NURSING HOME INCOME QUESTIONNAIRE

INCOME QUESTIONNAIRE FOR 36 MONTHS: FROM 2012 TO 2014

NAME & LOCATION OF PROPERTY

OWNER AND ADDRESS OF RECORD

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GROSS FLOOR AREA ___________________
TOTAL # OF ROOMS____________________
TOTAL # OF PRIVATE BEDS ____________
TOTAL # OF SEMI-PRIVATE BEDS _______
TOTAL # OF SUBSIDIZED BEDS__________
TOTAL # OF BEDS_____________________
ANNUAL OCCUPANCY RATE ____________

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REVENUE:
1. ROOM & BOARD
2. MEDICAL & NONMEDICAL ANCILLARY SERVICES
3. OTHER INCOME
4. LOSS DUE TO BAD DEBT
5. EFFECTIVE GROSS INCOME

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OPERATING EXPENSES:
1. ADMINISTRATION
2. MANAGEMENT FEE
3. DIETARY
4. LAUNDRY & LINEN
5. HOUSEKEEPING
6. PLANT OPERATIONS
7. SOCIAL SERVICES & ACTIVITIES
8. OTHER PATIENT CARE
9. NURSING
10. ANCILLARY
11. NON-REIMBURSABLE
12. MISCELLANEOUS
13. INSURANCE
14. RESERVES FOR REPLACEMENT
15. OTHER (LIST)
16. TOTAL OPERATING EXPENSES

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NET OPERATING INCOME ____________

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CAPITAL EXPENSES:
1) FURNITURE FIXTURES & EQUIPMENT
2) REAL ESTATE TAXES
3) MORTGAGE PAYMENT
4) BUILDING DEPRECIATION
5) CAPITAL IMPROVEMENTS

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MORTGAGE/SALES INFORMATION:
1. Is there a current mortgage on this property? Yes _________ No _________

2. If Yes, please provide the following data:

   Name of Mortgagee _____________________ Mortgage Amount ____________ Interest Rate ____________
   Term of Mortgage ____________ Date 1st Payment ____________ Monthly Payment ____________

3. Please provide: Date Purchased ____________ Consideration ____________

I declare, under the penalties of perjury, that the contents of this form and all the accompanying schedules and statements have been examined by me and are true, correct, and complete to the best of my knowledge, information, and belief.

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Signature ___________________ Title of Signer ____________ Date ____________

Print/Type Name of Signer ___________________ Phone Number ____________

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