NORTH CAROLINA DEPARTMENT OF INSURANCE

Financial Oversight and Special Entities Section

Disclosure Statement Handbook

Guidance for Preparing and Submitting Disclosure Statements Pursuant to N.C. Gen. Stat. § 58-64A-150

Effective April 24, 2026

Issued under the authority of the North Carolina Commissioner of Insurance

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Part I – Introduction

Continuing care providers operating in North Carolina are required to prepare, maintain, and deliver Disclosure Statements that comply with Article 64A of Chapter 58 of the North Carolina General Statutes ("Article 64A"). These requirements are a central component of North Carolina's regulatory framework for continuing care retirement communities and are intended to ensure accurate and complete disclosure of material information to prospective and existing residents.

A Disclosure Statement is a formal regulatory filing, not a marketing document. It represents the provider's official disclosures regarding its organizational structure, governance, financial condition, contractual obligations, and resident protections. Providers are responsible for ensuring that disclosures are accurate in all material respects, internally consistent, and supported by underlying records and financial statements.

Article 64A requires that Disclosure Statements be filed with the North Carolina Department of Insurance ("Department") and made publicly available through posting on the Department's website. As a result, Disclosure Statements are subject to applicable Federal and State digital accessibility requirements governing public-facing content posted by State agencies, including requirements under Title II of the Americans with Disabilities Act and North Carolina's Digital Accessibility and Usability Standard. While Article 64A does not impose an independent accessibility mandate on providers, the statutory requirement that Disclosure Statements be filed with the Department and posted for public access necessarily implicates these accessibility standards, because the Department is required by law to post such materials on its website.

Recent statutory changes have expanded disclosure requirements and increased expectations for clarity and consistency. In combination with applicable Federal and State accessibility requirements, these developments have prompted the need for updated formatting, organization, and presentation standards to ensure that Disclosure Statements can be posted by the Department in an accessible format and meaningfully used by residents, prospective residents, and other users, including individuals who rely on assistive technologies.

In furtherance of these objectives, the Commissioner has determined that Disclosure Statements should follow a standardized structure. Standardization promotes accessibility by enabling predictable organization, consistent navigation, and compatibility with assistive technologies. It also enhances transparency and regulatory oversight by ensuring that required disclosures appear in consistent locations and formats across provider filings. Standardization applies to the organization and presentation of required disclosures, not to the substantive content of a provider's operations, financial arrangements, or contractual terms.

Purpose of Handbook

The purpose of this Handbook is to assist continuing care providers in the preparation of Disclosure Statements that comply with the requirements of Article 64A and with applicable formatting, accessibility, delivery, and revision standards.

In furtherance of the Commissioner's decision to require standardized Disclosure Statements, this Handbook is designed to guide providers on the required content, organization, format, and overall presentation of Disclosure Statements submitted to the Department and delivered to prospective residents. The Handbook is intended to promote consistency, clarity, and completeness across provider filings and to support meaningful, informed review by residents and prospective residents.

By establishing a standardized structure and clear disclosure expectations, this Handbook reinforces the Disclosure Statement's role as the primary transparency and accountability mechanism under Article 64A. A well-prepared Disclosure Statement protects residents and prospective residents by ensuring full and fair disclosure of a provider's governance, operations, financial condition, and resident protections, and supports effective regulatory oversight by the Department.

This Handbook is issued as regulatory guidance. It does not replace or supersede statutory requirements, administrative rules, or formal Department orders. Providers remain responsible for ensuring that Disclosure Statements are accurate, complete, and compliant with all applicable laws and regulations.

This Handbook interprets and operationalizes the disclosure requirements set forth in Article 64A but does not impose substantive obligations beyond those required by statute or applicable law.

Illustrative Example Disclosure Statement

The Department has issued a separate Illustrative Example Disclosure Statement as a companion document to this Handbook. The Illustrative Example Disclosure Statement is provided for illustrative purposes and demonstrates one way in which a Disclosure Statement may be organized and formatted to comply with Article 64A and this Handbook.

The Illustrative Example Disclosure Statement may be used as a reference or starting point; however, it is not a template, does not establish requirements beyond those set forth in Article 64A or this Handbook, and does not ensure compliance. Each provider remains solely responsible for preparing a Disclosure Statement that accurately reflects its own operations, contracts, governance, and financial condition, complies with all applicable statutory and regulatory requirements, and conforms to the mandatory structure, section headers, section sequencing, appendix organization, and accessibility standards prescribed in this Handbook.

Authority

This Handbook is issued under the Commissioner's authority in Article 64A. Under § 58-64A-150(h), the Commissioner may prescribe a standardized format for Disclosure Statements.

Applicability

Who: All continuing care providers doing business in North Carolina.

Compliance Date: The requirements set forth in this Handbook apply to all Disclosure Statements filed on or after April 24, 2026, aligned with statewide digital accessibility requirements.

Why Disclosure Statements Matter

A Disclosure Statement is both a regulatory filing and a consumer-protection document. Accurate, complete disclosure:

1. Empowers residents and prospective residents to make informed decisions.
2. Supports the Department's review of provider solvency, governance, and statutory compliance.
3. Advances public accountability through posting on the Department's website.
4. Promotes confidence and trust among residents, providers, and the Department by establishing a shared, reliable information baseline.

Failure to prepare, file, or deliver a Disclosure Statement in accordance with Article 64A and this Handbook may subject a provider to regulatory action by the Department.

Overview & Timing

Every continuing care provider doing business in North Carolina must prepare a Disclosure Statement annually and whenever revisions are required under Article 64A.

Article 64A became effective on December 1, 2025. Beginning on that date, all Disclosure Statements filed with the Department must include any new or revised content required by Article 64A, including additional financial, governance, and ratio disclosures.

The Department selected April 24, 2026 as the compliance date to coincide with the Federal ADA Title II web-accessibility compliance deadline and North Carolina's Digital Accessibility and Usability Standard, ensuring consistency across State and Federal requirements.

Any Disclosure Statement filed on or before April 23, 2026, may continue to follow the provider's previous formatting conventions, provided it incorporates all new statutory content required by Article 64A.

Beginning April 24, 2026, every Disclosure Statement must fully comply with:

- The content requirements of Article 64A; and

- The formatting, accessibility, delivery, and revision standards set forth in this Handbook.

Providers are strongly encouraged to begin applying these standards after December 1, 2025, so that their next annual Disclosure Statement cycle is fully compliant by April 24, 2026.

General Principles

Disclosure Statements must communicate clearly, accurately, and completely to residents, prospective residents, and the Department. They are legal and regulatory filings, not marketing materials, and must present information objectively and without promotional language. The goal is full, fair, and comprehensible disclosure, not persuasion.

When preparing a Disclosure Statement, providers should:

- Use plain, accurate language that conveys information clearly.
- Ensure all information is correct in every material respect and filed on time.
- Avoid jargon, unnecessary complexity, and excessive length.
- Provide narrative explanations alongside financial tables or schedules.
- Exclude promotional or marketing content.
- Provide optional or promotional materials separately, outside of the Disclosure Statement.
- Strive for completeness without unnecessary expansion.

Omission or misstatement of a material fact may constitute a violation of Article 64A. The Department may require corrections if a Disclosure Statement is incomplete, inaccurate, misleading, or inaccessible. Accordingly, a Disclosure Statement should be viewed not merely as a compliance obligation, but as a core regulatory document central to resident protection and the integrity of North Carolina's continuing care framework.

How to Use This Handbook

Providers should use this Handbook as follows:

1. Begin with Part II for formatting, file naming, accessibility, and submission requirements.
2. Use Part III for required section-by-section disclosure content.
3. Follow Part IV for delivery and revision requirements.
4. Refer to Appendices A–C for the statutory crosswalk, sample acknowledgment of receipt, and Provider/Community ID directory.
5. Refer to the Illustrative Example Disclosure Statement, issued as a separate companion document, for an illustrative example of a completed Disclosure Statement prepared in accordance with this Handbook.

Together, the Handbook, statutory crosswalk, and Illustrative Example Disclosure Statement are intended to help providers prepare filings that are complete, consistent, accessible, and usable by all residents, including individuals who rely on assistive technologies.

Part II – Formatting, Accessibility & Submission Mechanics

This Part sets the mandatory formatting, structural, and accessibility standards for Disclosure Statements and describes the steps required to produce a compliant, tagged PDF for filing with the Department and posting on the Department's website.

Use of the Illustrative Example Disclosure Statement

The Department has issued an Illustrative Example Disclosure Statement as a companion document to this Handbook. The Illustrative Example Disclosure Statement demonstrates the required structure, section order, section titles, and appendix organization for Disclosure Statements prepared under Article 64A.

While the Illustrative Example Disclosure Statement is illustrative and does not prescribe a single visual layout or narrative style, providers must organize their Disclosure Statements in a manner consistent with this Handbook and the Illustrative Example Disclosure Statement, including:

- Use of the same section numbering and section headers set forth in Part III of this Handbook;
- Presentation of disclosures in the same section sequence; and
- Use of consistent appendix labels and ordering.

Providers may vary page layout, table design, and narrative presentation, provided that the Disclosure Statement:

- Includes all disclosures required by Article 64A;
- Follows the required structure, section headers, and organization prescribed in this Handbook;
- Complies with the formatting, accessibility, and electronic filing standards set forth in this Part; and
- Is accurate, internally consistent, and free from misleading or promotional content.

A Disclosure Statement that departs from the required structure or section headers, even if all substantive information is present, may be deemed noncompliant and subject to correction.

Each required disclosure must appear in the section designated in this Handbook. Cross-referencing or relocation of required content to other sections is not a substitute for compliance.

Providers must follow the section sequence, section titles, and appendix structure set forth in Part III of this Handbook. This structural consistency is required to ensure standardized review, accessibility, and public posting. Providers may vary narrative content and formatting within sections, but may not reorder, omit, or rename required sections.

A. Standard Page and Text Settings

(Applies to the entire Disclosure Statement)

1. Page Setup

- Margins: 1" on all sides
- Orientation: Portrait (landscape permitted only for wide tables)
- Body font: Aptos, 12 pt
- Line spacing: Single
- Paragraph spacing: 0 points before / 6 points after
- Spacing rule: Do not insert blank paragraphs for spacing; use paragraph spacing setting instead

2. Core Styles

(use built-in Microsoft Word styles)

Element	Font	Size	Paragraph	Notes
Body text	Aptos	12 pt	Single; 0 pt before /6 pt after	No manual blank lines
Heading 1 (title -cover page)	Aptos Bold	28 pt	Single; 24/12 pt	Outline level 1
Heading 2 (section)	Aptos Bold	16-18 pt	Single; Keep with next; 18/12 pt	Outline level 2
Heading 3 (sub-section)	Aptos Bold	14 pt	Single; Keep with next; 12/6 pt	Outline level 3
Heading 4 (sub-sub section	Aptos Bold	12 pt	Single; Keep with next; 6/6 pt	Outline level 4
Bulleted/numbered lists	Aptos	12 pt	Single; Hanging indent 0.25"; +0.25" per level; 0/6 pt	Use Word list tools
Table header	Aptos Bold	12 pt	—	Mark as Header Row; repeat on each page
Table body	Aptos	11-12 pt	6/6 pt	Use DS-Table style (below)

3. Color Use

- Text and headings must meet WCAG 2.1 AA contrast (minimum 4.5:1 for normal text)
- Navy or dark blue may be used for headings
- Low-contrast colors (e.g., gold) may be used for rules, dividers, or shading—not for text

- Color must never be the sole means of conveying meaning

4. Table of Contents

- Place the Table of Contents immediately after the Financial Snapshot page
- Generate the Table of Contents from Heading 2 style (References → Table of Contents), not typed text

5. Headings, Numbering & Cross-References

- Apply Heading 2 to each required Disclosure Statement section title, using the exact section titles prescribed in Part III of this Handbook
- Use multilevel automatic numbering linked to heading levels; do not type section numbers manually
- Use live cross-references instead of typed references (Insert → Link → Cross-reference)

6. Lists

- Use Microsoft Word's Bullets and Numbering tools
- Indents: 0.25" hanging indent for first level; add 0.25" for each sub-level
- Prefer short, parallel bullets for multi-part requirements

7. Tables

Providers must create and consistently apply a reusable table style (e.g., "DS-Table").

Header row

- Font: Aptos Bold, 12 pt
- Table Design: Header Row enabled
- Layout: Repeat Header Rows on each page
- Shading: light gray (HEX #E8E8E8)
- No merged or split cells

Body

- Font: Aptos, 11–12 pt
- Borders: 1.0 pt gray grid (HEX #D9D9D9), or the closest available standard Word table border width; optional light row banding (≤ 8% gray)
- Alignment:
    - Text: left-aligned
    - Numbers: right-aligned
    - Percents: right-aligned, no more than two decimals

Captions and Footnotes

- Caption above the table, (e.g., *Table 21.1: Current Monthly Fees (CCRC Contracts))*
- Footnotes must be 10-point font and placed directly below the table

Sizing

- Use Autofit Contents or manual column widths
- Tables must fit within page margins

8. **Images, Charts, and Icons**
    - Provide alternative text that conveys the message (e.g., “Five-year occupancy increases from 86% to 92%")
    - Mark purely decorative images as decorative so screen readers skip them.
    - Do not embed important text inside images
    - Ensure chart colors have sufficient contrast and include data labels or a companion data table
9. **Hyperlinks, Bookmarks, and Reading Order**
    - Use descriptive hyperlink text (not raw URLs)
    - When exporting a tagged PDF, headings will automatically generate bookmarks
    - Maintain logical reading order (top-to-bottom, left-to-right)
    - Avoid floating text boxes for core narrative content

B. Creating and Verifying an Accessible PDF

From Word:

1. File → Save As → PDF
2. Click Options and ensure:
    - Document structure tags for accessibility is checked
    - Create bookmarks using: Headings is checked

Then in Adobe Acrobat Pro:

1. File → Properties → Description: confirm the Title matches the required metadata format
2. Tools → Accessibility → Full Check (or equivalent) and review/fix all issues flagged

Verification

Before submission, providers must:

- Run Microsoft Word Accessibility Checker
    - Review → Check Accessibility
    - Correct headings, alt text, table headers, and reading-order issues
- After conversion, run Adobe Acrobat Pro Accessibility Check (or another recognized tool)
    - Confirm tags, bookmarks, alt text, table headers, link text, and color-contrast notes are acceptable

Quick "Do / Don't" Reference

Do

- Use Heading 1–4, the DS-Table style, and live cross-references
- Keep paragraphs short; use lists for multi-part items
- Provide alt text and mark decorative items correctly
- Right-align numbers and use units/decimals consistently
- Use navy or other dark colors for headings

Don't

- Paste screenshots of text or tables
- Merge header cells
- Type section or table numbers manually
- Rely on color alone to signal meaning
- "Print" to PDF—always export a tagged PDF

C. File Naming and Submission Standards

To ensure uniform intake, tracking, and posting on the Department's website, each Disclosure Statement must follow a consistent file-naming structure and be submitted in accessible PDF format.

