

# **CONTINUING CARE RETIREMENT COMMUNITIES**

## **Introduction**

Continuing Care Retirement Communities (CCRCs) are an excellent alternative for long term care for the middle and upper middle income population. These facilities offer residents an active lifestyle with many friends and plenty of activities. In fact, most people enter CCRCs close to their home and know a certain number of residents upon admission. A good CCRC can provide an excellent lifestyle for senior citizens. The person to whom the CCRC appeals is an adult who wants recreation and activities, wants to know that his health care costs are covered at a fairly foreseeable fixed fee, and wants daily assistance provided, if needed.

Statistics show that approximately 43% of the population aged 65 and over will spend some time in a nursing home. Most people fail to plan for this eventuality and suffer the devastating financial consequences of spending down and eventually qualifying for Medicaid. Medicaid, as we know it, is not likely to continue to exist indefinitely. It was never wise to rely on Medicaid, but now it is even more foolish. Few people can afford to pay privately for long-term care on an indefinite basis. According to a 1990 study made by Weiner and Harris, less than 3% of the elderly are covered by long term care insurance and only about 1% of nursing home expenditures are met by private insurance. An attractive alternative for providing for long-term care is the Continuing Care Retirement Community (CCRC).

CCRCs offer contracts to residents, which provide for shelter, activities and a health care system. The health care is based on a concept of a continuum of care. Under the continuum of care, the resident starts in independent living and, as his or her health declines, progresses to assisted living in many cases and, finally, to the health care unit or nursing

facility. The resident has access to health care services for life, while remaining in facilities which are familiar.

The concept of a continuing care retirement community began to develop approximately 100 years ago. CCRCs were originally church-sponsored groups, which provided lifetime care for aging seniors who had no family, in exchange for the aging senior turning his or her assets over to the organization. Since 1960, there has been a marked increase in the number of these facilities. It is estimated that in 1993 there were approximately 900 CCRCs in the United States. Over 350,000 older adults are served by these facilities. They are located in 42 states and the District of Columbia. The number increases at the rate of 15% to 20% per year. Ninety-seven percent (97%) of CCRCs are not-for-profit facilities. The national organization for not-for-profit CCRCs is the American Association of Homes and Services for the Aging (AAHSA). There is also a certification organization known as the Continuing Care Accreditation Commission (CCAC), which ensures that accredited CCRCs achieve high standards. According to David Scruggs, Director, Continuing Care Retirement Communities for AAHSA, most people enter CCRCs between the ages of 72 and 78. The norm is 76 years of age. According to AAAH/Ernst and Young Data Base 77% of residents of CCRCs are women, and the average annual turnover is 11.7%.

It is important to determine if the not-for-profit facility is an AAHSA member. It is also worthwhile looking to see if the facility is CCAC accredited. Accreditation is very expensive, and some fine facilities elect not to become accredited. However, the accreditation guarantees that those who are accredited meet rigid standards.

Participation in the Medicare and Medicaid programs is a significant consideration, because these programs can have a great effect on operating costs and fee structures.

However, not all facilities are Medicaid and Medicare certified. Prior to signing the residence and care agreement, the resident should inquire as to these certifications.

Each CCRC has its own personality, which reflects the mission and philosophy of the sponsor. Facilities are located throughout the United States in urban, suburban and rural areas. Facilities range from high-rise, mid-rise, low-rise or garden style. Living units are sometimes apartments, cottages, townhouses or single family homes. Amenities, such as dining rooms and swimming pools, vary from community to community. Typical amenities include: meals; maintenance; housekeeping; social, physical, religious, recreational, cultural and activity programs; scheduled transportation; bed and bath linens; security systems; and, social services and counseling.

For classification as a CCRC, a facility must offer independent living and health care, and the Residence and Care Agreement (Agreement) must cover more than one year.

### **Continuum of Care**

In independent living, residents live in independent living units, and are independent in their daily activities. Certain convenience services are usually available, such as meals, housekeeping and laundry. Health services are also available. Emergency systems and wellness programs are common.

