RISKS AND REWARDS OF CONTINUING CARE RETIREMENT COMMUNITIES: A DEVELOPER'S PERSPECTIVE

by

Latham Lloyd Williams

Bachelor of Science
University of California, Berkeley
Berkeley, California
1983

SUBMITTED TO THE DEPARTMENT OF ARCHITECTURE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE MASTER OF SCIENCE IN REAL ESTATE DEVELOPMENT at the MASSACHUSETTS INSTITUTE OF TECHNOLOGY SEPTEMBER, 1986

(© Latham Lloyd Williams

The Author hereby grants to M.I.T. permission to reproduce and distribute publicly copies of this thesis document in whole or in part.

Signature of the Author

Latham Lloyd Williams
Department of Architecture
August 15, 1986

Certified by

James McKellar
Professor of Architecture and Planning
Thesis Supervisor

Accepted by

James McKellar
Chairman
Interdepartmental Degree Program in Real Estate Development
RISKS AND REWARDS OF
CONTINUING CARE RETIREMENT COMMUNITIES:
A DEVELOPER'S PERSPECTIVE

by

Latham Lloyd Williams

Submitted to the Department of Architecture
in partial fulfillment of the requirements
of the degree
Master of Science in Real Estate Development

ABSTRACT

Projections of the increase in demand for housing
alternatives which meet the needs of a growing elderly
population are dramatic. Continuing Care Retirement
Communities, defined for this paper as organizations
established to provide housing, services and health care to
individuals of retirement age, provide a promising option.

Until recently, however, this market has been
addressed by only the non-profit development community. As
demand and need for this product continue to grow, private,
for-profit developers will increasingly be called upon to
enter this market. This paper explores and evaluates the
potential risks and rewards from a private developer's
perspective of making the move into this field.

The analysis concludes that the development of CCRCs
offers the potential for attractive financial rewards to
those developers who 1) understand and have the ability to
control the elements of risk inherent in the complex
development process, and 2) can afford to carry the land
cost and the up-front costs over a long approvals period.

Thesis Supervisor: James McKellar
Title: Professor of Architecture and Planning
# TABLE OF CONTENTS

I. FORWARD ............................................................................. 5

II. INTRODUCTION ............................................................... 6
   A. OVERVIEW
      1. UNDERSTANDING THE PRODUCT
         HOW IT WORKS AND WHY IT SELLS ............ 7
         BRIEF HISTORICAL REVIEW ....................... 9

III. DEFINING THE REWARDS
   A. FINANCIAL ................................................................. 11
   B. UNDERSTANDING THE MARKET'S ABILITY TO PAY ...... 13
   C. BASIC ECONOMIC ISSUES ............................................. 14
      START-UP COSTS .......................................................... 15
      SELECTING A FINANCIAL ORGANIZATION ............ 15
      RESERVES .................................................................. 16

IV. MINIMIZING THE RISKS
   A. UNDERSTANDING THE MARKET
      1. INTRODUCTION: UNDERSTANDING PRODUCT APPEAL. 17
      2. BASIC DEMOGRAPHICS .......................................... 19
      3. MORE THAN DEMOGRAPHICS .................................. 20
      4. UNDERSTANDING THE MARKET ANALYSIS ............. 21
   B. RELEVANT REGULATIONS AND LEGAL ISSUES
      1. STATE AND FEDERAL REGULATIONS
         CERTIFICATE OF NEED ........................................... 23
         ENVIRONMENTAL IMPACT REPORTS .................... 24
         FULL DISCLOSURE REQUIREMENTS ..................... 25
      2. LOCAL REGULATIONS ................................................ 26
      3. LOCAL SUPPORT AND OPPOSITION ....................... 27
      4. FUTURE CHANGES ................................................... 28
C. DESIGN ISSUES
1. SITE CONSIDERATIONS: WHAT TO LOOK FOR ..... 28
2. IMPORTANCE OF THE DESIGN CONSULTANT ...... 30
3. GENERAL DESIGN CONSIDERATIONS ............. 32
   BUILDING SCALE .................................. 33
   RESIDENTIAL UNIT SCALE ..................... 35

E. MARKETING
1. PRE-MARKETING PROGRAM ............................ 38
2. FULL-SCALE MARKETING—BACK MARKET" .......... 39
3. SALES RETENTION EFFORT .......................... 41
4. QUALIFICATIONS .................................. 42

F. MANAGEMENT
1. MANAGEMENT OPTIONS .............................. 44
2. THE ROLE OF MANAGEMENT ........................ 45
3. LABOR INTENSIVE PRODUCT ....................... 48
4. TURNOVER PROBLEMS .............................. 49

G. UNDERSTANDING LONG-TERM PERFORMANCE
1. LONG-TERM COMMITTMENT ......................... 50
2. MULTI-FACETED CHANGES OVER TIME .............. 50
3. IMPLICATIONS OF AN AGING POPULATION ......... 52
4. EXAMPLES OF FAILURES ........................... 53
5. NEW INSURANCE DEVELOPMENTS ................... 53
   CONTROLLING THE ACTUARIAL RISK

H. POTENTIAL COMPETITION
1. CHANGES IN THE CERTIFICATE OF NEED REQ .... 55
2. FUTURE PLAYERS ................................. 56

V. SUMMARY .......................................... 58
   THE ROAD AHEAD ................................... 59

VI. BIBLIOGRAPHY AND REFERENCES
I. FORWARD

The elderly are the second biggest demographic discovery of this century. There are more of them, they are living longer and healthier lives, they have more money to spend than at any time in our history and their lifestyles are changing dramatically.¹

This paper explores, from a for-profit developer's viewpoint, the risks and rewards associated with the development of one elderly housing alternative: the Continuing Care Retirement Community (CCRC), or Lifecare Community as it is also commonly called.

The CCRC concept has had a turbulent history. Many early projects, often sponsored by non-profit and religious organizations with little business experience, have met with financial disaster due to rising operating costs, longer life expectancies, poor financial planning and poor understanding of demand. These well publicized bankruptcies have caused fundamental changes in both the concept of lifecare and the nature of the sponsorship of the projects.²

Today, the vast majority of CCRC projects continue to be sponsored by non-profit and religious groups, but for the first time for-profit developers have entered the market. This trend will continue as demand grows and as developers begin to understand the profit potential of this growing, important market.
Of course the success of these developers will rest to no small degree upon the developer's understanding and knowledge of those factors which will determine such success. As Grubb & Ellis notes in its Investor Outlook, Housing for the Elderly, "Developers who ignore the principals of good design and solid market research will fail or experience very limited success."³

II. INTRODUCTION

The decision to enter the CCRC market involves two important steps. First, the developer must understand the risks and rewards associated with this unique product, and second, he must determine whether the potential rewards and his ability to control the risks justify his move into the field.

This paper is divided into three parts: the first attempts to quantify the rewards of developing a CCRC. It focuses primarily on financial aspects, identifying where potential profits are, examining the overall market's ability to pay and understanding the basic economic issues of development.

The second section identifies and analyzes the development risks associated with this product and, where appropriate, suggests ways of minimizing those risks.
The third section, the conclusions, discusses, in light of the previous two sections, where development of CCRCs is headed and recommends development strategies for the private developer.

A. UNDERSTANDING THE PRODUCT

CCRCs are unique in that, unlike many other retirement alternatives, they provide private residential living units, supportive services, and health care in a single environment. In this way, CCRCs address three critical needs of the elderly person: the need for private dignified housing, the need for supportive services which help to maintain independent living, and finally, the need for health care on both a temporary and long-term basis. CCRCs are more than real estate, they are a lifestyle.

The Health Center is the key to the CCRC concept. It is typically attached to, but separate from, the residential units of the project. Residents who are no longer able to live independently in their units are able to move directly into the Health Center where a bed is always available for resident's use. Typically, no limit is placed on the length of stay and there is no additional cost above their regular monthly fee except for the cost of two extra meals per day.

[ In many cases these provisions are changing ].
The emphasis of the Health Center is on restorative care; while residents are almost always responsible for their own hospital expenses, many are able to return early from the hospital to the Health Center for convalescent care.

CCRCs have the potential for playing an increasingly important role in the retirement housing market because they address the needs of the elderly on several different levels. Other retirement housing alternatives do not have this ability. Retirement communities, such as Sun City in Arizona and Leisure World in California, have experienced problems because the original plans did not include the services and medical care later required by their aging populations. [The response in many cases has been to build nursing homes and hospitals within these communities, evolving them, in a sense, into CCRCs. ] Congregate housing, an alternative which has many similarities to the CCRC without the Health Center, lacks the ability to meet the temporary medical and assistance needs of its population; as a result, many residents are moved into nursing homes before they need to be.

It is only the CCRC that is able to provide residents with a continuum of care, with the security of knowing that even as their needs change over time, those needs will be met within the single community.
BRIEF HISTORICAL REVIEW

Early CCRC projects were built almost exclusively by religious and non-profit sponsors; residents typically turned over their assets (or paid a large fee) and contracted to pay a fixed monthly fee in exchange for a promise of care for life. The entrance fees became reserves whose income would be used to cover the difference between actual operating costs and the set monthly fees.

The problem that occurred in many of these early CCRCs was that entrance funds became depleted more rapidly than anticipated. Turnover did not occur at the levels expected (turnover that was counted on to replenish reserve accounts) and funds that were collected were not always used wisely. As operating costs increased, many sponsors would subsidize operations from what was supposed to be their capital reserve rather than raise monthly fees. Other communities used funds to embark on expansion plans for which a market often never developed. Still others experienced occupancy problems when they did not adequately market themselves or when they overestimated the size of the local market.

Finally, some simply fell victim to crooked developers and managers who misappropriated funds. [see "The Broken Promise of Lifecare Communities" in Money Magazine.]
In response to the many failures, some states began to adopt regulations governing the development of CCRCs, and sponsors began to change the concept of lifecare. Some of the state regulations included refund obligations, termination rights for residents, reserve funding requirements, and escrowing requirements. These regulations have had two effects: they have provided the consumer with a greater level of protection and they have pushed up development costs (by making the development process more complicated).

Sponsors, for their part, have created new, sophisticated forms of ownership and management. These sometime overly complex structures are a response to the operational realities in today's environment.

Service packages are also being modified. Some projects still continue to offer nursing care when needed, at the same rate one pays for their living unit. But many other sponsors have found that it is no longer feasible to offer a full lifecare contract in this day of increasing costs. Some projects limit how long a resident may stay in the health center at the individual unit rate before an additional charge is incurred. And still others offer medical care strictly on a fee-for-service basis. The common factor that remains in each, however, is that the medical care and individual living units continue to exist in a single environment.
III) DEFINING THE REWARDS

A. FINANCIAL

As the industry currently stands, private development only makes sense for projects which cater to the high end of the market. It is only this group which can afford to offer the developer a return that is commensurate with the risk he must assume.

Exhibit I analyzes the costs of developing 44 residential units, a health center, and common area for Phase I of a proposed CCRC project. The cost per square foot averages $118 excluding land (which in this case is extremely low; total price is $850,000 for 95 acres. This works out to $6,300 per unit or less than $10 per square foot of building). Soft costs are high because of legal and management fees, design fees, and equipment costs.

Exhibit II looks at Phase II which is the building of 44 residential units. This shows estimated revenue as well as cost.

