Property Name	Tax Map ID	Element No.	Property Type

COUNTY OF FAIRFAX, DEPARTMENT OF TAX ADMINISTRATION, REAL ESTATE DIVISION
INSTRUCTIONS FOR COMPLETING
INCOME AND EXPENSE SURVEY FORM
CONTINUING CARE

The following instructions are provided to aid you in filling out this survey form. If you have any questions, please call this office at (703) 324-4802.

A. General Information

1. Please provide the property name, year built and any addition years.
2. Please provide the type of property (office, retail, etc), # of elevators and # of stories.
3. Please provide the address of the property.
4. Please provide the 'Trading as' name reported on your business license. Do you have owner occupied space in the building and if so please provide the amount of square feet you occupy.
5. Please provide the total building area of the property including basement and mezzanine space but not parking space.
6. Please provide the total leasable area of the property.
7. Please provide the total basement area of the property. Provide the finished, unfinished and parking area too.
8. Please provide the total number of parking spaces and the total reserved/rental parking spaces.

B. Debt Service Information

Please provide information in regard to any loan placed on this property within the last five years. Please include any new loans or refinancing of original debt. This information is requested to study the financing trends for this property type to determine typical debt coverage ratios. By obtaining this information we may also be able to see if your particular property is unusual in its financial arrangements.

C. Independent Living

In addition to the prior 12-month operating statement, please attach any fee schedules applicable over same reporting period.

1. Self-explanatory.
2. Self-explanatory.
3. Self-explanatory.
4. Self-explanatory.
5. An established price list would be acceptable.
6. Self-explanatory.
7. Please include the most recent Actuarial Study.
8. Self-explanatory.
9. Self-explanatory.
10. Self-explanatory.
11. Self-explanatory.
12. Self-explanatory.

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Property Name	Tax Map ID	Element No.	Property Type

Independent Living – continued

13. Please complete the entire rent roll form. Copy the page if there are more than 30 independent units. Further instructions are presented as footnotes on the rent roll form.

D. Assisted Living Component

In addition to the prior 12-month operating statement, please attach any fee schedules applicable over same reporting period.

1. **Total number of beds** – Self-explanatory.

2. **Total potential resident days** – Provide the total potential (maximum) and actual resident days for all bed types over the most recently completed fiscal period.

3. **Total potential private resident days** – Provide the private potential (maximum) and private actual resident days over the most recently completed fiscal period.

4. **Total potential semi-private resident days** – Provide the semi-private potential (maximum) and semi-private actual resident days over the most recent completed fiscal period.

5. Self-explanatory.

6. An established price list would be acceptable.

7. Please complete the entire rent roll form. Copy the page if there are more than 27 beds. Further instructions are presented as footnotes on the rent roll form.

E. Nursing Beds

In addition to the prior 12-month operating statement, please attach any fee schedule applicable over same reporting period.

1. **Bed Count** – Self-explanatory.

2. **Patient Days** - Self-explanatory.

3. **Medicare** – Complete if applicable.

4. **Medicaid** – Complete if applicable.

5. **Revenue** - Self-explanatory.

Please complete the entire rent roll form. Copy the page if there are more than 25 beds. Further instructions are presented as footnotes on the rent roll form.

Property Name	Tax Map ID	Element No.	Property Type

F. Annual Net Operating Income Information

NOTE: IN ADDITION TO THE INFORMATION REQUESTED, YOU MUST ATTACH TO THIS SURVEY THE MOST RECENT FULL TWELVE-MONTH OPERATING INCOME AND EXPENSE STATEMENT FOR YOUR FACILITY. IF YOUR LAST FISCAL PERIOD ENDED ON ANY OTHER DATE THAN DECEMBER 31, PLEASE ALSO ATTACH A YEAR-TO-DATE OPERATING STATEMENT WHICH COVERS THE PERIOD THROUGH DECEMBER 31. ALSO, ATTACH ANY FEE SCHEDULES THAT WERE IN EFFECT DURING THIS REPORTING PERIOD. PLEASE ROUND YOUR NUMBERS, NO DECIMALS.

G. Capital Improvements, Renovations, Deferred Maintenance

Capital expenditures are investments in remodeling or replacements that materially add to the value of the property, or appreciably prolong its economic life. Generally, expenditures on materials or equipment with a life of more than one year should be considered capital and included here. If this section applies to your property, please answer yes and list on an attached sheet the items considered to be capital improvements. Enter the total amount of the capital cost for this reporting period only. For each line enter a description of the improvements, the total cost and the life of the improvements in years. The life of the improvements is the number of years the improvement will last, or the number of years over which it will be amortized. This section helps to compile accurate maintenance expense data for each property type. Furthermore, list all items of deferred maintenance with the cost to repair the item.

