

**Continuing Care Retirement Community  
Disclosure Statement**

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: _____	OVERALL CCRC 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)  Refundable  Repayable  90%  75%  50%  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' roles) > \_\_\_\_\_

\*\*\*\*\*

<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 (_3_/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: \_\_\_\_\_

	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)				

\*\*\*\*\*

**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**  
**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>			

\*\*\*\*\*

**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								

\*\*\*\*\*

**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**

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

**DEBT SERVICE COVERAGE RATIO**

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

**DAYS CASH ON HAND RATIO**

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

**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.