

# CONTINUING CARE RETIREMENT COMMUNITY DISCLOSURE STATEMENT

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

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Facility Operator: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Year Opened: \_\_\_\_\_

# of Acres: \_\_\_\_\_

Miles to Shopping Center: \_\_\_\_\_

Miles to Hospital: \_\_\_\_\_

Single Story

Multi-Story

Other: \_\_\_\_\_

**Number of Units:**

<b>Residential Living</b>	<b>Number of Units</b>	<b>Health Care</b>	<b>Number of Units</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 By: \_\_\_\_\_

No

**Form of Contact:**  Continuing Care

Life Care

Entrance Fee

Fee for Service

(Check all that apply)  Assignment of Assets

Equity

Membership

Rental

**Refund Provisions:**  Refundable

90%

50%

(Check all that apply)  Repayable

75%

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 Members on, the Board:**

(briefly describe provider's compliance and residents' roles):

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.

Facility Services and Amenities

Common Area Amenities	Available	Fee for Service	Services Available	Included in Fee	For Extra Charge
Beauty/Barber Shop	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping (___Times/	<input type="checkbox"/>	<input type="checkbox"/>
Billiard Room	<input type="checkbox"/>	<input type="checkbox"/>	Month at \$_____each)		
Bowling Green	<input type="checkbox"/>	<input type="checkbox"/>	Meals (___/Day)	<input type="checkbox"/>	<input type="checkbox"/>
Card Rooms	<input type="checkbox"/>	<input type="checkbox"/>	Special Diets Available	<input type="checkbox"/>	<input type="checkbox"/>
Chapel	<input type="checkbox"/>	<input type="checkbox"/>			
Coffee Shop	<input type="checkbox"/>	<input type="checkbox"/>	24-Hour Emergency Response	<input type="checkbox"/>	<input type="checkbox"/>
Craft Rooms	<input type="checkbox"/>	<input type="checkbox"/>	Activities Program	<input type="checkbox"/>	<input type="checkbox"/>
Exercise Room	<input type="checkbox"/>	<input type="checkbox"/>	All Utilities Except Phone	<input type="checkbox"/>	<input type="checkbox"/>
Golf Course Access	<input type="checkbox"/>	<input type="checkbox"/>	Apartment Maintenance	<input type="checkbox"/>	<input type="checkbox"/>
Library	<input type="checkbox"/>	<input type="checkbox"/>	Cable TV	<input type="checkbox"/>	<input type="checkbox"/>
Putting Green	<input type="checkbox"/>	<input type="checkbox"/>	Linens Furnished	<input type="checkbox"/>	<input type="checkbox"/>
Shuffleboard	<input type="checkbox"/>	<input type="checkbox"/>	Linens Laundered	<input type="checkbox"/>	<input type="checkbox"/>
Spa	<input type="checkbox"/>	<input type="checkbox"/>	Medication Management	<input type="checkbox"/>	<input type="checkbox"/>
Swimming Pool – Indoor	<input type="checkbox"/>	<input type="checkbox"/>	Nursing/Wellness Clinic	<input type="checkbox"/>	<input type="checkbox"/>
Swimming Pool – Outdoor	<input type="checkbox"/>	<input type="checkbox"/>	Personal Home Care	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Court	<input type="checkbox"/>	<input type="checkbox"/>	Transportation – Personal	<input type="checkbox"/>	<input type="checkbox"/>
Workshop	<input type="checkbox"/>	<input type="checkbox"/>	Transportation – Prearranged	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Provider Name:** \_\_\_\_\_

Affiliated 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:** \_\_\_\_\_

**Income and Expenses [Year]**

**Income from Ongoing Operations**

**Operating Income**

(Excluding amortization of entrance fee income)

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**Less Operating Expenses**

(Excluding depreciation, amortization, and interest)

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**Net Income From Operations**

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**Less Interest Expense**

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**Plus Contributions**

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**Plus Non-Operating Income**

**(Expenses)**

(Excluding extraordinary items)

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**Net Income (Loss) Before Entrance Fees, Depreciation And Amortization**

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**Net Cash Flow From Entrance Fees**

(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 Origination	Date of Maturity	Amortization Period

**Financial Ratios** *(see last page for ratio formulas)*

**CCAC Medians 50th Percentile** *(optional)*

**Financial Ratios [Year]**

**Debt to Asset Ratio**

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**Operating Ratio**

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**Debt Service Coverage Ratio**

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**Days Cash On Hand Ratio**

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**Provider Name:** \_\_\_\_\_

**Historical Monthly Service Fees** (Average Fee and Change Percentage)

<b>Residence/Service [Year]</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
Studio								
One Bedroom								
Two Bedroom								
Cottage/House								
Assisted Living								
Skilled Living								
Special Care								

**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**

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

**Debt Service Coverage Ratio**

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

**Days Cash On Hand Ratio**

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

**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.