HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 10. Continuing Care Contracts [1770 - 1793.91] *(Chapter 10 repealed and added by Stats. 1990, Ch. 875, Sec. 2.)*

ARTICLE 6. Reporting and Reserve Requirements [1789 - 1793] *(Article 6 added by Stats. 1990, Ch. 875, Sec. 2.)*

1789. (a) A provider shall notify the department and obtain its approval before making any changes to any of the following: its name; its business structure or form of doing business; the overall management of its continuing care retirement community; or the terms of its financing.

(b) The provider shall give written notice of proposed changes to the department at least 60 calendar days in advance of making the changes described in this section.

(c) This notice requirement does not apply to routine facility staff changes.

(d) Within 10 calendar days of submitting notification to the department of any proposed changes under subdivision (a), the provider shall notify the resident association of the proposed changes in the manner required by subdivision (e) of Section 1779.

(Amended by Stats. 2000, Ch. 820, Sec. 52. Effective January 1, 2001.)

1789.1. (a) Before executing a deposit agreement or continuing care agreement, or receiving any payment from a depositor or prospective resident, a provider shall deliver to the other parties in the deposit or continuing care agreement a disclosure statement in the form prescribed by the department.

(b) The department shall issue a disclosure statement form that shall generally require disclosure, at a minimum, of the following information:

(1) General information regarding the provider and the continuing care retirement community, including at a minimum all of the following:

(A) The continuing care retirement community's name, address, and telephone number.

(B) The type of ownership, names of the continuing care retirement community's owner and operator, the names of any affiliated facilities, and any direct religious affiliation.

(C) Whether accredited and by what organization.

(D) The year the continuing care retirement community opened and the distance to the nearest shopping center and hospital.

(E) Whether the continuing care retirement community offers life care contracts or continuing care contracts, and whether the continuing care retirement community is single story or multistory.

(F) The number of the continuing care retirement community's studio units, one bedroom units, two bedroom units, cottages or houses, assisted living beds, and skilled nursing beds.

(G) The continuing care retirement community's percentage occupancy at the provider's most recent fiscal yearend.

(H) The form of contracts offered, the range of entrance fees, the percentages of a resident's entrance fees that may be refunded, and the health care benefits included in contract.

(I) Any age and insurance requirements for admission.

(J) A listing of common area amenities and other services included with the monthly service fee, and a listing of those amenities and services that are available for an additional charge.

(K) The number of meals each day included in the monthly service fee, the number of meals available for an extra charge, the frequency of housekeeping services, and additional cost, if any , for housekeeping services.

(2) Income from operations during the most recent five years for which audited financial statements have been completed, including all of the following:

(A) Operating income (excluding amortization of entrance fee income).

(B) Operating expense (excluding depreciation, amortization, and interest).

(C) Net income from operations.

(D) Interest expense.

(E) Unrestricted contributions.

(F) Nonoperating income or expense, excluding extraordinary items.

(G) Net income or loss before entrance fees.

(H) Net cash-flow from entrance fees, that is the total deposits less refunds.

(3) The name of the lender, outstanding balance, interest rate, date of origination, date of maturity, and amortization period for all secured debt.

(4) Financial ratios for each of the three most recent years for which audited financial statements have been prepared, including all of the following: debt-to-asset ratio, operating ratio, debt service coverage ratio, and days cash-on-hand. The formulas for each ratio shall be determined by the department after consultation with the Continuing Care Advisory Committee.

(5) The average monthly service fees charged during the most recent five years, and the percentage changes in the average from year to year, for each of the following: studio units, one bedroom units, two bedroom units, cottages and houses, assisted living units, and skilled nursing units.

(6) Comments from the provider explaining any of the information included in the disclosure form.

(c) Each provider shall update its disclosure statement at least annually when it completes its annual audited financial statements. Each provider shall file its updated version of the disclosure statement with the department not later than the final filing date for its annual report.

(d) The form prescribed by the department under this section shall be used by providers to comply with the requirements of this section.

(Added by Stats. 2000, Ch. 820, Sec. 53. Effective January 1, 2001.)

1789.2. (a) A provider shall provide the department with written notice at least 90 calendar days prior to closing any transaction that results in an encumbrance or lien on a continuing care retirement community property or its revenues.

(b) The written notice required by this section shall include all of the following:

(1) A description of the terms and amount of the proposed transaction.

(2) An analysis of the sources of funds for repayment of principal and interest.

(3) An analysis of the impact of the proposed transaction on monthly care fees.

(4) An analysis of the impact that the proposed encumbrance would have on assets available for liquid reserves required by Section 1792, and refund reserves required by Section 1792.6.

(c) Within seven calendar days of receipt of notice of proposed changes, the department shall acknowledge receipt of the notice in writing.

