

**Continuing Care Retirement Community  
Disclosure Statement  
General Information**

Date Prepared: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 PROVIDER NAME: \_\_\_\_\_ FACILITY OPERATOR: \_\_\_\_\_  
 RELATED FACILITIES: \_\_\_\_\_ RELIGIOUS AFFILIATION: \_\_\_\_\_  
 YEAR OPENED: \_\_\_\_\_ # OF ACRES: \_\_\_\_\_  SINGLE STORY  MULTI-STORY  OTHER: \_\_\_\_\_  
 MILES TO SHOPPING CTR: \_\_\_\_\_  
 MILES TO HOSPITAL: \_\_\_\_\_

**NUMBER OF UNITS:**

<b>RESIDENTIAL LIVING</b>	<b>HEALTH CARE</b>
APARTMENTS — STUDIO: _____	ASSISTED LIVING: _____
APARTMENTS — 1 BDRM: _____	SKILLED NURSING: _____
APARTMENTS — 2 BDRM: _____	SPECIAL CARE: _____
COTTAGES/HOUSES: _____	DESCRIPTION: > _____
RLU OCCUPANCY (%) AT YEAR END: _____	> _____

**TYPE OF OWNERSHIP:**  NOT-FOR-PROFIT  FOR-PROFIT ACCREDITED?:  YES  NO BY: \_\_\_\_\_

**FORM OF CONTRACT:**  CONTINUING CARE  LIFE CARE  ENTRANCE FEE  FEE FOR SERVICE  
 (Check all that apply)  ASSIGNMENT OF ASSETS  EQUITY  MEMBERSHIP  RENTAL

**REFUND PROVISIONS:** (Check all that apply)  90%  75%  50%  FULLY AMORTIZED  OTHER: \_\_\_\_\_

**RANGE OF ENTRANCE FEES:** \$ \_\_\_\_\_ - \$ \_\_\_\_\_ **LONG-TERM CARE INSURANCE REQUIRED?**  YES  NO

**HEALTH CARE BENEFITS INCLUDED IN CONTRACT:** \_\_\_\_\_

**ENTRY REQUIREMENTS:** MIN. AGE: \_\_\_\_\_ PRIOR PROFESSION: \_\_\_\_\_ OTHER: \_\_\_\_\_

**RESIDENT REPRESENTATIVE(S) TO, AND RESIDENT MEMBER(S) ON, THE BOARD** (briefly describe provider's compliance and residents' role): > \_\_\_\_\_

> \_\_\_\_\_

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<b>FACILITY SERVICES AND AMENITIES</b>					
<u>COMMON AREA AMENITIES</u>	<u>AVAILABLE</u>	<u>FEE FOR SERVICE</u>	<u>SERVICES AVAILABLE</u>	<u>INCLUDED IN FEE</u>	<u>FOR EXTRA CHARGE</u>
BEAUTY/BARBER SHOP	<input type="checkbox"/>	<input type="checkbox"/>	HOUSEKEEPING (____ TIMES/MONTH)	<input type="checkbox"/>	<input type="checkbox"/>
BILLIARD ROOM	<input type="checkbox"/>	<input type="checkbox"/>	MEALS (____/DAY)	<input type="checkbox"/>	<input type="checkbox"/>
BOWLING GREEN	<input type="checkbox"/>	<input type="checkbox"/>	SPECIAL DIETS AVAILABLE	<input type="checkbox"/>	<input type="checkbox"/>
CARD ROOMS	<input type="checkbox"/>	<input type="checkbox"/>			
CHAPEL	<input type="checkbox"/>	<input type="checkbox"/>	24-HOUR EMERGENCY RESPONSE	<input type="checkbox"/>	<input type="checkbox"/>
COFFEE SHOP	<input type="checkbox"/>	<input type="checkbox"/>	ACTIVITIES PROGRAM	<input type="checkbox"/>	<input type="checkbox"/>
CRAFT ROOMS	<input type="checkbox"/>	<input type="checkbox"/>	ALL UTILITIES EXCEPT PHONE	<input type="checkbox"/>	<input type="checkbox"/>
EXERCISE ROOM	<input type="checkbox"/>	<input type="checkbox"/>	APARTMENT MAINTENANCE	<input type="checkbox"/>	<input type="checkbox"/>
GOLF COURSE ACCESS	<input type="checkbox"/>	<input type="checkbox"/>	CABLE TV	<input type="checkbox"/>	<input type="checkbox"/>
LIBRARY	<input type="checkbox"/>	<input type="checkbox"/>	LINENS FURNISHED	<input type="checkbox"/>	<input type="checkbox"/>
PUTTING GREEN	<input type="checkbox"/>	<input type="checkbox"/>	LINENS LAUNDERED	<input type="checkbox"/>	<input type="checkbox"/>
SHUFFLEBOARD	<input type="checkbox"/>	<input type="checkbox"/>	MEDICATION MANAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>
SPA	<input type="checkbox"/>	<input type="checkbox"/>	NURSING/WELLNESS CLINIC	<input type="checkbox"/>	<input type="checkbox"/>
SWIMMING POOL-INDOOR	<input type="checkbox"/>	<input type="checkbox"/>	PERSONAL HOME CARE	<input type="checkbox"/>	<input type="checkbox"/>
SWIMMING POOL-OUTDOOR	<input type="checkbox"/>	<input type="checkbox"/>	TRANSPORTATION-PERSONAL	<input type="checkbox"/>	<input type="checkbox"/>
TENNIS COURT	<input type="checkbox"/>	<input type="checkbox"/>	TRANSPORTATION-PREARRANGED	<input type="checkbox"/>	<input type="checkbox"/>
WORKSHOP	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>
OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>			