Exhibit III puts the information from Exhibits I and II together into a discounted cash flow analysis. Based on the assumptions given, the development projects only a 7.5% internal rate of return.
**SAMPLE FEASIBILITY PRO-FORMA (SPAULDING CO. PROJECT)**

**PHASE I:**

**DEVELOPMENT ASSUMPTIONS**

| 50,000 sf | Residential Units | 44 units total |
| 24,000 sf | Health Center     |
| 16,000 sf | Common area       |

**DEVELOPMENT BUDGET**

<table>
<thead>
<tr>
<th></th>
<th>Residential</th>
<th>Common</th>
<th>Health CNTR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HARD COSTS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td>3,500,000</td>
<td>1,600,000</td>
<td>1,950,000</td>
<td>7,050,000</td>
</tr>
<tr>
<td><strong>SOFT COSTS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td>400,000</td>
<td>150,000</td>
<td>150,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Equipment &amp; Furnishings</td>
<td>450,000</td>
<td>150,000</td>
<td>incl</td>
<td>600,000</td>
</tr>
<tr>
<td>Design</td>
<td>275,000</td>
<td>85,000</td>
<td>340,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Legal &amp; Management</td>
<td>260,000</td>
<td>80,000</td>
<td>340,000</td>
<td>680,000</td>
</tr>
<tr>
<td>Marketing (1)</td>
<td>150,000</td>
<td></td>
<td></td>
<td>150,000</td>
</tr>
<tr>
<td>Financial (2)</td>
<td>400,000</td>
<td>200,000</td>
<td>170,000</td>
<td>770,000</td>
</tr>
</tbody>
</table>

| Sub total soft costs   | 1,935,000   | 665,000 | 1,000,000   | 3,600,000 |
| Soft as % of total     | 35.6%       | 29.4%   | 33.9%       | 33.8%    |

| Total Const Costs      | 5,435,000   | 2,265,000 | 2,950,000   | 10,650,000 |
| Cost per sf            | $109        | $142      | $123        | $118      |

| LAND COSTS             |             |          |             | 850,000   |
| CONTINGENCY            |             |          |             | 850,000   |

**TOTAL COSTS**

12,350,118

(1) Marketing: 44 units @ $3,500/unit
(2) Financial: ($5,500,000)*1.5yrs*(15%/yr)*(1/2avg.bal) = 600,000
Health Center financing during construction = 150,000

**EXHIBIT 1**
PHASE II: 44 units, 49,620 sf buildable

DEVELOPMENT ASSUMPTIONS

ASSUME RESIDENTIAL UNITS WILL SELL OUT 75% DURING CONSTRUCTION

REVENUE:

<table>
<thead>
<tr>
<th></th>
<th>Studios @</th>
<th>1 Bedroom @</th>
<th>2 Bedroom @</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units</td>
<td>4</td>
<td>24</td>
<td>16</td>
<td>44</td>
</tr>
<tr>
<td>Price</td>
<td>$85,000</td>
<td>$132,000</td>
<td>$190,000</td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>$340,000</td>
<td>$3,168,000</td>
<td>$3,040,000</td>
<td>$6,548,000</td>
</tr>
</tbody>
</table>

Average sales price unit = $148,818
Average sales price per sf = $132

COSTS:

<table>
<thead>
<tr>
<th></th>
<th>Hard costs @ $70.54 /sf</th>
<th>Soft costs @ $14.47 /sf</th>
<th>Total cost @ $85.01 /sf</th>
<th>Land cost paid for in Phase I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>$3,500,000</td>
<td>$718,000</td>
<td>$4,218,000</td>
<td>$340,000</td>
</tr>
</tbody>
</table>

Soft cost breakdown:

- Marketing: $150,000
- Legal & mgmt: $168,000
- Design (1): $100,000
- Financing (2): $300,000

Total soft costs: $718,000

(1) Design @ 3% hard cost because most of design work completed in Phase I
(2) ($4,000,000) * (1yr) * (15%)* (1/2) = 300,000

EXHIBIT 2
## DEVELOPMENT PRO-FORMA

### EXPENSES:
- **Land**: 850,000
- **Design**: 200,000
- **Legal and management**: 350,000
- **Financing**: 770,000
- **Marketing**: 112,500
- **Equipment and Furniture**: 350,000
- **Hard Construction cost**: 7,050,000
- **Soft Construction cost**: 700,000
- **Contingency**: incl

### Total Net Expenses:
- **Year 0**: 850,000
- **Year 1**: 550,000
- **Year 2**: 10,912,500
- **Year 3**: 375,000
- **Year 4**: 4,180,500
- **Year 5**: 375,000
- **Year 6**: 4,180,500
- **Year 7**: 375,000

### INCOME:
- **Sales Proceeds**: 4,911,000
- **Agency Bond**: 2,500,000

### NET INCOME:
- **Year 0**: (650,000)
- **Year 1**: (550,000)
- **Year 2**: (3,501,500)
- **Year 3**: 1,599,500
- **Year 4**: 730,500
- **Year 5**: 1,599,500
- **Year 6**: 730,500
- **Year 7**: 1,599,500

### NPV @ 15%:
- Net Present Value: (794,174)

### IRR:
- Internal Rate of Return: 7.46%
This example illustrates why it is so difficult to make the numbers work for projects which do not cater to the high-end of the market. There are several important points to look at:

1) The developer has $1,400,000 invested in the project at the end of Year 1; he has not yet started construction or marketing.
2) Land cost is extremely low yet even that does not make for an attractive rate of return.
3) Soft costs, especially legal, design, and equipment are very high.
4) This is not the low end of the market; prices are $85,000 for a studio and $132,000 for a one-bedroom.

The second set of exhibits (Exhibits 4-6) make a new set of assumptions for the same project, but on the premise that the project is being considered closer to a more affluent location.

First, a more realistic land cost is assumed at $1,500,000. Second, hard construction costs for the residential units is increased to $4,000,000 to reflect the higher quality units that market will desire. Third, prices are assumed to increase to $105,000 for a studio, $185 for a one-bedroom, and $240,000 for a two-bedroom. The IRR under these assumptions jumps to 25.1%.
SAMPLE FEASIBILITY PRO-FORMA (SPAULDING CO. PROJECT)

PHASE I:

DEVELOPMENT ASSUMPTIONS

| 50,000 sf | Residential Units | 44 units total |
| 24,000 sf | Health Center |
| 16,000 sf | Common area |

DEVELOPMENT BUDGET

<table>
<thead>
<tr>
<th>HARD COSTS:</th>
<th>RESIDENTIAL</th>
<th>COMMON</th>
<th>HEALTH CNTR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>4,000,000</td>
<td>1,600,000</td>
<td>1,950,000</td>
<td>7,550,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOFT COSTS:</th>
<th>RESIDENTIAL</th>
<th>COMMON</th>
<th>HEALTH CNTR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>400,000</td>
<td>150,000</td>
<td>150,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Equipment &amp; Furnishings</td>
<td>450,000</td>
<td>150,000</td>
<td>incl</td>
<td>600,000</td>
</tr>
<tr>
<td>Design</td>
<td>275,000</td>
<td>85,000</td>
<td>340,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Legal &amp; Management</td>
<td>260,000</td>
<td>80,000</td>
<td>340,000</td>
<td>680,000</td>
</tr>
<tr>
<td>Marketing (1)</td>
<td>150,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial (2)</td>
<td>400,000</td>
<td>200,000</td>
<td>170,000</td>
<td>770,000</td>
</tr>
</tbody>
</table>

Sub total soft costs | 1,935,000 | 665,000 | 1,000,000 | 3,600,000 |
Soft as % of total | 32.6% | 29.4% | 33.9% | 32.3% |

Total Const Costs | 5,935,000 | 2,265,000 | 2,950,000 | 11,150,000 |
Cost per sf | $119 | $142 | $123 | $124 |

LAND COSTS | 1,500,000 |
CONTINGENCY | 850,000 |

TOTAL COSTS | 13,500,124 |

(1) Marketing: 44 units @ $3,500/unit
(2) Financial: ($5,500,000)*(1.5yrs)*(15%/yr)*(1/2avg.bal) = 600,000
   Health Center financing during construction = 150,000

EXHIBIT 4
**PHASE II:** 44 units, 49620 sf buildable

**DEVELOPMENT ASSUMPTIONS**

ASSUME RESIDENTIAL UNITS WILL SELL OUT 75% DURING CONSTRUCTION

**REVENUE:**

<table>
<thead>
<tr>
<th></th>
<th>Studios @ 4</th>
<th>$105,000</th>
<th>=</th>
<th>$420,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Bedroom @ 24</td>
<td>$185,000</td>
<td>=</td>
<td>$4,440,000</td>
</tr>
<tr>
<td></td>
<td>2 Bedroom @ 16</td>
<td>$240,000</td>
<td>=</td>
<td>$3,840,000</td>
</tr>
</tbody>
</table>

Total sales revenue: $8,700,000

Average sales price unit: $197,727

Average sales price per sf: $175

**COSTS:**

<table>
<thead>
<tr>
<th></th>
<th>Hard costs @ $80.61 /sf</th>
<th>=</th>
<th>$4,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Soft costs @ $14.47 /sf</td>
<td>=</td>
<td>$718,000</td>
</tr>
</tbody>
</table>

Total cost @ $95.08 /sf = $4,718,000

Land cost paid for in Phase I: $4,000,000

Soft cost breakdown:

- Marketing: $150,000
- Legal &accounting: $168,000
- Design (1): $100,000
- Financing (2): $300,000

Total soft cost: $718,000

(1) Design @ 3% hard cost because most of design work completed in Phase I
(2) ($4,000,000) * (1 yr) * (15%) * (1/2) = 300,000

**EXHIBIT 5**
## DEVELOPMENT PRO-FORMA

<table>
<thead>
<tr>
<th>YEAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPENSES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>1,500,000</td>
<td>200,000</td>
<td>500,000</td>
<td>100,000</td>
<td>100,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td>350,000</td>
<td>350,000</td>
<td>168,000</td>
<td>168,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing</td>
<td>770,000</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td></td>
</tr>
<tr>
<td>Equipment and Furniture</td>
<td>600,000</td>
<td>600,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard Construction cost</td>
<td>7,550,000</td>
<td>7,550,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Construction cost</td>
<td>700,000</td>
<td>700,000</td>
<td>700,000</td>
<td>700,000</td>
<td>incl</td>
<td>incl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>850,000</td>
<td>850,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Net Expenses</td>
<td>1,500,000</td>
<td>1,500,000</td>
<td>550,000</td>
<td>550,000</td>
<td>11,112,500</td>
<td>37,500</td>
<td>4,680,500</td>
<td>37,500</td>
</tr>
<tr>
<td>INCOME:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales Proceeds</td>
<td>6,525,000</td>
<td>2,175,000</td>
<td>2,175,000</td>
<td>2,175,000</td>
<td>6,525,000</td>
<td>6,525,000</td>
<td>2,175,000</td>
<td></td>
</tr>
<tr>
<td>Agency Bond</td>
<td>2,500,000</td>
<td>2,500,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET INCOME</td>
<td>(1,500,000)</td>
<td>(550,000)</td>
<td>(2,387,500)</td>
<td>2,137,500</td>
<td>1,844,500</td>
<td>2,137,500</td>
<td>1,844,500</td>
<td>2,137,500</td>
</tr>
<tr>
<td>MPP @ 15%</td>
<td>1,340,195</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRR</td>
<td>25.14%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXHIBIT 6
These figures are clearly an oversimplification but they do illustrate two important points: 1) under development conditions as they are today, the middle- and low-income markets cannot afford the development costs of such projects (see "The Road Ahead", the last section of this paper), and 2) it does appear, on a rough basis, that there are profits to be made in the development of CCRCs.

B. UNDERSTANDING THE MARKET'S ABILITY TO PAY

General statistics in this area are plentiful but may tell you little about a specific market that you are considering.