(d) Within 30 calendar days following its receipt of the notice, the department shall inform the provider in writing whether additional materials are required to evaluate the transaction.

(e) Within 90 calendar days following its receipt of additional materials, the department shall inform the provider of its approval or denial of the proposed transaction.

(f) Providers shall not execute the proposed financial transaction for which notice has been given pursuant to subdivision (a) without the department's written authorization unless either the 30-day response period or the 90 calendar day period for the department's review of the provider's request has expired without any response by the department.

(g) If the department determines that the proposed financial transaction will materially increase monthly care fees or impair the provider's ability to maintain required reserves, the department may:

(1) Refuse to approve the transaction.

(2) Record a notice of lien on the provider's property pursuant to Section 1793.15 after notifying the provider and giving the provider an opportunity to withdraw the planned transaction.

(3) Take both actions and any other action that it determines is necessary to protect the best interests of the residents.

(h) Within 10 calendar days of submitting notification to the department of any proposed encumbrance to the community property, the provider shall notify the resident governing body or association of the proposed encumbrance in the manner required by subdivision (e) of Section 1779.

(Amended by Stats. 2000, Ch. 820, Sec. 54. Effective January 1, 2001.)

1789.4. (a) A provider for a continuing care retirement community shall obtain approval from the department before consummating any sale or transfer of the continuing care retirement community or any interest in that community, other than sale of an equity interest in a unit to a resident or other transferor.

(b) The provider shall provide written notice to the department at least 120 calendar days prior to consummating the proposed transaction.

(c) The notice required by this section shall include all of the following:

(1) The identity of the purchaser.

(2) A description of the terms of the transfer or sale, including the sales price.

(3) A plan for ensuring performance of the existing continuing care contract obligations.

(d) The provider shall give written notice to all continuing care contract residents and depositors 120 calendar days prior to the sale or transfer. The notice shall do all of the following:

(1) Describe the parties.

(2) Describe the proposed sale or transfer.

(3) Describe the arrangements for fulfilling continuing care contract obligations.

(4) Describe options available to any depositor or resident who does not wish to have his or her contract assumed by a new provider.

(5) Include an acknowledgment of receipt of the notice to be signed by the resident.

(e) Unless a new provider assumes all of the continuing care obligations of the selling provider at the close of the sale or transfer, the selling provider shall set up a trust fund or secure a performance bond to ensure the fulfillment of all its continuing care contract obligations.

(f) The purchaser shall make applications for, and obtain, the appropriate licenses and a certificate of authority before executing any continuing care contracts or assuming the selling provider's continuing care contract obligations.

(Amended by Stats. 2000, Ch. 820, Sec. 55. Effective January 1, 2001.)

1789.6. A provider shall record with the county recorder a "Notice of Statutory Limitation on Transfer" for each community as required by subdivision (aa) of Section 1779.4 and Section 1786.

(Amended by Stats. 2000, Ch. 820, Sec. 56. Effective January 1, 2001.)

1789.8. Each provider shall obtain and maintain in effect insurance or a fidelity bond for each agent or employee, who, in the course of his or her agency or employment, has access to any substantial amount of funds. This requirement is separate from the bonding requirements of residential care facility for the elderly regulations.

(Amended by Stats. 2000, Ch. 820, Sec. 57. Effective January 1, 2001.)

1790. (a) Each provider that has obtained a provisional or final certificate of authority and each provider that possesses an inactive certificate of authority shall submit an annual report of its financial condition. The report shall consist of audited financial statements and required reserve calculations, with accompanying certified public accountants' opinions thereon, the reserve information required by paragraph (2), Continuing Care Provider Fee and Calculation Sheet, evidence of fidelity bond as required by Section 1789.8, and certification that the continuing care contract in use for new residents has been approved by the department, all in a format provided by the department, and shall include all of the following information:

(1) A certification, if applicable, that the entity is maintaining reserves for prepaid continuing care contracts, statutory reserves, and refund reserves.

(2) Full details on the status, description, and amount of all reserves that the provider currently designates and maintains, and on per capita costs of operation for each continuing care retirement community operated.

(3) Disclosure of any amounts accumulated or expended for identified projects or purposes, including, but not limited to, projects designated to meet the needs of the continuing care retirement community as permitted by a provider's nonprofit status under Section 501(c)(3) of the Internal Revenue Code, and amounts maintained for contingencies. The disclosure of a nonprofit provider shall state how the project or purpose is consistent with the provider's tax-exempt status. The disclosure of a for-profit provider shall identify amounts accumulated for specific projects or purposes and amounts maintained for contingencies. Nothing in this subdivision shall be construed to require the accumulation of funds or funding of contingencies, nor shall it be interpreted to alter existing law regarding the reserves that are required to be maintained.

(4) Full details on any increase in monthly care fees, the basis for determining the increase, and the data used to calculate the increase.