New Construction – submit most recent AIA documents G702 and G703 with the itemized construction costs and all associated soft costs.

H. Furniture, Fixture and Equipment (FF&E) and Personal Property

Self-explanatory.

I. Additional Information

Self-explanatory.

J. Certification

Certification of this information by the owner or officially authorized representative is required by state law (Code of Virginia 58.1-3294). A copy of this code will be provided upon request. Please print or type the name and title of the person certifying the information. Also, provide the name and phone number of the person to contact with questions about the information. Indicate the type of accounting method employed in this survey.

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County of Fairfax, Department of Tax Administration

12000 Government Center Pkwy., Suite 357
Fairfax, Virginia 22035-0032
https://www.fairfaxcounty.gov/taxes/real-estate
DTAREDsurveys@fairfaxcounty.gov | 703-222-8234 (TTY 711)

Continuing Care Income and Expense Survey - Real Estate Division

Calendar Year 2024 **For Tax Year 2026**

Instructions
Instructions are found as a supplemental document as noted above. Please read these instructions and confirm the statement below before completing your survey. **"I have read and understand the survey instructions."**

A. General Information (Property Identification)			
Property Name		Owner/Agent ☐ No Longer Owns Property ☐	
Tax Map ID	Element No.	Property Type	
Please list all additional elements included in the income and expense data.			
Property Location			
Street #	Street Name	Direction	Suffix
City			Zip/Postal Code
Property Improvement Information			
Owner Occupied ☐ Yes ☐ No	Owner Occupied SF		
Year Built	Year Addition	Total Building Area	Total Leasable Area	Total Basement Area
Year Renovated		Finished Bsmt Area	Unfinished Bsmt Area	Bsmt Parking Area
No. Stories	No. Elevators	No. Parking Spaces	No. Reserved/Rental Parking Spaces	

B. Debt Service Information (within the last 5 years)

	Loan Amount	Loan Date	Term	Interest Rate %	Payment (P & I)	Payment Frequency (Mo. or Year)
1						
2						

FOR INTERNAL USE ONLY

Initial		Date	Click or tap to enter a date.	☐ Entered into IAS	☐ Added to IDOCS

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Property Name	Tax Map ID	Element No.	Property Type

C. Independent Living	
Total # of units	
Average occupancy over the last fiscal period	
Occupancy as of January 1	
Are you anticipating a significant change in occupancy rate over the current fiscal period? If yes, please explain.	☐ Yes ☐ No
Are you anticipating a significant change in the number of residents over the current fiscal period? If yes, please explain.	☐Yes ☐ No
What services are standard? (i.e., # of meals, laundry, housekeeping, linen, etc.)	
What additional services are offered that are not included within the basic plan (i.e., meds, incontinence care/products, reminiscence care, etc.)?	
What was the total other revenue received for additional services for this component over the last fiscal period?	
What is the second person fee? How many "second persons" were there as of January 1 of this year? Is the revenue from the second person included in the offered services listed above?	☐Yes ☐ No
What is the average entrance age?	
What is the average life expectancy? Please attach the most recent actuarial study.	
What was the total cash paid to patrons/heirs over the last fiscal period due to refundable entrance fees?	
Is the revenue generated from non-refundable fees included within the Income & Expense statement?	☐Yes ☐ No
If interest is reported as a line-item on the attached Income and Expense statement, please explain in detail how interest revenue was calculated.	
Attach a copy of the most recent "Disclosure Statement" that was filed with the Commonwealth of Virginia State Corporation Commission Bureau of Insurance.	

Property Name	Tax Map ID	Element No.	Property Type

INDEPENDENT LIVING – CURRENT RENT ROLL

Please fill out the rent roll on the next page then fill out the rent roll summary below. If there are more tenants than lines available in the table, attach a rent roll that includes the following tenant information. (Annualize rents and expense reimbursements.)

1. Unit #
2. Unit type
3. Total room size (square feet)
4. Entrance fee & % refundable (if left blank, no entrance fee will be assumed;)
5. Actual current monthly rent
6. Date admitted

SUMMARY OF RENT ROLL			
Unit Type	**Total Units**	**Average Room Size**	**Average Market Rent**
Total # of Units*			

* Total each unit type. Total # of beds should match question #1 of the previous Independent Living section.