The elderly in this country are not poor. Seventy-five percent of them own their own homes and more than 60% of that group own it free and clear; the median home value is about $45,000 and the elderly have a collective equity estimated by a US Senate study to be $600 billion.

Home value statistics are particularly important to the developer of a CCRC. Because many residents will sell their home in order to afford the entrance fee, the median home value statistics for a site's primary market will give a good indication of just how much the market can afford.

The average cash income of those 65 and older is about $20,000 per year which, considering their reduced need for material things, is more than adequate to provide monthly living costs. The income breakdown in 1983 showed 37% coming from Social Security, 24% from earnings, 23% from asset incomes and 13% from pensions.
The market's ability to pay extends beyond simply qualifying financially to live in a given CCRC. There are instances in every CCRC where a resident is unable to meet his monthly fee charges. Sponsors have come up with several solutions to this problem and almost never has anyone been forced to leave a CCRC. In refundable fee projects, one solution has been to subtract the amount the resident is unable to pay each month from the refund balance due him when residency is terminated. In this way, the resident can "draw down" his equity and use it to support himself. Another solution has been for sponsors to establish reserve accounts in their financial plans which are specifically targeted to cover these cases.

B. BASIC ECONOMIC ISSUES

This section will not discuss financing alternatives for CCRC projects. Financing is a highly complex area which may involve government programs, tax exempt bonds, joint venture agreements or conventional financing. This paper leaves the financing issue with those more qualified to address it.

This section will discuss three other economic issues which are important to the developer: start-up costs, the selection of a financial organization, and the establishing of reserves.
START-UP COSTS

Start-up costs for CCRC projects are substantial yet are often overlooked in the feasibility study. The ideal situation is to complete the residential units and the health center at the same time so that the health center is operational to meet the needs of the resident population. The health center can be filled with private-pay and Medicaid patients who will be phased out in later years as the CCRC's population matures and requires more care.

The first two years of operation for a CCRC are the most challenging. Most management staffs are swamped during this time integrating the new residents into a new environment while at the same time trying to get the health center licensed and operational.

This period is an extremely disruptive time. The only real solution in many cases is to provide more staff; the developer should be aware that there will be a need for staff and should have planned and budgeted ahead of time.

SELECTION OF A FINANCIAL ORGANIZATION

The issues that are most important in establishing the financial organization of the CCRC are regulation, taxes and control.

Many states have, or are considering, regulation governing the operation of CCRCs and these should be considered when reviewing options. The requirement in many
states that a resident is entitled to a refund of his up-front fee at any time (less 1%/mo. for each month of occupancy) has undoubtedly led to the trend of higher, refundable fees in the industry.

Because the IRS considers all money received by CCRCs, including entry fees, as current income, developers may want to consider forms of financial arrangement, such as the setting up of a corporation, which allow the entity to avoid taxation on those entry fees. This option, however, as well as others, raises questions of how the deal can be structured to maintain maximum control for the developing entity. Professional legal and accounting advice is recommended.

RESERVES

With the exception of debt service reserves, which are usually required by lenders through loan covenants, reserves, if help at all, are generally held as a result of management policy.7

Developers should consider including the following reserves in the financial plan for the CCRC:

1) Debt Service reserves
2) Equipment replacement reserves
3) Health Care reserves
4) Financial Aid reserves
5) Contingency reserves

For a more detailed study on reserves and actuarial planning, see "Continuing Care Retirement Communities: An Empirical, Financial and Legal Analysis", by Winklevoss and Powell.
IV. MINIMIZING THE RISKS

A. UNDERSTANDING THE MARKET

1. INTRODUCTION: UNDERSTANDING PRODUCT APPEAL

The CCRC concept appeals primarily to those elderly 75 years and older. The average age of residents at entrance, in fact, is 76 to 77. "Young retirees", those aged 65-75, generally are not good candidates for a CCRC; they are typically active, new to retirement, independent, and enjoying their new leisure. Although CCRCs are often marketed as being appropriate for anyone over 65, even when targeted, it has been found that this group is really not that interested in the CCRC concept.

The 75-85 age group is the strongest market for CCRCs. Typically individuals in this group are beginning to slow down quite a bit, often because of physical infirmities, and many need the supportive services a CCRC can offer. Additionally, members of this group recognize their mortality and place a higher value on the security of knowing that medical care is available if they need it.
CCRCs are also appropriate for the 85 and older age group, the "frail elderly" as they are often called, but many members of this group already require a great deal of assistance and may not be able to meet the qualification of being able to live independently that many CCRCs impose.

Finally, the appeal of CCRCs seems to be security. In a study of Friendship Village, a CCRC near Chicago, IL, it was found that:

"People move to Friendship Village because of their concern for security... Two types of security are being sought by residents: medical and financial. Medical security takes the form of the health care unit while the financial security occurs through the residents' knowledge that a serious illness will not deplete them or their families of their financial resources. In short, security is provided by the life-care contract offered by Friendship Village."
2. BASIC DEMOGRAPHICS

There are numerous statistics projecting rapid growth in the number of elderly in this country. Grubb & Ellis includes the following table from the US Bureau of Census in its Investor Outlook and notes that "Population statistics show that the older American population is increasing at a rate twice that of the total US population."\(^{11}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Pop.: Over 65</th>
<th>Labor Force: Over 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>10:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1965</td>
<td>10:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1970</td>
<td>10:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1975</td>
<td>9:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1980</td>
<td>8:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1985</td>
<td>8:1</td>
<td>4:1</td>
</tr>
<tr>
<td>1990</td>
<td>7:1</td>
<td>3:1</td>
</tr>
<tr>
<td>1995</td>
<td>7:1</td>
<td>3:1</td>
</tr>
<tr>
<td>2000</td>
<td>7:1</td>
<td>3:1</td>
</tr>
<tr>
<td>2010</td>
<td>7:1</td>
<td>3:1</td>
</tr>
<tr>
<td>2030</td>
<td>4:1</td>
<td>2:1</td>
</tr>
<tr>
<td>2050</td>
<td>4:1</td>
<td>2:1</td>
</tr>
<tr>
<td>2080</td>
<td>4:1</td>
<td>2:1</td>
</tr>
</tbody>
</table>


The elderly, (those 65 and older), now account for 11.6% of the population, or roughly 27 million people. Although the growth in the elderly population will slow temporarily as the relatively smaller number of babies born during the Depression of the 1930's reach retirement age, the Census Bureau projects that the percentage of elderly in the population will rise to 13.1% in the year 2000 and then explode to 21.7% in 2050.\(^{12}\)
The over-75 group is growing even faster. Currently, 38% of the elderly are 74 years of age or older. This will increase to 45% by the year 2030. The 85 and older group will explode in size from 2.2 million in 1980 to 5.1 million in 2000. Approximately 20% of this group will require some form of nursing care.¹³

For a more detailed report on the elderly, see "A Profile of Older Americans: 1984" attached as Appendix B.

3. MORE THAN DEMOGRAPHICS

The important considerations to keep in mind when looking at a potential market are:

(1) CCRCs appeal primarily to local markets, and hence national statistics are of little value except to indicate the absolute size of the market and how it will develop over time.¹⁴

(2) The market for CCRCs may be broad but is often not very deep. That is, there appears to be a potential market for CCRC projects in almost all parts of the country but it is important to remember that (1) over 92% of all retirees will never relocate more than 200 miles from their lifetime homes and that (2) the vast majority (over 90 percent) will age in place (i.e. they won't move at all.)¹⁵
(3) As a result of the above facts, market penetration for this type of project is very low. Often only 2-4% of the total number of age and income qualified candidates in the project's primary market area (usually defined as within a 25 mile radius) can be considered "serious potential customers". This should rise over time as the elderly become more educated about the product.

(4) Finally, developers must be wary of what demographics actually say. That is, while a need for a CCRC facility may exist, need does not equal demand. Demand will only result when the market judges the price-quality relationship of a given project to be favorable.

4. UNDERSTANDING THE MARKET ANALYSIS

The market analysis for a CCRC must focus primarily on the income and asset statistics of the project's primary market area because it is these figures which will indicate how much the market can afford to pay. These statistics should be used to make projections of market penetration for given levels of entrance and monthly fees. This information will have a significant impact on design and site selection.
Secondly, the market analysis should include a survey of potentially competitive projects, both existing and in the planning stage. In a thin market there is serious potential for short-term oversupply. For existing competitive projects, the market analysis should summarize the fee schedules, market shares, and absorption rates, as well as provide brief descriptions of operations, unique features and marketing success (or failure).

Finally, the market analysis should give some indication of the strength and activity of the local housing market. It is critically important that developers of CCRCs understand the enormous marketing risk they face because of the long lead times required to get these projects operating relative to the volatility of interest rates and their effect on the housing market. That is, because many potential residents of a CCRC will have to sell their homes in order to afford the project's entrance fee, a "soft" local housing market may considerably lengthen the time it takes to fill up a project. Depending on the severity of this delay and the loan terms, this can have a disastrous effect on the project's financial performance.
B. RELEVANT REGULATIONS AND LEGAL ISSUES

In most cases, regulation is the biggest hurdle a developer must overcome; the process can be very difficult, time consuming, and can cost a great deal of money. This section will discuss the regulations which are of greatest importance to the developer of a CCRC.

1. STATE AND FEDERAL REGULATIONS

A developer faces three main issues on the state and federal level:

CERTIFICATE OF NEED REQUIREMENT

A Certificate-of-Need will be required, in most states, for the Health Center part of the project regardless of whether it is closed-ended (available only to the residents of the project) or open-ended (available to non-residents as well). [In Massachusetts, a C.O.N. is required for any medical expenditure in excess of $500,000. ] The C.O.N. process is a lengthy one; the site must be properly zoned and under control before the application can be submitted. Final approval can often take up to two years.
In the application, the developer must clearly define:

(1) who the owners of the project will be, and

(2) the number and level of beds and how they will meet the needs of the project and, if applicable, the community.

The former is important because amending the CON application is very costly and time-consuming once the approval process has been started. The latter is important in order to keep public health officials from exercising their "regulatory tendency" to involve themselves in the residential portion of the CCRC.

ENVIRONMENTAL IMPACT REPORTS

State-required EIRs, such as that required by MEPA in Massachusetts when projects exceed certain threshold limits, can create significant delays in the development process. This is especially true when the requirement for this report is overlooked in the beginning and discovered only after one is well into the development process. If the project requires any type of state permit, check the relevant state laws concerning EIRs.
FULL DISCLOSURE LAWS

Developers must be aware of and pay strict attention to disclosure laws, both existing and proposed, because these regulations will often supercede any contract one may have with residents. [In Massachusetts, the existing is Chapter 93, Sections 76-94 of the General Laws and the proposed is House Bill 85.] Disclosure laws are intended, primarily, to protect consumers by legally requiring that they be fully informed about all important aspects of a given project.

Consumers, for their part, are becoming better educated about what to look for when evaluating a Continuing Care Contract. Appendix C includes a copy of "The Continuing Care Retirement Community: A Guidebook for Consumers" published by the American Association of Homes for the Aging.

The Massachusetts disclosure statute requires that the developer file a disclosure statement with the Division of Insurance. This statement must include, among other things, the name and business experience of the developer, audited financial statements of the developer, pro-formas for the project, a statement of the conditions required for admission, the conditions of the Continuing Care Contract, a description of all fees required of residents. The statute further requires that the developer obtain a Continuing Care license and provide the prospective resident with a copy of the disclosure statement before accepting any money or executing a Continuing Care Contract. The statute also
includes provisions governing refunds of entrance fees, escrowing of deposits, renewal of license, liability, construction and receivership.

