INSIGNIA
Financial Services

Borrower _____
Application Date _____
Originator _____

Commercial Mortgage Application
Property Type: **HEALTH CARE**

Loan Information

Loan Name/Description _____

Recourse Preference ☐ Recourse ☐ Non-Recourse ☐ Negotiable

Loan Purpose ☐ Purchase ☐ Refinance ☐ Construction

If Purchase, Purch Price $ _____ Closing Date _____

If Refinance, Loan Balance $ _____ Interest Rate _____% Type: Fixed____ Variable____

Cost of Recent Improvements $ _____ Improvements Documented? Yes____ No____ Unknown____

If Constr, Constr Cost+Land $ _____ Completion Date _____

Borrower Information

Borrower Name _____

Borrower Type ☐ Individual ☐ Corp ☐ LLC ☐ Trust ☐ Ltd or Gen Prtnrshp ☐ Other_____

Primary Contact _____ Contact Email _____

Address _____ City_____ State_____ Zip_____

Phone ( ) _____ Fax ( ) _____

Net Worth $ _____ FICO Score _____ Bankruptcy? Yes____ No____

Property Information

Property Name _____ No. of Bldgs _____

Property Subtype: Nursing Home_____ Congregate Care_____ Assisted Living_____ Other_____

Land Area _____ Property Management Contract in place? Yes____ No____

Last Appraised Value $ _____ Last Sale Price $ _____

Last Appraisal Date _____ Date of Last Sale _____

Property Attributes Adjacent to Sewage/Waste Treatment facility? Yes____ No____ Unlicensed Beds_____ %

Cafeterias___ Laundry Rms___ Pools___ Clubhses___ Rec. Areas___ Exercise Rooms___ Nursing Stations___ Security Gates___

Surrounding Land Use Light Industrial___ Heavy Industrial___ Industrial Park___ Office___ Residential___ Other_____

Distance from Hospital_____ miles Level A Deficiencies in the past 2 years? Yes___ No___ Don't Know___

Building Information

Building Address _____ City_____ State_____ Zip_____

Number of Stories_____ Year Built_____ Year Renovated_____ Overall Appearance: Avg____ Above____ Below____

Air Conditioning_____% Sprinklered_____% Flat Roof? Yes____ No____ T-111 Exterior? Yes____ No____

Est. Market Vacancy % _____% Gross Building Area_____SF Net Rental Area_____SF

Rent Roll

Building Name _____ Rent Roll Date _____

No.	Unit Type: Assisted Living, Independent Living, Skilled Nursing, Intermediate Care, Sub-Acute Care	No. of Occupied Beds	No. of Vacant Beds	Total Occupied Area (SF)	Total Vacant Area (SF)	Avg. Monthly Rent per Bed	Est. Market Rent per Bed	% of Month to Month	Utilities/Services Included in Rent						
									Utilities	Storage	Parking	Meals	Trans	Landsc	Hskeep
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Income & Expenses

Building Name _____

Item	3rd Preceding Year _____	2nd Preceding Year _____	Preceding Year _____	YTD No of Months____	Trailing 12 Months	Notes
Private Pay						
Medicare/Medicaid						
Nursing/Medical Income						
Meals Income						
Other Income						
Vacancy & Coll. Loss						
Effective Gross Income						
Real Estate Taxes						
Property Insurance						
Utilities						
Repairs and Maintenance						
Management Fees						
Payroll and Benefits						
Advertising and Marketing						
Professional Fees						
General and Administrative						
Room Exp.-House Keeping						
Meal Expense						
Other Expenses						
Ground Rent						
Total Operating Expenses						
Net Operating Income						
Cap Ex. (Repl. Reserves)						
Extraordinary Capital Exp.						
Total Capital Items						
Net Cash Flow						