Financial Analysis and Receivership Division
Special Entities Section, 1203 Mail Service Center
Raleigh, NC 27699-1203 (919)807-6178

North Carolina Department of Insurance
Continuing Care Retirement Community
Annual Disclosure Statement Filing Supplement

Submit filings or questions to:
SpecialEntitiesSubmissions@ncdoi.gov

Instructions:

Type or print your responses. Do not use pencil. If information is pre-printed, verify the information pre-printed, and correct any information that is incorrect.

Unanswered questions and blank lines will not be accepted. If no answers or entries are to made, write "None", "Not Applicable", "N/A", or "-0-" in the space provided. Do NOT leave a blank space.

If additional information, explanations, supporting statements or schedules are added or are necessary, the additions should be properly marked with a cross-reference to the item being answered.

Section I. Facility Information:

A. General Information:

Facility Name: _____ **License Number:** _____

Address 1: _____

Address 2: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____ **Toll Free Number:** _____

Year Opened: _____ **Date Licensed:** _____ **Web Page:** _____

Administrator/Executive Director:

Prefix: _____ **First Name:** _____ **Middle Name:** _____ **Last Name:** _____ **Suffix:** _____

Title: _____ **E-Mail Address:** _____

Phone Number: _____ **Extension:** _____

Facility Contact (person to whom all correspondence should be addressed):

Prefix: _____ **First Name:** _____ **Middle Name:** _____ **Last Name:** _____ **Suffix:** _____

Title: _____ **E-Mail Address:** _____

Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Extension:** _____ **Fax Number:** _____

Facility Owner:

Name: _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Management Company (if applicable):

Management Company Name: _____

B. Unit/Occupancy Analysis:

Note: The total number of licensed ACH Beds and Nursing Beds is expected to agree with the total number of licensed beds listed in the most recent version of the State Medical Facilities Plan.

Data as of (fiscal year end): _____

Independent Living Units:

	A	B	= A - B				
	Total Units	Unoccupied and Unavailable	Total ILU Available	Unoccupied but Reserved *	Number Occupied	Under Development	Number Residents
Independent Living Units:	0	0	0	0	0	0	0

** Unit(s) must be reserved under a signed contract.*

If units are unoccupied and unavailable, explain (used as storage, under renovation, guest room, etc.):

Assisted Living:

	A			B	= A - B		
	Total Beds/Units	Total Open Beds	Total Closed Beds	Unoccupied and Unavailable	Total ALU Available	Number Occupied	Number Residents
Licensed ACH Beds:							
In Licensed Nursing Home:	0	0	0	0	0	0	0
In Licensed ACH:	0	0	0	0	0	0	0
Unlicensed AL Units:	0	0	0	0	0	0	0

"Closed beds" are beds that are available only to residents of the facility, in accordance with Policy LTC, who have entered into a continuing care contract with the provider.

"Open beds" are beds that are available to either residents of the facility or to individuals of the general community.

If beds/units are unoccupied and unavailable, explain (used as storage, under renovation, in a semi-private room, etc.):

Nursing Home Beds:

	A			B	= A - B		
	Total Beds	Total Open Beds	Total Closed Beds	Unoccupied and Unavailable	Total NH Beds Available	Number Occupied	Number Residents
Licensed NH Beds:	0	0	0	0	0	0	0

"Closed beds" are beds that are available only to residents of the facility, in accordance with Policy NH-2, who have entered into a continuing care contract with the provider.

"Open beds" are beds that are available to either residents of the facility or to individuals of the general community.

If beds are unoccupied and unavailable, explain (used as storage, under renovation, in a semi-private room, etc.):

Section II. Provider Information:

A. General Information:

Provider Name: _____

Mailing Address 1: _____

Mailing Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____ **Tax ID #:** _____

Phone Number: _____ **Fax Number:** _____ **Tax Status:** _____

Entity Type: _____ **Incorporation Date:** _____ **State of Incorporation:** _____

B. Answer the Questions Below:

1. On what dates did the provider hold the semi-annual meetings required by G.S. § 58-64-40(b) with the residents of the facility named above?

   Date #1: _____ Date #2: _____

   a. Were all residents given seven (7) days advance notice of each semi-annual meeting?

   _ *If "No" attach a statement explaining why.*

   b. Were the meetings open for free discussion of subjects including, but not limited to, revenue, expenses, and financial trends and problems as they apply to the facility and discussions of proposed changes in policy, programs, and services?

   _ *If "No" attach a statement explaining why.*

2. Has the provider been a party to any merger or consolidation?

   _ *If "Yes" attach a statement describing the merger or consolidation.*

3. Has the provider had any licenses or registrations suspended or revoked by any governmental entity during the previous year?

   _ *If "Yes" attach a statement describing the suspension or revocation.*

4. Has any change been made during the previous year in the by-laws, articles of incorporation, etc. of the provider?

   _ *If "Yes" furnish herewith a certified copy of the instrument as amended.*

5. Is the provider currently in default of any financial ratio or loan agreement covenants?

   _ *If "Yes" attach a statement describing the default.*

6. Have there been any changes in the criminal violation statement as required by G.S. § 58-64-20(a)(3)(c) since the last disclosure statement was filed with the North Carolina Department of Insurance?

   _ *If "Yes" attach a statement describing the violation.*

****NEW**** 7. Does the community owe entrance fee refunds to former residents that have not been paid according to the contract, as of the fiscal year end?