A developer should understand that the disclosure requirements protect the developer as well as the consumer. A carefully drafted disclosure statement helps protect the developer against the salesperson who unintentionally makes statements which allude to or promise conditions or events which may not occur. Considering the legal nature of a lifecare contract, the disclosure statement may prevent many potential lawsuits.

2. LOCAL REGULATIONS

Local regulations that a developer must address include: sewage/septic regulations and availability, wetlands regulations and, potentially, rent control laws. As with any new type of development, the developer must plan on spending an inordinant amount of time meeting with town planners, local officials and citizens to address the issues of traffic, aesthetics, benefit to the town, etc. This period can be characterized as one of "education" about the benefits of the product and why it will be run well.
3. LOCAL SUPPORT AND OPPOSITION

As with many types of development, the CCRC will more often than not require a rezoning or plan approval. In many cases this is the most challenging step in the development process. Villa Marin, a CCRC built recently in San Rafael, CA, was originally planned in two other locations; local political opposition, in both cases, prevented the project from being built.17

The two most important political groups a developer must usually deal with are: (1) local officials, both elected and appointed, and (2) abutters to the planned project.

In dealing with local officials, developers will almost invariably face a high degree of skepticism and criticism. In response, the developer must attempt to prove that the positive attributes of the project will outweigh any detrimental effect. The developer should also take advantage of the fact that the proposed product is for "mom and pop", that it addresses real needs of community residents.

Abutters who oppose the project can be particularly troublesome when an EIR, special permit or re-zoning is required. In each process an aggressive opponent can cause substantial delays. Often a developer's only defense is to address each issue rationally, hoping that the opposition, eventually, will appear unreasonable in the eyes of the decision-making body.
4. FUTURE CHANGES

The trend today is towards greater and greater regulation of CCRCs. Much of this is in response to the abuses and problems of the past.

The significance for developers is that increased regulation means longer lead times, larger budgets, and less control. These lead, in turn, to higher cost which must be passed on to the consumer, reducing further the percentage of the market able to afford entrance and monthly fees.

C. DESIGN ISSUES

1. SITE CONSIDERATIONS

In a survey of 207 facilities in 1981, Winklevoss and Powell found that CCRCs have an average of 165 independent living units and two or three other levels of care, in either a campus or high-rise setting. The Grubb & Ellis study finds that "the median lot size for an in-city lifecare project is 6 acres; those located in rural areas have a median site size of 29 acres." The 1985 survey of 102 facilities by Laventhol & Horwath found larger acreage as shown in the following exhibit:
The Villa Marin project is located on approximately 6 acres (surrounded by 20 of protected land), North Hill on 59 acres and the Spaulding "project" on 95 acres.

Developers will minimize their risk by selecting sites that are near metropolitan areas and that are close to shopping, financial and medical facilities. Other locational factors to consider are: distance to cultural, recreational and social activities, driving times to primary market area (the resident's old neighborhoods), level of crime, and quality of the surrounding community. Locations that are on or near college campuses have been found to be particularly good for this type of project.
When examining a potential site, the developer should consider the following "site design resources":

1) Location: Does the location suggest a form or character for the facility

2) Shape: How does the shape of the site impact the cost of development and the circulation pattern

3) Topography: What natural features (especially views) exist which will make for a more interesting project

4) Vegetation: What types of vegetation exist. Can vegetation be preserved and, if not, how will that affect the project

5) Edge Treatment: How does the site relate to the neighborhood and to sites it borders

6) Access: Is access convenient for visitors, staff and public services

7) Building Needs: Can the site accommodate all the building structures that make up a CCRC

8) Microclimate: Are there surrounding or nearby uses which may make the site unattractive as a residential use

2. IMPORTANCE OF THE DESIGN CONSULTANT

Next to location, design is the most important element to be considered during the development process. The market for CCRCs is extremely selective; if the project is poorly designed and does not meet the real needs of the market, many potential residents will choose to remain in their homes.
As a warning, it has been found that most design problems stem from the fact that very often the goals of the developer run at cross purposes to good design. Quality design takes time and money, two things developers never have enough of. Keep in mind that, more often than not, the "return", in terms of fewer operating problems, shorter sell-out period and higher resident satisfaction, is usually worth the investment.

In almost all cases, the developer should hire an independent consultant to help to architect understand the specific needs of the target market. There are no hard and fast design rules which apply to every project; because there are differences in state regulations, structures, sites and the goals of providers, no two CCRCs are alike.

There is a limit to what can be done through design before one begins to significantly impact the budget. An experienced consultant will help the architect identify those features which will have the greatest impact on quality and marketability.

The design consultant should be familiar not only with the physical and perceptual issues of designing this type of project but also with the interaction between these issues as they relate to the needs of the target market. Some of those issues might be:
Physical Issues:
- Codes and Regulations
- Architectural Requirements (not necessarily found in codes, these are dimensional requirements determined from experience)
- Physical Requirements of the Elderly

Perceptual Issues:
- Sense (creating a sense of community, excitement)
- Exploration (how to keep the design from being boring)
- Choice (how to make the project architecturally stimulating)

3. GENERAL DESIGN CONSIDERATIONS

This section is not intended to serve as a checklist for every project; the intent is to provide the potential developer with some knowledge of general design issues so that he may work more effectively with the architect during the design process. Quality design, in both the short and long term, is one of the most important contributors to a successful marketing campaign.
BUILDING SCALE ISSUES

Because the CCRC is a community which offers care on a variety of levels, one of the most important design considerations become the balance between integration and separation. It is generally agreed (by users, medical professionals and designers alike) that there must be some separation, architecturally, between levels of care. Many codes, in fact, require a separation between skilled nursing and intermediate care, acknowledging the fact that mixing of the two does not work.

Secondly, successful design will introduce elements which continue the sense of place found in a home. By minimizing the institution aspects of the project, the architect is able to create an environment with which the resident can more easily identify. This in turn leads to a shorter adjustment period, a greater sense of security and an increased level of comfort. As one minister said in a metaphor, "When we transplant flowers it is always wise to move along as much native soil as we can."^20

The following, more-detailed issues should also be considered at the building scale:

COMMON AREAS

- DINING ROOM(S): Dining rooms have a significant marketing impact; meals are an important part of the elderly person's day. Design should create some sense of excitement, and opportunities for views and natural light should be maximized. Private dining rooms should be provided for resident's use when increased privacy for special events is desired.
- **CORRIDORS**: Corridors, lobbies and public space should also include a liberal use of natural light and, where possible, should afford views to the outside. The objective is to make these areas more pleasant and interesting spaces.

- **PUBLIC SPACE**: Public space, both inside and out, should be designed to provide areas of privacy while maximizing the opportunity for interaction between residents.

- **SELECTION OF USES**: Understand your market before planning the common rooms. It may be wise to leave several rooms unfinished and allow the resident's association to determine their use. CCRC residents generally have a higher preference for passive pursuits. Beauty salons, gift shop/convenience store, convocation room, libraries and card rooms are popular, as are recreational rooms equipped with a pool table (for grandchildren to use) and cozy, comfortable furniture. Other uses to consider (again, it depends on your targeted market) are: woodworking shop (keep locked to avoid accidents), arts and crafts room, and exercise room (perhaps with a Jacuzzi).

- **AUDITORIUM**: Small auditoriums for meetings, presentations, movies and entertainment are very useful. May be used to present marketing package.

- **POOL**: A pool can be an expensive amenity, especially when it must be staffed with a lifeguard. Amount of actual use varies considerably from project to project.

- **OUTDOOR USES**: Garden plots are popular in almost all locations. Other uses to consider include: walking paths, horseshoes and putting green.

- **STORAGE ROOMS**: It is almost impossible to provide too much storage space as residents are generally moving out of much larger residences. Thought should be given to making the individual storage spaces intentionally too small to hold a mattress and boxspring.

- **HANDRAILS**: Handrails are essential. Generally they are installed on one side of the corridor only. Handrails will be used more as age of resident population increases over time.
- INDIRECT LIGHTING: In corridors especially this helps to minimize glare and eye strain. Florescent bulbs should be considered for more even light distribution and lower energy costs.

- COLOR, TEXTURE AND LIGHTING: These can facilitate movement and improve the legibility of the environment if used correctly.

PARKING: Demand for parking, both covered and exposed, will vary by location and income levels. As a general rule, one space for each three units is satisfactory.

ENTRY/EXIT: Entry and exit to each structure should be considered for residents, visitors and service. Attention should be given to avoiding barriers such as high door steps, uneven walking surfaces, thick carpet and hard to open doors. The complex should be linked, if possible, to facilitate movement between the structures. Grades should be limited to 3% for wheelchairs.

GUEST ROOMS: Guest rooms, which are rented to visitors on a daily basis, are a desired amenity. They are often an attractive marketing feature.

LAYOUT: Layout should be kept relatively simple in order to minimize disorientation. This will become a more serious problem as the population ages.

DETAILS: The selection of the window system is particularly important because of cost, code requirements and energy conservation. It is one of the most important details affecting the "look" of the facility.

RESIDENTIAL UNIT SCALE

The residential units provide the privacy which is essential to the elderly. Units vary in size; Laventhal & Horwath found the median sizes of studios, one-bedrooms and two-bedrooms to be 375, 615 and 940 sqft respectively. The two-bedroom units (and three-bedrooms when provided) are
generally the most popular; this is not surprising considering again the fact that most residents are moving out of a much larger home and have a substantial number of possessions.

The following design issues should be considered:

Door handles should be the lever type (turnknobs can be especially difficult for the arthritic elderly to operate) and entrance doors should lock from the outside with the key only (to keep residents from locking themselves out)

Tub/shower should be slip-resistant and equipped with grab bars. Reinforced towel bars should be considered.

Each bedroom and bathroom should be equipped with an emergency call switch connected to the Nurse's Station.

A higher-seat toilet should provided when a unit has more than one bathroom. This is an especially attractive amenity to those who have trouble getting up from a standard, lower toilet.

Appliances should have larger style controls located near the front.

Walk-in closets are a valuable amenity. Most elderly have extensive wardrobes which they find difficult to pare down.

In high-end projects, the washer/dryer should be located in the units. In other cases, facilities should be located on each floor, not in the basement.

Security tabs should be installed on the front door of each unit. This small item, combined with a daily patrol system, is extremely valuable.
D. MARKETING

A developer should establish the marketing program keeping three things in mind:

1) There are a sizable number of consultants in this field who will profess to have all the answers; remember that, like architecture and financial feasibility, each project is unique and that there really is no formula that works for everything.

2) With CCRCs, as mentioned earlier, you're not selling real estate, you're selling a lifestyle.

3) The potential resident is not a typical consumer. Making the decision to move into a CCRC is a major one; in most cases it is the final housing decision an elderly person will make. The process is filled with skepticism.

In establishing the marketing program, the developer should be aware that the traditional brokerage arrangement does not work well. The marketing of a CCRC is primarily an education process which addresses potential residents concerns and, as such, it doesn't really make much sense to compensate on a commission basis. The market makes slower decisions and sales take longer; a marketing program can only be successful when salespersons are patient and sensitive in answering all the prospective tenants questions, not when they are out simply to "close a deal".
The Laventhol & Horwath survey below found an average marketing cost per unit of $2,763. Spaulding & Co. recommends a higher figure of $3500-$4000 per unit. This figure will vary depending on the number of competitive projects, the success of the pre-sale campaign and the quality of the project.