The assisted living units are usually located separately, but on the grounds of the facility. Services in assisted living include helping a resident with the activities of daily living. The activities of daily living are eating, dressing, bathing, transferring, toileting or taking self-administered medications (ADLs). When a person needs assistance with the activities of daily living, he will usually be transferred from independent living to assisted living.

The final level in the continuum of care is nursing care. Both short-term and long-term nursing care, such as rehabilitative and round-the-clock nursing services, are usually available in facilities located on the grounds of the CCRC. These are for residents who need 24-hour per day monitoring and assistance, which must be provided under the supervision of nurses. At that point, the resident must transfer from assisted living to the nursing facility. Usually, these residents are at least 80 years of age, cognitively impaired, and in need of assistance with at least three ADLs. There are some specialized units, such as those which care for persons with Alzheimer's Disease.

### **Admission**

Types of Agreements. There are three common types of payment methods for health care coverage in CCRC agreements.

An "**extensive agreement**" includes housing, residential services and amenities. The feature which distinguishes an extensive agreement is that the facility offers unlimited specific health-related services, at little or no increase in payment. This allows a resident to budget for future health care expenditures. The only additional costs, usually, are for additional meals and limited miscellaneous medical supplies. Until 1984, this was usually the only type of contract available.

The next variation of continuing care agreement is the "**modified agreement**". This includes the same housing and residential amenities. The distinguishing feature of these agreements is that the facility offers only a specific amount of long-term care, without substantial increase in payment. For example, a resident may receive 30, 60 or 90 days of nursing care without an increased charge. Thereafter, the resident would pay the standard daily rate, or a discounted daily rate, for all nursing care.

The final variation of CCRC agreements is a "**fee for service agreement**". This includes the same housing, residential services and amenities. However, under these agreements the resident pays for all health-related services as they are needed. Fee for service contracts usually result in lower entrance and monthly fees, but shift the risk of long-term care back to the resident.

A study of 51 CCRCs by AAHSA showed that 77% offered extensive agreements, 10% modified agreements, and 13% fee for service agreements.

Fees. There are three sources of income for the facility. They are entry fees, monthly fees and ownership fees.

Entry Fees. Entry fees are a one-time, up-front fee paid by the resident for the privilege of occupying a living unit. Entry fees sometimes cover health care services. Entry fees vary based on the type of living unit selected and the arrangement for services and care. The entry fee may or may not be refundable.

Some entry fees are **non-refundable**. After a certain period of time, the facility keeps the fee. Other agreements provide that an entry fee is **refundable on a declining scale**. For example, an entry fee may be refundable, except that the facility retains 2% per month, for each month the resident is in independent living and 4% per month for each month the resident is in the nursing unit. Other agreements provide that an entry is **partially refundable**. These agreements specify that a certain percentage of the entry fee is refundable within certain, specified time limits. Some entry fees are **fully refundable**, but these are far more expensive. Ninety-eight percent (98%) of communities with entry fees offered some type of refund plan, and 53% offered a choice of refund plans.

Monthly Fees. Monthly fees are usually paid in advance on the first day of every month like rent, and they typically cover housing and convenience services associated with the housing. Sometimes, the fees include health care services. Increases in monthly fees are based on increased operating expenses of the facility and inflation.

Monthly Fee-Only. In this type of arrangement, there is no entry fee. The cost of the living unit and services and care are covered solely by the monthly fees. In the long run a monthly fee-only arrangement is usually more expensive than the entry fee and monthly fee combination.

Ownership or Equity. Some of the newer facilities are based on the concept of having the resident purchase a condominium or cooperative. These types of CCRC agreements involve the actual purchase of real estate. These types of facilities are fairly new and few in number. The service and health care package transactions are separate from the purchase transaction.

In ownership or equity situations, the sale and resale are usually limited to those who meet the community's entry eligibility criteria. An owner's association governs residential services and health care. Often, management firms are retained for day to day management. Services and health care packages are usually at additional cost.