1. File Naming Convention

Element	Definition / Format	Example
Provider ID	Four-digit numeric identifier assigned by the Department to each provider. See Appendix C – Provider and Community ID Directory.	0043
Community ID	Two-digit numeric identifier assigned by the Department to each community. See Appendix C.	01
DS	Abbreviation for "Disclosure Statement." Always written in uppercase.	DS
Fiscal Year End (YYYYMMDD)	Fiscal year-end date of the financial statements included in the Disclosure Statement, in YYYYMMDD format.	20251231
v[Number]	Version number if a revision is filed (e.g., v2, v3). Omit for the initial filing.	v2 (or omit)

File Name Pattern

{ProviderID}_{CommunityID}_DS_{YYYYMMDD}{_v2}.pdf

Examples

- Initial annual submission:
  0043_07_DS_20251231.pdf
- Revised submission for same fiscal year:
  0043_07_DS_20251231_v2.pdf

2. General Rules

- PDF format only; files must be generated directly from the source document (Word or other authoring tool), not scanned, to preserve accessibility and tags.
- No spaces or special characters; use only letters, numbers, and underscores.
- Versioning numbers must increment sequentially:
  - Initial annual submission: no version suffix.
  - Each subsequent revision for the same fiscal year increments sequentially: v2, v3, etc.
- Metadata Title must match the file name and include the provider name, community name, and fiscal year-end date.
- File integrity. Confirm that the file name, fiscal year-end date, and version number, if applicable, and content all match before submission.

D. Accessibility Compliance

Beginning April 24, 2026, every Disclosure Statement submitted to and posted by the Department must meet Federal and State accessibility standards.

Under Section 508 of the Rehabilitation Act (29 U.S.C. § 794d) and the Web Content Accessibility Guidelines (WCAG 2.1 AA), electronic documents must be accessible to individuals with disabilities. North Carolina's statewide IT policies incorporate these standards. (see *North Carolina Digital Accessibility and Usability Standard,* NCDIT v1.1 (Jan. 16, 2025); and U.S. Department of Justice ADA Title II Final Rule, 89 Fed. Reg. 30184 (Apr. 24, 2024)).

Beginning April 24, 2026, Disclosure Statements that do not meet accessibility standards cannot be accepted for posting by the Department.

1. Minimum Requirements

Providers must ensure that:

- The reading order follows a logical sequence throughout the document.
- Headings and bookmarks are applied consistently and accurately.

- Tables include header rows, avoid merged cells, and have a clear structure.
- All images and charts include descriptive alternative text or are marked decorative.
- Color is not the sole means of conveying information.

2. Verification

Before filing, providers must:

- Run Microsoft Word's Accessibility Checker and resolve all errors and warnings
- After conversion to PDF, verify accessibility using Adobe Acrobat Pro (or another recognized tool)
- Confirm that hyperlinks, bookmarks, tags, and metadata function properly

3. Third-Party Documents

Providers remain responsible for the accessibility of all documents incorporated into the Disclosure Statement, including:

- Audited financial statements
- Five-year prospective financial statements
- Actuarial opinions

These documents must be provided in an electronic format that is accessible, or capable of being made accessible, and must meet the standards set forth in this Handbook.

Documents that are image-only, scanned, or otherwise not capable of being converted into an accessible format may result in the Disclosure Statement filing being deemed incomplete and returned for correction.

Providers should coordinate with their auditors and actuaries to ensure that third-party reports are delivered in a format that complies with this Handbook.

4. Accessibility Pre-Submission Checklist

Before filing, providers should confirm:

☐ Logical reading order verified
☐ Headings and bookmarks applied consistently
☐ Tables include header rows and no merged cells
☐ Alt text provided or decorative set for all images and charts
☐ Color not used as the sole means of conveying information
☐ Accessibility verified in Word and PDF

Providers must retain documentation confirming accessibility verification and provide it to the Department upon request.

E. Provider and Community IDs

Provider and Community ID numbers used for file naming and labeling are listed in Appendix C – Provider and Community ID Directory.

F. Questions and Clarifications

Providers with questions regarding preparation, formatting, accessibility, or submission should contact the Department's Financial Oversight and Special Entities Division before filing or submitting a revised Disclosure Statement. Early consultation can prevent errors, delays, and corrective filings.

Part III – Required Content of Disclosure Statements

This Part describes the substantive information that every Disclosure Statement must contain, organized in accordance with the statutory requirements of G.S. § 58-64A-150.

Each section below identifies the required disclosures for a specific statutory item and provides direction on the information that must be presented to ensure complete, accurate, and consistent disclosure across providers.

All content described in this Part must be prepared and presented in accordance with the formatting, accessibility, and submission standards set forth in Part II of this Handbook.

Structure of the Disclosure Statement

Each Disclosure Statement must be organized in a standardized sequence to promote consistency, comparability, and ease of review for prospective residents and the Department.

Except as expressly noted below, all required disclosure items must appear in the order prescribed in this Part.

Required Sequence

A Disclosure Statement must be organized as follows:

1. Cover Page
2. Financial Snapshot
3. Table of Contents
4. Require Disclosure Sections
5. Appendices and Incorporated Materials, as applicable

Front-Matter Elements (Unnumbered)

The Cover Page, Financial Snapshot, and Table of Contents are required components of every Disclosure Statement but do not carry section numbers and are not part of Sections 1–39.

These front-matter elements must appear in the order listed above and must comply with the formatting and accessibility requirements set forth in Part II of this Handbook.

Required Disclosure Sections (Sections 1–39)

The numbered sections that follow correspond to the disclosure items required by G.S. § 58-64A-150.

- Each required section title must appear verbatim as prescribed in this Part.
- Section numbers and titles must be generated using Word's automatic heading and numbering tools in accordance with Part II.
- Providers may not reorder, rename, omit, or consolidate required sections.

If a particular disclosure item is not applicable to a provider, the section must still appear with a clear statement explaining why the item does not apply.

Appendices and Incorporated Materials

Appendices may be used only where expressly permitted or where necessary to include required documents such as audited financial statements, actuarial reports, or other materials incorporated by reference.

Appendices must be clearly labeled, accessible, and referenced in the appropriate disclosure section. Providers may not use appendices to avoid or obscure required disclosures within Sections 1–39.

Cover Page Requirements

Statutory Reference: § 58-64A-150(c)–(d)

Every Disclosure Statement must begin with a standardized Cover Page. The Cover Page provides essential identifying information and must appear as the first page of the Disclosure Statement.

The Cover Page is a required front-matter element and does not carry a section number.

Required Elements

The Cover Page must include all of the following:

- Name of the Continuing Care Retirement Community and the words "Disclosure Statement."
- Legal name of the Provider.
- Date of the Disclosure Statement – The date of the provider's most recent fiscal year end.
- Last Date of Permissible Delivery - No more than one year plus 160 days after the Disclosure Statement date (which is the provider's most recent fiscal year end).
- A statement that the Disclosure Statement must be delivered to a contracting party before the execution of any binding reservation agreement, continuing care contract, or continuing care at home contract.
- A statement that the Disclosure Statement has not been reviewed or approved by any government agency or representative to ensure the accuracy of the information provided.
- A statement that the Disclosure Statement has been filed with, and recorded by, the North Carolina Department of Insurance in accordance with Article 64A of Chapter 58 of the North Carolina General Statutes.
- A statement that the Disclosure Statement contains all information required by Article 64A and is correct in all material respects, and that knowingly delivering a Disclosure Statement that contains an untrue statement or omits a material fact may subject the provider to penalties under Article 64A.

Standardization Requirements

- Providers must present the Cover Page using the standardized layout illustrated in the Illustrative Example Disclosure Statement to ensure uniform presentation and accessibility.
- The Cover Page must not include marketing language, slogans, photographs, or promotional content.
- Logos may be included only if they do not interfere with readability or accessibility and do not displace required information.

Formatting and Accessibility

- The Cover Page must comply with all formatting, accessibility, and tagging requirements set forth in Part II of this Handbook.
- All required information must be presented as real text (not embedded in images) and properly tagged for accessibility.
- The document title metadata must be consistent with the information shown on the Cover Page.

Note to Providers:

- The cover page is intended to provide clear, standardized identification of the provider and community for residents, potential residents, and for posting on the Department's website.
- Provider should verify that the information on the Cover Page is consistent with licensing records, file naming conventions, and metadata before submission.

Financial Snapshot

Statutory Authority: § 58-64A-150(a)(39)

Purpose: The Financial Snapshot Page presents a concise, standardized summary of a provider's financial condition and direction. It enables residents, prospective residents, and the Department to quickly assess a provider from a financial perspective using uniform ratios and a common presentation format that promotes transparency and comparability to other North Carolina providers.

Instructions: The Financial Snapshot Page must appear immediately after the Cover Page and before the Table of Contents. The Financial Snapshot Page must follow the same structure, order, and definitions as illustrated in the Illustrative Example Disclosure Statement.

Note to Providers:

- The Financial Snapshot is often the first substantive financial information reviewed by residents, prospective residents and the Department. Accuracy, clarity, and comparability are critical.
- Providers should verify that Snapshot figures reconcile to audited financial statements and five-year prospective financial statements.
- If a required metric is not applicable, the Snapshot must clearly state "Not Applicable" or "N/A".
- The Department may require correction of the Financial Snapshot if it is incomplete, inconsistent, misleading, or not prepared in the required format.

Table of Contents

Statutory Authority: § 58-64A-150(h)

Each Disclosure Statement must include a Table of Contents immediately following the Financial Snapshot.

The Table of Contents is a required front-matter element and does not carry a section number.

Requirements

- The Table of Contents must list:
  - All front-matter elements (Cover Page, Financial Snapshot, Table of Contents); and
  - All required disclosure sections (Sections 1–39), using the standardized section titles verbatim as prescribed in this Handbook.
  - All required appendices.
- The Table of Contents must be generated automatically using Heading 1–3 styles, in accordance with Part II of this Handbook.
- Page numbers must update automatically and accurately reflect the final document.

Formatting and Accessibility

- The Table of Contents must be created using Word's built-in Table of Contents tool (References → Table of Contents).
- Manually typed tables of contents are not permitted.
- All entries must be properly tagged and accessible in the final PDF.
- The Table of Contents must generate functional bookmarks in the tagged PDF

Consistency Requirements

- Section titles and numbering in the Table of Contents must exactly match the titles and numbering used in the body of the Disclosure Statement.
- Providers may not rename, omit, consolidate, or reorder required sections in the Table of Contents.

Note to Providers:

- The Table of Contents is a primary navigation tool for residents, prospective residents and the Department.
- Providers should regenerate the Table of Contents after all edits are complete and verify that page numbers and bookmarks are accurate before submission.

Section 1 — Provider Identification

Statutory Reference: § 58-64A-150(a)(1)–(3)

Purpose: This section establishes the organizational identity of the entity offering continuing care, identifies who is legally responsible for providing continuing care, and describes the provider's ownership and control structure. This information provides the foundation for all other disclosures.

Instructions: Provide the following identifying and organizational information about the provider:

- Legal name of the provider.
- Any assumed name, trade name, or "doing business as" (DBA) name used for branding or operations, if different from the provider's legal name.
- Business address and telephone number.
- Legal entity type (e.g., nonprofit corporation, for-profit corporation, limited liability company, partnership, or trust).
- A statement identifying the entity that is legally responsible for providing continuing care to residents, if different from the entity name used for branding or operations.
- A statement disclosing whether the provider is for-profit or nonprofit, and if nonprofit, the applicable section of the Internal Revenue Code under which it is exempt from federal income tax.
- A statement disclosing whether it is current on all required tax filings.
- A statement disclosing whether the provider is privately owned or publicly owned.
- Identification of any parent organization, controlling person, or controlling entity, if applicable, and a brief description of the nature of that ownership or control.

This information must be accurate and current as of the end of the provider's fiscal year.

Note to Providers:

- Verify that the legal name matches corporate filings and the provider's license.
- Clearly identify the entity that bears legal responsibility for providing continuing care.
- If the provider is nonprofit, include the correct federal tax-exemption citation.
- Do not use marketing or trade names in place of the legal provider name.
- Ensure consistency with names and entities referenced elsewhere in the Disclosure Statement and in the audited financial statements.

Section 2 — Organizational Structure

Statutory Reference: § 58-64A-150(a)(4)–(5)

Purpose: This section explains the provider's organizational structure and the relationships among affiliated entities so that residents and prospective residents can understand how governance, financial reporting, and operational oversight may be affected.

Instructions: This section requires disclosure of the provider's organizational structure and any controlling persons or entities.

Providers must include:

- A statement indicating whether the provider is part of a multi-entity organization or affiliated system.
- If the provider is part of a multi-entity organization or affiliated system:
    - A statement indicating whether the audited financial statements are prepared on a consolidated basis with all entities included in the consolidation; or, if not consolidated, an explanation of how the financial statements are prepared.
    - A company structure chart showing the provider's relationship to parent entities, subsidiaries, affiliates, and any other entities that materially affect the provider's operations or finances.
- Identification of any controlling person or controlling entity, including the legal name and business address, and a brief description of the nature of the control.
- If the provider is not part of a multi-entity organization, a statement affirmatively indicating that fact.

Note to Providers:

- Include a clear, labeled company structure chart identifying parent, subsidiary, affiliate, and other relevant entities.
- Identify controlling persons or entities by legal name and address; generic descriptions such as "parent company" or "affiliate" are insufficient.
- Ensure that entity names, relationships, and consolidation practices are consistent with audited financial statements and filings with the Department.

Section 3 — Key Persons and Management Personnel

Statutory Reference: § 58-64A-150(a)(6)–(7)

Purpose: This section identifies the individuals responsible for governance and management of the provider and discloses information relevant to their qualifications, control, and potential conflicts of interest.

Instructions: This section requires disclosure of information regarding individuals who govern or manage the provider or who exercise control over the provider.

Providers must include:

- The name, business address, education, work experience, and length of service of:
    - All officers, directors, trustees, managers, and managing or general partners of the provider;
    - The same individuals of any controlling person; and
    - Any individual who directly or indirectly holds a ten percent (10%) or greater equity or beneficial interest and exercises control over the provider or a controlling person.
- Identification of any person responsible for day-to-day management of the continuing care retirement community, including a description of the person's role and any interest in or occupation with the provider or any controlling person.