All providers are required by Health and Safety Code section 1789.1 to provide this report to prospective residents before executing a deposit agreement or continuing care contract, or receiving any payment. Many communities are part of multi-facility operations which may influence financial reporting. Consumers are encouraged to ask questions of the continuing care retirement community that they are considering and to seek advice from professional advisors.

**PROVIDER NAME:** \_\_\_\_\_

**OTHER CCRCs**

**LOCATION (City, State)**

**PHONE (with area code)**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MULTI-LEVEL RETIREMENT COMMUNITIES**

**LOCATION (City, State)**

**PHONE (with area code)**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FREE-STANDING SKILLED NURSING**

**LOCATION (City, State)**

**PHONE (with area code)**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**SUBSIDIZED SENIOR HOUSING**

**LOCATION (City, State)**

**PHONE (with area code)**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**NOTE:** PLEASE INDICATE IF THE FACILITY IS A LIFE CARE FACILITY.

PROVIDER NAME: \_\_\_\_\_

	2016	2017	2018	2019
<b>INCOME FROM ONGOING OPERATIONS</b>				
<b>OPERATING INCOME</b> (Excluding amortization of entrance fee income)				
<b>LESS OPERATING EXPENSES</b> (Excluding depreciation, amortization, and interest)				
<b>NET INCOME FROM OPERATIONS</b>				
<b>LESS INTEREST EXPENSE</b>				
<b>PLUS CONTRIBUTIONS</b>				
<b>PLUS NON-OPERATING INCOME (EXPENSES)</b> (excluding extraordinary items)				
<b>NET INCOME (LOSS) BEFORE ENTRANCE FEES, DEPRECIATION AND AMORTIZATION</b>				
<b>NET CASH FLOW FROM ENTRANCE FEES</b> (Total Deposits Less Refunds)				

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**DESCRIPTION OF SECURED DEBT** *(as of most recent fiscal year end)*

LENDER	OUTSTANDING BALANCE	INTEREST RATE	DATE OF ORIGATION	DATE OF MATURITY	AMORTIZATION PERIOD

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**FINANCIAL RATIOS** (see next page for ratio formulas)

**2018 CCAC Medians**  
**50<sup>th</sup> Percentile**  
*(optional)*

	2017	2018	2019
<b>DEBT TO ASSET RATIO</b>			
<b>OPERATING RATIO</b>			
<b>DEBT SERVICE COVERAGE RATIO</b>			
<b>DAYS CASH ON HAND RATIO</b>			

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**HISTORICAL MONTHLY SERVICE FEES** (Average Fee and Change Percentage)

	2016	%	2017	%	2018	%	2019	%
STUDIO								
ONE BEDROOM								
TWO BEDROOM								
COTTAGE/HOUSE								
ASSISTED LIVING								
SKILLED NURSING								
SPECIAL CARE								

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**COMMENTS FROM PROVIDER:** > \_\_\_\_\_  
> \_\_\_\_\_  
> \_\_\_\_\_

**FINANCIAL RATIO FORMULAS**

**LONG-TERM DEBT TO TOTAL ASSETS RATIO**

$$\frac{\text{Long-Term Debt, less Current Portion}}{\text{Total Assets}}$$

**OPERATING RATIO**

$$\frac{\begin{array}{l} \text{Total Operating Expenses} \\ - \text{ Depreciation Expense} \\ - \text{ Amortization Expense} \end{array}}{\text{Total Operating Revenues} - \text{Amortization of Deferred Revenue}}$$

**DEBT SERVICE COVERAGE RATIO**

$$\frac{\begin{array}{l} \text{Total Excess of Revenues over Expenses} \\ + \text{ Interest, Depreciation, and Amortization Expenses} \\ \text{Amortization of Deferred Revenue} + \text{ Net Proceeds from Entrance Fees} \end{array}}{\text{Annual Debt Service}}$$

**DAYS CASH ON HAND RATIO**

$$\frac{\begin{array}{l} \text{Unrestricted Current Cash \& Investments} \\ + \text{ Unrestricted Non-Current Cash \& Investments} \end{array}}{(\text{Operating Expenses} - \text{Depreciation} - \text{Amortization})/365}$$

**NOTE:** These formulas are also used by the Continuing Care Accreditation Commission. For each formula, that organization also publishes annual median figures for certain continuing care retirement communities.