Entry Requirements. Most CCRCs require proof of financial ability to meet anticipated costs, certain underlying insurance, minimum health requirements and Advanced Directives and Durable Powers of Attorney.

Financial. The resident must show sufficient financial resources to cover the entry fee, and monthly fees and expenses at the then current level, together with sufficient funds for future increases. Detailed financial disclosure is often required. Many of the not-for-profit

CCRCs provide financial assistance to those who run out of money. Applications are screened carefully to minimize this risk. CCRCs with extensive and modified agreements have very rigorous underwriting criteria.

Health. Most CCRCs require health screening at the time of admission. The goal is for the resident to live independently for the foreseeable future. This is particularly true of communities that offer extensive and modified agreements. The facility may require the applicant's health records and may also require a physical administered by a physician selected by the CCRC. Potential residents with frailties or older than 80, may be denied admission. Certain pre-existing medical conditions may be excluded from the health care coverage.

Religion. Some sponsors limit admission to co-religionists, and others grant preferential treatment to those applications.

Insurance. Many CCRCs require that the resident have Medicare Part A and Part B coverage. The CCRC will usually require Medi-gap insurance. Some CCRCs insist on long-term care insurance. Documents. CCRCs often suggest that resident have Living Wills and Durable Powers of Attorney. Some even require a Will disposing of the personal property of the resident.

### **The Sponsor**

Sponsorship. Most CCRCs are not-for-profit and are associated with churches, fraternal organizations or other charitable organizations. The sponsor may have financial responsibility for the CCRC. It is also important to know the philosophy of the sponsoring organization, because this will be reflected in the operation of the facility.

Care for Life. In some instances, the resident outlives his resources. Not-for-profit organizations are more likely to continue to provide care in this situation. This is because some of the shortfall is covered by the sponsoring organization, or by charitable gifts, or by special resident funds. Conversely, many for-profit organizations are not able to continue to provide services to a person who is no longer in a position to make regular payment.

Financial Condition. One of the critical points to consider is the financial condition of the CCRC. What will happen to the resident if the facility goes bankrupt? CCRCs are service-intensive businesses where a large portion of expenses go to salaries. They are highly sensitive to inflation. Fees must be constantly adjusted to keep pace. Again, a strong sponsor who is committed to the CCRC will take steps to ensure that the facility continues to function.

### **Tax Considerations**

Refundable Entry Fee. If the facility offers a refundable entry fee, it is possible that, under I.R.C. §7872, the entry fee may be considered a below market interest rate loan. In such cases, imputed interest would be charged to the resident. The IRS would expect payment of taxes by the resident on this imputed interest. Amounts under \$158,100 in 2005 and amounts which are refundable within short periods of time (i.e., six months) are usually exempt. If the refundable entry fee is treated as an interest-free loan, there would be no medical deduction on the portion of the entry fee attributable to long-term medical care. Rev. Rul. 93-72. Some facilities send the residents a 1099 Form showing the imputed interest for the tax year.

Medical Expense Tax Deduction. Usually, a portion of the CCRC entry fee and a portion of the monthly fee are tax deductible medical expenses. IRS Ruling 76-481. The

deductible amount should be calculated annually by the facility management and provided to the resident.

Regulation. The **federal government** does not regulate CCRCs, except for the nursing homes. The federal regulation of nursing homes in CCRCs, is the same as those for nursing homes in general. In 35 states, CCRCs are regulated by **state government**. Typically, this is by the Department of Insurance, since the CCRC provides insurance-like coverage. Most states license assisted living facilities also known as residential health care facilities. Assisted living facilities located within the CCRCs are subject to the same licensing requirement as those outside of CCRCs.

In determining if a facility is subject to regulation most states use a four-pronged test:

1. Independent housing or services for the elderly.
2. A promise of future nursing or assisted living services, in and for as long as needed.
3. An agreement for more than one year.
4. Payment of an entry fee, as well as monthly or periodic fees.