If any person required to be named does not have a business address or uses their home address as the person's business, the provider must list the provider's business address. In no event may a personal residential address be disclosed.

For "length of service," providers must report the total time served (in years and months) with the provider or controlling person. If the individual has served multiple terms, providers may indicate the number of terms completed.

Background information

For each individual required to be disclosed above, the provider must include:

- Relevant business experience, particularly experience related to the operation or management of a continuing care retirement community;
- Identification of any professional service firm, association, trust, partnership, or corporation in which the individual holds, or which holds in the individual, a ten percent (10%) or greater interest and that currently provides or is intended to provide goods, leases, or services to the provider, including:
    - A description of the goods, leases, or services; and
    - The actual or probable cost to the provider, or a statement explaining why the cost cannot be estimated; and
- Disclosure of any matter in which the individual:
    - Has been convicted of a felony or pleaded nolo contendere to a felony charge;

- Has been held liable or enjoined by final judgment in a civil action involving fraud, embezzlement, fraudulent conversion, or misappropriation of property; or
- Is subject to a currently effective injunctive or restrictive court order, or within the past five years has had any state or federal license or permit suspended or revoked as a result of governmental action.

Note to Providers:

- Clearly distinguish governance roles from day-to-day management roles.
- Provide complete and current information for all required individuals.
- Use business addresses only; never disclose personal residential addresses.
- Ensure consistency with disclosures in Section 5 (Related Parties) and other sections of the Disclosure Statement.

Section 4 — Governing Body and Oversight

Statutory Reference: § 58-64A-150(a)(8)

Purpose: This section explains how the provider is governed, identifies the body or bodies responsible for oversight, and describes how accountability for management, finances, and resident welfare is exercised.

Instructions: This section requires a description of the governing body of the provider (typically the board of directors or trustees, or an equivalent body). Unlike Section 3, which identifies individual people, this section focuses on the governing body as an institution and its oversight role.

Providers must include:

- A description of the governing body, including its authority and primary oversight responsibilities with respect to financial condition, regulatory compliance, management performance, and resident welfare.
- An explanation of how members of the governing body are selected, including nomination, election, or appointment processes.
- A description of how the governing body oversees management and operations, including how authority is delegated, monitored, or retained.
- If the provider is subject to control by a controlling person, a description of:
    - The governing body of the controlling person; and
    - How oversight authority is allocated or shared between the provider's governing body and the governing body of the controlling person.

Note to Providers:

- Use concise, factual descriptions; do not include governance philosophy statements or promotional content.
- Ensure that descriptions are consistent with bylaws, governance documents, and management agreements.
- Where oversight authority exists at more than one organizational level, clearly describe the oversight structure and lines of accountability.

Section 5 — Related Parties

Statutory Reference: § 58-64A-150(a)(9)

Purpose: This section requires disclosure of material related-party arrangements so that residents and prospective residents can understand transactions and relationships that may affect the provider's operations, finances, or decision-making.

Instructions: This section requires disclosure of related-party arrangements regardless of whether the related party is an officer, director, manager, controlling person, or otherwise disclosed in Section 3.

Providers must include:

- Disclosure of each related party that provides or will provide (in the case of a continuing care retirement community under development) goods, leases, or services to the provider having an aggregate value of $5,000 or more within any fiscal year, whether directly or indirectly.
- A description of the goods, leases, or services provided and the actual or probable cost to the provider.
- If the cost cannot presently be estimated, a statement to that effect and an explanation of why the cost cannot be estimated.

For purposes of this section, a related party includes any person or entity that, directly or indirectly, has common ownership, common control, shared management, significant influence, or other affiliation with the provider, including entities owned, controlled, or significantly influenced by officers, directors, trustees, managers, controlling persons, or their immediate family members.

Cross-Reference: If a management company is an independent, unaffiliated third party, it must be disclosed under Section 10 – Third-Party Management. Management companies that are related parties must be disclosed in this section.

Note to Providers:

- Do not omit relationships simply because they are longstanding, customary, or viewed as low-risk.
- Aggregation applies to all transactions with the same related party within a fiscal year.
- Disclosure must be substantive. Naming the related party alone is insufficient; the nature and value of the goods, leases, or services must be clearly described.

Section 6 — Relationships with Religious, Charitable, or Other Organizations

Statutory Reference: § 58-64A-150(a)(10)

Purpose: This section discloses relationships with external religious, charitable, or other organizations that may influence the provider's governance, operations, or financial condition.

Instructions: Providers must disclose whether they have a relationship with any religious, charitable, or other organization or person that materially affects, or has the ability to affect, the provider's governance, operations, or financial support, and describe the nature and extent of that relationship.

The purpose of this disclosure is to ensure that prospective residents, current residents, and other users understand whether the provider is connected to an outside organization in a manner that could influence decision-making, accountability, or financial stability. Such relationships may present both benefits (such as financial backing, access to charitable resources, or reputational support) and risks (such as external control, competing obligations, or reliance on another entity's financial condition).

Examples of relationships that must be disclosed include:

- A sponsoring religious denomination or faith community.
- A charitable foundation that provides regular grants or endowment support, or financial guarantees.
- A parent nonprofit corporation that governs or oversees the provider.
- An affiliated educational institution (such as a university or seminary).
- Any other organization that has authority to appoint or approve governing body members, exercise control, or provide material financial support.

Providers must state whether any board members or governing body members are appointed, approved, or otherwise influenced by an external organization and explain how this affects the provider's governance.

Membership in professional or trade associations (such as LeadingAge NC or LeadingAge) is not required to be disclosed unless the association exercises governance authority or provides direct financial or operational support.

Note to Providers:

This disclosure should be substantive, not ceremonial. Naming an external organization without describing its actual role is insufficient. Providers must clearly state whether the relationship is symbolic only (e.g., historical or mission-based with no governance or financial role) or substantive (e.g., authority over governance, funding, or operations).

Section 7 — Other Persons Responsible for Obligations

Statutory Reference: § 58-64A-150(a)(11)

Purpose: This section discloses whether any person or entity other than the provider is responsible, directly or indirectly, for the provider's financial or contractual obligations, and the extent of that responsibility.

Instructions: Providers must disclose the name of any other person or entity (other than those already identified in earlier sections) that is responsible, in whole or in part, for the provider's financial or contractual obligations, whether such responsibility is direct, indirect, contingent, or conditional, and describe the nature and extent of that responsibility.

This requirement captures situations in which responsibility for provider obligations rests with a person or entity that is not an officer, director, trustee, manager, or controlling person. Such responsibility may arise through guarantees, indemnification agreements, support or keep-well agreements, letters of credit, or other contractual or financial arrangements.

Examples of disclosures include:

- A corporate parent or related party that guarantees repayment of debt or other obligations.
- An affiliated entity that is contractually obligated to provide financial support or assumes liabilities under specific conditions.
- An individual guarantor who has pledged assets or executed loan guarantees.

If no other person or entity outside of those already disclosed in Sections 1 through 6 is responsible, directly or indirectly, for any of the provider's financial or contractual obligations, the provider must explicitly state:

> *"No other person or entity is responsible, directly or indirectly, for the financial or contractual obligations of the provider."*

Note to Providers:

- Disclosures must identify the responsible party by legal name and describe whether the responsibility is full, partial, limited, or contingent (e.g., limited to specific obligations or triggered by specified events).
- Do not include obligated groups in this section. Obligated groups must be disclosed separately under Section 8 – Obligated Groups.
- If another entity provides guarantees or shares liability but is not part of an obligated group, it must be disclosed in this section.

Section 8 — Obligated Groups

Statutory Reference: § 58-64A-150(a)(12)

Purpose: This section discloses whether the provider's financial obligations are supported, shared, or constrained by membership in an obligated group and explains how that structure may affect the provider's financial condition and long-term stability.

Instructions: Providers must disclose whether they are, or have committed to become, members of an obligated group, including any obligated group membership that is contingent upon future financing or contractual events. If so, the provider must identify all other members of the obligated group.

An obligated group is a formal arrangement, typically established through bond covenants, loan agreements, or similar financing instruments, under which multiple entities are jointly or severally responsible for meeting specified financial obligations.

The disclosure must clearly state:

- Whether the provider is currently a member of an obligated group or has committed to become a member of an obligated group.
- The legal name of each member of the obligated group.
- The nature and scope of the group's shared financial obligations, such as joint or cross-liability for debt, guarantees, or shared covenants.
- The type of instrument creating the obligated group (e.g., master trust indenture, loan agreement, bond resolution).

If the provider is not a member of an obligated group and has not committed to become one, the Disclosure Statement must explicitly state:

"The provider is not a member of an obligated group."

Note to Providers:

- The description must be specific. Simply stating that the provider is part of an obligated group is not sufficient.
- Ensure consistency between this disclosure and audited financial statements, bond offering documents, and financing agreements.
- Do not combine obligated-group disclosures with those required in Section 7 — Other Persons Responsible for Provider Obligations. Obligated groups must be disclosed only in this section, while guarantors or other entities that share financial responsibility but are not obligated group members must be disclosed under Section 7.

Section 9 — Debt Covenants and Compliance

Statutory Reference: § 58-64A-150(a)(13)

Purpose: This section discloses whether the provider or any obligated group is subject to risks arising from noncompliance with debt covenants and explains how such risks are being addressed.

Instructions: Providers must disclose whether they, or any obligated group of which they are a member, are currently in compliance with all covenants contained in any debt agreement, including any covenant that has been breached, waived, cured, or is subject to a forbearance or cure period.

Debt covenants are legally binding promises made to lenders or bondholders and may relate to financial ratios (such as debt service coverage or days cash on hand), limits on additional borrowing, or restrictions on asset transfers. Failure to comply with these covenants may result in penalties, default provisions, or acceleration of debt repayment.

The disclosure must include:

- A statement indicating whether the provider and any obligated group are in compliance with all debt covenants as of the most recent covenant testing date.
- If any covenant is not in compliance, has been breached, or is subject to a waiver, cure, or forbearance:
- Identification of each affected covenant;
- The nature and reason for the noncompliance; and
- The steps taken or planned to restore or maintain compliance, including the existence, terms, and duration of any waiver or forbearance.

If the provider and any obligated group are fully compliant with all debt covenants, the Disclosure Statement must explicitly state:

> *"As of the most recent covenant testing date, the provider and its obligated group are in compliance with all covenants contained in debt agreements."*

If the provider and any obligated group are not subject to any debt covenants, the Disclosure Statement must explicitly state:

> *"The provider is not subject to any debt covenants."*

Note to Providers:

- Do not provide general assurances. Any breach, waiver, cure period, or forbearance must be disclosed.
- Ensure consistency with audited financial statements, bond offering documents, and continuing disclosure filings.
- If covenant compliance is dependent on assumptions or projections, that fact must be disclosed.

Section 10 — Third-Party Management Arrangements

Statutory Reference: § 58-64A-150(a)(14)

Purpose: This section discloses whether management of the continuing care retirement community is performed by an independent third party and explains the nature of that management arrangement.

Instructions: Providers must disclose whether they currently employ, or have entered into an agreement to employ, a third-party manager to operate the continuing care retirement community, including any management arrangement that will become effective upon a future or contingent event.

If a third-party manager is employed or will be employed, the disclosure must include:

- The legal name of the third-party manager.
- A description of the manager's experience in providing management services within the continuing care retirement community industry.
- A description of the scope of the manager's authority, including whether the manager has responsibility for day-to-day operations, staffing, financial management, contracting, or other operational functions.

For purposes of this disclosure, a third-party manager means an independent company or individual that is not a related party of the provider. If the manager is affiliated with the provider, a controlling person, or any related party, the arrangement must be disclosed under Section 5 — Related Parties, not in this section.

If no third-party manager is currently employed and no agreement exists to employ one, the Disclosure Statement must explicitly state:

> *"The provider does not employ a third-party manager to operate the continuing care retirement community."*

Note to Providers:

- Disclosure must describe the substance of the management arrangement, not merely identify the manager by name.
- If management authority is limited or shared with the provider's governing body, that limitation should be clearly stated.
- Do not disclose affiliated or related-party management arrangements in this section; such arrangements must be disclosed under Section 5.

Section 11 — Real Property Leases

Statutory Reference: § 58-64A-150(a)(15)

Purpose: This section discloses whether the facilities of the continuing care retirement community are owned or leased and explains how any lease arrangements may affect stability, costs, and long-term control of the community.

Instructions: Providers must disclose whether they lease, or have entered into an agreement to lease, any part of the real property of the continuing care retirement community, including any lease that will become effective upon a future or contingent event.

If the provider leases any real property, the disclosure must identify, for each lease:

- The parties to the lease.
- The original lease term.
- The remaining term of the lease, reported in years and months as of the date of the Disclosure Statement.
- Any material terms affecting cost, control, or continuity, including but not limited to:
    - Rent escalation provisions;
    - Responsibility for operating expenses, taxes, insurance, and capital expenditures;
    - Termination, renewal, or purchase options; and
    - Any provisions that materially affect the provider's ability to continue operations at the leased property.

Leasing rather than owning core facilities may materially affect the provider's long-term financial stability and the security of residents. Lease arrangements involving related parties must also be disclosed under Section 5 — Related Parties.

Examples of disclosures include:

- A nonprofit provider leasing its entire campus from an affiliated real estate entity.
- A provider leasing specific facilities (such as a healthcare center or administrative building) from an unrelated landlord.

If the provider does not lease, and has not committed to lease, any part of the real property of the continuing care retirement community, the Disclosure Statement must explicitly state:

> *"The provider does not lease any part of the real property of the continuing care retirement community."*

Note to Providers:

- Identify each lessor by legal name and disclose each lease separately, even if multiple leases exist with the same party.
- Do not omit disclosure because the lessor is a related party. Such leases must be disclosed here and cross-referenced in Section 5.
- If the provider holds renewal or purchase options, disclose whether the options are binding or discretionary.
- Lease accounting under ASC 842 does not replace or satisfy this statutory disclosure. All material lease terms must be disclosed regardless of financial statement classification.

Section 12 — Endowment Funds

Statutory Reference: § 58-64A-150(a)(16)

Purpose: This section discloses whether benevolent care or hardship assistance for residents is supported by endowment funds and explains the extent to which such funds are restricted, discretionary, or subject to conditions.

Instructions: Providers must disclose whether they maintain endowment funds or have access to endowment funds held by a related party, that are available to provide financial assistance to residents. The disclosure must describe the nature of the funds, the entity holding the funds, and any restrictions or conditions governing their use.

Endowment funds may provide important support to residents facing financial hardship. However, the availability and use of such funds may vary significantly depending on legal restrictions, donor conditions, or approval requirements.

