

PRE-LISTING EVALUATION FORM

For Residential Care Facilities (Rev. 08/2004)
(All information will be kept confidential)

Linda Meim Real Estate

POB 5432, Novato, CA 94945
(925) 584-8898; (415) 873-1989 fax

Please use back of form if additional sheets are necessary.

Today's Date: _____

FACILITY NAME: _____ # Licensed Beds _____

TYPE OF FACILITY: () RCFE () ARF () Group Home () Other _____

AMBULATORY _____ # NON AMBULATORY _____ ALZHEIMER/DEMENTIA/HOSPICE _____

FACILITY ADDRESS: _____ COUNTY _____

CITY/STATE _____ ZIP CODE _____

OWNER'S NAME(S) _____

OWNER'S ADDRESS: _____

CITY/STATE _____ ZIP CODE _____

FACILITY PHONE () _____ OWNER'S PHONE () _____

OWNER'S FAX () _____

OWNER'S EMAIL ADDRESS _____

A. PROPERTY INFORMATION

BEDROOMS _____ (# PRIVATE ROOMS _____ # SHARED ROOMS _____)

BATHROOMS _____ (# PRIVATE _____ # SHARED _____ # HALLWAY _____)

BUILDINGS _____ BUILDING AGE _____ BUILDING SQ FOOTAGE _____

CONDITION OF BUILDING: () Excellent () Very Good () Good () Fair () Poor

LOT SIZE _____ ZONING _____ USE PERMIT? _____

OTHER FEATURES: (Check all that apply)

() LIVING ROOM () DINING ROOM () KITCHEN () BREAKFAST NOOK

() FAMILY ROOM () BONUS ROOM () STAFF ROOM _____ () FLOORS _____

() RAMPS _____

() EXIT DOORS _____

() FIRE ALARM () FIRE SPRINKLERS () SMOKE DETECTORS () BURGLAR ALARM

() INTERCOM/CALL SYSTEMS () LANDSCAPING _____

() GARAGE: # CAR _____ () ROOM CONVERSIONS? IF SO, ARE CONVERSIONS WITH PERMITS? DESCRIBE:

GIVE ADDITIONAL DESCRIPTION OF YOUR PROPERTY'S SPECIAL FEATURES: (Use back of this page if necessary; submit brochures or marketing materials if materials cover facility descriptions)

SELLER'S ESTIMATE OF REAL ESTATE VALUE: \$ _____

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B. LOAN INFORMATION

FIRST SECOND OTHER

Present Balance	\$	_____	_____	_____
Monthly Payments (P + I)	\$	_____	_____	_____
Present Interest Rate/Fixed or Adj	%	_____	_____	_____
Original Date of Loan		_____	_____	_____
Terms of Loan (Years)		_____	_____	_____
Assumable? Yes or No		_____	_____	_____
Balloon Payment and Due Dates:	\$	_____	_____	_____

Other Loan Information _____

Amount of Possible Seller Carried Loan secured by a Second Trust Deed? \$ _____

SELLER DESIRED SELLING PRICE FOR FACILITY \$ _____

C. INCOME INFORMATION

Estimated Annual Gross Income at 100% filled \$ _____

Actual Annual Gross Income as of year _____ \$ _____

Other Income \$ _____ Source _____

Vacancy Rate _____ % Waiting List? Yes or No _____ Total Years in Business? _____

Nearest Competitor? _____

Remarks: _____

NOTE: Pls provide copies of your last 3 years Profit & Loss Statements (or Schedule C from Fed Tax Ret)

D. OCCUPANCY INFORMATION (Please note, P = Private, S = Shared; O = Occupied, V = Vacant, and per bed Income) ex. Room 1:P/O, \$3000; Room 2: S/O, \$1,500+\$1,500; Room 3: S/1V, \$1,500+\$0

Room 01 _____	Room 11 _____
Room 02 _____	Room 12 _____
Room 03 _____	Room 13 _____
Room 04 _____	Room 14 _____
Room 05 _____	Room 15 _____
Room 06 _____	Room 16 _____
Room 07 _____	Room 17 _____
Room 08 _____	Room 18 _____
Room 09 _____	Room 19 _____
Room 10 _____	Room 20 _____
	TOTAL GROSS/MONTH \$ _____

- You can attach a per bed breakdown in your own format if a current one is available.
- Use the back of this page if additional space is needed.

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E.	EXPENSE INFORMATION	Monthly	Annual	Projected
	Advertising	_____	_____	_____
	Automobile	_____	_____	_____
	Cable	_____	_____	_____
	Due & Subscriptions	_____	_____	_____
	Entertainment & Promotions	_____	_____	_____
	Food	_____	_____	_____
	Insurance – Property & Liability	_____	_____	_____
	Insurance – Workmans Comp/etc	_____	_____	_____
	Laundry & Linens	_____	_____	_____
	Legal & Accounting	_____	_____	_____
	Licenses & Fees	_____	_____	_____
	Medical Expenses	_____	_____	_____
	Miscellaneous: _____	_____	_____	_____
	Miscellaneous: _____	_____	_____	_____
	Office Expenses	_____	_____	_____
	Operating Expenses	_____	_____	_____
	Payroll Deductions	_____	_____	_____
	Rental Equipment	_____	_____	_____
	Repairs & Maintenance	_____	_____	_____
	Salaries & Wages	_____	_____	_____
	Supplies	_____	_____	_____
	Taxes – Property	_____	_____	_____
	Telephone	_____	_____	_____
	Utilities: Gas & Electricity	_____	_____	_____
	Utilities: Garbage	_____	_____	_____
	Utilities: Water	_____	_____	_____
	TOTAL EXPENSES	\$ _____	\$ _____	\$ _____

Explain any unusual expenses or one-time expenses noted above: _____

E. EMPLOYEE INFORMATION
 Owner Operated Facility Owner Resides in Facility Staff Operated Facility
 Total Number of Owner Hours per Month _____ Owner Wages Paid/month \$ _____
 Owner Wages included in Salaries Figure Above? YES NO
 Owner Job Title/Description of Duties _____

Total Number of Staff _____ # of Full Time Staff _____ # of Part Time Staff _____ Live-in Staff _____
 Benefits Paid to Staff? _____
 Staff Breakdown by: Position/Duties, FT, PT, # of Hours Worked, Wages/Hour or Wages/Month, Benefits:
 Ex. Staff 1, Asst Administrator, PT, 20 hours/wk, \$12/hr, half of medical insurance after 6 months
 Staff 2, Caregiver, PT, 20 hours/wk, \$8/hr, no benefits

Staff 1: _____
 Staff 2: _____
 Staff 3: _____

BY THEIR SIGNATURE AND DATE OF SIGNATURE BELOW, OWNER CERTIFIES ALL THE INFORMATION PROVIDED HEREIN IS TRUE TO THE BEST OF THEIR KNOWLEDGE:

 Owner Signature Date Owner Signature Date

NOTE: Please provide the following: copies of your facility’s floor plans, a sample of your brochure (if available), 3 years of Schedule Cs (or comparable statements) + year-to-date Profit & Loss Statements