Therefore, those facilities offering only fee-for-service contracts are exempt from regulation. Regulation usually consists of required disclosure. State review focuses only on the completeness of the disclosure, rather than it's content. Except for California, states do not make a real effort to determine the financial soundness of a CCRC. Some states do impose reserve requirements related to costs, expenses, resident deposits and/or refund obligations.

Typical state regulation requires:

1. Full disclosure of the facility's financial standing.

2. Full disclosure of the contractual obligations and ownership of the facilities.
3. Full disclosure of the rights of residents in the facility, and the cost to the residents of residing in the facility.
4. Minimum standards concerning financial status of facilities to ensure their financial solvency.
5. Each facility must obtain a Certificate of Authority prior to offering continuing care services.

Many states require certain disclosures in the continuing care contract. These usually include:

1. Services provided to the residents.
2. Description of the rights of the residents to continue residing at the facility under various circumstances.
3. Procedures for cancellation of the agreement.

In many states, liquid reserves in an amount equal to or greater of the total of all principal and interest payments due during the next twelve months, or 15% of the projected annual operating expenses must be established. Some states require that liquid reserves be maintained in an escrow account, and that a portion of all entry fees received by the facility be placed in the escrow account, not to exceed the standard above. Special rules often apply to facilities under construction.

In 1987, AAHSA developed guidelines for states in the development of state laws. Most states tend to follow these recommendations. Statutes typically contain twelve sections: definitions, registration procedures, resident contract, disclosure, refund provisions

and termination rights, escrow of entrance fees, reserve funds, regulatory agency, enforcement, advertising, residents' associations, and accreditation.

In addition to government regulation, the American Institute of Certified Public Accountants (AICPA) has issued an accounting standard requiring that all CCRCs recalculate the life expectancy and future costs of care on a resident by resident basis each year. If the present value of entrance fees and projected monthly payments for the future life care expectancy of each resident falls short of the projected costs of providing care, the CCRC would then be required to report this shortfall as a liability. Such an accounting standard is particularly important if the CCRC attempts to obtain financing. Not all CCRCs use this standard.

### **Reviewing the Agreement**

There are a number of factors which should be considered by the practitioner in reviewing CCRC agreements.

1. **Entry Fee.** What is the amount of the entry fee? Is it computed on an actuarial basis? Does the Agreement require the CCRC to render a statement as to what portion of the entry fee is tax deductible? If the entry fee is refundable, does the CCRC issue a Form 1099 to the resident showing the amount of imputed income? If not, will the facility reimburse the resident for interest, if taxes are later assessed. If the CCRC treats the entry fee as a loan, it is unlikely that a medical deduction will be allowed. See Rev. Rul. 93-72.
2. **Monthly Fees.** Is there a grace period? Are there late charges? Can the Agreement be terminated for failure to pay a monthly payment?

What is the specific basis for increases in the monthly fees of the future? Are there caps on any increases? How much notice of planned increases is required? Is there a credit for unused services while a resident is away from the facility.

3. Living accommodations and community facility services. The unit should be specified clearly, household improvements should be identified, provision should be made for lease-hold improvements by the resident. Community services and facilities should be identified. These should include meal service, guest policies, housekeeping services, recreational activities and transportation services. Whether or not individual services can be accepted or declined should be clear. Extra services not included in the basic fee should be specified.
4. Health care related services for independently living residents. What type of emergency response system is available? Will the CCRC check the unit, if a resident misses a certain number of meals? What non-emergency health care services are available on the campus and at what cost?
5. Nursing and assisted living services. The Agreement should specify the scope of services provided. What happens if the resident develops a condition which cannot be met by the CCRC? What about pre-existing conditions?

The Agreement should specify where services will be provided, and what happens if there is no vacancy in that facility. What services are

covered by the entry fee and monthly fees, and what additional charges can be anticipated?

Who determines if a resident needs to be moved from independent living to assisted living or the nursing unit? The Agreement should provide that the resident, his family and personal physician will be consulted, and that the resident will have a chance to ask for an independent reconsideration to a transfer decision.