The disclosure must include:

- Whether the provider maintains endowment funds directly or has access to endowment funds held by a related party (such as a foundation or sponsoring organization).
- The legal name of the entity holding the funds.
- The stated purpose of the funds, such as resident financial assistance, benevolent care, healthcare support, or other specified uses.
- Any material restrictions or conditions on the use of the funds, including whether distributions are legally restricted, donor-restricted, subject to external approval, or discretionary.

If the provider does not maintain endowment funds and does not have access to endowment funds through a related party, the Disclosure Statement must explicitly state:

> *"The provider does not maintain any endowment funds and does not have access to endowment funds through a related party."*

Note to Providers:

- Disclosure must distinguish between legally restricted endowment funds and discretionary assistance policies.
- Do not describe general operating reserves or unrestricted assets as "endowment funds" unless they are formally designated and restricted for resident assistance.
- If endowment funds are held by a related party (such as a religious denomination or affiliated foundation), the nature of that relationship must also be disclosed under Section 6 — Relationships with Religious, Charitable, or Other Organizations.

Section 13 — Description and Location of the Community

Statutory Reference: § 58-64A-150(a)(17)

Purpose: This section describes the physical property of the continuing care retirement community and discloses whether the community is complete, under expansion, or under development, including any material contingencies that may affect the facilities.

Instructions: Providers must disclose the name, address, and description of the physical property or properties of the continuing care retirement community, whether existing or proposed, and indicate whether each property is owned, leased, or otherwise controlled by the provider.

If the community is under development or expansion, the disclosure must also include:

- The estimated completion date or dates.
- Whether construction has begun.
- Material contingencies under which construction may be deferred or not completed, including financing, regulatory approvals, zoning or permitting requirements, or other conditions affecting delivery.

This disclosure is intended to provide prospective residents and other users with a clear understanding of the community's physical setting and the status and risks of any development activities.

The disclosure must include:

- The name of the community as marketed.
- The street address and location of each property or campus.
- A narrative description of the facilities, such as the number and type of residential units, healthcare facilities, common areas, and major amenities.
- For proposed or expanding communities, a description of construction timelines, financing status, and conditions that could delay or prevent completion.

If the provider does not own, lease, or otherwise control any property beyond what is disclosed in this section, the Disclosure Statement must explicitly state.

> *"The provider operates [Community Name] located at [address]. No other properties are owned, leased, or controlled."*

Note to Providers:

- Provide sufficient detail to describe the scope of the community without promotional language.
- Describe each campus or property separately if multiple locations exist.
- Ensure consistency with lease disclosures in Section 11 — Leases of Real Property.
- For communities under development or expansion, disclose realistic timelines and material conditions that may affect completion.

Section 14 — Living Units by Level of Care

Statutory Reference: § 58-64A-150(a)(18)

Purpose: This section discloses the number of living units by level of care and explains whether unit development is complete or planned, so readers can understand the scale and capacity of the community.

Instructions: Providers must disclose the number of living units currently constructed and available for occupancy. If the community is under development or expansion, providers must also disclose the number of living units planned to be constructed.

The disclosure must include, for each level of care:

- The number of independent living units.
- The number of assisted living units.
- The number of skilled nursing units or beds.

For each category above, providers must indicate whether the number reflects:

- Units or beds currently constructed and available, and
- Units or beds planned or under development, including any phasing of construction.

Where applicable, providers must also state whether the disclosed numbers represent licensed capacity, physical units or beds, or both, and explain any material differences.

If no living units are currently constructed, the Disclosure Statement must explicitly state:

> *"No living units are currently constructed. The provider plans to construct [X independent living units, Y assisted living units, Z skilled nursing beds] as part of the continuing care retirement community."*

Note to Providers:

- Break out living units by level of care rather than providing only a total count.
- If non-standard terminology is used (e.g., "cottages" or "villas"), also identify the corresponding level of care (independent living, assisted living, or nursing care).
- For communities under development or expansion, ensure that unit counts are consistent with prospective financial statements disclosed in Section 37 and with development disclosures in Section 13.

Section 15 — Continuing Care at Home Program

Statutory Reference: § 58-64A-150(a)(19)

Purpose: This section discloses whether the provider offers a Continuing Care at Home (CCaH) program and explains the scope, geographic reach, and operational structure of that program.

Instructions: If the provider is licensed to offer Continuing Care at Home, the Disclosure Statement must include a description of the program and the primary market area served.

Continuing Care at Home programs allow individuals to contract for continuing care services while remaining in their own homes rather than relocating to a campus. Because CCaH programs involve different contractual, operational, and actuarial considerations than campus-based continuing care, these programs must be clearly described and distinguished.

The disclosure must include:

- A description of the CCaH program, including the services covered under the CCaH contract.
- The geographic area in which the program is offered, including any contractual or operational limits on service areas.
- The number of participants currently enrolled, or, if the program is under development, the anticipated number of enrollees and any maximum enrollment limits.
- A description of the staffing and resources dedicated to the CCaH program.
- A statement explaining whether CCaH obligations are financially and actuarially integrated with, or segregated from, the provider's campus-based continuing care obligations.

If the provider is not licensed to offer a Continuing Care at Home program, the Disclosure Statement must explicitly state:

> *"The provider does not operate a continuing care at home program."*

Note to Providers:

- Ensure that CCaH disclosures are consistent with the contracts provided in Section 39.
- Do not describe traditional home health or ancillary services as CCaH unless they are licensed and marketed as such under Article 64A.
- If the provider operates both a campus and a CCaH program, clearly explain how the two programs are related, including whether they share financial resources, staff, or facilities.
- If a CCaH program is offered, ensure that the actuarial opinion required under Section 36 — Actuarial Opinion and Balance explicitly addresses the CCaH program and its impact on actuarial balance and assumptions.

Section 16 — Resident Population Served

Statutory Reference: § 58-64A-150(a)(20)

Purpose: This section helps prospective residents and other users understand the size of the current or planned resident population and provides a baseline for evaluating occupancy, growth, and financial sustainability.

Instructions: Providers must disclose the number or estimated number of residents of the continuing care retirement community who are provided services under a continuing care or continuing care at home contract. This disclosure establishes the scale of the provider's operations and allows prospective residents and other users to evaluate how many people the community currently serves or expects to serve. It also provides context for occupancy levels, financial statements, staffing resources, and projected growth.

The disclosure must include, as of the date of the Disclosure Statement:

- The number of residents under contract in independent living.
- The number of residents under contract in assisted living.
- The number of residents under contract in skilled nursing.
- If applicable, the number of participants under contract in a Continuing Care at Home program.

If the community is under development or not yet at stabilized occupancy, the provider must also disclose:

- The projected number of residents expected to be served at full occupancy, clearly identified as an estimate.

If the provider is not yet serving any residents, the Disclosure Statement must explicitly state:

> *"As of the date of this Disclosure Statement, the provider has no residents. At full occupancy, the provider anticipates serving [X] residents."*

If the provider maintains a waitlist for admission to independent living, the Disclosure Statement must disclose, as of the date of the Disclosure Statement:

- The number of individuals on the independent living waitlist.
- A brief description of whether individuals on the waitlist have executed a continuing care contract or are prospective applicants who have not yet entered into a contract.

If the provider also maintains a waitlist for other levels of care or for a Continuing Care at Home program, the Disclosure Statement must disclose the number of individuals on each such waitlist, if applicable.

If the provider requires a deposit to be placed on a waitlist, the Disclosure Statement must also disclose:

- The amount of the waitlist deposit required for independent living.

- Whether the waitlist deposit is refundable or nonrefundable.
- Whether the waitlist deposit is held in escrow or applied to a future entrance fee, if applicable.
- A brief description of the circumstances under which a waitlist deposit may be refunded, forfeited, or applied to a continuing care contract.

Waitlist disclosures are intended to provide context regarding demand for the provider's services and do not represent guaranteed admission, priority, or contractual rights unless expressly stated in a continuing care contract.

Note to Providers:

- Report residents under contract, not licensed capacity or physical bed counts.
- Ensure consistency with occupancy and utilization data disclosed in Section 17 — Occupancy Rates and unit counts disclosed in Section 14 — Number of Living Units
- If reporting projected figures for communities under development, clearly label all such figures as estimates.
- Do not include individuals on a waitlist in resident counts unless they are under an executed continuing care or continuing care at home contract.

Section 17 — Occupancy Rates

Statutory Reference: § 58-64A-150(a)(21)

Purpose: This section discloses historical occupancy trends, which are key indicators of resident demand, utilization, financial performance, and long-term viability.

Instructions: This section builds on Section 16 — Resident Population by presenting historical occupancy rates that place current resident levels in context.

Providers must disclose the 12-month average daily occupancy rate, by level of care, for the continuing care retirement community as of the provider's fiscal year-end for the past five fiscal years (or for each completed year of operation if less than five years).

Occupancy rates must be calculated using the average number of units or beds available for occupancy during the period as the denominator and must follow the same structure, labels, and presentation format illustrated in the Illustrative Example Disclosure Statement.

If the community has operated for fewer than five years, providers must disclose occupancy data for each completed year of operation.

If no occupancy data exists (for example, for a start-up community that has not yet commenced operations), the Disclosure Statement must explicitly state:

> *"The community has not yet commenced operations; therefore, no occupancy history is available."*

Note to Providers:

- Report average daily occupancy over a 12-month period, not point-in-time occupancy.
- Break out occupancy rates by independent living, assisted living, and skilled nursing only. Memory care units must be reported under assisted living.
- Percentages must be reported to one decimal place.
- Clearly disclose any material changes in unit availability during the reporting period (such as phased openings, closures, or units temporarily taken out of service).
- Ensure consistency with unit counts disclosed in Section 14 — Number of Living Units, resident counts disclosed in Section 16 — Resident Population, and prospective financial statements disclosed in Section 33.

Section 18 — Semiannual Resident Meetings

Statutory Reference: § 58-64A-150(a)(22)

Purpose: This section discloses whether the provider has complied with the statutory requirement to hold semiannual meetings with residents and to ensure participation by an independent board or other governing body member, providing transparency regarding resident engagement and governance oversight.

Instructions: Providers must disclose the dates of all semiannual resident meetings held during the previous fiscal year and provide information sufficient to verify compliance with statutory requirements governing resident meetings, including attendance by an independent board or other governing body member.

This disclosure allows prospective residents, current residents, and other users to verify compliance with Article 64A's resident-engagement requirements and to understand the provider's practices regarding communication with residents.

The disclosure must include:

- The date of each semiannual resident meeting held during the previous fiscal year.
- For each meeting, a statement indicating whether an independent board or other governing body member attended the meeting, including the name of the independent board member.
- A statement indicating whether at least two semiannual resident meetings were held during the fiscal year.
- If fewer than two meetings were held, an explanation of the reason and, if applicable, the date of the next scheduled meeting.

A brief description of general topics discussed may be included to provide context but is not required.

If the provider did not hold two semiannual resident meetings during the previous fiscal year, the Disclosure Statement must explicitly state the number of meetings held, whether an independent board or other governing body member attended any such meetings, and the reason fewer than two meetings occurred.

Note to Providers:

- List meeting dates in chronological order (most recent first).
- Disclosure is limited to verifying compliance with statutory meeting and attendance requirements; providers are not required to include meeting minutes or full attendance lists.
- The provider must identify the individual who attended as an independent board or other governing body member based on the provider's governance structure and representations made to residents and the Department.

Section 19 — Resident Property Rights

Statutory Reference: § 58-64A-150(a)(23)

Purpose: This section discloses whether residents hold any ownership or other property rights in the real property of the continuing care retirement community and explains how any such rights relate to the continuing care contract.

Instructions: Providers must describe any property rights, if any, that residents hold in the real property of the community.

If residents do not hold any ownership or property rights in the real property of the community, the Disclosure Statement must clearly state:

> *"Residents do not hold any ownership or property rights in the real estate of the community. Residency and access to services are governed solely by the continuing care contract."*

If residents do hold property rights, such as through a condominium structure, cooperative ownership, recorded life estate, or other legally recognized interest, the disclosure must explain:

- The type of property right (condominium deed, cooperative share, life estate, or other interest).
- The extent of the right, including rights to occupy, transfer, sell, or encumber the interest.
- Any material restrictions on the right, such as resale limitations, approval requirements, use restrictions, fees, or conditions imposed by the provider or governing documents.
- How the property right interacts with the continuing care contract, including whether the contract governs services, occupancy, fees, and termination regardless of the property interest.

Note to Providers:

This disclosure must be unambiguous. If residents have no property rights, state that explicitly. If residents hold limited, conditional, or indirect property-related interests, describe those interests clearly and distinguish them from full ownership. The disclosure should enable prospective residents and other users to understand the nature of their rights and limitations without referring to outside documents.

Section 20 — Services Provided Under the Contract

Statutory Reference: § 58-64A-150(a)(24)

Purpose: This section discloses the services furnished under the continuing care and continuing care at home contracts and distinguishes between services included in periodic fees and those available at additional cost, so that residents and prospective residents can understand what is guaranteed, what is optional, and under what conditions services are provided.

Instructions: Providers must describe, in clear and complete terms, the services that are or will be furnished under the continuing care and continuing care at home contracts. The disclosure must address the following:

- Health Care Services: A description of the extent to which health care is furnished, including the levels of care provided (such as assisted living, skilled nursing, or memory care), and any material conditions, eligibility criteria, or capacity limitations affecting access to those services.
- Services Included in Periodic Fees: A clear listing of the services included in the specified periodic fees (such as meals, housekeeping, transportation, and basic utilities), together with any material limitations or conditions on the availability, frequency, or scope of those services.
- Services Available at Additional Charge: A description of services that are available but billed separately (such as guest meals, expanded cable, additional housekeeping, or concierge services).
- Direct vs. Contracted Services: A statement identifying which health care and other services are provided directly by the provider, which are provided through contracts with unrelated third parties, and which (if any) are provided through related-party arrangements. Related-party service arrangements must be cross-referenced to Section 5 — Related Parties.

Where services differ materially by contract type, level of care, or program (including Continuing Care at Home), the provider must clearly identify those differences.

Providers may satisfy this requirement by cross-referencing the specific provisions of the continuing care or continuing care at home contracts that describe the services furnished, rather than restating those provisions in full. Any cross-reference must identify the exact contract section or article number where the information appears (see Section 39 — Contract Attachments). If services differ by contract type, the disclosure must identify which provisions apply to each contract type.

Note to Providers:

- Avoid generic statements such as “full range of health services.” Specify the actual services and levels of care provided.
- If services are contingent on availability, clinical appropriateness, staffing, or other conditions, those conditions must be disclosed.
- For Continuing Care at Home programs, describe the geographic area served, the services offered, and any material differences from on-campus services.