(5) The required reserve calculation schedules shall be accompanied by the auditor's opinion as to compliance with applicable statutes.

(6) Any other information as the department may require.

(b) Each provider shall file the annual report with the department within four months after the provider's fiscal yearend. If the complete annual report is not received by the due date, a one thousand dollar ($1,000) late fee shall accompany submission of the reports. If the reports are more than 30 days past due, an additional fee of thirty-three dollars ($33) for each day over the first 30 days shall accompany submission of the report. The department may, at its discretion, waive the late fee for good cause.

(c) The annual report and any amendments thereto shall be signed and certified by the chief executive officer of the provider, stating that, to the best of his or her knowledge and belief, the items are correct.

(d) A copy of the most recent annual audited financial statement shall be transmitted by the provider to each transferor requesting the statement.

(e) A provider shall amend its annual report on file with the department at any time, without the payment of any additional fee, if an amendment is necessary to prevent the report from containing a material misstatement of fact or omitting a material fact.

(f) If a provider is no longer entering into continuing care contracts, and currently is caring for 10 or fewer continuing care residents, the provider may request permission from the department, in lieu of filing the annual report, to establish a trust fund or to secure a performance bond to ensure fulfillment of continuing care contract obligations. The request shall be made each year within 30 days after the provider's fiscal yearend. The request shall include the amount of the trust fund or performance bond determined by calculating the projected life costs, less the projected life revenue, for the remaining continuing care residents in the year the provider requests the waiver. If the department approves the request, the following shall be submitted to the department annually:

(1) Evidence of trust fund or performance bond and its amount.

(2) A list of continuing care residents. If the number of continuing care residents exceeds 10 at any time, the provider shall comply with the requirements of this section.

(3) A provider fee as required by subdivision (c) of Section 1791.

(g) If the department determines a provider's annual audited report needs further analysis and investigation, as a result of incomplete and inaccurate financial statements, significant financial deficiencies, development of work out plans to stabilize financial solvency, or for any other reason, the provider shall reimburse the department for reasonable actual costs incurred by the department or its representative. The reimbursed funds shall be deposited in the Continuing Care Contract Provider Fee Fund.

(Amended by Stats. 2009, Ch. 513, Sec. 1. (AB 1169) Effective January 1, 2010.)

1791. (a) An annual fee shall be required of each provider which has obtained a provisional or final certificate of authority.

(b) Each annual report submitted pursuant to Section 1790 shall be accompanied by a payment to the Continuing Care Provider Fee Fund in the amount of one-tenth of 1 percent of the portion of total operating expenses, excluding debt service and depreciation from audited financial statements, which has been allocated to continuing care contract residents. The allocation shall be based on the ratio of the mean number of total residents.

(c) If a provider is granted an exemption from filing annual reports to the department pursuant to subdivision (f) of Section 1790, the minimum annual provider fee shall be two hundred fifty dollars ($250). This fee shall be submitted after the end of the provider's fiscal year with proof of trust fund or performance bond as required by subdivision (f) of Section 1790.

(Amended by Stats. 1995, Ch. 920, Sec. 45. Effective January 1, 1996.)

1792. (a) A provider shall maintain at all times qualifying assets as a liquid reserve in an amount that equals or exceeds the sum of the following:

(1) The amount the provider is required to hold as a debt service reserve under Section 1792.3.

(2) The amount the provider must hold as an operating expense reserve under Section 1792.4.

(b) The liquid reserve requirement described in this section is satisfied when a provider holds qualifying assets in the amount required. Except as may be required under subdivision (d), a provider is not required to set aside, deposit into an escrow, or otherwise restrict the assets it holds as its liquid reserve.

(c) A provider shall not allow the amount it holds as its liquid reserve to fall below the amount required by this section. In the event the amount of a provider's liquid reserve is insufficient, the provider shall prudently eliminate the deficiency by increasing its assets qualifying under Section 1792.2.

(d) The department may increase the amount a provider is required to hold as its liquid reserve or require that a provider immediately place its liquid reserve into an escrow account meeting the requirements of Section 1781 if the department has reason to believe the provider is any of the following:

(1) Insolvent.

(2) In imminent danger of becoming insolvent.

(3) In a financially unsound or unsafe condition.

(4) In a condition such that it may otherwise be unable to fully perform its obligations pursuant to continuing care contracts.

(e) For providers that have voluntarily and permanently discontinued entering into continuing care contracts, the department may allow a reduced liquid reserve amount if the department finds that the reduction is consistent with the financial protections imposed by this article. The reduced liquid reserve amount shall be based upon the percentage of residents at the continuing care retirement community who have continuing care contracts.

(Amended by Stats. 2004, Ch. 129, Sec. 2. Effective January 1, 2005.)