EXHIBIT 6
Marketing Costs, Pre-Construction Sales Results and Fill-up Time For Communities Built 1977 and Later*

<table>
<thead>
<tr>
<th>Marketing Cost Per Unit</th>
<th>$2,763</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Months of Pre-Construction Sales to Reach 50%</td>
<td>13</td>
</tr>
</tbody>
</table>

Percentage of Apartment Units Filled During:

| 1st Six Months | 60% |
| 2nd Six Months | 16% |
| 3rd Six Months | 20% |

Number of Months to Achieve 95% Occupancy: 15

*All amounts are medians.

The average resident who makes a sales commitment will have made 8-9 visits to the sales office and will take 3-4 months from the first visit to make a decision.

1. THE PRE-MARKETING PROGRAM

The goal of the pre-marketing program is to create an awareness of the project within the primary market area. Materially, this means developing a mailing list of potential residents who: 1) have been contacted and have expressed some interest in the project, 2) recognize the name of the project and know generally where it is, and 3) know what the project (as a CCRC) is all about.
The pre-marketing program should be started before applying for financing, but after the Certificate-of-Need has been obtained. The reason for waiting is that the C.O.N. demonstrates that the project is a serious one; the market typically does not respond well if a project has too many uncertainties.

Reaching the potential market can be done in a variety of ways: direct calls, presentations to church and elderly groups, and direct mail are all possibilities. A lack of hard number estimates is expected and one should not worry if figures can not be presented at this point; the emphasis is on "awareness", not selling.

2. FULL-SCALE MARKETING

Once a financing commitment and hard construction estimates are obtained, the developer is in a position to put together a price schedule (which he should be willing to live with for the first 1-2 years out) and proceed into full-scale marketing.

The ideal marketing situation is to establish an on-site marketing office while construction is occurring. Because of pre-sale requirements imposed by lenders and regulatory agencies, however, the marketing effort must often begin sooner. The developer should understand that it is difficult to get consumers to part with a deposit before construction has started and that he should therefore negotiate with the lender for lower deposit requirements during that period.
Setting up the full-scale marketing program takes both a good portion of the marketing budget and a substantial time commitment from the developer. The following steps are typical:

1) Establish a sales office with a model, if possible, showing textures, colors and finishes

2) Staff the office with salaried sales people who are chosen carefully and trained well. This is the most critical time in the marketing program. Selecting the marketing staff is the most important decision a developer makes; those chosen are the front-line contact, as discussed earlier, and the relationships they establish are critical to both the marketing and sales retention efforts (discussed next). Additionally, it has been found that many of the sales people later become part of the operations or social services staffs.

3) A disclosure statement, as mentioned previously, should be carefully drafted by an attorney and given to all serious potential residents

4) Literature at this point should be of high quality with good graphics as this is the first viable contact many potential residents will have with the quality of the project. Direct mail services and a quality brochure will play a major role in getting people in the door. College alumni magazines are an excellent place to advertise.
Once a few residents have signed up, word-of-mouth references become a very important part of the marketing program. Take subtle advantage of this by encouraging those who have signed up to let their friends know. It is interesting to note that a survey conducted at Friendship Village to determine how people who inquire about living there heard about the project, the most common source was a friend's referral. The second and third most common sources were newspaper advertisements and current residents, respectively. Thus, out of the three most common courses, two involved word-of-mouth.24

3. SALES RETENTION EFFORT

Because the decision to move into a CCRC is such a major one for most people, there is a strong tendency for many to back out of their commitment, especially at the last minute. This happens for a variety of reasons: the stress involved in actually moving, the anxiety of having to adjust to a new environment, etc. One should expect about 20-25% of the commitments to fall through. This is especially true among the pre-sale group because of the long waiting period before actual occupancy (often 9 months pre-sale period and 1-2 years of construction).
The sales retention effort is designed to minimize the number of commitments which fall through. Elements of this effort often include:

1) A newsletter for those who have signed up. This should be a quality document and it often includes a report of the status of the project, features on the sales staff and periodic biographies of key administrators.

2) Parties and media events create additional excitement about the project and allow those who have signed up to meet one another. This helps to reduce the stress many elderly feel prior to moving into a new environment.

3) Periodic telephone calls by the sales staff (confirming the move-in date or just saying hello) help to assure those who have signed up that a caring, friendly environment awaits them.

4. QUALIFICATIONS

Most CCRCs in existence require that residents meet certain health and financial qualifications. This has special importance to the private developer who: 1) must keep costs low by admitting healthy residents, and 2) must be assured that residents have the ability to pay both the entrance fee and the monthly charges.
Before being allowed to enter into a contract, prospective residents should fill out "pre-qualification forms" (financial, medical and legal) and should only be issued a priority number (for unit selection) after they have been approved by the Admissions Board.

Because of the long lead time between when a prospective resident puts down a deposit and when he moves in (often up to three years later), and because of the potential for quickly deteriorating health among the elderly, developers are advised to require that the qualifying physical be completed within 90 days before move-in. [In some cases the developer/project will pay for this physical.] The requirement that all residents be "qualified candidates for independent living" when they move in is essential if the project is to retain the character of a "retirement community", not a "giant nursing home".

Finally, the developer should be aware that no matter how formally structured the qualification program is, there will be problems and exceptions. It is impossible to provide guidelines for all the cases that will come up.

F. MANAGEMENT

While design, location and marketing may contribute to a project's marketing success, no other factor is more important to the long-term success of a CCRC than management.
1) MANAGEMENT OPTIONS

The first choice made by the developer is whether to self-manage the project or to hire a professional management firm. Factors to be considered include: the size of the project, its location, and the developer's experience in managing this type of product. Management should not be attempted by a novice; if the developer lacks sufficient experience and capability in this area, professional management should be sought. CCRCs are among the most complicated developments to operate.

In selecting a professional management firm, the developer should look for a firm with experience and a successful track record in managing CCRCs, a management philosophy sensitive to both financial and social issues, a responsive management plan, and day-to-day operating systems procedures.25

An alternative for the developer who wants to be involved in management but who lacks sufficient experience is "turn-key" management. Under this system, a professional management firm provides on-the-job training to the developer's staff over a two-to-three year period during which the operating control is gradually turned over.
2. THE ROLE OF MANAGEMENT

To minimize the risk of operating problems, the developer should make sure the following management issues are addressed:

1) Budgeting: Budgeting, of both operating expenses and reserves (discussed earlier), plays a critical role in maintaining the financial success of a CCRC. The budget plays two roles: 1) it serves as an important planning tool because, in preparing a budget plan properly, management is required to pre-plan the full operation for the next year, and 2) it serves as an evaluation tool for the project operations. Budgeted vs. actual expense comparisons reveal rising costs or operating problems; either can be dealt with once identified (either by raising monthly fees to maintain reserves or by improving operations).

2) Occupancy: Management should work with the marketing staff to coordinate resident move-ins as efficiently as possible. Empty units mean higher monthly fees for occupied units. Once a unit is available, refurbishment and occupancy should occur as soon as possible.
3) Maintenance: Well-maintained buildings and grounds are an important part of the marketing effort and of continued resident satisfaction. Particular attention should be given in CCRCs to any failures or deficiencies which endanger the health and safety of an aging population; examples include icy/slippery walkways, poor lighting where bulbs have burned out, and loose railings.

It has been observed that housekeeping personnel are often most in tune with the residents' true condition because of their frequent visits to the resident's private environment (the living unit). Managers should encourage housekeeping personnel to report any unusual conditions they observe, such as alcoholism, severe depression or personal neglect, which might signal the unspoken need for help.

4) Service and Medical Activities: Management must monitor these activities on an on-going basis to evaluate their efficiency and utilization (i.e. are the current activities really meeting resident's needs (which change over time) and are they cost-effective).
5) Safety/Security: Because the elderly are particularly vulnerable both to crime and to sudden illness, safety and security are two important management issues at a CCRC. Most projects employ at least some level of security personnel and many have initiated "patrols" each day which monitor the safety tabs [mentioned in the design section]. Tabs are placed in position during the night by security personnel and checked again during the next day; tabs which have not been disturbed (occurs automatically when the front door is opened) indicate that a resident may have had a problem in his/her living unit and may be unable to call for help.

6) Personnel: Management is to long-term project success as "staff attitude" is to long-term marketing success. Residents of a community whose staff is positive, caring and responsive will encourage others to move into the project based often solely on the quality of the staff. Management must have the ability to maintain staff morale. Additionally, because CCRCs are so labor intensive, the management staff must be experienced in hiring, training, supervising and evaluating large numbers of employees.
3. LABOR INTENSIVE MANAGEMENT

CCRCs are labor intensive because of the range of services and medical care provided. Laventhol & Horwath find that the average number of full time equivalent employees is 97.8 for a CCRC of about 200 units, a 60-bed health center and a 25-bed personal care unit. North Hill, with 341 units and a 60-bed health center, has 210 employees on its payroll. Robert Marans, in a 1982 study on the changing properties of retirement communities, found that, "the continuing care retirement center has the highest resident to staff ratio ... In the centers visited, ratios ranged from 1.5 to 1, to 3 to 1."  

The labor intensive nature of CCRC's implies that developers who decide to self-manage the projects they build will experience significant changes in the character of their own operation. Most development firms do not have experience dealing with a large in-house management payroll; property management functions are usually either contracted out or handled in-house by a relatively small staff. Development firms with experienced management staffs will be in the strongest position to control the operations of CCRCs they develop. Others should expect to experience an adjustment period while they adapt internally to the increase in management personnel.
4. TURNOVER PROBLEMS

Labor turnover in the CCRC field is high for two reasons. The first is that there continues to be an increase in the demand for skilled on-site management as the number of CCRCs completed each year increases. The second is that CCRCs employ a large number of lower-wage personnel in the dining, maintenance and housekeeping operations. These employees are difficult to keep because either they are young and only available for temporary periods, or they take jobs elsewhere when offered what may be only a slight increase in wage.

The turnover problem is not easily solved because the cause is generally external. Often the best thing a developer/manager can do is to anticipate turnover. This can be done by initiating established, internal career paths in management, or by developing a management training program.

Finally, those development organizations with ready access to trained or experienced personnel, through a broad internal organization, will again be in a stronger position to control the problems associated with higher turnover.
. UNDERSTANDING LONG-TERM PERFORMANCE

Potential developers should understand that CCRCs have unique characteristics with respect to long-term performance. The population will age, operating costs may rise and government almost assuredly will continue to adopt new policies regarding health care for the elderly.

1) LONG-TERM COMMITMENT

Developing a CCRC means making a long-term commitment to future residents; it is not inconceivable that some will spend as much as 30 years of their life at the facility. Developers should consider this fact when specifying construction materials and when selecting the management team. Remember that demand for CCRCs will continue to increase well into the next century; building a project that ages well and is maintained properly will benefit the developer's reputation in this field.

2) MULTI-FACETED CHANGES OVER TIME

Developers should anticipate changes in regulation, government subsidies, operating costs and life expectancies.

As mentioned, increased regulation has been the trend over the past few years. Some states, on the other hand, have gone the other way by abolishing the CON requirement for the health center portion of CCRCs. Grubb & Ellis predicts
that the pressure on government for elderly housing will lead to a relaxation of zoning laws and to tax incentives of all kinds designed to transfer elderly care costs to the private sector. They also believe the HUD 202 program will change to allow joint ventures between non-profit and for-profit entities.²⁸

Because successful development is often the result of "being in the right place at the right time" or anticipating events before they occur, developers should closely monitor these changes and how they affect development opportunities.

Operating costs will almost certainly increase over time and the developer should anticipate this when structuring the financial plan for the CCRC.

One solution is to structure a program in which increases in operating costs are passed on to the residents in the form of higher monthly fees. This, however, may impact the marketing of the project; many potential candidates may not consider the project for fear that rising operating costs might eventually exceed what they would be willing to pay.