   _ *If "Yes" attach a listing of all unpaid entrance fee refunds including amount due, payee, and the date first due to be paid according to the contract.*

****NEW**** 8. Does the CCRC offer a Continuing Care Services Without Lodging program? Is it Early Acceptance or Care Coordination or Both?

   Early Acceptance _

   Care Coordination _

Section III. Operating Reserve:

Pursuant to G.S. § 58-64-33, a provider shall maintain after the opening of a facility: an operating reserve equal to fifty percent (50%) of the total operating costs of the facility forecasted for the 12 month period following the period covered by the most recent disclosure statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. If a facility maintains an occupancy level in excess of ninety percent (90%), a provider shall only be required to maintain a twenty five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating reserve must be funded by cash, by invested cash, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies. Surety bonds and letters of credit approved by the Commissioner will also meet this funding requirement.

In accordance with N.C.G.S. § 58-64-33(c), operating reserves shall only be released upon the submittal of a detailed request from the provider and must be approved by the Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal. Any request for the release of an operating reserve must include a plan for the replacement of the operating reserve.

A. Operating Reserve Calculation:

Using the table below, compute the required operating reserve for the facility named above. All numbers included in the table must be able to be traced back to the five-year forecasted financial statements included in the revised disclosure statement.

Total operating expenses		
Principal payment on any long-term debt or mortgage payment	+	
Depreciation expense	-	
Amortization expense	-	
Extraordinary items as approved by the Commissioner *	-	
Debt service portion, if provided for by way of a separate reserve account **	-	
Total operating costs	=	$ 0
Occupancy Factor (see subsection C)	X	0%
OPERATING RESERVE REQUIREMENT ***	=	$ 0

*Submit a copy of the approval letter from the Commissioner.

**A provider may take a credit for debt service (principal and/or interest) if the debt service included in the operating reserve calculation is required in accordance with covenants in the provider's loan document(s) and is being held in a separate reserve account. The amount deducted must not exceed the lesser of the amount in the separate reserve account per the audited financial statement or the amount of principal and/or interest of the debt service reserve requirements that will be paid within the next forecasted fiscal year. If a credit is claimed, provide an explanation in subsection D of this section and attach proof of the requirement from the loan document(s) (i.e. copy of debt service covenant).

*** The operating reserve requirement listed on this page must match the operating reserve requirement disclosed in the facility's disclosure statement in the five-year forecasted financial statements.

B. Operating Reserve Assets:

Identify below the assets currently serving as the operating reserve for the facility named above:

	Description of Asset	Institution Holding Assets	Market Value
1.			
2.			
3.			
4.			
5.			
		Total Market Value	$ 0.00

C. Occupancy Factor:

For the purpose of the operating reserve, occupancy is calculated by dividing the sum of the total number of independent living units and assisted living units occupied by the sum of the total number of independent living units and assisted living units available. These occupancy numbers must match those reported in Section B and be for the latest fiscal year end.

1.	**Total ILU + ALU Occupied + Reserved**	0
2.	**Total ILU + ALU Available**	0
3.	**Occupancy Percentage (Line 1 divided by Line 2 times 100)**	0.0%

If the Occupancy Percentage from Line 3 above is >90% use 25% as the Occupancy Factor

If the Occupancy Percentage from Line 3 above is < or = to 90% use 50% as the Occupancy Factor

D. Explanations:

E. Provide the number of each type of contract (A=Extensive, B=Modified, C=Fee for Service, D=Ownership, E=Rental) in place on the reporting date stated in section B.

	% refunding of entrance fee:	Timing of refund (minimum/maximum):	# of contracts:
Type A:	_____	_____	_____
Type B:	_____	_____	_____
Type C:	_____	_____	_____
Type D:	_____	_____	_____
Type E:	_____	_____	_____

Section IV. Attestation:

Under the penalties of perjury, I attest that:

1. I have reviewed this filing, and to the best of my knowledge and belief it is true, correct and complete.
2. A disclosure statement has been given to each person with whom a contract for continuing care has been entered into, either at the time of, or prior to, the execution of the contract to provide continuing care, or at the time of. or prior to, the transfer of any money or other property by or on behalf of the prospective resident.
3. Disclosure Statements distributed to current/prospective residents are identical to the Disclosure Statements on file with the Commissioner of Insurance.
4. The continuing care retirement community license held by the Provider for the facility named above will not be transferred, nor will ownership of the Facility, or any part thereof, be sold or transferred, nor will the Provider enter into a contract with a third-party provider for management of Facility, without the prior approval of the Commissioner.
5. The Provider is in compliance with 11 NCAC 11H.0002 (if expanding).
6. The Provider has kept the North Carolina Department of Insurance informed of any material changes regarding the Provider and the continuing care retirement community.

I, on behalf of _____
(Provider)

hereby accept in good faith the terms and obligations of the Insurance Laws of the State of North Carolina, presently existing or enacted in the future, as a part of the consideration for a continuing care license, and that said provider has neither directly nor indirectly violated any of the provisions of the said Insurance laws and of all acts amendatory or supplementary thereto. It is understood and agreed that said license may be revoked as provided for in said laws.

I am authorized to make and sign this statement on behalf of the provider.

Date: _____ Signature: _____

Name: _____

Title: _____