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 <u>five years</u>. 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

Self-explanatory.

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

- Self-explanatory.
   Self-explanatory.
   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.

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.
- 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.
- Patient Days Self-explanatory.
- 3. **Medicare** Complete if applicable.
- 4. **Medicaid** Complete if applicable.
- 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 <u>FULL</u> 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.

<u>New Construction</u> – 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 (<u>Code of Virginia</u> 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.



# **County of Fairfax, Department of Tax Administration**

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

# **Continuing Care Income and Expense Survey - Real Estate Division**

Calendar Year 2023

For Tax Year 2025

## 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 date.

						A. Ge	neral Inf	ormation (	Pro	perty Identif	ficatio	n)
Pro	Property Name					Owner/Age	nt	No Longer Owns Property				
Tax	«Мар I	D				Elemen	t No.			Property Type		
Ple	ase list	t all	additional	l elem	ents in	cluded ir	the incom	e and expens	e da	ta.		
							Pr	operty Loc	atio	on		
Str	eet#		Street Na	ame						Direc	tion	Suffix
Cit	/									1		Zip/Postal Code
						Pr	operty In	nprovemer	nt Ir	formation		
Ow	ner Oc Yes	cup	oied No	Owi	ner Oc	cupied S	F					
Ye	ar Built		Year Addition			Total Building Area To		Total Leasable Area		a	Total Basement Area	
Ye	ar Rend	ova	ted			Finished Bsmt Area		Unfinished Bsmt Area		rea	Bsmt Parking Area	
No	Storie		No. Elevators			No. Parking Spaces		No.	No. Reserved/Rental Parking Spaces		ing Spaces	
					В.	Debt S	Service Ir	nformation	(wi	thin the last	5 yea	rs)
Loan Amount Loar			n Date	Term	Interest Rate	e %	Payment (P	& I)	Payment Frequency (Mo. or Year)			
1	1											
2												
							FOR IN	TERNAL US	SF (	ONI Y		
Init	ial			Date	Clic	ck or tap	to enter			d into IAS		☐ Added to IDOCS

# **CONFIDENTIAL**

C. Independent	t 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?	□ Ye	s 🗆 No
If yes, please explain.		
Are you anticipating a significant change in the number of residents over the current fiscal period?	□Ye	s 🗆 No
If yes, please explain.		
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?	□Ye	s 🗆 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?	□Ye	s 🗆 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 Commission Bureau of Insurance.	with the Commonwealth	of Virginia State Corporation

Property Name

Tax Map ID

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 Re						
Total # of Units*						

<sup>\*</sup> 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 <sup>1</sup>	Actual Current Monthly Rent	Date Admitted

D. Assisted Living Co	mponent		
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?	☐ Yes ☐ No		
If yes, please explain.			
What services are standard? (i.e., # of meals, laundry, housekeeping, linen, etc.)			
What additional services are offered that are not included within the	Service	Cost \$	
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?			
and design and the sact needs portion.	l		

Property Type

Tax Map ID

Property Name

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*							

<sup>\*</sup> 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 <sup>1</sup>	Daily/Monthly Rate for Non- Residents <sup>2</sup>	Date Admitted

E. Nursing Bed	ds
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 Type

Property Name

Tax Map ID

Medicaid	Medicaid						
Medicaid certified bed count	# total beds # of private beds # of semi-private # 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?	□Y€	es □ 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?	□Y€	es 🗆 No					
If yes, please explain.							
Actual Medicare revenue received over the last fiscal period							
Are you anticipating a significant change in Medicare revenue over the current fiscal period?	□Y€	es 🗆 No					
If yes, please explain.							
Actual Medicaid revenue received over the last fiscal period							
Are you anticipating a significant change in Medicaid revenue over the current fiscal period?	□Y€	es 🗆 No					
If yes, please explain.							
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?	□Y€	es □ No					
If yes, please explain.							

Property Name

Tax Map ID

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*						

<sup>\*</sup> 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, <u>Semi</u> <u>Private</u> or Ward <sup>1</sup>	Private Pay, Medicare Pay. Medicaid Pay, Temp. Stay, Vacant, or Other <sup>2</sup>	Actual Daily Rate, Medicare, or Medicaid Reimbursable Rate <sup>3</sup>	Daily Rate for Non- Residents <sup>4</sup>	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 managemen	nt fees)		
Other Administrative/Payroll			
Resident Services/Activities			
Nursing/Medical			
Insurance (1 year)			
Other  Total Operating Evenness			
Total Operating Expenses	account)		
Replacement Reserves (actual \$ amount in reserve Net Operating Income	account)		
Total Actual Income less Total Expenses before Real E	Estate Taxes & Reserves		
Real Estate Taxes			

G. Capital Improvements, Reno	vations, Deferred Mainto	enance					
Has the property had capital improvements or capital renovation the reporting period?	ns during [	□Yes □ No					
If yes, please provide total cost here and attach a detailed list on a separate page.							
Does the property contain any items of deferred maintenance?		□Yes □ No					
If yes, please provide total cost here and attach a detailed list on a se	parate page.						
New construction: Submit the most recent AIA documents G702 and G703 with associated soft costs, and attach a marketing brochure.							
H. Furniture, Fixtures, and Equipme	ent (FF & E) and Person	al Property					
Was a Fairfax County Business Personal Property declaration previous 12 months?	filed in the	□Yes □ No					
If yes, what is the "Trade Name" of the business specified on the declaration?							
	Information						
Are land and/or buildings now being leased?		□Yes □ No					
If yes, please describe terms (e.g., lease term, rent, special conditions	5)						
Has the property or a portion of the property been marketed for broker, owner, signage, internet, etc., within the past 3 years?	r sale via a	□Yes □ No					
If yes, please disclose asking prices, asking dates, any offers, and ma	arketing time.						
Is there any other information you consider pertinent to the equivaluation of the subject property?	litable [	□Yes □ No					
If yes, please attach information.  Is this property a participant in one of the HUD/other low-income housing programs?	□Yes	□ No					
	Housing Program	# Units					
If yes, please specify type.	ADU						
	WDU						
	Section 8 Project-Based						
	Section 8 Tenant-Based						
	221-D3						
	221-D4						
	236						
	LIHTC						
	Sec 42						
	Other						

Property Name

Tax Map ID

			ADDITIO	ONAL CO	OMMENT:	S	
Please include	any details	you feel are r	necessary for the	e valuatior	of this pro	pperty:	
			ELECT	RONICS	SURVEYS		
Please enter th	he preferred	email for surv	veys to be sent to	0:			
			J. CI	ERTIFIC	ATION		
	State lav					DDE OF VIRGINIA ly authorized repres	sentative
Name of Manag	gement Com	pany		(	Contact Per	rson	
Street#	Stree	et Name/P.O.	Box	l.		Direction	Suffix
2 <sup>nd</sup> Line of Add	ress					1	,
Unit/Suite/Floor	r		City			State/Country	Zip/Postal Code
Phone Number Email Address							
	•				-		examined by me and to the
best of my k	nowledge ar			•		ledge that a Docusigr taxpaying entity.	n signature constitutes an
Signature			<u> </u>		Date	1 - 7 37	
Print Name Title							

Tax Map ID

Property Name