Residential Medical Facility Income/Expense Survey

Harrison Township Assessor

167 Oak St, Terre Haute, IN 47807
Phone (812) 462-3271 Fax (812) 462-3273
PRIVILEGED and CONFIDENTIAL

Section A: Owner/Filer Information

Owner Name: _____

Business Name: _____

Mailing Address: _____

Contact #: _____

E-Mail Address: _____

Section B: Property Information

Franchise Name _____

Property Address: _____

Gross Sq Ft: _____

Parcel(s): _____

Section C: Reporting Info

1. Bed Count

For 2015:	Total # of Beds: _____	Potential Patient Days: _____	Actual Patient Days: _____
For 2016:	Total # of Beds: _____	Potential Patient Days: _____	Actual Patient Days: _____
For 2017:	Total # of Beds: _____	Potential Patient Days: _____	Actual Patient Days: _____

2. Facility Type

Skilled Nursing: _____ % Memory Care: _____ % Assisted Living: _____ %

Independent Living: _____ % Other _____ %

3. Overall Occupancy Rate (2017)

Medicare Part A: _____ % Medicaid: _____ % Private & Other: _____ %

Managed Care: _____ % Assisted Living: _____ %

4. Amenities Offered: (Yes/No)

Dining Room: _____ Library: _____ Physical Therapy: _____

Activity Room _____ Other: _____

5. Furnished Rooms: Number Provided: _____

6. Units unable to be occupied: Number: _____

Reason: _____

5. Please submit your last three years (2015, 2016, & 2017) Income & Expense information to complete this filing.

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.

Contact Person: _____

Management Firm (if applicable) _____

Address: _____

Phone: _____

Signature: _____ Title: _____ Date: _____

Per IC 6-1.1-35-9, any information pertaining to income expense is constitutionally protected and will remain confidential.