Section 21 — Resident Fees

Statutory Reference: § 58-64A-150(a)(25)

Purpose: This section discloses the nonancillary fees charged to residents and provides information necessary to evaluate affordability, stability, and historical trends in fee increases across providers and contract types.

Instructions: For purposes of disclosure, nonancillary fees are the required resident fees under the continuing care or continuing care at home contracts, as opposed to optional ancillary charges (such as guest meals, salon services, or other discretionary add-ons). Nonancillary fees include:

- Entrance Fees – the initial fee paid for admission.
- Periodic Fees – ongoing monthly or other recurring charges for services and occupancy.
- Transfer Fees – charges assessed when a resident changes units. Levels of care, or contract status.
- Resale Fees – assessments against proceeds from the resale or re-occupancy of a unit.

Providers must disclose all nonancillary fees and include the following information:

- Household composition changes: A description of fees and conditions applicable when a resident marries or otherwise increases the number of persons residing in a living unit, including admission requirements and consequences if those requirements are not met.
- Periodic fees: A description of how periodic fees may be adjusted, including the method or basis for adjustments (such as contractual formulas, cost-based increases, or discretionary board action), any limitations or caps on adjustments, and whether adjustments apply uniformly or vary by unit type, contract type, or level of care.
- Historical periodic fee increases: A five-year historical table (or all years of operation if fewer than five) showing, for each year:
    - The frequency of periodic fee increases;
    - The average percentage increase; and
    - The average dollar increase.

  If no increase occurred in a year, the table must state “no increase.”
- Entrance fees:
    - A table showing current entrance fee charges by unit type or contract type; and
- A five-year historical table (or all years of operation if fewer than five) showing the frequency, average percentage increase, and average dollar increase in entrance fees.

- Providers not yet in operation: For new communities, tables showing expected frequency, percentage, and dollar increases in both entrance and periodic fees, consistent with the five-year prospective financial statements required in Section 33.

Transfer fees and resale fees may be disclosed narratively if they are not charged on a recurring basis; however, the description must clearly explain when such fees apply and how they are calculated.

Where fee structures or increases differ materially by contract type, unit type, or level of care, the provider must disclose those differences.

Note to Providers:

- Tables must cover the most recent five fiscal years or all years of operation if fewer than five.
- Each contract type or fee structure must be shown separately where applicable.
- Provide narrative explanations for unusual, irregular, or material changes in fee trends.
- Ensure consistency with service descriptions in Section 20 — Services Provided and contract provisions disclosed in Section 39 — Contract Attachments.

Section 22 — Refundable Entrance Fee Obligations

Statutory Reference: § 58-64A-150(a)(26)

Purpose: This section discloses the provider's obligations related to refundable entrance fees and provides information necessary to evaluate the timing, security, and funding of those refund obligations.

Instructions: Providers that offer refundable entrance fee contracts must disclose the conditions under which refunds become payable and the provider's outstanding refund obligations as of the most recent fiscal year-end.

The disclosure must include:

- Conditions for refunds: A clear description of the contractual conditions that must be satisfied before all or any portion of an entrance fee becomes refundable, including any events or time periods that trigger payment of the refund.
- Refund timing standards: A statement identifying when refunds become contractually due once conditions are met, including any applicable contractual or statutory deadlines.
- Refund obligations as of fiscal year-end: A breakdown of refundable entrance fee obligations, as of the provider's most recent fiscal year-end, categorized as follows:
    - Refunds for which all contractual conditions have been satisfied but payment is not yet due under the contract.
    - Refunds currently due and payable, including an aging of amounts that are 30 days or more past due, measured from the contractual due date, by aging category (e.g., 30–59 days, 60–89 days, 90+ days past due).
    - Refunds due to residents who have vacated their independent living unit and now reside in a non-independent living unit either within or outside the community.
    - Refunds due to residents who have vacated their independent living unit, now reside in a non-independent living unit, and whose former unit has already been resold.
- Funding of refunds: A brief description of the primary sources used to satisfy refundable entrance fee obligations (such as operating cash flow, proceeds from unit resales, entrance fees from new residents, or designated reserves), and whether any funds are restricted or designated for this purpose.

If the provider does not offer refundable entrance fee contracts, the Disclosure Statement must explicitly state:

"The provider does not offer refundable entrance fee contracts."

Note to Providers:

- Refund obligations must be reported as of the provider's most recent fiscal year-end.
- Amounts disclosed must reconcile to audited financial statements and related notes.
- Providers must explain any material delays in refunds, changes in refund practices, or reliance on alternative funding sources.
- Refundable entrance fees must be disclosed using standardized tables and narrative presentation consistent with the formats illustrated in the Illustrative Example Disclosure Statement.

Section 23 — Financial Hardship Policies

Statutory Reference: § 58-64A-150(a)(27)

Purpose: This section discloses the provider's policies for residents who experience financial hardship and explains whether, and under what conditions, residents may continue to reside in the community if they are unable to pay required fees.

Instructions: Providers must disclose the circumstances under which a resident will be permitted to remain in the continuing care retirement community if the resident exhausts assets or becomes unable to meet required fees.

The disclosure must address the following:

- Policies for residents unable to pay: Whether residents are permitted to remain in the community after becoming unable to pay periodic fees, and, if so, whether continued residency is permitted indefinitely, for a limited period, or subject to relocation, transfer, or other conditions.
- Nature of the protection: A statement indicating whether any financial hardship protections are contractual rights provided under the continuing care contract or discretionary policies applied by the provider on a case-by-case basis.
- Sources of financial support: Whether the provider maintains an assistance fund, endowment fund, or other financial resources to support residents in hardship, including whether such resources are restricted or limited in amount or duration.
- Conditions and limitations: Any material qualifications, restrictions, or exceptions to hardship policies, including eligibility criteria, duration limits, requirements for asset exhaustion, or circumstances under which assistance may be denied or discontinued.

If the provider does not permit residents to remain in the community after becoming unable to pay required fees, the disclosure must explicitly state that fact.

Note to Providers:

- Avoid vague or aspirational assurances. The disclosure must clearly describe what happens if a resident can no longer pay required fees.
- If financial assistance depends on an endowment fund or outside source, describe the size of the fund (if publicly disclosed), restrictions on its use, and whether assistance is guaranteed or discretionary.
- Ensure consistency with disclosures in Section 12 — Endowment Funds and contract provisions included in Section 39 — Contract Attachments.

Section 24 — Contract Cancellation and Refund Policies

Statutory Reference: § 58-64A-150(a)(28)

Purpose: This section discloses the circumstances under which a continuing care or continuing care at home contract may be canceled and explains the associated refund rights and consequences, so that residents and prospective residents understand their rights and obligations if a contract ends.

Instructions: Providers must disclose the terms and conditions under which a continuing care or continuing care at home contract may be canceled by either the provider or the resident. The disclosure must explain the circumstances, process, and consequences of cancellation, as well as the conditions under which entrance fees or other fees are refunded in the event of cancellation or the death of the resident.

The disclosure must include:

- Provider-initiated cancellation: The circumstances under which the provider may terminate a contract (such as failure to meet health or financial requirements, nonpayment, or disruptive conduct), together with any required notice periods, cure opportunities, or procedural protections available to the resident.
- Resident-initiated cancellation: The conditions under which a resident may cancel the contract, both before and after occupancy or commencement of services, including any required notice, effective dates, or penalties.
- Refunds upon cancellation: A description of whether all or a portion of entrance fees or other fees are refundable upon cancellation, the conditions that trigger refunds, and the timing of refund payments.
- Refunds upon death: The conditions under which refunds are made if a resident dies before occupancy or after occupancy, including any differences in treatment based on contract type or timing.
- Consequences of cancellation: A description of any material consequences of cancellation beyond refunds, such as loss of priority rights, forfeiture of re-entry or transfer rights, or requirements to reapply for admission if the resident seeks to return.

Note to Providers:

- Disclosures must be consistent with the provider's contract forms included in Section 39 — Contract Attachments.
- If multiple contract types have different cancellation or refund terms, those differences must be clearly identified.
- This section should explain the rules and circumstances governing cancellation and refunds and should not duplicate the quantitative reporting of refundable entrance fee obligations required in Section 22 — Refundable Entrance Fees.

Section 25 — Re-occupancy of Units

Statutory Reference: § 58-64A-150(a)(29)

Purpose: This section discloses the circumstances under which a living unit may be made available for reassignment to another resident while the original resident is still living and explains the associated contractual and financial consequences.

Instructions: Providers must disclose the conditions under which a living unit previously occupied by a resident may be declared available for reassignment to a different or new resident, other than upon the death of the prior resident.

The disclosure must identify:

- Circumstances permitting re-occupancy, including but not limited to:
    - When a resident permanently vacates the unit, voluntarily or as a result of contract termination;
    - When a resident transfers to another level of care and the contract permits reassignment of the original unit;
    - When a resident defaults on financial obligations or otherwise materially breaches the continuing care contract.
- Determination and authority: A description of how and by whom a unit is determined to be permanently vacated or otherwise available for reassignment, including whether the determination is based on contractual criteria, clinical determinations, or provider discretion.
- Notice and timing: Whether notice is provided to the resident, the resident's representative, or the resident's estate before the unit is reassigned, and when re-occupancy may occur relative to the triggering event.
- Consequences of re-occupancy: A description of the material contractual and financial effects of re-occupancy, including whether reassignment of the unit:
    - Triggers or accelerates any refundable entrance fee obligation;
    - Affects the amount or timing of any refund;
    - Terminates or modifies the resident's continuing care contract; or
    - Eliminates any right of the resident to return to the unit.

If the provider does not permit re-occupancy of a unit prior to the resident's death, the Disclosure Statement must explicitly state that fact.

Note to Providers:

- All circumstances permitting re-occupancy must be disclosed, even if infrequent.
- The disclosure must be consistent with the provider's contract provisions included in Section 39 — Contract Attachments.
- Providers must clearly distinguish between temporary absences (such as hospital stays) and permanent vacating of a unit.

Section 26 — Resident Relocation

Statutory Reference: § 58-64A-150(a)(30)

Purpose: This section discloses the circumstances under which a resident may be required to relocate to another unit within the community and explains the process, authority, and consequences of such relocation.

Instructions: Providers must disclose the conditions or circumstances under which a resident may be required to move from the resident's current unit to another unit within the continuing care retirement community for the safety of the resident or for the good of the provider.

The disclosure must address:

- Circumstances permitting relocation, which may include:
    - When a resident's health or functional status requires transfer to a more supportive level of care;
    - When the current unit no longer meets the resident's safety or accessibility needs;
    - When construction, renovation, emergency conditions, or other operational needs require temporary or permanent relocation.
- Authority and determination: A description of who determines that relocation is required and the basis for that determination (such as clinical assessment, contractual standards, or provider operational needs).
- Notice and process: Whether advance notice is provided to the resident or the resident's representative, the timing of such notice, and whether the resident has any opportunity to participate in or review the relocation decision.
- Financial and contractual consequences: A description of any material effects of relocation, including changes in periodic fees, application of transfer fees, responsibility for moving costs, and any effect on entrance fee or refund calculations.
- Temporary vs. permanent relocation: A statement identifying whether relocation is intended to be temporary or permanent and the conditions under which a resident may return to the original unit, if applicable.

Note to Providers:

- Conditions triggering relocation must be stated clearly and specifically; vague phrases such as "as needed" are not sufficient.
- Disclosures must be consistent with the provider's contract provisions included in Section 39 — Contract Attachments.
- Providers must avoid implying unlimited discretion; relocation authority must be tied to identifiable safety, clinical, or operational criteria.

Section 27 —Admission and Continuation Standards

Statutory Reference: § 58-64A-150(a)(31)

Purpose: This section discloses the health and financial standards used to determine eligibility for admission and continued residency and explains how changes in condition may affect admission, occupancy, or continuation in the community.

Instructions: Providers must disclose the health and financial conditions that an individual must meet to be accepted as a resident and the conditions under which a resident may continue to reside in the community once admitted. The disclosure must also address the effect of any changes in health or financial condition occurring after contract execution but before initial occupancy or commencement of services.

The disclosure must include:

- Admission requirements: A description of minimum financial standards (such as income or asset requirements), health assessments, insurance requirements, and any other criteria used to determine eligibility for admission, including who applies these standards and whether any discretion or exceptions are permitted.
- Continuation requirements: The conditions under which a resident must maintain financial or health qualifications to remain in the community, including whether continuation is guaranteed once admitted or subject to ongoing standards.
- Changes in condition before occupancy: The provider's policies if a prospective resident's financial or health condition changes after signing a contract but before occupancy or commencement of services, including whether the provider may delay, deny, or cancel admission.
- Consequences of not meeting standards: A description of the material consequences if admission or continuation standards are not met, such as denial of admission, required relocation, contract termination, or conditional continuation.
- Financial effects: A statement addressing whether entrance fees, deposits, or other payments are refundable or forfeited if admission is denied or delayed due to failure to meet admission standards.

If admission or continuation in the community is guaranteed once a contract is executed or once residency begins, that fact must be stated explicitly.

Note to Providers:

- Financial criteria should be described clearly without requiring disclosure of proprietary underwriting formulas.
- Health requirements should be stated in plain language (e.g., ability to live independently, absence of certain diagnoses at entry)
- If standards differ by contract type, unit type, or level of care, each set of standards must be disclosed separately.
- Disclosures must be consistent with cancellation and refund provisions described in Section 24 — Contract Cancellation and Refund Policies.

Section 28 — Age and Insurance Requirements

Statutory Reference: § 58-64A-150(a)(32)

Purpose: This section discloses the age and insurance requirements that affect eligibility for admission and, where applicable, continued residency in the community.

Instructions: Providers must disclose any minimum or maximum age requirements and any insurance requirements applicable to admission to the continuing care retirement community. The disclosure must also identify whether such requirements apply on an ongoing basis as a condition of continued residency or access to services.

The disclosure must include:

- Age requirements: The minimum age for admission, whether any exceptions apply (such as admission of a younger spouse or companion), and whether any maximum age limits apply.
- Insurance requirements: Any insurance coverage required as a condition of admission or continued residency (such as Medicare enrollment, Medicare supplemental coverage, or long-term care insurance), including whether coverage must be maintained throughout residency.
- Application and consequences: A description of how age and insurance requirements are applied and the consequences of failing to meet or maintain such requirements, including whether noncompliance may result in denial of admission, delayed occupancy, relocation, or contract termination.
- Exceptions or waivers: Any exceptions, waivers, or special rules that apply, including whether such exceptions are contractual rights or discretionary determinations by the provider.