1792.2. (a) A provider shall satisfy its liquid reserve obligation with qualifying assets. Qualifying assets are:

(1) Cash.

(2) Cash equivalents as defined in paragraph (4) of subdivision (c) of Section 1771.

(3) Investment securities, as defined in paragraph (2) of subdivision (i) of Section 1771.

(4) Equity securities, including mutual funds, as defined in paragraph (7) of subdivision (e) of Section 1771.

(5) Lines of credit and letters of credit that meet the requirements of this paragraph. The line of credit or letter of credit shall be issued by a state or federally chartered financial institution approved by the department or whose long-term debt is rated in the top

three long-term debt rating categories by either Moody's Investors Service, Standard and Poor's Corporation, or a recognized securities rating agency acceptable to the department. The line of credit or letter of credit shall obligate the financial institution to furnish credit to the provider.

(A) The terms of the line of credit or letter of credit shall at a minimum provide both of the following:

(i) The department's approval shall be obtained by the provider and communicated in writing to the financial institution before any modification.

(ii) The financial institution shall fund the line of credit or letter of credit and pay the proceeds to the provider no later than four business days following written instructions from the department that, in the sole judgment of the department, funding of the provider's minimum liquid reserve is required.

(B) The provider shall provide written notice to the department at least 14 days before the expiration of the line of credit or letter of credit if the term has not been extended or renewed by that time. The notice shall describe the qualifying assets the provider will use to satisfy the liquid reserve requirement when the line of credit or letter of credit expires.

(C) A provider may satisfy all or a portion of its liquid reserve requirement with the available and unused portion of a qualifying line of credit or letter of credit.

(6) For purposes of satisfying all or a portion of a provider's debt service reserve requirement described in Section 1792.3, restricted assets that are segregated or held in a separate account or escrow as a debt service reserve under the terms of the provider's long-term debt instruments are qualifying assets, subject to all of the following conditions:

(A) The assets are restricted by the debt instrument so that they may be used only to pay principal, interest, and credit enhancement premiums.

(B) The provider furnishes to the department a copy of the agreement under which the restricted assets are held and certifies that it is a correct and complete copy. The provider, escrow holder, or other entity holding the assets must agree to provide to the department any information the department may request concerning the debt service reserve it holds.

(C) The market value, or guaranteed value, if applicable, of the restricted assets, up to the amount the provider must hold as a debt reserve under Section 1792.3, will be included as part of the provider's liquid reserve.

(D) The restricted assets described in this paragraph will not reduce or count towards the amount the provider must hold in its liquid reserve for operating expenses.

(7) For purposes of satisfying all or a portion of a provider's operating expense reserve requirement described in Section 1792.4, restricted assets that are segregated or held in a separate account or escrow as a reserve for operating expenses, are qualifying assets subject to all of the following conditions:

(A) The governing instrument restricts the assets so that they may be used only to pay operating costs when operating funds are insufficient.

(B) The provider furnishes to the department a copy of the agreement under which the assets are held, certified by the provider to be a correct and complete copy. The provider, escrow holder, or other entity holding the assets shall agree to provide to the department any information the department may request concerning the account.

(C) The market value, or the guaranteed value, if applicable, of the restricted assets, up to the amount the provider is required to hold as an operating expense reserve under Section 1792.4, will be included as part of the provider's liquid reserve.

(D) The restricted assets described in this paragraph shall not reduce or count towards the amount the provider is required to hold in its liquid reserve for long-term debt.

(b) Except as otherwise provided in this subdivision, the assets held by the provider as its liquid reserve may not be subject to any liens, charges, judgments, garnishments, or creditors' claims and may not be hypothecated, pledged as collateral, or otherwise encumbered in any manner. A provider may encumber assets held in its liquid reserve as part of a general security pledge of assets or similar collateralization that is part of the provider's long-term capital debt covenants and is included in the provider's long-term debt indenture or similar instrument.

(Repealed and added by Stats. 2000, Ch. 820, Sec. 57.25. Effective January 1, 2001.)

1792.3. (a) Each provider shall include in its liquid reserve a reserve for its long-term debt obligations in an amount equal to the sum of all of the following:

(1) All regular principal and interest payments, as well as credit enhancement premiums, paid by the provider during the immediately preceding fiscal year on account of any fully amortizing long-term debt owed by the provider. If a provider has incurred new long-term debt during the immediately preceding fiscal year, the amount required by this paragraph for that debt is 12 times the provider's most recent monthly payment on the debt.

(2) Facility rental or leasehold payments, and any related payments such as lease insurance, paid by the provider during the immediately preceding fiscal year.

(3) All payments paid by the provider during the immediately preceding fiscal year on account of any debt that provides for a balloon payment. If the balloon payment debt was incurred within the immediately preceding fiscal year, the amount required by this paragraph for that debt is 12 times the provider's most recent monthly payment on the debt made during the fiscal year.

