total Income from Rooms</b>				

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)_____	_____

**Total Operating Expenses \$ \_\_\_\_\_**

**Net Operating Income \$ \_\_\_\_\_**  
(Effective Annual Income – Total-Operating Expenses)

Real State Taxes	_____
Depreciation	_____
Mortgage Interest	_____

**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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Please attach comments or other information on a separate page.