If the provider does not impose any age or insurance requirements for admission or continued residency, the Disclosure Statement must explicitly state:

> *"The provider does not impose age or insurance requirements for admission or continued residency."*

Note to Providers:

- Requirements must be stated clearly and without ambiguity (for example, specify the exact minimum age or required insurance type).
- Ensure consistency with admission standards disclosed in Section 27 — Health and Financial Admission / Continuation Standards and cancellation provisions disclosed in Section 24 — Contract Cancellation and Refund Policies.
- Disclosures must align with the provider's contract forms and any referenced eligibility provisions.

Section 29 — Reserve Funding and Refund Security

Statutory Reference: § 58-64A-150(a)(33)

Purpose: This section discloses the financial safeguards in place to protect residents' deposits, entrance fees, and other contractual obligations, including the security mechanisms used to ensure refunds when due and compliance with operating reserve requirements.

Instructions: Providers must disclose the provisions made to ensure that entrance fees and deposits can be refunded when due and that all other obligations under reservation agreements and continuing care contracts can be fulfilled. This disclosure must address compliance with statutory operating reserve and refund security requirements.

The disclosure must include:

- Reserves and security mechanisms: A description of any escrow accounts, trusts, reserve funds, surety bonds, letters of credit, or other mechanisms established to provide financial protection for residents, including whether such mechanisms are dedicated exclusively to resident obligations or shared with other purposes.
- Investment management: The manner in which reserve or trust funds are invested and the names and experience of the persons or entities responsible for investment decisions.
- Operating reserve calculation: A schedule showing how the operating reserve has been calculated in accordance with § 58-64A-245, reconcilable to the amount reported to the Commissioner and to audited financial statements.
- Refund security arrangements: A description of the specific mechanisms used to secure repayment of entrance fees and deposits when due, including:
    - The type of mechanism (e.g., escrow, trust, surety bond, letter of credit);
    - The counterparty or issuer;
    - The maximum amount available;
    - The events or conditions that permit access to the funds; and
    - Any approval requirements or limitations on use.
- Priority and limitations: A statement explaining whether refund security mechanisms are subject to caps, expiration dates, renewal requirements, or competing claims, and whether the mechanisms fully cover outstanding refundable entrance fee obligations.
- Use of operating reserve: A statement clarifying that the Operating Reserve is not a designated refund reserve and that use of funds counted toward the operating reserve requirement requires approval of the Commissioner.

If reserve funding or refund security does not fully meet statutory requirements, the provider must disclose the nature of the deficiency and the plan and timeline for remediation.

Note to Providers:

- Disclosures must be detailed, factual, and consistent with audited financial statements and related notes.
- Vague assurances such as "adequate reserves are maintained" are not acceptable.
- If refund security relies on a related party, that relationship must also be disclosed in Section 5 — Related Parties.
- Ensure consistency with refundable entrance fee disclosures in Section 22 — Refundable Entrance Fees.

Section 30 — Expansion and Renovation Plans

Statutory Reference: § 58-64A-150(a)(34)

Purpose: This section discloses significant planned expansions, renovations, or capital projects and explains the timing, financing, regulatory contingencies, and potential impacts on residents and the provider's financial condition.

Instructions: Providers must disclose any plans for expansion, renovation, or other significant capital projects at the continuing care retirement community.

The disclosure must include:

- Description of the project: The nature and scope of the expansion or renovation (for example, construction of new independent living units, additions to health care facilities, or major common-area upgrades).
- Timing and status: The planned or estimated start and completion dates, whether construction has begun, and any material contingencies or conditions under which the project may be delayed, modified, or deferred.
- Financing and funding: A description of how the project will be financed (such as through debt, operating funds, entrance fees, or other sources), including whether additional borrowing is required and whether the project is expected to affect resident fees or entrance fees.
- Regulatory approvals: Identification of any material regulatory approvals or authorizations required for the project (including approvals under Article 64A, certificates of need, or local permits) and whether such approvals have been obtained.
- Impact on residents: Any anticipated effects on current or future residents, including changes in services, fees, availability of units, or temporary disruptions during construction.
- Risks and contingencies: A description of material risks associated with the project, including the potential effects of delays, downsizing, or cancellation on residents and on the provider's financial condition.

If the provider has no plans for expansion or renovation, the Disclosure Statement must explicitly state:

"The provider has no current plans for expansion or renovation."

Note to Providers:

- If projects are in preliminary stages and details are not finalized, disclose that fact and provide all material information currently available.
- Disclosures must be factual and objective and should not include promotional language.
- Ensure consistency with prospective financial information disclosed in Section 33 — Prospective Financial Statements and any fee impacts disclosed in Section 21 — Resident Fees

Section 31 — Audit Opinion and Timeliness

Statutory Reference: § 58-64A-150(a)(35)

Purpose: This section discloses the timeliness and reliability of the provider's audited financial statements, including whether the audit was completed on time and whether the audit opinion was unqualified.

Instructions: Providers must disclose whether their most recent audited financial statements were prepared within 150 days of the provider's fiscal year-end and whether the audit opinion was unqualified. If either condition is not met, the provider must explain the reason and describe corrective actions.

The disclosure must include:

- Timeliness: A statement indicating whether the audited financial statements were completed within 150 days of the provider's fiscal year-end.
- Audit opinion: A statement indicating whether the audit opinion was unqualified. If the opinion was qualified, adverse, or disclaimed, the provider must identify the type of opinion issued.
- Explanation of exceptions: If the audit was not completed within 150 days or the opinion was not unqualified, a plain-language explanation of:
    - The nature and scope of the issue giving rise to the delay or modified opinion;
    - Whether the issue affects the provider's financial condition, results of operations, or disclosures; and
    - The steps being taken to correct or remediate the issue.
- Recurring matters: A statement indicating whether the delay or modified opinion is a recurring issue from prior fiscal years or a one-time occurrence, and whether the matter has been resolved.
- If the audit was completed within 150 days and the opinion was unqualified, the Disclosure Statement must explicitly confirm both facts.

Note to Providers:

- Explanations should be written in plain language and should not rely solely on technical audit terminology.
- Disclosures must align with the audit report filed with the Commissioner and any related notes.
- If the auditor included an emphasis-of-matter paragraph or going-concern disclosure, providers should consider whether additional explanation is necessary to avoid misleading readers.

Section 32 — Audited Financial Statements

Statutory Reference: § 58-64A-150(a)(36)

Purpose: This section provides audited financial statements prepared by an independent auditor so that prospective residents, current residents, and other users may review complete and reliable financial information regarding the provider before entering into or continuing a contractual relationship.

Instructions: Providers must include audited financial statements that meet the requirements of § 58-64A-200 as part of the Disclosure Statement. These financial statements form the foundation of financial transparency and must be consistent with filings made to the Commissioner.

The disclosure must include:

- Scope: Complete audited financial statements for the provider, prepared in accordance with generally accepted accounting principles (GAAP).
- Required components: At a minimum, the audited financial statements must include:
    - A balance sheet;
    - A statement of operations;
    - A statement of cash flows;
    - A statement of changes in net assets or equity; and
    - Notes to the financial statements.
- Comparative presentation: The audited financial statements must be comparative, presenting amounts for the most recent fiscal year and the immediately preceding fiscal year, except in the first year in which the provider is required to file audited financial statements.
- Consistency with regulatory filings: The audited financial statements included in the Disclosure Statement must be identical to those filed with the Commissioner under § 58-64A-200.
- Basis of presentation: A statement identifying whether the audited financial statements are prepared on a stand-alone, combined, consolidated, or obligated-group basis.
    - If the audited financial statements are prepared on a consolidated or combined basis, the disclosure must align with Section 2 — Organizational Structure and explain the entities included.
    - If the audited financial statements are prepared on an obligated-group basis, the provider must clearly state that the audit reflects the financial position and results of the obligated group rather than the provider on a stand-alone basis and must cross-reference Section 8 — Obligated Groups, which identifies the members of the obligated group and the nature of their shared financial obligations.

- Required supplemental information: Providers must include all supplemental schedules required by § 58-64A-200, as applicable, including:
    - Consolidating or combining balance sheets, statements of operations and changes in net assets or equity, and statements of cash flows;
    - A statement of operations for each continuing care retirement community operated by the provider under Article 64A; and
    - If the provider is licensed to offer continuing care at home, separate reporting of revenue and expenses attributable to the continuing care at home program.
- Material inclusions and exclusions: If the audited financial statements do not include all material assets, liabilities, revenues, or obligations associated with the continuing care retirement community, the provider must describe:
    - The nature of any material operations, assets, or obligations held outside the audited entity; and
    - Whether those items are held by related parties or affiliates.

If the audited financial statements include material activities unrelated to the continuing care retirement community, the provider must disclose that fact and explain how those activities affect the presentation of the provider's financial condition.

Note to Providers:

- Audited financial statements must be attached in full to the Disclosure Statement as Appendix A. Summaries or excerpts are not sufficient.
- All financial ratios and metrics disclosed elsewhere (see Section 35 – Key Financial Metrics) must reconcile to the audited financial statements.
- If audited financial statements are consolidated, combined, or prepared on an obligated-group basis, providers should cross-reference Section 2 — Organizational Structure, Section 5 — Related Parties, and Section 8 — Obligated Groups, as applicable, to explain the treatment.
- Accessibility requirement: Audited statements must be provided as born-accessible documents with proper table headers, logical reading order, and tagged PDFs. Scanned or image-based statements are not acceptable.

Section 33 — Five-Year Prospective Financial Statements

Statutory Reference: § 58-64A-150(a)(37)

Purpose: The purpose of this section is to ensure that prospective residents, current residents, and other users understand the provider's financial outlook, underlying assumptions, and the realism of projections. These statements allow for evaluation of whether future obligations can be met.

Instructions: Providers must include five-year prospective financial statements that are either compiled or examined by an independent certified public accountant. The prospective financial statements must cover at least five fiscal years beginning with the first fiscal year following the most recent audited financial statements. These statements may be prepared on a stand-alone basis or on a consolidated or combined basis consistent with the provider's audited financial statements.

The disclosure must include:

- Required financial statements: Prospective financial statements must include, at a minimum:
    - A prospective balance sheet;
    - A prospective statement of operations;
    - A prospective statement of cash flows; and
    - Any related notes necessary to explain the projections.
- CPA involvement: A compilation or examination report issued by an independent certified public accountant must be included and must clearly identify whether the engagement was a compilation or an examination.
- Summary of significant assumptions: A clear narrative description of the significant assumptions and accounting policies used in preparing the projections, including assumptions related to:
    - Occupancy and unit absorption;
    - Entrance fee pricing and refund assumptions;
    - Periodic fee growth;
    - Staffing levels and compensation;
    - Healthcare utilization and expense trends; and
    - Capital expenditures and financing.
- Hypothetical assumptions: If the prospective financial statements include hypothetical assumptions, the provider must:
    - Identify each hypothetical assumption; and
    - Describe any limitations on the usefulness of the projections resulting from those assumptions.
- Basis of presentation and alignment: Prospective financial statements must:

    - Use the same line items and categories as the provider's audited financial statements; and
    - Be prepared on the same basis (stand-alone, combined, consolidated, or obligated-group) as disclosed in Section 32 — Audited Financial Statements, unless a different basis is clearly explained and justified.
- Supplemental consolidating or combining information: If the prospective financial statements are prepared on a consolidated or combined basis, the provider must also include:
    - A consolidating or combining balance sheet;
    - A consolidating or combining statement of operations and changes in net assets or equity; and
    - A consolidating or combining statement of cash flows.
- Community-level information: If the provider operates more than one continuing care retirement community, the prospective financial statements must include a separate statement of operations for each community.
- Consistency with actuarial disclosures: The assumptions used in the prospective financial statements must be consistent with the assumptions used in the actuarial opinion and actuarial balance disclosure in Section 36. Any material differences must be explained.

Special requirements for communities under development: For continuing care retirement communities that are not yet in operation, the prospective financial statements must also include narrative disclosure of significant assumptions addressing:

- Long-term financing arrangements, including interest rates, repayment terms, loan covenants, and pledged collateral;
- Lease arrangements for real property, including the original term and remaining term;
- Other funding sources expected to cover start-up losses, operating deficits, or required reserves;
- Total entrance fees expected to be received at or prior to commencement of operations, including refund obligations and revenue recognition methods;
- Equity capital expected to be received;
- Costs of acquisition, construction, and development, including land, financing, and soft costs;
- Marketing, sales, and resident acquisition costs; and
- Occupancy and absorption assumptions, including the effect of any governmental subsidies or assistance programs.

Note to Providers:

- Assumptions must be explained in clear, plain language and not solely through accounting terminology.
- If prospective financial statements are consolidated or combined, the supplemental schedules must allow readers to understand the projected financial performance of the specific community.
- Projections must be internally consistent with audited financial statements, fee disclosures, occupancy disclosures, and actuarial assumptions elsewhere in the Disclosure Statement.
- Providers must ensure that all tables, schedules, and narrative disclosures included in the prospective financial statements are complete, labeled clearly, and accessible.

Section 34 — Variances from Prospective Financial Statements

Statutory Reference: § 58-64A-150(a)(38)

Purpose: The purpose of this section is to ensure that prospective residents, current residents, and other users understand whether the provider's prior prospective financial statements have been reliable and, if not, why actual performance differed. This promotes transparency and accountability in prospective financial reporting.

Instructions: Providers must include a narrative explaining any material differences between:

1. The five-year prospective financial statements included in the Disclosure Statement filed most immediately after the start of the provider's most recent fiscal year, and
2. The actual results of operations for the most recently completed fiscal year.

The disclosure must identify the specific areas where actual results differed from prospective amounts and provide a clear explanation for the variance. Materiality should be assessed based on whether a reasonable reader would consider the variance important in evaluating the provider's financial performance or outlook. For purposes of this section, prospective financial statements include both forecasts and projections, as those terms are used in professional accounting standards.

Examples of variances that must be explained include:

- Occupancy levels significantly above or below prospective assumptions.
- Entrance fee receipts or refunds that differ materially from prospective amounts.
- Operating expenses or staffing costs that exceeded or fell short of prospective assumptions.
- Debt service or financing costs that varied from prospective assumptions.

Note to Providers:

- Do not state "no variance" unless the prospective amounts and actual results are materially identical.
- Explanations should be written in plain English and avoid overly technical accounting language.
- Variance explanations must be consistent with both the audited financial statements included under Section 32 and the five-year prospective financial statements included in the Disclosure Statement filed most immediately after the start of the fiscal year being evaluated, as required by Section 33.

Section 35 — Key Financial Metrics

Statutory Reference: § 58-64A-150(a)(39)

Purpose: The purpose of this section is to ensure that prospective residents, current residents, and other users can evaluate the financial condition and trends of the provider in a standardized, comparable format.