What are the criteria for determining whether a transfer is permanent or temporary? If the transfer is temporary, does the resident have the right to move back into his unit? If the transfer is permanent, does the spouse have the option to move to a smaller unit and receive the appropriate financial adjustment.

6. Changes in the resident's household. Suppose there is a change in the resident's household due to death or divorce. If the resident wants another person to move in, and that person does not meet the criteria, what happens? Could the person move in, but not be entitled to health-related services? What are the financial ramifications?

7. Termination and refund. What is the rescission period for the Agreement? Under what circumstances after rescission is the entry fee refundable?

Under what circumstances can the CCRC terminate the Agreement? What happens if the resident is unable to continue payment?

Is death of the resident a refundable termination event? What does the contract provide for a resident who dies after moving in?

8. Resident default. Non-profit CCRCs are anxious to retain their tax exempt charitable organization status under I.R.C. §501(c)(3). If they provide housing, health care and financial security, they will meet this test. The CCRC will be deemed to meet the need for financial security, if it has a policy permitting residents to remain at the CCRC after the resident runs out of money, so long as that is economically feasible for the CCRC. Rev. Rul. 72-124. Therefore, most non-profit CCRCs subsidize residents who run out of money, although there may not be any such provision in the agreement.
9. Resident rights and obligations. If the resident is purchasing an interest in a condominium or co-operative, he will have rights in real estate. Landlord/tenant laws do not apply. Onderdonk v. Presbyterian Homes, 171 N.J. Super. 529, 410 F2d 252 (1979). The resident is not a secured creditor of the CCRC in the event of bankruptcy.

CCRC residents like to have some voice in their community. Under typical regulations, the residents are permitted to form advisory groups.

What insurance coverage is required? Is the resident required, at any point, to apply for Medicaid or SSI?

Is the resident required to have a Power of Attorney and/or a Living Will?

Is there a Resident's Handbook setting up policies in the CCRC for such things as visitor parking, dress codes in the dining room, etc.? If so, this should be reviewed prior to signing the Agreement.

Financial Condition. The person entering the CCRC has often sold his home for purposes of obtaining the entry fee, and is not in a position to recoup any losses, if he makes a mistake. According to the Government Accounting Office, between 1980 and 1990, tax-exempt bond issues for CCRCs had a default rate of 20%, as compared to 1% for all other bond issues. The causes of the failures are:

1. New projects and development with inadequate pre-sales.
2. Poor or inexperienced management.
3. Poor financial planning.
4. Fraud.

Surprisingly, few failures have been attributed to the CCRC offering pre-funded health care. To ensure financial stability, the fees paid to a CCRC should include the component for future expenses, sometimes called Present Value of Future Expenses or PVFE. PVFE should be set at the present value of the cost to the CCRC to meet its future obligations to provide health care services. PVFE should be based on the following actuarial assumptions:

1. Resident mortality. This is the probability that residents will live to and beyond a certain number of years.
2. Resident morbidity. This is a projection of what long-term health care services will be required by the residents.
3. The resident's age and resident withdrawal rate. The earlier a resident enters, the more likely it is that he will not need nursing services for

some time to come. Residents who withdraw may never need such services, however, refund policies must be taken into account.

4. Economic Factors. The CCRC must project income, interest rates, inflation rates, etc. The CCRC must then allocate the PVFE between the entry fee and the monthly fee. To the extent that the fee is included in the entry fee, any mistakes are irreversible. To the extent that they are included in the monthly fee, the risk is that the monthly fee will be raised too quickly.

