OFFICIAL REQUEST

ELDERLY HOUSING, ASSISTED LIVING AND NURSING HOME
INCOME AND EXPENSE SURVEY

CITY OF ALEXANDRIA
DEPARTMENT OF REAL ESTATE ASSESSMENTS
703.838.4646

Tax Assessment Map #	Abstract Code	Account #

Return to:
Department of Real Estate Assessments
P.O. Box 178
Alexandria, Virginia 22313-1501

Dear Property Owner:

The Department of Real Estate Assessments is in the process of collecting and analyzing information for the annual reassessment of real estate located in the City of Alexandria. This is an official request pursuant to Title 58.1-3294 of the Code of Virginia that requires you to furnish this office with income and expense data for any income producing properties for calendar year 2008. This request is also in compliance with Section 3-2-186 of the Alexandria City Code. All information submitted will be kept strictly confidential under the stipulations of Section 58.1-3 of the **Code of Virginia.**

This survey form is to be completed by the property owner or a duly authorized agent, showing the gross income (at 100% occupancy), vacancies and expenses for the above referenced property. The information should encompass the 2008 calendar year.

Income information related to calendar year 2008 that you may have previously submitted to the Department of Real Estate Assessments or to the Board of Equalization as part of a review or an appeal, must be resubmitted at this time to satisfy this request. The income information requested by the Department of Finance in regard to business licenses is not associated with this request. In addition to the information requested as part of this survey, we request that you submit any other income or expense information that you believe to be relevant to the assessment of your property.

I would like to remind you that any Request for Review of Assessment filed with this office, or any Appeal of Assessment filed with the Board of Equalization, that is based upon the income or expense attributable to your property will not be considered unless this information has been filed on time.

The enclosed self-addressed envelope is provided for your convenience. The income information must be returned to our office no later than **May 1, 2009** or postmarked by the U.S. Postal Service no later than **May 1, 2009.**

If you have any questions regarding this matter, or wish to discuss this request form with a member of our appraisal staff, please call between 8:00 a.m. and 5:00 p.m., Monday through Friday. Your cooperation and timely response to this legal requirement will be greatly appreciated.

Sincerely,

Cynthia A. Smith-Page, ASA
Director

The Income and Expense Information must be placed on this form. No alternative forms may be used. A detailed set of instructions is part of this survey. These instructions are provided to assist you in completing the form. If you should have any questions or need assistance please call our office at 703.838.4646.

CERTIFICATION

(State law requires certification by the owner or officially authorized representative. Please type or print.)

Facility Name:		Property Address:
Owner Name(s):		
Property Type: (Check all that apply)	❑ Skilled Nursing Facility ❑ Assisted Living / Personal Care	❑ Independent Living Units or Elderly Apartments ❑ Lifecare facility or Continuing Care Retirement Community

All information including the accompanying schedules and statements have been examined by me and to the best of my knowledge and belief are true, correct, and complete.

Name of Management Company:	Contact Person:
Mailing Address:	Print Name:
Phone:	Title:
Date:	Signature (required)

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A. UNIT / BED, VACANCY AND RATE INFORMATION (calendar year 2008)

1. Independent Living: Total number of units: _____

Unit Type (Apartment or other)	# Units	# Bedrooms	Current Rate per Month / Day
What services are offered to independent living residents and included in the above rates? _____			
How much of the rates are allocated to these services?			

2. Assisted Living: Total number of units: _____ Total number of beds _____

	Rate per Month / Day (specify) -List range if necessary
Private Room	$
Semi-Private Room	$
Does the pay rate differ based on the acuity level of each resident? Yes _____ No _____ If yes, specify_____	
What services are offered to Assisted Living or Personal Care residents? _____	
How much of the rates are allocated to these services? _____	

3. Lifecare Facilities or Continuing Care Retirement Communities:

Does the facility have any endowment or entrance fee? Yes _____ No _____
Is the fee refundable or partially refundable? Yes _____ No _____

(Please attach a schedule of fees for the different plans available)

4. Nursing Beds: Total number of beds: _____

a. PRIVATE PAY

	Private Room	Semi-Private	Ward	Total
1. Private Pay bed count:				
2. Private Pay occupied beds as of January 1, 2008				
3. Daily Private pay rate for:				
4. Total private patient days during this reporting period: _____		5. Actual annual private pay income received during this reporting period $_____		

b. MEDICAID PAY

	Private Room	Semi-Private	Ward	Total
1. Medicaid certified bed count				
2. Occupied Medicaid beds as of January 1, 2008				
3. Current Medicaid Reimbursement Rate: (per patient day) Routine: _____ Ancillary: _____ Capital Payment: _____ Total Medicaid Rate: _____				
4. Total Medicaid patient days during this reporting period: _____		5. Actual annual Medicaid income received during this reporting period: _____		

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c. MEDICARE PAY

	Private Room	Semi-Private	Ward	Total
1. Medicare certified bed count				
2. Occupied Medicare beds as of January 1, 2008				
3. Current Medicare Reimbursement Rate: (per patient day)	Routine: _____ Ancillary: _____ Capital Payment: _____ Total Medicare Rate: _____			
4. Total Medicare patient days during this reporting period: _____	5. Actual annual Medicare income received during this reporting period:$_____			

d. OTHER REVENUE NOT INCLUDED IN DAILY OR MONTHLY RATE (during this reporting period)

1. Ancillary Services and Therapy: _____	4. Special Dietary: _____
2. Medicare: _____	5. Other Supplies: _____
3. Linen / Laundry Services: _____	6. Other (specify): _____ _____

B. In addition to the information requested, you must attach to this survey the 2008 year ending operating statement for your facility.

C. CAPITAL IMPROVEMENTS, RENOVATIONS:

Has the property had Capital Improvements or Capital Renovations during this reporting period: Yes _____ No _____

If yes, please provide total cost here and attach a detailed list on separate page. Total capital cost: _____

D. FURNITURE, FIXTURES AND EQUIPMENT (FF&E) AND PERSONAL PROPERTY:

What was the value of personal property or FF&E as reported on the 2008 City of Alexandria Personal Property Tax form? _____

E. ADDITIONAL INFORMATION:

1. Are land and/or buildings now being leased: Yes _____ No _____ If, yes, please describe terms, (e.g. lease term, rent, special conditions).

_____

_____

2. Is there any other information you consider pertinent to the equitable valuation of this property? (please attach additional sheets if necessary)

_____

_____

F. DEBT SERVICE INFORMATION:

	LOAN AMOUNT	LOAN DATE	TERM	INTEREST RATE %	PAYMENT (P&I)	PAYMENT FREQUENCY MO. OR YR.
1						
2						

Has there been a professional appraisal on this real property in the last five years? Yes _____ No _____

If yes, appraiser's estimate of value $_____ Date of value _____

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