(b) If any balloon payment debt matures within the next 24 months, the provider shall submit with its annual report a plan for refinancing the debt or repaying the debt with existing assets.

(c) When principal and interest payments on long-term debt are paid to a trust whose beneficial interests are held by the residents, the department may waive all or any portion of the debt service reserve required by this section. The department shall not waive any debt service reserve requirement unless the department finds that the waiver is consistent with the financial protections imposed by this chapter.

(Added by Stats. 2000, Ch. 820, Sec. 57.3. Effective January 1, 2001.)

1792.4. (a) Each provider shall include in its liquid reserve a reserve for its operating expenses in an amount that equals or exceeds 75 days' net operating expenses. For purposes of this section:

(1) Seventy-five days net operating expenses shall be calculated by dividing the provider's operating expenses during the immediately preceding fiscal year by 365, and multiplying that quotient by 75.

(2) "Net operating expenses" includes all expenses except the following:

(A) The interest and credit enhancement expenses factored into the provider's calculation of its long-term debt reserve obligation described in Section 1792.3.

(B) Depreciation or amortization expenses.

(C) An amount equal to the reimbursement paid to the provider during the past 12 months for services to residents other than residents holding continuing care contracts.

(D) Extraordinary expenses that the department determines may be excluded by the provider. A provider shall apply in writing for a determination by the department and shall provide supporting documentation prepared in accordance with generally accepted accounting principles.

(b) A provider that has been in operation for less than 12 months shall calculate its net operating expenses by using its actual expenses for the months it has operated and, for the remaining months, the projected net operating expense amounts it submitted to the department as part of its application for a certificate of authority.

(Amended by Stats. 2004, Ch. 129, Sec. 4. Effective January 1, 2005.)

1792.5. (a) The provider shall compute its liquid reserve requirement as of the end of the provider's most recent fiscal yearend based on its audited financial statements for that period and, at the time it files its annual report, shall file a form acceptable to the department certifying all of the following:

(1) The amount the provider is required to hold as a liquid reserve, including the amounts required for the debt service reserve and the operating expense reserve.

(2) The qualifying assets, and their respective values, the provider has designated for its debt service reserve and for its operating expense reserve.

(3) The amount of any deficiency or surplus for the provider's debt service reserve and the provider's operating expense reserve.

(b) For the purpose of calculating the amount held by the provider to satisfy its liquid reserve requirement, all qualifying assets used to satisfy the liquid reserve requirements shall be valued at their fair market value as of the end of the provider's most recently

completed fiscal year. Restricted assets that have guaranteed values and are designated as qualifying assets under paragraph (6) or (7) of subdivision (a) of Section 1792.2 may be valued at their guaranteed values.

(Amended by Stats. 2004, Ch. 129, Sec. 5. Effective January 1, 2005.)

1792.6. (a) Any provider offering a refundable contract, or other entity assuming responsibility for refundable contracts, shall maintain a refund reserve in trust for the residents. The amount of the refund reserve shall be revised annually by the provider and the provider shall submit its calculation of the refund reserve amount to the department in conjunction with the annual report required by Section 1790. This reserve shall accumulate interest and earnings and shall be invested in any of the following:

(1) Qualifying assets as defined in Section 1792.2.

(2) Real estate, subject to all of the following conditions:

(A) To the extent approved by the department, the trust account may invest up to 70 percent of the refund reserves in real estate that is both used to provide care and housing for the holders of the refundable continuing care contracts and is located on the same campus where these continuing care contractholders reside.

(B) Investments in real estate shall be limited to 50 percent of the providers' net equity in the real estate. The net equity shall be the book value, assessed value, or current appraised value within 12 months prior to the end of the fiscal year, less any depreciation, and encumbrances, all according to audited financial statements acceptable to the department.

(b) Each refund reserve trust shall be established at an institution qualified to be an escrow agent. The escrow agreement between the provider and the institution shall be in writing and include the terms and conditions described in this section. The escrow agreement shall be submitted to and approved by the department before it becomes effective.

(c) The amount to be held in the reserve shall be the total of the amounts calculated with respect to each individual resident holding a refundable contract as follows:

(1) Determine the age in years and the portion of the entry fee for the resident refundable for the seventh year of residency and thereafter.