In evaluating the CCRCs finances, there are a number of considerations:

1. Is the sponsor honest and does it have a good track record?
2. Is the CCRC an existing, successful facility? CCRCs are considered mature when they are more than 8 years old. Has the CCRC been operating continuously since opening? The occupancy rate should be at least 90%. The annual turnover rate should not be more than 1% for each year of operation, and never more than 8%. No more than 20% of the population should use health-related services. The average number of residents per unit is no more than 1.5. The average age of residents is no more than 80.
3. Are the CCRCs finances sound? In making this determination one would normally look at the balance sheet, the income and expense sheet, and statement of changes in the financial position. However, none of these tell us much with respect to a CCRC. For example, if the facility is on a cash basis, the entry fee is recognized before the care

expense is incurred. If it is on an accrual basis, the care expenses are recognized before the entry fee is counted. The best statement is an actuarial income statement. In such a statement, revenues are composed of monthly fees, and an amortization of entry fees is made over the expected years of residency. Expenses are calculated as operating expenses and capital expenses. If the facility prepares a modified GAAP income statement, it amortizes its entry fees and establishes a health care reserve for the unamortized portion of the fees.

The Continuing Care Accreditation Committee (CCAC) uses certain financial ratios in evaluating facilities for accreditation.

1. Excess Margin Ratio. Is the facility earning income in excess of its current needs? Divide the sum of the excess of cash revenues over operating expenses and other cash outlays by total revenues. CCAC accredited facilities have a median excess margin ratio of between 2% and 4%. A negative ratio indicates no margin for error.
2. Liquidity Ratio. Divide the CCRCs liquid assets by its current liabilities. CCAC accredited facilities have a median current ratio of between 1.25% and 1.75%.
3. Capital Structure Ratio. Take the total annual principal and interest due and divide by the amount resulting from the total annual revenues, reduced by the amount of entry fees the CCRC has reserved for future

expenses and adjust to reflect gains or losses carried over from the previous year. CCAC accreditation requires 10% to 11%.

Most state regulatory authorities do not evaluate the financial soundness of CCRCs. CCRCs that use debt financing may have the debt offerings evaluated by professional debt rating services, such as Standard and Poors or Fitch Investor Service Inc. Standard and Poors looks for an occupancy level of at least 90%, and experienced management team, a credible sponsor, cash reserves equal to 50% of long-term debt, debt-to-total capital ratio of no more than 80%, and appropriate debt service charges.

CCAC also does evaluations for financial soundness as a part of its accreditation process.

ccrc.art

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3. Assisted-Living, CCRCs and Other Senior Housing With a Health Care Component, New Jersey Lawyer, by Todd D. Johnston.
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## APPENDIX

1. Continuing Care Retirement Communities: A Guide Book for the New Jersey Consumer, published by Department of Community Affairs.
2. N.J.A.C. 8:33H, Continuing Care Retirement Community Regulation and Financial Disclosure Act Regulations.

CHECKLIST FOR REVIEWING THE CCRC AGREEMENT

**SPONSOR**

1. Name of sponsor:
2. Is the sponsor affiliated with any other group? Yes \_\_\_ No \_\_\_  
If yes, name of group:
3. What is the track record of the sponsoring organization?
4. Is the sponsor not-for-profit? Yes \_\_\_ No \_\_\_
5. Is the facility a member of AAHSA? Yes \_\_\_ No \_\_\_
6. Is the facility accredited by CCAC? Yes \_\_\_ No \_\_\_
7. Has the CCRC been issued a Certificate of Authority by the New Jersey Department of Community Affairs? Yes \_\_\_ No \_\_\_
8. Is the CCRC an existing successful facility? Yes \_\_\_ No \_\_\_
9. Is the CCRC mature (i.e., more than 8 years old or at least between 3 and 9 years old)? Yes \_\_\_ No \_\_\_
10. Has the CCRC been continuously operating since opening? Yes \_\_\_ No \_\_\_
11. Is the occupancy rate at least 90%? Yes \_\_\_ No \_\_\_
12. Is the annual turnover rate 1% for each year of operation, but not more than 8% annually? Yes \_\_\_ No \_\_\_
13. Is the percentage of the population using health-related services less than 20%? Yes \_\_\_ No \_\_\_

14. Is the average number of residents per unit not more than 1.5? Yes \_\_\_ No
15. Is the average age of residents no more than 80 years? Yes \_\_\_ No
16. If the CCRC is under construction, has it met an 80% pre-sale? Yes \_\_\_ No