Property Name	Tax Map ID	Element No.	Property Type

Unit #	Unit Type	Total Room Size (Sq. Ft.)	Entrance Fee & % Refundable[1]	Actual Current Monthly Rent	Date Admitted

Property Name	Tax Map ID	Element No.	Property Type

D. Assisted Living Component

Total # of beds	# total beds # of private beds # of semi-private beds
Total potential resident days	
Actual resident days over last fiscal period If applicable, of the actual resident days reported above, how many resident days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Total potential private resident days	
Actual private resident days over last fiscal period If applicable, of the actual private resident days reported above, how many resident days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Total potential Semi-Private resident days	
Actual semi-private resident days over last fiscal period If applicable, of the Private Resident days reported above, how many resident days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Are you anticipating a significant change in the number of residents over the current fiscal period? If yes, please explain.	☐ Yes ☐ No
What services are standard? (i.e., # of meals, laundry, housekeeping, linen, etc.)	
What additional services are offered that are not included within the basic plan (i.e., meds, incontinence care/products, reminiscence care, etc.)?	
What was the total other revenue received for additional services for this component over the last fiscal period?	

Service	Cost $

Property Name	Tax Map ID	Element No.	Property Type

ASSISTED LIVING – CURRENT RENT ROLL

Please fill out the rent roll on the next page then fill out the rent roll summary below. If there are more tenants than lines available in the table, attach a rent roll that includes the following tenant information. (Annualize rents and expense reimbursements.)

1. Bed number
2. Unit type
3. Private or semi-private room
4. Total room size (square feet)
5. Actual current daily/monthly rent (as if the unit was rented as of a current date)
6. Daily/monthly rent for non-residents (actual rent paid, if left blank we will assume the actual rent is the same as the asking rent; if the bed is vacant, label as “vacant”)
7. Date admitted

SUMMARY OF RENT ROLL				
Unit Type	**Total Beds**	**Private or Semi-Private**	**Average Room Size**	**Average Current Daily/Monthly Rent**
Total # of Beds*				

* Total each unit type. Total # of beds should match question #1 of the previous Assisted Living Component section.

Property Name	Tax Map ID	Element No.	Property Type

Bed #	Unit Type	Private or Semi-Private Room	Total Room Size (Sq. Ft.)	Actual Current Daily/Monthly Rent[1]	Daily/Monthly Rate for Non-Residents[2]	Date Admitted

Property Name	Tax Map ID	Element No.	Property Type

E. Nursing Beds	
Total # of beds	# total beds # of private beds # of semi-private beds # of ward beds
Total Potential Patient Days	
Actual Total Patient Days over last fiscal period If applicable, of the Total Patient Days reported above, how many Patient Days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Actual Private Patient days over last fiscal period If applicable, of the Private Patient Days reported above, how many Patient Days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Actual Semi-Private Patient Days over last fiscal period If applicable, of the Semi-Private Patient Days reported above, how many Patient Days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Actual Ward Patient Days over last fiscal period If applicable, of the Ward Patient Days reported above, how many Patient Days represent a temporary stay where no additional fee is charged via the contract agreement (other than extra meal charges, etc.)?	
Medicare	
Medicare certified bed count	# total beds # of private beds # of semi-private beds # of ward beds
Current daily Medicare reimbursement rate If the rate varies, please list.	
Total Medicare patient days over last fiscal period Are these patient days included with the patient days in the “Nursing Beds” section?	☐Yes ☐ No

Property Name	Tax Map ID	Element No.	Property Type

Medicaid	
Medicaid certified bed count	# total beds # of private beds # of semi-private beds # of ward beds
Current daily Medicaid reimbursement rate If the rate varies, please list.	
Total Medicaid patient days over last fiscal period Are these patient days included with the patient days in the "Nursing Beds" section?	☐Yes ☐ No
Revenue	
Actual private pay revenue received over the last fiscal period	
Are you anticipating a significant change in private pay revenue over the current fiscal period? If yes, please explain.	☐Yes ☐No
Actual Medicare revenue received over the last fiscal period	
Are you anticipating a significant change in Medicare revenue over the current fiscal period? If yes, please explain.	☐Yes ☐ No
Actual Medicaid revenue received over the last fiscal period	
Are you anticipating a significant change in Medicaid revenue over the current fiscal period? If yes, please explain.	☐Yes ☐ No
Actual other revenue (all other revenue not included above) received over the last fiscal period	
Are you anticipating a significant change in other revenue over the current fiscal period? If yes, please explain.	☐Yes ☐ No

Property Name	Tax Map ID	Element No.	Property Type

NURSING – CURRENT RENT ROLL

Please fill out the rent roll on the next page then fill out the rent roll summary below. If there are more tenants than lines available in the table, attach a rent roll that includes the following tenant information. (Annualize rents and expense reimbursements.)