Instructions: Providers must present a table of key financial metrics covering the past three fiscal years (including the most recent fiscal year) and the next three fiscal years. Historical ratios must be calculated using the provider's audited financial statements. Prospective ratios must be calculated using the five-year prospective financial statements included in the Disclosure Statement filed under Section 33. If the provider has been in operation for less than three years, the table must include all years of operation.

Metrics required:

- Liquidity ratios:
  - Days cash on hand ratio.
  - Cushion ratio.
- Profitability ratios:
  - Operating ratio.
  - Net operating margin ratio.
  - Adjusted net operating margin ratio.
- Capital structure ratios:
  - Debt service coverage ratio.
  - Unrestricted cash and investments to long-term debt ratio.
  - Capital expenditures as a percentage of depreciation expense ratio.

Additional requirements:

- For providers that are part of an obligated group, ratios must be shown for the provider alone and for the obligated group as a whole.
- If there is a material year-over-year change in any ratio, the provider must include a narrative explaining the reason for the change. Materiality should be assessed based on whether a reasonable reader would consider the change important in evaluating the provider's financial condition or outlook.
- Ratios must be calculated consistently with the statutory definitions in §58-64A-145.

Appendix Reference:

Statutory definitions for the financial ratios and related terms used in this section must be included as Appendix F — Statutory Ratio and Supporting Definitions. Appendix F must follow the definitions, ordering, and presentation illustrated in the Illustrative Example Disclosure Statement.

Note to Providers:

- Ratios must reconcile with audited financial statements and prospective financial statements, as applicable.
- Do not omit ratios; if a ratio is not applicable, state "not applicable" and explain why.
- Narrative explanations must be provided in plain language to aid residents' and prospective residents' understanding.
- Providers are encouraged to include brief contextual explanations that help residents and prospective residents interpret the ratios presented. For example, indicating how the provider's results compare with its historical performance, internal targets, or general industry ranges (if publicly available). The Department does not prescribe or endorse specific benchmarks, but comparative context promotes understanding and allows residents to interpret the provider's financial condition more meaningfully.

Section 36 — Actuarial Opinion and Balance

Statutory Reference: § 58-64A-150(a)(40); § 58-64A-210

Purpose: The purpose of this section is to ensure that prospective residents, current residents, and other users have access to an independent assessment of the provider's long-term ability to meet its contractual obligations, to the extent required by law or directed by the Commissioner based on the provider's contract and service model.

Applicability: The disclosure required by this section depends on whether the provider is subject to the actuarial study requirement under § 58-64A-210:

1. Providers required to file an actuarial study under § 58-64A-210(a) must include a statement of actuarial opinion and actuarial study as described below.
2. Providers exempt under § 58-64A-210(f) are not required to include an actuarial study or statement of actuarial opinion in the Disclosure Statement and must disclose that they are exempt from the actuarial study requirement.

Instructions – Providers Required to File an Actuarial Study

Providers subject to § 58-64A-210(a) must include a statement of actuarial opinion and the actuarial study prepared by a qualified actuary in accordance with accepted actuarial standards of practice. The actuarial study and statement of actuarial opinion must be attached to the Disclosure Statement as Appendix C.

The actuary must be independent of the provider, have no material financial interest in or employment relationship with the provider or its controlling persons, and meet the professional qualification standards of the American Academy of Actuaries.

Required elements include:

- Scope of review: A description of the period reviewed, the projection horizon, and the actuarial methods and assumptions applied.
- Balance determination: A statement as to whether the provider is in satisfactory actuarial balance, considering projected revenues, expenses, assets, liabilities, and resident contractual obligations.
- Key assumptions: Disclosure of material assumptions, which may include mortality, morbidity, utilization of health care services, entrance and withdrawal rates, fee increases, and investment return assumptions.
- Limitations and qualifications: Disclosure of any material limitations, uncertainties, or conditions identified by the actuary that may affect the reliability of the conclusions.

If the actuary is unable to form an opinion, or if the opinion is qualified or adverse, the actuarial opinion and actuarial study must specifically state the reasons, consistent with § 58-64A-210(b).

Instructions — Providers Exempt From the Actuarial Study Requirement

Providers exempt under § 58-64A-210(f) must disclose that they are not required to obtain an actuarial study under North Carolina law. No actuarial study or actuarial opinion is required to be attached to the Disclosure Statement for exempt providers.

Transitional Timing Considerations

Because the actuarial study requirements under § 58-64A-210 apply on a rolling, multi-year cycle and include delayed initial filing deadlines for existing and newly licensed providers, a provider required to obtain an actuarial study may not yet have a completed study at the time a Disclosure Statement is filed.

In these circumstances, the provider must clearly disclose:

1. Why the required actuarial study is not yet available (e.g., statutory timing, first-time filing deadline not yet reached); and
2. The date by which the provider is required to submit the actuarial study to the Commissioner.

A provider may not imply that no actuarial study is required if the absence of the study is solely due to statutory timing.

Required Interim Disclosure Content — Actuarial Study Pending

If a required actuarial study has not yet been prepared due to statutory timing, the Disclosure Statement must include an interim narrative disclosure addressing:

- A statement that the actuarial study has not yet been completed;
- The statutory basis for the delayed timing under § 58-64A-210; and
- The date by which the provider is required to file the actuarial study with the Commissioner.

Model Disclosure Language — Actuarial Study Pending:

> *North Carolina Gen. Stat. § 58-64A-210 requires certain continuing care providers to obtain an actuarial study, including a statement of actuarial opinion, at least once every three years. Due to the timing of the enactment of this requirement and the applicable statutory filing schedule, the actuarial study for this community has not yet been completed. The Provider is required to submit its actuarial study to the North Carolina Department of Insurance no later than [insert date].*

Note to Providers:

- The statement of actuarial opinion, if required, must be attached in full as Appendix C; summaries are not sufficient..
- Actuarial assumptions should be consistent with those used in the prospective financial statements presented in Section 33.
- If the actuary issues a qualified or adverse opinion, the provider must explain the reasons and implications in plain language.

Section 37 — Most Recent Department Examination Report

Statutory Reference: § 58-64A-150(a)(41)

Purpose: The purpose of this section is to ensure that prospective residents, current residents, and other users are informed of the North Carolina Department of Insurance's most recent formal examination of the provider's financial condition and operations, if any.

Instructions: Providers must include a copy of the most recent examination report issued by the Department under Article 64A as Appendix E to the Disclosure Statement. If the examination report is too lengthy to include in full, the provider may include a summary of the material findings in Appendix E only if the summary has been reviewed and approved by the Commissioner prior to filing the Disclosure Statement.

Required elements include:

- Report inclusion: A complete copy of the most recent examination report, or a Commissioner-approved summary of that report, must be included as **Appendix E**.
- Date of report: The disclosure must clearly state the date the examination report was issued by the Department.
- Material findings (summary only): If a summary is used, it must fairly and accurately represent all material findings and conclusions contained in the examination report.
- Commissioner approval: Summaries may only be included if expressly approved by the Commissioner prior to filing the Disclosure Statement.
- Examination in progress: If a formal examination is underway but no report has yet been issued, the provider must disclose the examination start date, the current status of the examination, and whether a draft report has been received.

Note to Providers:

- Examination reports or approved summaries included in Appendix E must be reproduced exactly as issued or approved by the Department.
- Providers must not alter, edit, paraphrase or selectively excerpt examination findings.
- If no examination has yet been conducted under Article 64A, the provider must state: "*The North Carolina Department of Insurance has not conducted an examination of this provider under Article 64A.*"
- If an examination is in progress, include the status disclosure above. Providers must not summarize, characterize, or describe preliminary or draft findings unless expressly authorized by the Department.

Section 38 — Other Material Information

Statutory Reference: § 58-64A-150(a)(42)

Purpose: The purpose of this section is to serve as a safeguard, ensuring that residents and other users receive full and fair disclosure of all material information relevant to evaluating the provider and the continuing care contract, even if that information is not expressly required to be disclosed elsewhere in the Disclosure Statement.

Instructions: Providers must disclose any additional information that is material to prospective residents, current residents, or other users in making an informed decision about entering into or maintaining a continuing care contract. Information is material if a reasonable reader would consider it important in evaluating the provider's financial condition, governance, operations, or ability to meet contractual obligations.

Required elements include:

- Any fact, circumstance, risk, or event that could reasonably influence a prospective resident's decision to contract with the provider or continue residency.
- Examples of material information include, but are not limited to:
    - Pending or threatened litigation, enforcement actions, or regulatory proceedings not otherwise disclosed.
    - Material changes in governance, ownership, control, or senior management.
    - Significant changes in financing arrangements, debt structure, guarantees, or covenants.
    - Adverse events affecting the provider's financial condition, liquidity, or reputation.
    - Any other matter not addressed elsewhere in the Disclosure Statement that is material to decision-making.

Note to Providers:

- Disclosures under this section should be specific and substantive; conclusory statements are not sufficient unless reasonably supported by a reasonable factual basis.
- Providers should evaluate materiality using the same reasonable-reader standard applied elsewhere in this Disclosure Statement.
- Avoid generic statements such as "no other matters are material" unless the provider has conducted reasonable due diligence to confirm that no such matters exist.
- This section must not be used to restate or duplicate disclosures required in other sections

Section 39 — Contract Forms and Attachments

Statutory Reference: § 58-64A-150(b)

Purpose: This requirement ensures that prospective residents, current residents, and other users are able to review the standard contract terms governing continuing care and, where applicable, continuing care at home, and to understand how alternative contract forms differ in material respects.

Instructions: Providers must attach to the Disclosure Statement in Appendix D a copy of the most common continuing care contract and, if applicable, the most common continuing care at home contract currently in use.

For purposes of this section, the "most commonly used" contract means the contract form under which the largest number of current residents are enrolled, as of the date of the Disclosure Statement.

If the provider offers more than one type of continuing care contract or continuing care at home contract, the provider must also include a narrative that:

- Identifies each contract type currently offered; and
- Explains the material differences among the contract types.

Examples of material differences include, but are not limited to:

- Refund provisions and refund timing;
- Scope and level of health care services covered;
- Entrance fee and periodic fee structures;
- Contract duration or termination rights; and
- Differences in financial or health eligibility standards.

Cross-Reference Requirement: Where disclosures in other sections of this Disclosure Statement refer the reader to specific contract provisions (including Sections 20, 22, 24, 27, and 28), the attached contract(s) must contain those provisions, and the narrative must identify which contract type(s) each provision applies to if multiple forms are used.

Note to Providers:

- Providers must not attach every contract form in use; only the most commonly used contract form(s) are required.
- Contract attachments must be complete, unredacted copies of the contract forms currently in use
- If a provider updates or replaces its standard contract form, the Disclosure Statement must be revised accordingly.
- Providers must ensure consistency between the attached contract(s), the narrative explanation required by this section, and the disclosures provided elsewhere in the Disclosure Statement.

Required Appendices to the Disclosure Statement

In addition to the narrative disclosures required in Sections 1 through 39, each Disclosure Statement must include the appendices described below. These appendices are considered part of the Disclosure Statement and must comply with the formatting, accessibility, and submission requirements set forth in Part II of this Handbook.

Appendices must appear in the order listed below and must be clearly labeled and bookmarked in the electronic document.

Appendix A — Audited Financial Statements

The Disclosure Statement must include the provider's most recent annual audited financial statements prepared in accordance with § 58-64A-200. The audited financial statements must be included in full and must be identical to those filed with the Commissioner.

If the audited financial statements are prepared on a consolidated, combined, or obligated-group basis, the appendix must include all required consolidating or combining schedules and supplemental statements required by statute.

Appendix B — Five-Year Prospective Financial Statements

The Disclosure Statement must include the five-year prospective financial statements required by § 58-64A-150(a)(37), prepared and reviewed in accordance with Section 33 of this Handbook.

If prepared on a consolidated or combined basis, the appendix must include the required consolidating or combining schedules and community-level statements.

Appendix C — Statement of Actuarial Opinion

If the provider is required to obtain an actuarial study under § 58-64A-210, the Disclosure Statement must include the statement of actuarial opinion as this appendix.

The actuarial study itself is not required to be included in the Disclosure Statement.

If the statement of actuarial opinion is not yet available due solely to statutory timing under § 58-64A-210, the Disclosure Statement must instead include the interim disclosures described in Section 36 — Actuarial Opinion and Balance of this Handbook.

Appendix D — Representative Contract(s)

The Disclosure Statement must include a copy of the most common continuing care contract currently in use, as required by § 58-64A-150(b).

If the provider also offers continuing care at home, the most common continuing care at home contract must also be included.

If multiple contract types are offered, the appendix must include the contract form(s) referenced in Section 39 and must align with the narrative description of material differences.

Appendix E — Examination Report

If the Department has issued an examination report for the provider, the most recent examination report—or an approved summary, if permitted by the Commissioner—must be included as an appendix, consistent with Section 37 of this Handbook.

If no examination has been conducted, no appendix is required, but the Disclosure Statement must include the statement required by Section 37.

Appendix F — Statutory Ratio and Supporting Definitions

The Disclosure Statement must include Appendix F, consisting of the statutory definitions for the financial ratios and related terms used in Section 35 — Key Financial Metrics and elsewhere in the Disclosure Statement.

Appendix F must:

- Include only definitions and supporting statutory language, and must not include provider-specific calculations, tables, or narrative analysis.
- Use definitions drawn from N.C. Gen. Stat. §§ 58-64A-5 and 58-64A-145, as applicable.
- Present definitions in alphabetical order by ratio or term name, using the statutory terminology.
- Be organized and formatted in a manner consistent with the presentation illustrated in the Illustrative Example Disclosure Statement.

Appendix F is intended to promote consistency, transparency, and comparability across Disclosure Statements by providing residents and other users with a common reference point for understanding statutory financial metrics.

Appendix F is provided as a reference and does not substitute for or modify the disclosures required in Section 35.

Part IV – Delivery and Revision Requirements

This Part explains how and when Disclosure Statements must be delivered, updated, and filed to remain in compliance with Article 64A.

Required Delivery

Statutory Reference: § 58-64A-155

Providers must deliver a current Disclosure Statement to each prospective resident (or their legal representative) before the execution of any binding reservation agreement, continuing care contract, or continuing care at home contract, or before accepting any payment other than a nonbinding reservation deposit.

A Disclosure Statement is "current" if:

- It is dated within one year plus 160 days prior to delivery, and
- It is the most recently recorded Disclosure Statement on file with the Commissioner.

Delivery may be electronic if the prospective resident consents in writing. Acceptable methods include:

- Direct delivery to the prospective resident's designated email address, or
- Posting on a secure electronic site, accompanied by separate email notice of the posting.