A second solution might be to put a cap on monthly fee increases; this gives residents a better sense of security but may, in time of high inflation threaten the economic stability of the facility.²⁹
Finally, a developer should anticipate increases in life expectancy over time. Financial projections for a CCRC are often based on reserves and turnover rates which have been calculated using current life expectancies. This is a dangerous assumption for two reasons: 1) medical technology will most likely continue to achieve the breakthroughs it has in the past (i.e. prolonging life mechanically and finding new cures for diseases), and 2) preliminary studies by gerontology experts indicate that residents in continuing care communities might even live longer than their counterparts in society at large - thanks to improved nutrition, reduction of stress, and companionship. 30

3. IMPLICATIONS OF AN AGING POPULATION

The average age of a CCRC population will increase about one-half year for each year of operation until it stabilizes near 83-85. This occurs because existing residents grow older and the average age of new residents increases. This older population requires two things: more services and more medical care. Both the physical structure and the financial plan should anticipate these changes,
4. EXAMPLES OF FAILURES

CCRC projects have gone bankrupt in the past primarily for two reasons: 1) operating costs rose faster than expected and 2) turnover rates were lower than expected. Admittedly these projects were structured differently than most are today. Many non-profit sponsored facilities wanted to guarantee flat, non-raisable monthly fees which ended up being too low. Others were relying on infusions of entrance fees which would not occur because of enhanced life-expectancies.31

It is important to note that both of these problems occurred in the longer term; many projects were launched successfully but ran into trouble down the road due to circumstances which were neither anticipated nor, more importantly, planned for in the beginning.

5. NEW INSURANCE DEVELOPMENTS

Several insurance companies are now providing limited long-term health care insurance, but so far the typical benefit is not enough to cover the cost of nursing care. One policy covers $40/day for a maximum of three years, but the private rate is in excess of $90/day. The exhibit below gives the result of the 1985 Laventhol & Horwath survey of
nursing home costs:

<table>
<thead>
<tr>
<th>EXHIBIT 10</th>
<th>Nursing Center Daily Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private Room</td>
</tr>
<tr>
<td></td>
<td>Lower Quartile</td>
</tr>
<tr>
<td>Prihcipally Retirement Center</td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>$65.75</td>
</tr>
<tr>
<td>Intermediate</td>
<td>$53.75</td>
</tr>
<tr>
<td>Oriented Toward Nursing Care</td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>61.25</td>
</tr>
<tr>
<td>Intermediate</td>
<td>53.25</td>
</tr>
</tbody>
</table>

The problem is that, generally speaking, one cannot purchase reasonable insurance to pay for the costs of nursing home care. The limited insurance that is available is, at best, a partial solution. [Some, in fact, cut off at the age of 85, after which they will not insure at all.] The Medicaid program has become so heavily used because the elderly who require nursing home care quickly spend down whatever assets they have paying the high cost of that level of care.

Working with an insurance firm to develop a policy for a given project may be the way to keep an actuarial deviation on a given project from causing financial disaster.
H. POTENTIAL COMPETITION

1. CHANGES IN THE CERTIFICATE OF NEED REQUIREMENT

Several states already have abolished, or will soon abolish, the Certificate-of-Need requirement for nursing homes. This may have several implications for those considering developing CCRCs.

Eliminating the CON requirement eliminates several hurdles for the developer of a CCRC: the development schedule is shortened (which reduces the cost of land carry and construction interest) and the marketing program can be started sooner (increasing the number of pre-sales). Together these lower both the cost and the risk of development.

On the other hand, eliminating the CON means that a greater number of nursing homes and CCRCs will be built. The potential for competition in a given market is substantially increased, as is the possibility that occupancy rates will fall for the nursing home market as a whole.

Under the CON program, most nursing homes that are efficiently managed are profitable because they collect Medicaid revenue (which, although set, does provide for a reasonable return) as well as private-rate revenue. The market demand for nursing home beds generally remains strong because the supply of those beds is regulated according to demonstrated need.
When the CON requirement has been abolished, states have experienced a dramatic increase in the number(supply) of nursing home beds and a decrease in occupancy rates. Competition results and individual nursing homes lower their rates in order to remain full.

The implication for developers is that, in such a market, the CCRC's nursing facility may find revenue dropping sharply as it lowers fees in order to attract outside patients.

2. FUTURE PLAYERS

Two important players are entering the CCRC field: hotel operators (such as Marriott) and medical organizations (such as hospitals and nursing homes) that have surplus land available for development. Both are entering the market because they perceive a high profit potential. Marriott's for example, reports that it only launches new businesses projected to earn $1.00 per share from the outset. Each is also in a strong position to develop projects which other private developers might not find the incentive to attempt.
Hotel operators, like Marriott, are in a strong position for several reasons: 1) they understand the real estate development process, 2) they are well capitalized and can afford to purchase and carry the land and up-front development costs over the long period that it takes to obtain approvals, and 3) they are experienced at operating service-intense projects and have a management base from which to draw.

Hospitals and nursing homes may not be experienced in development, but they understand health care operation and do not have large carrying costs because they already own the land.

A related type of project that we will undoubtedly see more of in the future is the congregate housing project, which is only loosely tied to a N.H. facility. The incentive for developing this type of product is that many of the regulatory problems confronting CCRC developers are avoided; essential services are still provided.

It is worthwhile to note two things, however, about these products: 1) it may be difficult to get approvals because the product is really only multi-family housing for the elderly, and 2) this type is really an entirely different product from CCRCs. The CCRC emphasis is on the security of a continuum of care; this product can really only emphasize services.
V. SUMMARY

The development of the CCRCs offers the potential for attractive financial reward to those developers who, 1) understand and have the ability to control the elements of risk inherent in the complex development process, and 2) can afford to carry the land cost and the up-front costs over a long approvals period. At the present time, the chances of success are highest for projects which:

1) are well-located
2) target a high-income market
3) involve quality design and construction

The choice of location is especially important for two reasons. First the project must be located where there is a need and where there is a market which has the ability to pay for the project. Second, the specific location must be one which will attract the targeted market.
THE ROAD AHEAD

The unfortunate fact is that under current conditions it is extremely difficult, if not impossible, to make the numbers work for this type of project in median income locations. Because costs are so high, the resulting returns are too low to justify the development risk. There is clearly an untapped market at the median income level if a developer can structure a financially sound project.

If we assume that median income and asset values will not change drastically in the future, then the solution to motivating private development efforts is to find ways of reducing development costs so as to allow a more favorable return to the developer than currently exists. There is some potential in reducing development costs, as has been seen in the following areas:

- through the use of manufactured housing
- by obtaining concessions on zoning
- through creation of new government subsidies or tax incentives
- by taking greater advantage of the medicaid program
- by building projects without the health center in order to reduce carrying costs and shorten the development schedule
- by building more rural projects where land costs are lower
- through the use of creative financing plans

These issues require further research beyond the scope of this paper.
REFERENCES

1) Discussion on June 27, 1986 with Dr. John Siemens, M.D., General Partner and developer of Villa Marin Retirement Residences, San Rafael, CA

2) Discussion on July 17, 1986 with Barara Nelson, Marketing Director of North Hill, Needham, MA


4) Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis, by Howard E. Winklevoss and Alwyn V. Powell, 1984 by Richard D. Irwin, Inc., Homewood, IL

5) The Retirement Residence, by James Frush, Jr. and Benson Eschenbach, 1968 by Charles Thomas, Springfield, IL


7) "Retirement Communities: Present and Future", by Robert W. Marans, Administration on Aging, 1982

8) "Developing the Extended Care Community", a seminar by Frank Smith, Spaulding & Co., July 14-15, 1986. At the Center for Real Estate Development, M.I.T., Cambridge, MA


11) "What About Mom and Dad?", by Laura Elliot, The Washingtonian, March 1985
The Older Population

- The older population—persons 65 years or older—numbered 27.4 million in 1983. They represented 11.7% of the U.S. population, about one in every nine Americans. The number of older Americans increased by 1.7 million or 6% since 1980, compared to an increase of 3% for the under-65 population.

- In 1983, there were 16.4 million older women and 11.0 million older men, or a sex ratio of 149 women for every 100 men. The sex ratio increased with age, ranging from 124 for the 65-69 group to a high of 241 for persons 85 and older.

- Since 1900, the percentage of Americans 65+ almost tripled (4.1% in 1900 to 11.7% in 1983), and the number increased more than eight times (from 3.1 million to 27.4 million).

- The older population itself is getting older. In 1983 the 65-74 age group (16.4 million) was over seven times larger than in 1900, but the 75-84 group (6.5 million) was 11 times larger and the 85+ group (2.5 million) was 20 times larger.

- In 1982, persons reaching age 65 had an average life expectancy of an additional 16.8 years (18.8 years for females and 14.4 years for males).

- A child born in 1982 could expect to live 74.5 years, about 27 years longer than a child born in 1900. The major part of this increase occurred because of reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 2.5 years since 1960.

- About 1.9 million persons celebrated their 65th birthday in 1982 (5,200 per day). In the same year, about 1.4 million persons 65 or older died, resulting in a net increase of over 560,000 (1,550 per day).

Future Growth

- The older population is expected to continue to grow in the future (see fig. 1). This growth will slow somewhat during the 1990s because of the relatively small number of babies born during the Great Depression of the 1930s. The most rapid increase is expected between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

- By 2030, there will be about 65 million older persons, 2 and one-half times their number in 1980. If current fertility and immigration levels remain stable, the only age groups to experience significant growth in the next century will be those past age 55.

- By the year 2000, persons 65+ are expected to represent 13.0% of the population, and this percentage may climb to 21.2% by 2030.

Marital Status

- In 1983, older men were twice as likely to be married as older women (79% of men, 40% of women).*

- Half of the older women were widows (50%). There were over five times as many widows (7.7 million) as widowers (1.4 million).

- Although divorced older persons represented only 4% of all older persons in 1983, their numbers (nearly one million) had increased four times as fast as the older population as a whole in the preceding 20 years (2.7 times for men, 5.4 times for women).*

Living Arrangements

- The majority (67%) of older noninstitutionalized persons lived in a family setting in 1983. Approximately 8.7 million or 82% of older men, and 8.7 million or 57% of older women, lived in families (see fig. 3). The proportion living in a family setting decreased with age. An additional 2% of both men and women, or one-half million older persons, lived with nonrelatives. *See footnotes on panel 14

Racial and Ethnic Composition

- About 31% (7.9 million) of all noninstitutionalized older persons lived alone (6.2 million women, 1.6 million men). They represented 41% of older women and 15% of older men. Older persons living alone increased in number by 130% between 1960 and 1983, nearly three times the growth rate for the older population in general.*
Geographic Distribution

In 1983, about half (45%) of persons 65+ lived in seven states, California and New York had over 2 million each, and Florida, Illinois, Ohio, Pennsylvania, and Texas each had over 1 million.

Persons 65+ constituted 13% or more of the total population in eleven states (see fig. 4). Florida (17%), Arkansas, Rhode Island, Iowa, Pennsylvania, South Dakota, and Missouri (14% each); and Kansas, Maine, Massachusetts, and Nebraska (13% each).

In twelve states, the 65+ population has grown by more than 10.0% since 1980 (see fig. 5). Alaska and Nevada (24% each), Hawaii (17%), Arizona (16%), Idaho, New Mexico, South Carolina, and Utah (12% each); Florida and North Carolina (11% each); and Delaware and Washington (10% each).