1. Bed number
2. Unit type (private, semi-private, or ward)
3. Tenant type (private pay, Medicare pay, Medicaid pay, temporary stay, vacant, or other (please specify))
4. Rent type (actual daily rate, Medicare, or Medicaid reimbursable rate)
5. Daily rate for non-residents
6. Daily/monthly rent for non-residents (actual rent paid, if left blank we will assume the actual rent is the same as the asking rent; if the bed is vacant, label as “vacant”)
7. Date admitted

SUMMARY OF RENT ROLL		
Private, Semi-Private, or Ward	**Total Beds**	**Average Daily Rate, Medicare, or Medicaid Reimbursable Rate**
Private		
Semi-Private		
Ward		
Total # of Beds*		

* Total each Bed type. Total # of beds should match question #1 of the previous Nursing Beds section.

Rent Roll:

Property Name	Tax Map ID	Element No.	Property Type

Bed #	Private, Semi Private or Ward[1]	Private Pay, Medicare Pay. Medicaid Pay, Temp. Stay, Vacant, or Other[2]	Actual Daily Rate, Medicare, or Medicaid Reimbursable Rate[3]	Daily Rate for Non-Residents[4]	Date Admitted

Property Name	Tax Map ID	Element No.	Property Type

F. Annual Net Operating Income Information

Note: In addition to the information requested, YOU MUST ATTACH TO THIS SURVEY THE MOST RECENT FULL TWELVE MONTH INCOME AND EXPENSE OPERATING STATEMENT FOR YOUR FACILITY. If your fiscal period ended on any other date than December 31, please also attach a year-to-date operating statement which covers the period through December 31. Enter round numbers below. No decimals.

For Period to

	Amount	Imputed?
Vacancy & Collection Loss		
Annual Income		
Primary Rental Income		
Laundry Income		
Dietary Income		
Interest Income		
Medicare/Medicaid		
Resident Services/Community Fees		
Other Rental Income		
Miscellaneous Income (specify)		
Miscellaneous Income (specify)		
Miscellaneous Income (specify)		
Total Annual Income		
Operating Expense		
Water and Sewer		
Electricity		
Other Utilities		
Repairs/Maintenance		
Housekeeping		
Dietary		
Management Fees (not including asset management fees)		
Other Administrative/Payroll		
Resident Services/Activities		
Nursing/Medical		
Insurance (1 year)		
Other		
Total Operating Expenses		
Replacement Reserves (actual $ amount in reserve account)		
Net Operating Income Total Actual Income less Total Expenses before Real Estate Taxes & Reserves		
Real Estate Taxes		

Property Name	Tax Map ID	Element No.	Property Type

G. Capital Improvements, Renovations, Deferred Maintenance

Has the property had capital improvements or capital renovations during the reporting period? If yes, please provide total cost here and attach a detailed list on a separate page.	☐Yes ☐ No
Does the property contain any items of deferred maintenance? If yes, please provide total cost here and attach a detailed list on a separate page.	☐Yes ☐ No

New construction: Submit the most recent AIA documents G702 and G703 with associated soft costs, and attach a marketing brochure.

H. Furniture, Fixtures, and Equipment (FF & E) and Personal Property

Was a Fairfax County Business Personal Property declaration filed in the previous 12 months? If yes, what is the "Trade Name" of the business specified on the declaration?	☐Yes ☐ No

I. Additional Information

Are land and/or buildings now being leased? If yes, please describe terms (e.g., lease term, rent, special conditions)	☐Yes ☐ No
Has the property or a portion of the property been marketed for sale via a broker, owner, signage, internet, etc., within the past 3 years? If yes, please disclose asking prices, asking dates, any offers, and marketing time.	☐Yes ☐ No
Is there any other information you consider pertinent to the equitable valuation of the subject property? If yes, please attach information.	☐Yes ☐ No

Is this property a participant in one of the HUD/other low-income housing programs? ☐Yes ☐ No

If yes, please specify type.

Housing Program	# Units
ADU	
WDU	
Section 8 Project-Based	
Section 8 Tenant-Based	
221-D3	
221-D4	
236	
LIHTC	
Sec 42	
Other	

Property Name	Tax Map ID	Element No.	Property Type

ADDITIONAL COMMENTS
Please include any details you feel are necessary for the valuation of this property:

ELECTRONIC SURVEYS
Please enter the preferred email for surveys to be sent to:

J. CERTIFICATION			
OFFICIAL REQUEST: TITLE 58.1-3294 CODE OF VIRGINIA State law requires certification by the owner or officially authorized representative			
Name of Management Company		Contact Person	
Street#	Street Name/P.O. Box	Direction	Suffix
2nd Line of Address			
Unit/Suite/Floor	City	State/Country	Zip/Postal Code
Phone Number		Email Address	
All information including the accompanying schedules, statements, and attachments have been examined by me and to the best of my knowledge and belief are true, correct, and complete. I acknowledge that a Docusign signature constitutes an official signature on behalf of the taxpayer or taxpaying entity.			
Signature		Date	
Print Name		Title	

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