

# *Town of Manchester Assessor's Office* Skilled Nursing Facility

Income and Expense Survey for Calendar Year 2024

Information provided is CONFIDENTIAL, in accordance with Connecticut General Statutes

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

**GENERAL INSTRUCTIONS:** This form should be completed using the annual information for calendar year 2024, 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 calendar year 2024. 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.

<u>General Data</u>		
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 fa	cility? Please check all that apply.	
Long Term Care	□ Short Term Care	Out Patient Services
Independent Livin	g 🛛 Assisted Living	□ Other (Define)



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### Annual Gross Income

Potential Gross Income (At 100% Occupancy):					
Ту	pe of Patient	Daily Reimbursement Rates	Census (# Patient Days)	Annual Income	
Private	Private				
Pay	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)				
Total Operating Expenses	\$			
Net Operating Income \$				

### 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

lf yes, explain:

Please attach comments or other information on a separate page.



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#### **Verification of Purchase Price**

Purchase Price	\$	Down Payment		F	Date of Purchase		_	(Chec	k One)
Date of Last Appraisal		Appraisal Firm		A	ppraised Value		-	Fixed Rate	Vari- able Rate
First Mortgage	\$	Interest Rate	%	Payment Schedule	Term		Years		
Second Mortgage	\$	Interest Rate Interest	%	Payment Schedule Payment			Years		
Other	\$	Rate	%	Schedule			Years		
Chattel Mortgage	\$	Interest Rate	%	Payment Schedule	Term		Years		
Did the purchase price include payment for furniture and or equipment ?YesNo									
Has the property been listed for sale since your purchase? <u>Yes</u> 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 June 2, 2025, will receive a 10% penalty on the October 1, 2024 Grand List (July 2025 bill).				
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		