Persons 65+ were slightly less likely to live in the 65+ population has grown by more than 10% in eleven states (see fig. 4). Florida (17%), Alaska and Nevada (24% each), Hawaii (17%), Arizona (16%), Idaho, New Mexico, South Carolina, and Utah (12% each); Florida and North Carolina (11% each); and Delaware and Washington (10% each).

The elderly are less likely to change residence than other age groups. In 1960, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). About 32% of older persons live in central cities, and 39% live in suburbs.

The elderly are less likely to change residence than other age groups. In 1960, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). The elderly are less likely to change residence than other age groups. In 1960, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). About 32% of older persons live in central cities, and 39% live in suburbs.

The elderly are less likely to change residence than other age groups. In 1960, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). The elderly are less likely to change residence than other age groups. In 1960, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). About 32% of older persons live in central cities, and 39% live in suburbs.
The nine states with the highest poverty rates for older persons in 1979 were all in the South (see fig. 6). Mississippi (34%), Alabama, Arkansas, and Louisiana (28% each), Georgia (26%), South Carolina and Tennessee (25% each), North Carolina (24%), and Kentucky (23%).

Elderly persons living alone or with nonrelatives were likely to have low incomes, with half (51%) reporting $7,000 or less. Nearly a third (31%) had incomes under $5,000, while only 17% had $15,000 or more. The median income in 1983 for these individuals was $6,938 ($7,364 for Whites and $4,505 for Blacks).

The major source of income for older families and individuals in 1982 was Social Security (37%), followed by earnings (24%), asset income (23%), public and private pensions (13%), and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).

Older households were more likely than younger households to have one or more members covered by Medicaid in 1982 (13% vs. 9%), but less likely to have received food stamps (6% vs. 9%). About one-fourth (22%) of older renter households lived in publicly owned or subsidized housing (9% for younger renters).

For single copies of this brochure, write:
Profile of Older Americans: 1984
Department of Aging
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20006

For multiple copies of this brochure, write:
Program Resources Department
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20006

The major source of income for older families and individuals in 1983 was Social Security (37%), followed by earnings (24%), asset income (23%), public and private pensions (13%), and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).

Older households were more likely than younger households to have one or more members covered by Medicaid in 1982 (13% vs. 9%), but less likely to have received food stamps (6% vs. 9%). About one-fourth (22%) of older renter households lived in publicly owned or subsidized housing (9% for younger renters).

For single copies of this brochure, write:
Profile of Older Americans: 1984
Department of Aging
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20006

For multiple copies of this brochure, write:
Program Resources Department
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20006

Income

- The median income of older persons in 1983 was $9,766 for males and $5,599 for females. These incomes were 6% and 4.4% higher, respectively, than in 1982 but the increases were not statistically significant after adjusting for inflation.

- Families headed by persons 65+ reported a median income in 1983 of $16,862 ($17,342 for Whites and $10,438 for Blacks). Nearly one of every four (23%) families with an elderly head had incomes less than $10,000 and 23% had incomes of $25,000 or more (see fig. 7).

- Elderly persons living alone or with nonrelatives were likely to have low incomes, with half (51%) reporting $7,000 or less. Nearly a third (30%) had incomes under $5,000, while only 17% had $15,000 or more. The median income in 1983 for these individuals was $6,938 ($7,364 for Whites and $4,505 for Blacks).

- The major source of income for older families and individuals in 1982 was Social Security (37%), followed by earnings (24%), asset income (23%), public and private pensions (13%), and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).

- Older households were more likely than younger households to have one or more members covered by Medicaid in 1982 (13% vs. 9%), but less likely to have received food stamps (6% vs. 9%). About one-fourth (22%) of older renter households lived in publicly owned or subsidized housing (9% for younger renters).

Poverty

- About 3.7 million elderly persons were below the poverty level in 1983. The poverty rate for persons 65+ was 14%, less than the rate for persons 65 (15.4%). Another 2.2 million or 8% of the elderly were classified as "near poor." In general, the poverty level and 125% of this level. In total, one-fourth (22%) of the older population were poor or near-poor in 1983.

- One of every eight (12%) elderly Whites was poor, compared to one-third (36%) of elderly Blacks and about one-fourth (23%) of elderly Hispanics.

- Older women had a higher poverty rate (17%) than older men (10%). Likewise, older persons living alone or with nonrelatives were more likely to be poor (26%) than were older persons living in families (9%).

- The percent of elderly below the poverty level was higher in nonmetropolitan areas (18%) than in metropolitan areas (12%).

Housing

- The housing of older Americans is generally older and less adequate than the balance of the nation's housing. About 40% of homes owned by older persons in 1980 were built prior to 1940 (23% for younger owners) and 9% were classified as inadequate in 1981 (6% for younger owners).

- Households headed by older persons in 1980 spent about the same percentage of their incomes (22%) on housing (excluding maintenance and repair) as did younger households (20%). However, this similarity is due to the larger proportion of older households which own their own home free and clear. The percentage of income spent on housing was higher for older households than for younger households among homeowners without a mortgage (16% vs. 10%), homeowners with a mortgage (26% vs. 19%), and renters (32% vs. 25%).

- In 1981, the median value of homes owned by older persons was $44,400 ($28,900 for Blacks and $53,300 for Hispanics). About 6% of older homeowners in 1980 owned their homes free and clear.

Employment

- About 12% or 3 million older Americans were in the labor force (working or actively seeking work) in 1983, including 1.6 million men and 1.2 million women. They constituted 3% of the U.S. labor force. About 4% of these were unemployed.

*See footnotes on page 14.
The need for functional assistance also increases sharply with age (see fig. 8). In 1979-80, about 2.7 million older persons living in the community needed the assistance of another person to perform one or more selected personal care or home management activities. This figure represented 11.5% of institutionalized older persons (9% of males, 14% of females), but the percentage ranged from 7% for persons 65-74 to 16% for persons 75-84 and 39% for persons 85+ (31% of males, 44% of females). (Selected personal care activities included bathing, dressing, eating, using the toilet, getting in or out of a bed or chair, or caring for a bowel control device. Selected home management activities included walking or going outside, preparing meals, shopping, routine chores, or handling money. Persons were classified as needing assistance if they needed help from another person to do one or more of these activities, could not do one or more of them at all, or stayed in bed all or most of the time.)

Figure 8
PERCENT NEEDING FUNCTIONAL ASSISTANCE, BY AGE: 1979-80

Most older persons have at least one chronic condition and many have multiple conditions. The most frequently occurring conditions for the elderly in 1981 were arthritis (46%), hypertension (38%), hearing impairments and heart conditions (29% each), skin conditions (19%), visual impairments and orthopedic impairments (14% each), arthritis (10%), and diabetes (8%).

Footnotes:
* Numbers or percentages in paragraphs and figures followed by this symbol refer to the noninstitutionalized population only.
** By the official 1983 definition of $6,023 for average income household or $4,775 for an older individual living alone.
THE CONTINUING CARE RETIREMENT COMMUNITY

A GUIDEBOOK FOR CONSUMERS

AAHA
American Association of Homes for the Aging
1050 17th St., N.W., Suite 770
Washington, D.C. 20036

Sister Marie Michelle Peartree, President
Sheldon L. Goldberg, Executive Vice President
Deborah A. Cloud, Editor
About This Guidebook

_The Continuing Care Retirement Community: A Guidebook for Consumers_ has been published by the American Association of Homes for the Aging to assist persons about to enter a home for the aging and their families in evaluating contractual arrangements for continuing care (sometimes called “life care”) offered by certain retirement communities.

This guidebook examines all aspects of the contractual arrangements for continuing care. It contains information about payment plans for care, financial conditions of the facility, facility administration, styles of shelter and service, refunds and adjustments in fees, and a checklist of facts the consumer should know before signing a continuing care contract.

The first edition of this guidebook was prepared by a committee of members of the American Association of Homes for the Aging: Eugene T. Hackler, Esq., chairman, Olathe, Kans.; Lloyd Gluck, Esq., Pittsburgh, Pa.; Richard E. Ice, Oakland, Calif.; John A. Murdock, New York, N.Y.; and Robert Parry, Bradenton, Fla. Present and former AAHA staff members who contributed materially to the first or second editions are Lois Wasser, Ann Trueblood Raper, and Deborah A. Cloud. The association also thanks the many individual consumers, providers and representatives of national organizations whose contributions made this publication possible.
Continuing Care

Continuing care (also called life care) contracts are available in a variety of settings: retirement communities, facilities, and centers; residential or personal care facilities; and, in some cases, nursing care centers and facilities. Traditionally, continuing care is offered by organizations sponsored by churches, fraternal groups, and other nonprofit, community groups.

A continuing care contract is a legal agreement between you and a continuing care provider to secure living accommodations and services, including health care services, over the long term. The costs for services and health care are at least partly pre-paid by you.

The continuing care contract spells out the provider's obligations to you for the length of the contract. One way a continuing care contract differs from contracts offered by other types of retirement communities and nursing care facilities is that it remains in effect for longer than one year, usually for the rest of your lifetime.

Continuing care contracts can offer the security of knowing you will have a place to live and the services you will need for many years to come. But because contracts can be complicated, it is sometimes difficult to determine whether the provisions of a contract and the organization offering it will be able to meet your needs in the future.

This guidebook has been written to help you understand continuing care and evaluate several important aspects of continuing care contracts and providers. A "Consumer Checklist" is included to suggest questions you should ask and information to consider before signing a continuing care contract. Entering into a continuing care agreement involves a long-term commitment on the part of the provider and a high degree of trust on the part of the resident: yourself. Your trust can be well-placed if it is backed up by "doing your homework."

Paying for Care

Because the continuing care retirement community provides care for life, it necessarily involves a financial investment by the resident. But when you consider that continuing care residents may enjoy more active lives longer than older persons living alone and that your needs, regardless of how they might change after entering the community, will be met for the rest of your life (although some
contracts may specify certain exclusions—read terms carefully), then continuing care can be a prudent use of retirement income.

Many continuing care providers use principles from actuarial science to set their fee schedules just as insurance companies do. Before signing a contract for continuing care, you should clearly understand the fees and the payment schedule by which you will be expected to pay for the shelter and services you receive.

Keep in mind that some continuing care retirement communities and facilities have more than one type of contract and payment plan for continuing care, enabling residents to choose the plan most convenient or beneficial to them.

**Entrance Fee with Monthly Payments.** The most common type of continuing care arrangement requires the consumer to pay a one-time, lump-sum payment upon becoming a resident of the community and to make monthly payments thereafter. These fees vary from place to place depending on the type of living arrangements and services provided. When comparing fees and contracts, it is important to know exactly which services are covered by the basic monthly fees and which are available for an additional charge.

**Changes in Fees.** Because monthly fees are related to the services offered, it is reasonable to expect that they will vary according to changes in the economy as a whole: that is, when the facility's cost of services goes up or down, the monthly fee will be adjusted. The continuing care contract should spell out the circumstances, if any, under which the monthly fee will be increased or decreased.

**Advance Deposits.** Continuing care retirement communities under construction, and those already in operation with waiting lists, require deposits from potential residents in order to secure their future places in the community. These deposits, less any processing fees, should be refundable and should be placed in an escrow account. Obtain assurance of this in writing, and clearly understand the terms by which either you or the continuing care provider can terminate the pre-occupancy reservation agreement.

**Role of Medicare and Private Insurance.** Although Medicare does not cover long-term nursing care for the most part, it does cover many of the other medical and health care services provided by a continuing care retirement community. Many communities require you to have both Part A and Part B Medicare coverage as well as private insurance, such as the Blue Cross/Blue Shield 65 Special Plan. Full-service or comprehensive continuing care contracts cover much of the cost, most significantly the cost of long-term nursing care, not paid by these insurance plans.
A new type of insurance is being developed which will be increasingly important to consumers of continuing care: long term care insurance. Continuing care providers may begin offering modified contracts to complement this new insurance plan. Read the details carefully and know exactly what is covered by the contract you sign and the fees you pay.