(2) Determine life expectancy of that individual based on all of the following rules:

(A) The following life expectancy table shall be used in connection with all continuing care contracts:

Age	Females	Males		Age	Females	Males
55	26.323	23.635		83	7.952	6.269
56	25.526	22.863		84	7.438	5.854
57	24.740	22.101		85	6.956	5.475
58	23.964	21.350		86	6.494	5.124
59	23.199	20.609		87	6.054	4.806
60	22.446	19.880		88	5.613	4.513
61	21.703	19.163		89	5.200	4.236
62	20.972	18.457		90	4.838	3.957
63	20.253	17.764		91	4.501	3.670
64	19.545	17.083		92	4.175	3.388
65	18.849	16.414		93	3.862	3.129
66	18.165	15.759		94	3.579	2.903
67	17.493	15.116		95	3.329	2.705
68	16.832	14.486		96	3.109	2.533

69	16.182	13.869	97	2.914	2.384
70	15.553	13.268	98	2.741	2.254
71	14.965	12.676	99	2.584	2.137
72	14.367	12.073	100	2.433	2.026
73	13.761	11.445	101	2.289	1.919
74	13.189	10.830	102	2.152	1.818
75	12.607	10.243	103	2.022	1.723
76	12.011	9.673	104	1.899	1.637
77	11.394	9.139	105	1.784	1.563
78	10.779	8.641	106	1.679	1.510
79	10.184	8.159	107	1.588	1.500
80	9.620	7.672	108	1.522	1.500
81	9.060	7.188	109	1.500	1.500
82	8.501	6.719	110	1.500	1.500

(B) If there is a couple, the life expectancy for the person with the longer life expectancy shall be used.

(C) The life expectancy table set forth in this paragraph shall be used until expressly provided to the contrary through the amendment of this section.

(D) For residents over 110 years of age, 1.500 years shall be used in computing life expectancy.

(E) If a continuing care retirement community has contracted with a resident under 55 years of age, the continuing care retirement community shall provide the department with the methodology used to determine that resident's life expectancy.

(3) For that resident, use an interest rate of 6 percent or lower to determine from compound interest tables the factor that, when multiplied by one dollar ($1), represents the amount, at the time the computation is made, that will grow at the assumed compound interest rate to one dollar ($1) at the end of the period of the life expectancy of the resident.

(4) Multiply the refundable portion of the resident's entry fee amount by the factor obtained in paragraph (3) to determine the amount of reserve required to be maintained.

(5) The sum of these amounts with respect to each resident shall constitute the reserve for refundable contracts.

(6) The reserve for refundable contracts shall be revised annually as provided for in subdivision (a), using the interest rate, refund obligation amount, and individual life expectancies current at that time.

(d) Withdrawals may be made from the trust to pay refunds when due under the terms of the refundable entrance fee contracts and when the balance in the trust exceeds the required refund reserve amount determined in accordance with subdivision (c).

(e) Deposits shall be made to the trust with respect to new residents when the entrance fee is received and in the amount determined with respect to that resident in accordance with subdivision (c).

(f) Additional deposits shall be made to the trust fund within 30 days of any annual reporting date on which the trust fund balance falls below the required reserve in accordance with subdivision (c) and the deposits shall be in an amount sufficient to bring the trust balance into compliance with this section.

(g) Providers who have used a method previously allowed by statute to satisfy their refund reserve requirement may continue to use that method.

(Added by Stats. 2000, Ch. 820, Sec. 57.36. Effective January 1, 2001.)

1792.7. (a) The Legislature finds and declares all of the following:

(1) In continuing care contracts, providers offer a wide variety of living accommodations and care programs for an indefinite or extended number of years in exchange for substantial payments by residents.

(2) The annual reporting and reserve requirements for each continuing care provider should include a report that summarizes the provider's recent and projected performance in a form useful to residents, prospective residents, and the department.

(3) Certain providers enter into "life care contracts" or similar contracts with their residents. Periodic actuarial studies that examine the actuarial financial condition of these providers will help to assure their long-term financial soundness.

(b) Each provider shall annually file with the department a report that shows certain key financial indicators for the provider's past five years, based on the provider's actual experience, and for the upcoming five years, based on the provider's projections. Providers shall file their key indicator reports in the manner required by Section 1792.9 and in a form prescribed by the department.

(c) Each provider that has entered into Type A contracts shall file with the department an actuary's opinion as to the actuarial financial condition of the provider's continuing care operations in the manner required by Section 1792.10.

(Added by Stats. 2004, Ch. 129, Sec. 6. Effective January 1, 2005.)

1792.8. (a) For purposes of this article, "actuarial study" means an analysis that addresses the current actuarial financial condition of a provider that is performed by an actuary in accordance with accepted actuarial principles and the standards of practice adopted by the Actuarial Standards Board. An actuarial study shall include all of the following:

(1) An actuarial report.

(2) A statement of actuarial opinion.

(3) An actuarial balance sheet.

(4) A cohort pricing analysis.

(5) A cashflow projection.

(6) A description of the actuarial methodology, formulae, and assumptions.

(b) "Actuary" means a member in good standing of the American Academy of Actuaries who is qualified to sign a statement of actuarial opinion.