After delivery, the prospective resident must sign an acknowledgment of receipt, which must include the date, the prospective resident's name, and the date of the Disclosure Statement delivered. The acknowledgment must also confirm that the Disclosure Statement was received before execution of any binding agreement or payment other than a non-binding deposit.

Providers must give a copy of the acknowledgment to the prospective resident and retain the original, either in paper or electronic form.

A sample acknowledgment of receipt form is included in this Handbook as Appendix B. Providers are not required to use this form; it is provided for illustrative purposes only. Providers may use an alternative acknowledgment, provided it contains all information required by Article 64A.

Annual Revised Disclosure Statements

Statutory Reference: § 58-64A-160

Within 150 days after the end of each fiscal year, the provider must file a revised Disclosure Statement with the Commissioner, including the required annual filing fee of $2,000. Filings must be submitted electronically through the Department's designated portal in accordance with this Handbook's electronic-filing standards.

The Department will:

- Confirm receipt and recording of the filing within five business days.
- Post the revised Disclosure Statement to the Department's website within five business days of notice.

After receiving confirmation, the provider must make the revised Disclosure Statement available to all residents and depositors, in either paper or electronic form. Providers must notify residents, such as through a newsletter, portal posting, or written communication, when the new annual Disclosure Statement becomes available and explain how residents may access it.

Extensions of up to 30 days may be granted by the Commissioner for good cause. If the filing is late without an extension, a $1,000 late fee must be submitted, unless waived for good cause.

Interim Revisions

Statutory Reference: § 58-64A-165

A provider must revise its Disclosure Statement at any time if a material misstatement of fact would otherwise exist, or if a material fact required by statute has been omitted. A fact is "material" if it could reasonably influence a prospective or current resident's decision to contract with, or remain at, the community.

Revised statements must be filed with the Commissioner before delivery to any prospective or current resident. The cover page of the revised Disclosure Statement must be updated to show the revision date.

The Department will confirm receipt and posting of the revised Disclosure Statement within five business days. After confirmation, the provider must make the revised Disclosure Statement available to all residents in either paper or electronic form.

Compliance Reminder

The Disclosure Statement is a living document. Providers must keep it current, ensure residents always receive the latest version, and promptly correct any material inaccuracies. Failure to comply with delivery or revision requirements may result in regulatory action.

Appendix A — Statutory Crosswalk: Article 64A Disclosure Requirements

Purpose

This Appendix provides a cross-reference between the disclosure requirements set forth in Part 5 of Article 64A of Chapter 58 of the North Carolina General Statutes and the corresponding sections of the Disclosure Statement, as organized in Part III of this Handbook. This crosswalk is intended to assist providers, auditors, counsel, and regulators in verifying statutory compliance.

Table A-1: Statutory Crosswalk – Article 64A Disclosure Requirements

Statutory Citation	Disclosure Statement Section	Topic
§ 58-64A-150(a)(1)–(3)	Section 1	Provider Identification
§ 58-64A-150(a)(4)–(5)	Section 2	Organizational Structure
§ 58-64A-150(a)(6)–(7)	Section 3	Key Persons and Management Personnel
§ 58-64A-150(a)(8)	Section 4	Governing Body and Oversight
§ 58-64A-150(a)(9)	Section 5	Related Parties
§ 58-64A-150(a)(10)	Section 6	Relationships with Religious, Charitable, or Other Organizations
§ 58-64A-150(a)(11)	Section 7	Other Persons Responsible for Obligations
§ 58-64A-150(a)(12)	Section 8	Obligated Groups
§ 58-64A-150(a)(13)	Section 9	Debt Covenants and Compliance
§ 58-64A-150(a)(14)	Section 10	Third-Party Management Arrangements
§ 58-64A-150(a)(15)	Section 11	Real Property Leases
§ 58-64A-150(a)(16)	Section 12	Endowment Funds
§ 58-64A-150(a)(17)	Section 13	Description and Location of the Community
§ 58-64A-150(a)(18)	Section 14	Living Units by Level of Care
§ 58-64A-150(a)(19)	Section 15	Continuing Care at Home Program
§ 58-64A-150(a)(20)	Section 16	Resident Population Served
§ 58-64A-150(a)(21)	Section 17	Occupancy Rates

Statutory Citation	Disclosure Statement Section	Topic
§ 58-64A-150(a)(22)	Section 18	Semiannual Resident Meetings
§ 58-64A-150(a)(23)	Section 19	Resident Property Rights
§ 58-64A-150(a)(24)	Section 20	Services Provided Under the Contract
§ 58-64A-150(a)(25)	Section 21	Resident Fees
§ 58-64A-150(a)(26)	Section 22	Refundable Entrance Fee Obligations
§ 58-64A-150(a)(27)	Section 23	Financial Hardship Policies
§ 58-64A-150(a)(28)	Section 24	Contract Cancellation and Refund Policies
§ 58-64A-150(a)(29)	Section 25	Re-occupancy of Units
§ 58-64A-150(a)(30)	Section 26	Resident Relocation
§ 58-64A-150(a)(31)	Section 27	Admission and Continuation Standards
§ 58-64A-150(a)(32)	Section 28	Age and Insurance Requirements
§ 58-64A-150(a)(33)	Section 29	Reserve Funding and Refund Security
§ 58-64A-150(a)(34)	Section 30	Expansion and Renovation Plans
§ 58-64A-150(a)(35)	Section 31	Audit Opinion and Timeliness
§ 58-64A-150(a)(36)	Section 32	Audited Financial Statements
§ 58-64A-150(a)(37)	Section 33	Five-Year Prospective Financial Statements
§ 58-64A-150(a)(38)	Section 34	Explanation of Material Variances from Prior Prospective Financial Statements
§ 58-64A-150(a)(39)	Section 35	Key Financial Metrics
§ 58-64A-150(a)(40)	Section 36	Actuarial Opinion and Balance
§ 58-64A-150(a)(41)	Section 37	Most Recent Department Examination Report
§ 58-64A-150(a)(42)	Section 38	Other Material Information
§ 58-64A-150(b)	Section 39	Contract Forms and Attachments

Notes

- This crosswalk is provided for reference only and does not modify or supersede statutory requirements.
- Providers remain responsible for ensuring that all disclosures fully comply with Article 64A, regardless of section numbering or formatting.

Appendix B — Sample Acknowledgment of Receipt

Purpose and Use

This Appendix provides a sample acknowledgment of receipt of a Disclosure Statement for use by continuing care providers to document compliance with the delivery requirements of § 58-64A-155.

This sample is provided for illustrative purposes only. Providers may use a different format, provided the acknowledgment includes all required elements and accurately documents delivery of the Disclosure Statement in accordance with Article 64A.

Acknowledgment of Receipt of Disclosure Statement

I hereby acknowledge that I have received a copy of the Disclosure Statement for:

Provider Name: _____

Community or Continuing Care at Home Program Name: _____

Date of Disclosure Statement: _____

I acknowledge that this Disclosure Statement has been provided to me pursuant to the North Carolina Continuing Care Retirement Communities Act (N.C. Gen. Stat. Chapter 58, Article 64A).

The Disclosure Statement contains important information regarding the provider's ownership, governance, financial condition, services, fees, and contractual obligations.

I further acknowledge that I have received the Disclosure Statement and have had the opportunity to review its contents and to ask questions regarding the Disclosure Statement prior to executing a continuing care or continuing care at home contract.

This acknowledgment does not constitute acceptance of the terms of any continuing care or continuing care at home contract.

Resident Name: _____

Signature: _____

Date: _____

Provider Representative Name: _____

Title: _____

Signature: _____

Date: _____

Appendix C — Provider and Community ID Directory

Purpose

This directory assigns each provider, and each CCRC operated by that provider, a unique numeric identifier.

The identifiers must be used in all file names, correspondence, and regulatory filings to ensure consistent tracking, cross-referencing, and posting on the Department's website.

Each provider is assigned a four-digit Provider ID, and each CCRC operated by that provider, is assigned a two-digit Community ID.

Table C-1: Provider and Community ID Directory

Provider ID	Community ID	Provider Legal Name	Community Name
0001	01	Aldersgate United Methodist Retirement Community, Inc.	Givens Aldersgate
0002	01	Arbor Acres United Methodist Retirement Community, Inc.	Arbor Acres
0004	01	Baptist Retirement Homes of North Carolina, Incorporated	Brookridge Retirement Community
0004	02	Baptist Retirement Homes of North Carolina, Incorporated	The Gardens of Taylor Glen
0004	03	Baptist Retirement Homes of North Carolina, Incorporated	Ardenwoods
0004	04	Baptist Retirement Homes of North Carolina, Incorporated	Brice Pointe
0005	01	Carmel Hills, Inc.	Carmel Hills
0006	01	The Chapel Hill Residential Retirement Center, Inc.	Carol Woods
0007	01	Carolina Meadows, Inc.	Carolina Meadows
0008	01	Carolina Village, Inc.	Carolina Village
0009	01	ARCLP – Charlotte, LLC	Brookdale Carriage Club Providence
0010	01	Covenant Village, Inc.	Covenant Village

Provider ID	Community ID	Provider Legal Name	Community Name
0011	02	United Methodist Retirement Homes, Inc.	Wesley Pines
0011	04	United Methodist Retirement Homes, Inc.	Croasdaile Village Retirement Community
0011	05	United Methodist Retirement Homes, Inc.	Cypress Glen
0012	01	Deerfield Episcopal Retirement Community, Inc.	Deerfield
0013	03	Friends Homes, Inc.	Friends Homes
0014	01	The Givens Estates, Inc.	Givens Estates
0015	01	Glenaire, Inc.	Glenaire
0016	01	Grace Lifecare, Inc.	Grace Ridge Retirement Community
0017	01	Maryfield, Inc.	Pennybyrn at Maryfield
0018	01	The Masonic and Eastern Star Home of North Carolina, Inc.	WhiteStone: Masonic and Eastern Star Community
0020	01	Penick Village, Inc.	Penick Village
0021	01	EveryAge	Abernethy Laurels
0021	02	EveryAge	Piedmont Crossing
0022	01	Pittsboro Christian Village, Inc.	Pittsboro Christian Village
0023	02	1. Quail Haven of Pinehurst, LLC 2. Quail Haven Healthcare Center of Pinehurst, LLC 3. Quail Haven Properties of Pinehurst, LLC	Quail Haven Village
0024	01	Moravian Home, Inc.	Salemtowne
0025	02	The Presbyterian Homes, Inc.	Scotia Village Retirement Community

Provider ID	Community ID	Provider Legal Name	Community Name
0025	03	The Presbyterian Homes, Inc.	River Landing at Sandy Ridge
0026	01	The Presbyterian Home at Charlotte, Inc.	The Sharon at SouthPark
0027	01	Southminster, Inc.	Southminster
0028	01	Springmoor, Inc.	Springmoor
0029	03	St. Joseph of the Pines, Inc.	Belle Meade / Pine Knoll
0030	01	Stanley Total Living Center, Inc.	Stanley Total Living Center
0031	01	1. The Cypress of Charlotte, LLC 2. The Cypress of Charlotte Club, Inc. 3. The Cypress of Charlotte Home Owners' Association, Inc.	The Cypress of Charlotte
0032	01	The Forest at Duke, Inc.	The Forest at Duke
0033	01	The Pines at Davidson, Inc.	The Pines at Davidson
0034	01	Lutheran Retirement Center-Salisbury, Inc.	Trinity Oaks
0035	01	ACTS Retirement-Life Communities, Inc.	Matthews Glen
0035	02	ACTS Retirement-Life Communities, Inc.	Tryon Estates
0036	01	Lutheran Retirement Ministries of Alamance County, North Carolina	Twin Lakes Community
0037	01	Well-Spring Retirement Community, Inc.	Well-Spring
0038	01	Windsor Point, Inc.	Windsor Point
0040	01	Galloway Ridge, Inc.	Galloway Ridge

Provider ID	Community ID	Provider Legal Name	Community Name
0039	01	Plantation Village, Inc.	Porter's Neck Village
0041	01	Alamance Extended Care, Inc.	The Village at Brookwood
0043	01	1. The Cedars of Chapel Hill, LLC 2. The Cedars of Chapel Hill Club, Inc. 3. The Cedars of Chapel Hill Condominium Association	The Cedars of Chapel Hill
0047	01	Whitaker Glen, Inc.	The Oaks at Whitaker Glen
0048	02	NHC HealthCare/Charlotte, LLC	Sharon Village Apartments
0049	02	NHC HealthCare/Tryon, LLC	White Oak Village Apartments
0050	02	NHC HealthCare/Burlington, LLC	Oak Creek Apartments
0052	01	1. The Cypress of Raleigh, LLC 2. The Cypress of Raleigh, Club, Inc. 3. The Cypress of Raleigh Owners Association, Inc.	The Cypress of Raleigh
0053	01	United Methodist Women	Brooks-Howell Home
0058	01	1. Pisgah Valley Retirement Center, LLC 2. Pisgah Valley Retirement Center Properties, LLC	Pisgah Valley Retirement Community
0059	01	The Tower at the Cardinal, LLC	The East Tower at the Cardinal North Hills
0061	01	Samaritan Housing Foundation, Inc.	SearStone
0062	01	The Cardinal at North Hills, LLC	The Cardinal at North Hills
0063	01	Windsor Run, LLC	Windsor Run

Provider ID	Community ID	Provider Legal Name	Community Name
0064	01	1. Cary Senior Housing I OPCO, LLC 2. Cary Senior Housing I PROPCO, LLC 3. Brightmore Senior Living of Cary, LLC	The Templeton of Cary
0065	01	1. Charlotte SP Senior Housing OPCO, LLC 2. Charlotte SP Senior Housing PROPCO, LLC 3. Barclay Senior Living SouthPark, LLC	The Barclay at South Park
0066	01	1. Lutheran Retirement Center-Clemmons, Inc. 2. Lutheran Home-Forsyth County, Inc. 3. Lutheran Home Forsyth County Property, Inc. 4. LSA Elms Tanglewood, Inc. 5. LSA Elms Property, Inc.	Trinity Elms
0067	01	1. HBP Oberlin SeniorHousing OPCO KP6, L.P. 2. HBP Oberlin SeniorHousing PROPCO KP6, L.P.	Hayes Barton Place
0068	01	Providence Place, LLC	Providence Place
0069	01	Givens Highland Farms, LLC	Givens Highland Farms Retirement Community
0070	01	630 Carolina Bay Opco, LLC	Carolina Bay at Autumn Hall
0071	01	1. Lutheran Retirement Center-Wilmington, Inc. 2. Lutheran Home – Wilmington, Inc. 3. Lutheran Home Wilmington Property, Inc.	Trinity Landing
0072	01	Blue Ridge Development Partners, LLC	Legacy at Mills River