**Policies on Refunds.** Before signing a continuing care contract, make sure the conditions under which refunds are available and owed to you are clearly stated in the contract and understood by you. Because there is no consistent policy regarding refunds among continuing care providers, the specific refund policy and schedule followed by any particular community should be part of the contract you sign. If you decide to leave the community voluntarily, the amount of your refund probably will be related to the length of time you have lived there and may be contingent upon a new resident taking your place.

Some facilities make a refund to a resident's estate in the event of his or her death; many do not. The community's policy regarding refunds in the event of death should be included in the terms of the continuing care contract.

**Policies Regarding Contract Termination and Transfer.** It is important to know in advance under what circumstances the continuing care contract can be terminated by the provider. The terms and procedure for such a termination should be carefully spelled out in the contract, and you should understand what they are.

Similarly, find out how the decision is made to move permanently from your living accommodation to the health care center or another facility. The contract should state clearly what, if any, adjustment will be made in the monthly fee in the event of a permanent transfer. In addition, the contract should state the length of time a resident's living quarters will be maintained by the community during a temporary transfer to the health center or another facility. If you are one of two persons living together in one living unit, the contract should state whether or not the remaining resident can stay in the same unit in the event the other is permanently transferred to the health center. In this case, determine what, if any, adjustments will be made to your monthly payments.
Community Sponsorship

Nonprofit continuing care retirement communities have sponsors who assume some responsibility for running them. Finding out who sponsors a community can help you determine its quality of service and reputation. For example, a nonprofit continuing care community may be sponsored by a church, fraternal group, or other community organization, and its members will have an interest in maintaining its high standards.

Before signing a continuing care contract, determine the financial and other obligations that exist between the sponsor and the continuing care retirement community. While almost all sponsors have a strong, moral commitment to the financial security of a community, it is less likely that a sponsor has a binding, legal obligation for it financially. In addition to the sponsor's financial obligations, you will want to know the other ways in which a sponsor is involved, including whether the sponsor is responsible for setting operating policies.

Boards of directors or trustees also assume responsibilities for establishing policies, assuring good administration, and making long-range plans for continuing care retirement communities. These boards are made up of community people, often members of the sponsoring organization, interested in the well-being of residents. Ask for a list of the board members' names and business addresses.

Some communities are owned for profit by a single person, partnership, private corporation, or other legal entity. Unlike nonprofit continuing care retirement communities, they do not have sponsors. They do, however, have boards of directors, though the boards are not always local. Find out who owns equity or beneficial interest in the community you are considering; request their names, business addresses and summaries of their business experiences related to continuing care.

Community Management

The way a continuing care retirement community is administered affects both the quality of care offered residents and the community's long-term financial stability. In a majority of communities, the board hires an executive director or administrator to manage the...
community. About one-third of continuing care communities are administered by a separate management company under contract to the board of directors or sponsoring organization. In either case, look into the financial and contractual relationships among these parties and parent or related organizations.

Along with your financial or legal advisor, determine whether the persons or corporations who own, and especially those who manage, the community have sufficient stability, experience, and commitment to provide you the services and care covered in the continuing care contract, not only for now but for the foreseeable future.

On your visit to a continuing care retirement community, talk with the administrator long enough to get a feeling for his or her involvement with the community and experience in continuing care management. Look over the community, talk with several staff members and visit a few residents. This will give you an opportunity to see and hear how the community is run. Ask to see a copy of the "resident handbook" and learn how rules and regulations are established, including the roles residents have in determining them.

Any nursing unit within the continuing care community must be inspected regularly by a government official to determine if the nursing facility is in compliance with federal and state standards. The most recent inspection report should be available from the continuing care provider upon request. You may also wish to meet briefly with the medical director and tour the nursing facilities. Although you may not need them when you first move to a continuing care retirement community, you will want to know about the quality of care, the various therapies and programs available, and the overall appearance of the health care facilities.

Discuss with the administrator or his or her representative the community's policies and practices regarding issues concerning you. For example: Is an allowance made for long absences from the community? Can you bring a pet with you? If you remarry, can your new spouse become a resident also? If a level of nursing care you require is not available at the community, who decides where you go? When? Who pays? These are examples; if you have specific concerns, discuss them with the administrator and, if appropriate, make any agreements part of the contract, or at the very least, get them in writing.

The community you choose should offer security and protection while at the same time allowing you to maintain your lifestyle and maximum independence. You should be able to retain the right to make decisions affecting your life, the right to participate in the life of the community, and the right to privacy.
Entrance Requirements. Learn whether the community has any restrictions for signing a contract and becoming a resident regarding minimum and maximum age at entrance, health conditions, economic resources, and marital status. Determine what, if any, insurance coverage you are required to have. Generally, continuing care retirement communities want you to come to the community while you are still independent and able to “do for yourself.” If continuing care is your choice, don’t wait too long to make the move.

Shelter and Services

In a continuing care retirement community some kinds of services will be provided at the regular fee; other services may be available only for additional charges. The contract you sign should describe the type of shelter and services covered under the payment schedule listed in the contract. While it is difficult to offer an exhaustive list of services that can be found in continuing care retirement communities, the following are among services that may be offered.

- Accommodation (living quarters)
- Utilities
- Meals and prescribed diets
- Housecleaning and laundry
- Maintenance and repairs
- Lawn maintenance and landscaping
- Transportation
- Recreational and educational opportunities
- Security system
- Emergency alert and assistance
- Personal assistance (such as with bathing and walking)
- Social services
- Medical care (physician’s visits)
- Nursing care
- Rehabilitation and physical therapy

For each service, ask how often and for how long it will be available. For example, if housecleaning is to be provided, you need to know whether it will be available daily, weekly, or on another schedule. If nursing care is promised, find out if there is a limit to the number of days or type of care covered under the contract.

Pay particular attention to specific types of care or services ex-
cluded by the contract terms. Generally, contracts offered by continuing care retirement communities do not cover such things as refractions, eye glasses, hearing aids, dentistry, dentures, podiatry services, and psychiatric treatment.

The Community’s Financial Condition

In order to deliver the services it promises over the length of a continuing care contract, a continuing care retirement community must be financially sound. It is difficult, however, to evaluate a community’s financial condition, particularly if it is a new one with no “track record” of success. Therefore, some people find it helpful to have their banker, accountant, or another financial advisor assist them in determining the financial stability of a community.

Any continuing care retirement community you are considering should make its financial condition known to you. A report on its most recent financial audit, conducted by a reputable accounting firm, should be available upon request.

Some state laws now require continuing care communities to give financial disclosure statements to prospective residents; communities in other states may do so voluntarily. But merely having such statements and annual reports does not necessarily mean you can ascertain a community’s financial health.

A continuing care retirement community that has been in operation for more than one year should have an established reserve account, separate from escrowed funds required by the mortgage lender or bond holders, to cover residents’ future health care costs. On some audited balance sheets this reserve appears as “deferred income” or “unamortized entry fees.” Look for such an item on financial statements, or ask the community for an explanation of future cost coverage.

Although communities under construction will not yet have established reserve accounts, their projected financial statements should indicate plans for such accounts. These projected statements should be available upon request.
Where to Get More Information

This guidebook has been written to assist you in weighing the advantages and disadvantages of any contractual arrangement for continuing care in which you are interested. The checklist beginning on page 11 will serve as a guide to the information you need to decide if a continuing care retirement community, and the contract for care it offers, will meet your individual needs.

Some states have enacted legislation and established regulations concerning continuing care providers. Contact your state association of homes for the aging, the department of health or insurance, or the state office on aging for more information on continuing care in your state.

For details about fees, special features and services provided by individual communities, consult the National Continuing Care Directory. The book, available in 1984, is a joint effort of the American Association of Homes for the Aging and the American Association of Retired Persons with support from The Commonwealth Fund. To order, write to AARP Books, 400 S. Edward St., Mount Prospect, IL 60056. Enclose $13.95 plus $1.30 postage and handling. If you are a member of AAHA or AARP, include your membership number and pay $9.95 plus $1.30 postage and handling.

Signing the Contract:
A Final Word

To make certain the continuing care provider will deliver the services you need, carefully review the written contract with appropriate personnel and your advisors using this booklet as a guide.

A few communities employ commissioned salespersons to seek out prospective residents. While most salespersons perform a legitimate function for the communities that employ them, they are not authorized to promise any services not listed in the written contract. By closing the contract with a paid staff member responsible for admissions, you will reduce any chance of misunderstanding about what is being provided and what your obligations will be.

Do not be pressured into signing any contract in a hurry. Reputable communities will want you to be satisfied with any arrangement you make and will encourage you to ask questions and get the information you need to make the decision that is right for you.
Consumer Checklist

Paying for Care

☐ Check with several continuing care retirement communities in your area offering similar services and contracts to determine if the fees are competitive.

☐ Find out how you will be expected to pay for the care you receive.

☐ Find out under what circumstances, if any, the monthly charges will be raised or lowered.

☐ Know what the community's policy is concerning residents who become unable to pay the monthly charges.

☐ Make sure any refundable deposit you are required to make prior to occupancy, in order to reserve accommodations for the future, is adequately protected.

☐ Receive assurance in writing that any large payment you are making prior to occupancy to reserve accommodations for the future will be returned in full in the event you decide not to enter the community.

☐ Learn what insurance coverage is required upon entering the community.

☐ Make sure the contract spells out the terms for refunding any fees paid by a resident in the event of terminating the contract.

☐ Find out what adjustment, if any, will be made in the monthly fee in the event a resident is transferred to other accommodations within the community, such as the nursing care facility.

☐ Find out how long a resident's living unit will be maintained when he or she is temporarily transferred to other accommodations within the community.

☐ Find out what refunds will be made in the event a resident decides to leave the community voluntarily.

☐ Find out whether or not a refund is available in the event of the death of a resident.

☐ Find out the circumstances under which a contract can be terminated by the community.
Find out the circumstances under which a resident can be transferred within the community, and learn how the decision is made.

Community Sponsorship

- Learn who sponsors or owns the community.
- Determine the sponsor's financial and other relationships to the community.
- Find out who is on the board of directors and determine their responsibilities to the community.

Community Management

- Meet the administrator.
- Review a copy of the "rules and regulations" and determine the role residents have in establishing them.
- Ask for, and receive, a copy of the most recent government inspection report for any nursing unit the community maintains.
- Determine whether the community is properly licensed and certified, if required by law.
- Visit with residents of the community to find out if they are satisfied.
- Discuss the community with its volunteers and staff.
- Ask about the admission policies and requirements.

The Community's Financial Condition

- Discuss with your financial advisor the community's audited annual report, or discuss projected financial statements with appropriate facility personnel.
- Determine the community's financial condition with your banker, accountant, or another qualified financial advisor.
- Ask for, and obtain, a copy of a report on the community's most recent financial or actuarial audit.
- Determine what kinds of reserves are being held by the community and how they are presented on the annual financial audit.
About Shelter, Services and Care

☐ Find out what shelter, services, and care are covered by the terms of the contract.

☐ Find out what shelter, services, and care are available only for additional fees.

☐ Determine how often each service will be available, and be sure it is stated in the contract.

☐ Determine for how long each service will be provided, as stated in the contract.

☐ Tour the nursing or health care facilities and meet the medical director and other staff members.

About Signing the Contract

☐ Review the contract with your legal representative.

☐ Review the contract with the community's administrator or other paid staff member in authority.