(c) "Type A contract" means a continuing care contract that has an up-front entrance fee and includes provision for housing, residential services, amenities, and unlimited specific health-related services with little or no substantial increases in monthly charges, except for normal operating costs and inflation adjustments.

(Added by Stats. 2004, Ch. 129, Sec. 7. Effective January 1, 2005.)

1792.9. (a) All providers shall file annually with the department a financial report disclosing key financial ratios and other key indicators in a form determined by the department.

(b) The department shall issue a "Key Indicators Report" form to providers that shall be used to satisfy the requirements of subdivision (a). The Key Indicators Report shall require providers to disclose the following information:

(1) Operational data indicating the provider's average annual occupancy by facility.

(2) Margin ratios indicating the provider's net operating margin and net operating margin adjusted to reflect net proceeds from entrance fees.

(3) Liquidity indicators stating both the provider's total cash and investments available for operational expenses and the provider's days cash on hand.

(4) Capital structure indicators stating the provider's dollar figures for deferred revenue from entrance fees, net annual entrance fee proceeds, unrestricted net assets, and annual capital expenditure.

(5) Capital structure ratios indicating the provider's annual debt service coverage, annual debt service coverage adjusted to reflect net proceeds from entrance fees, annual debt service over revenue percentage, and unrestricted cash over long-term debt percentage.

(6) Capital structure indicators stating the provider's average age of facility calculation based on accumulated depreciation and the provider's average annual effective interest rate.

(c) The department shall determine the appropriate formula for calculating each of the key indicators included in the Key Indicator Report. The department shall base each formula on generally accepted standards and practices related to the financial analysis of continuing care providers and entities engaged in similar enterprises.

(d) Each provider shall file its annual Key Indicators Report within 30 days following the due date for the provider's annual report. If the Key Indicators Report is not received by the department by the date it is due, the provider shall pay a one thousand dollar ($1,000) late fee at the time the report is submitted. The provider shall pay an additional late fee of thirty-three dollars ($33) for each day the report is late beyond 30 days. For purposes of this section, a provider's Key Indicators Report is not submitted to the department until the provider has paid all accrued late fees.

(Added by Stats. 2004, Ch. 129, second Sec. 7 (Sec. 7.5). Effective January 1, 2005.)

1792.10. (a) Each provider that has entered into Type A contracts shall submit to the department, at least once every five years, an actuary's opinion as to the provider's actuarial financial condition. The actuary's opinion shall be based on an actuarial study completed by the opining actuary in a manner that meets the requirements described in Section 1792.8. The actuary's opinion, and supporting actuarial study, shall examine, refer to, and opine on the provider's actuarial financial condition as of a specified date that is within four months of the date the opinion is provided to the department.

(b) Each provider required to file an actuary's opinion under subdivision (a) that held a certificate of authority on December 31, 2003, shall file its actuary's opinion before the expiration of five years following the date it last filed an actuarial study or opinion with the department. Thereafter, the provider shall file its required actuary's opinion before the expiration of five years following the date it last filed an actuary's opinion with the department.

(c) Each provider required to file an actuary's opinion under subdivision (a) that did not hold a certificate of authority on December 31, 2003, shall file its first actuary's opinion within 45 days following the due date for the provider's annual report for the fiscal year in which the provider obtained its certificate of authority. Thereafter, the provider shall file its required actuary's opinion before the expiration of five years following the date it last filed an actuary's opinion with the department.

(d) The actuary's opinion required by subdivision (a) shall comply with generally accepted actuarial principles and the standards of practice adopted by the Actuarial Standards Board. The actuary's opinion shall also include statements that the data and assumptions used in the underlying actuarial study are appropriate and that the methods employed in the actuarial study are consistent with sound actuarial principles and practices. The actuary's opinion must state whether the provider has adequate resources to meet all its actuarial liabilities and related statement items, including an appropriate surplus, and whether the provider's financial condition is actuarially sound.

(Added by Stats. 2004, Ch. 129, Sec. 8. Effective January 1, 2005.)

1793. (a) Any provider offering a refundable contract, or other entity assuming responsibility for refundable contracts, shall maintain a refund reserve fund in trust for the residents. This trust fund shall remain intact to accumulate interest earnings resulting from investments of liquid reserves in accordance with paragraph (1) of subdivision (e) and subparagraphs (A) through (E), inclusive, of paragraph (3) of subdivision (e) of Section 1792.2. The amount of the refund reserve shall be revised annually by the provider and submitted to the department in conjunction with the annual report required by Section 1790.

(b) Any providers or other entity assuming responsibility for refundable contracts, which has not executed refundable contracts in a continuing care retirement community prior to January 1, 1996, and proposes to execute these contracts in that continuing care retirement community after that date, shall maintain a refund reserve fund in trust for the residents holding such contracts.