17. If the CCRC uses a GAAP income statement, does it amortize its entry fees and establish a health care reserve for the unamortized portion of the fees? Yes \_\_\_ No
18. Is the Excess Margin Ratio between 2% and 4%? Yes \_\_\_ No
19. Is the Liquidity Ratio between 1.25% and 1.75%? Yes \_\_\_ No
20. Is the Capital Structure Ratio around 10% or 11%? Yes \_\_\_ No
21. If the CCRC is under construction or less than 3 years old, has an actuarial study been furnished showing the actuarial assumptions? Yes \_\_\_ No
22. Has Standard and Poors rated the debt of the CCRC? Yes \_\_\_ No
- If yes, what is the rating?
23. Has Fitch Investors Service rated the debt of the CCRC? Yes \_\_\_ No
- If yes, what is the rating?
24. Has the CCRC had a 90% occupancy rate for at least one year? Yes \_\_\_ No
25. Do residents have input into management decisions? Yes \_\_\_ No
- If yes, to what extent?
26. Is the facility operated by the sponsor or by a professional manager?
- If operated by a professional manager, who is the manager?
- If operated by a professional

manager, what is the track record of that manager?

29. Has the client reviewed the rules and regulations or facility handbook? Yes \_\_\_ No
- If yes, are the terms satisfactory to the client? Yes \_\_\_ No
30. Has the client reviewed the latest inspection reports available from the facility or from DCA? Yes \_\_\_ No
31. Has the client visited with residents and asked them about the CCRC? Yes \_\_\_ No

### ENTRY FEE

32. What is the entry fee? \$
33. Is the contract:
- Extensive? Yes \_\_\_ No
- Modified? Yes \_\_\_ No
34. What percentage of the entry fee is tax deductible as a medical expense?
35. Is the entry fee refundable? Yes \_\_\_ No
36. Is it refundable on a declining basis? Yes \_\_\_ No
- If yes, what is the basis?
37. Is it partially refundable? Yes \_\_\_ No
- If so, what portion is refundable during what period of time?
38. If the entry fee is refundable, does the CCRC send the resident a Form 1099? Yes \_\_\_ No

39. If the facility does not send the client a For 1099, does the facility reimburse the resident, if a tax is later assessed? Yes \_\_\_ No

### **MONTHLY FEE**

40. What is the amount of the monthly fee currently charged? \$
41. Are monthly fees for single and double occupancy clear? Yes \_\_\_ No
42. On what day of the month are monthly fees paid?
- Is there a grace period for payment of monthly fees?
43. What are the late charges for late payment?
44. What notice is required before increase in monthly fees?

45. What have the fee increases been over the last:
- One Year?
  - Two Years?
  - Three Years?
  - Four Years?
  - Five Years?
46. What are the formulas for increasing monthly fees?
47. Are increases in monthly fees capped? Yes \_\_\_ No
- If yes, what is the cap?
48. Will the monthly service change when the resident is permanently assigned to:
- Long-term care facility? Yes \_\_\_ No  
If yes, by what formula?
  - Assisted care facility? Yes \_\_\_ No  
If so, by what formula?
49. Are credits given for unused services? Yes \_\_\_ No
- If yes, detail:

**THE UNIT AND SERVICES**

50. Does the agreement identify a specific unit? Yes \_\_\_ No
51. Are lease-hold improvements covered in the agreement? Yes \_\_\_ No
52. Are lease-hold improvements made by the resident covered in the agreement? Yes \_\_\_ No

53. What are the leasehold improvement provisions?
54. Are the services offered to residents of independent living clearly spelled out? Yes \_\_\_ No
55. What are the number of meals provided?
56. What is the guest policy?
57. What housekeeping services are provided?
58. What recreational facilities are provided?
59. What transportation services are provided?
60. What extra services are provided and what are the extra fees?
61. What type of emergency-related services are provided by the CCRC?
62. Does the CCRC check a unit, if the resident misses a certain number of meals? Yes \_\_\_ No
- If yes, how many meals?

