Town of Stratford Assessor's Office
Skilled Nursing Facility
Income and Expense Survey for Calendar Year 2018

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 2018, 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 2018. 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) _____

RETURN TO ASSESSOR ON OR BEFORE May 31, 2019
May 31, 2019 is the FILING DEADLINE not a postmark date per CGS.

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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: _____

Please attach comments or other information on a separate page.

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Verification of Purchase Price

Purchase Price	$		Down Payment			Date of Purchase			(Check One)
Date of Last Appraisal			Appraisal Firm			Appraised Value			Fixed Rate / Variable Rate
First Mortgage	$		Interest Rate	%		Payment Schedule Term		Years	
Second Mortgage	$		Interest Rate	%		Payment Schedule Term		Years	
Other	$		Interest Rate	%		Payment Schedule Term		Years	
Chattel Mortgage	$		Interest Rate	%		Payment Schedule Term		Years	

Did the purchase price include payment for furniture and or equipment ?____ Yes ____No

Has the property been listed for sale since your purchase? ____Yes ____No If, Yes please state Asking Price _____, Date Listed _____, Broker _____

Remarks: Explain special circumstances or reason for your purchase. _____
_____
_____
_____

Signature and Affidavit of Facts

As Required by Section 12-63c (d), of the Connecticut General Statutes, as amended, any owner of rental real property who fails to file this form, files an incomplete or false form with intent to defraud, shall be subject to a penalty assessment equal to a Ten Percent (10%) increase in the assessed value of such property.

Any form returned incomplete will not be accepted and be subject to the 10 percent penalty. Any form received after May 31, 2019, will have a 10% penalty applied to the October 1, 2018 Grand List billing cycle.

I do hereby declare under penalties of false statement that the information provided is according to the best of my knowledge, remembrance and belief, is a complete and true statement of all the income and expenses attributable to the above identified property (section 12-63c (d) of the Connecticut General Statutes).

Signature _____ **Date** _____

Name (print) _____ **Title** _____ **Phone** _____

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