

**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:

RESIDENTIAL LIVING	HEALTH CARE
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): > _____

> _____

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/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: _____

	2018	2019	2020	2021
INCOME FROM ONGOING OPERATIONS				
OPERATING INCOME				
(Excluding amortization of entrance fee income)				
LESS OPERATING EXPENSES				
(Excluding depreciation, amortization, and interest)				
NET INCOME FROM OPERATIONS				
LESS INTEREST EXPENSE				
PLUS CONTRIBUTIONS				
PLUS NON-OPERATING INCOME (EXPENSES)				
(excluding extraordinary items)				
NET INCOME (LOSS) BEFORE ENTRANCE FEES, DEPRECIATION AND AMORTIZATION				
NET CASH FLOW FROM ENTRANCE FEES				
(Total Deposits Less Refunds)				

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

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

FINANCIAL RATIOS (see next page for ratio formulas)

**2017 CCAC Medians
50th Percentile
(optional)**

	2019	2020	2021
DEBT TO ASSET RATIO			
OPERATING RATIO			
DEBT SERVICE COVERAGE RATIO			
DAYS CASH ON HAND RATIO			

HISTORICAL MONTHLY SERVICE FEES (Average Fee and Change Percentage)

	2018	%	2019	%	2020	%	2021	%
STUDIO								
ONE BEDROOM								
TWO BEDROOM								
COTTAGE/HOUSE								
ASSISTED LIVING								
SKILLED NURSING								
SPECIAL CARE								

COMMENTS FROM PROVIDER: > _____
 > _____
 > _____

PROVIDER NAME: _____

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.