## HEALTH SERVICES

63. Are the health-related services offered to residents in independent living clearly spelled out? Yes \_\_\_ No
- What are those services?
- What are the fees for these services?
64. Does the agreement cover the situation where the resident develops a condition which cannot be met by the CCRC? Yes \_\_\_ No

What happens?

65. Are pre-existing conditions covered in the agreement? Yes \_\_\_ No

If yes, how are they handled?

66. What happens if there is no vacancy in the nursing facility at the time it is needed by the resident?

67. How much of the monthly fee is tax deductible as a medical expense? \_\_\_\_\_%

66. Does the resident or a member of his family participate in the decision to move him to assisted living or the nursing unit? Yes \_\_\_ No

69. Does the facility have a minimum transfer policy? Yes \_\_\_ No

If yes, what is that policy?

70. If the placement in assisted living or the nursing unit is temporary, does the resident reserve the right to move back into his unit? Yes \_\_\_ No

If yes, for how long is this right reserved?

71. If nursing home placement is permanent for one spouse, can the other move to a smaller, cheaper unit? Yes \_\_\_ No

72. Are changes in the family's household covered by the agreement? Yes \_\_\_ No

73. Can a new spouse move in who does not meet the admissions criteria? Yes \_\_\_ No

74. Does the agreement cover what happens if the resident marries another resident? Yes \_\_\_ No

75. Does the agreement cover what happens if the resident marries a non-resident? Yes \_\_\_ No

**CANCELLATION**

76. Is there a rescision period for the agreement? Yes \_\_\_ No

If yes, how long is the period?

77. What are the conditions for cancellation by the resident after 30 days but prior to taking occupancy of the unit?

78. What are the conditions for cancellation for each contracted individual?

79. Can the resident terminate the agreement? Yes \_\_\_ No

If yes, what notice is required?

80. Can the CCRC terminate the agreement for Just Cause? Yes \_\_\_ No

81. Can the CCRC terminate the agreement for non-payment? Yes \_\_\_ No

82. If the agreement is terminated for Just Cause or non-payment, does the resident receive any refund? Yes \_\_\_ No

If yes, what are the terms of the refund?

83. To what extent does the sponsor cover payment?

84. Does the resident receive a refund, if he dies before occupancy? Yes \_\_\_ No

85. Does the resident receive a refund,

if he dies after occupancy? Yes \_\_\_ No

If yes, under what circumstances?

## MISCELLANEOUS

86. Does the resident purchase an interest in real estate? Yes \_\_\_ No

87. Does the agreement provide for the resident's right to form an association? Yes \_\_\_ No

88. Does the agreement provide for the resident's right to have access to financial management information? Yes \_\_\_ No

89. Does the agreement provide for formal grievance procedure? Yes \_\_\_ No

90. Is the resident required to maintain Medicare Part B coverage? Yes \_\_\_ No

91. Is the resident required to maintain Medi-gap insurance? Yes \_\_\_ No  
If yes, at what level?

92. Is the resident required to maintain long-term care insurance? Yes \_\_\_ No

If so, what are the terms?

93. Is the resident required to apply for Medicaid and SSI? Yes \_\_\_ No

94. Is the resident required to have a Power of Attorney? Yes \_\_\_ No

95. Is the resident required to have a Living Will? Yes \_\_\_ No

96. Are assisted living facilities

available?

Yes \_\_\_ No

97. Are details of assisted living services clearly spelled out? Yes \_\_\_ No
98. Financial assets that must be demonstrated in order to qualify for entry into the CCRC: \$
99. What physical conditions will qualify or disqualify a person for entry into the CCRC?
100. What was the minimum age required for admission?
101. Percentage of an entry fee is required as a deposit: \$
102. Is the payment of a refund conditional upon resale of the unit? Yes \_\_\_ No
103. Can the resident have overnight guests in the living unit? Yes \_\_\_ No
- If yes, how many of the guests are permitted to stay in the living unit?
- If no, are there other accommodations for overnight guests? Yes \_\_\_ No
104. What costs are involved, if any, for overnight guests? \$

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