(1) Except as noted in paragraph (2), this trust fund shall remain intact as specified in subdivision (a).

(2) To the extent approved by the department, the trust account may invest up to 70 percent of the refund reserves in real estate that is used to provide care and housing for the holders of the refundable continuing care contracts and is located on the same campus where these continuing care contract holders reside.

These investments in real estate shall be limited to 50 percent of the providers' net equity in the real estate. The net equity shall be the book value, assessed value, or current appraised value within 12 months prior to the end of the fiscal year, less any depreciation, encumbrances, and the amount required for statutory reserves under Section 1792.2, all according to audited financial statements acceptable to the department. This paragraph shall apply to applications, and for those phases of the project that were identified as part of applications, submitted after May 31, 1995.

(3) Any provider who submitted an application on or before May 31, 1995, may provide for the refund obligation of this section with a trust account that invests up to 85 percent of the refund reserves in the continuing care retirement community's real estate and

the remaining 15 percent in the form of either cash or an unconditional, irrevocable letter of credit to be phased in over a two-year period beginning with initial occupancy in the facility.

(4) Each refund reserve trust fund shall be established at an institution qualified to be an escrow agent pursuant to an agreement between the provider and the institution based on this section and approved in advance by the department.

(5) The amount to be held in the reserve fund shall be the total of the amounts calculated with respect to each individual resident as follows:

(A) Determine the age in years and the portion of the entry fee for the resident refundable for the seventh year of residency and thereafter.

(B) Determine life expectancy of that individual from the life expectancy table in paragraph (1) of subdivision (b) of Section 1792.2. If there is a couple, use the life expectancy for the individual with the longer life expectancy.

(C) For that resident, use an interest rate of 6 percent or lower to determine from compound interest tables the factor which represents the amount required today to grow at compound interest to one dollar ($1) at the end of the period of the life expectancy of the resident.

(D) Multiply the refundable portion of the resident's entry fee amount by the factor obtained in subparagraph (C) to determine the amount of reserve required to be maintained.

(E) The sum of these amounts with respect to each resident shall constitute the reserve for refundable contracts.

(F) The reserve for refundable contracts will be revised annually as provided for in subdivision (a), using the interest rate, refund obligation amount, and individual life expectancies current at that time.

(6) Withdrawals may be made from the trust fund to pay refunds when due under the terms of the refundable entry fee contracts and when the balance in the trust fund exceeds the required refund reserve amount determined in accordance with paragraph (5) of subdivision (b).

(7) Deposits shall be made to the trust fund with respect to new residents when the entry fee is received and in the amount determined with respect to that resident in accordance with paragraph (5) of subdivision (b).

(8) Additional deposits shall be made to the trust fund within 30 days of any annual reporting date on which the trust fund balance falls below the required reserve in accordance with paragraph (5) of subdivision (b) and such deposits shall be in an amount sufficient to bring the trust fund balance into compliance with this section.

(c) Any provider which has executed refundable contracts in a continuing care retirement community prior to January 1, 1996, and which has not executed refundable contracts in a continuing care retirement community prior to January 1, 1991, shall submit, for the department's approval, a method of determining a refund reserve to be held in trust for the residents. Approved methods include any of the following:

(1) The establishment, at the time continuing care contracts are signed, of a reserve fund in trust for the full amount of the refunds promised.

(2) The purchase from an insurance company, authorized to do business in the State of California, of fully paid life insurance policies for the full amount of the refunds promised.

(3) A method approved by the American Academy of Actuaries in their Actuarial Standards of Practice Relating to Continuing Care Retirement Communities, which method provides for fully funding the refund obligations in a separate trust fund as provided in subdivision (b).

(d) Any provider offering a refundable contract, or other entity assuming responsibility for refundable contracts prior to January 1, 1991, shall maintain a refund reserve bank account in trust for the residents as described in subdivision (b) except that the amount of refund reserves shall be calculated based on the following assumptions and methods of calculation:

(1) The continuing care retirement community will no longer receive entry fee income after a period of 40 years following the commencement of operation.

(2) Approved long-term investments, such as treasury notes, will earn 3 percent more than the rate of inflation.

(3) Entrance fees will increase at the rate of inflation.

(4) Land values will increase at the rate of inflation.

(5) Investments in the refund reserve trust will increase at the rate for approved long-term investments.

(6) Calculate the number of units to be resold each year at the approved rate of turnover.

(7) Determine the mean entrance fee, as of the current date.

(8) Determine the factor for inflating the mean entrance fee at the rate of 3 percent below the interest rate on new 30-year treasury bonds, for each year from the current date to the 40th year of operation, or until all units have been turned over.

(9) Calculate the inflated mean entrance fees for the 40th year and for each preceding year, until all units have been turned over.

(10) Multiply the inflated mean entrance fee for the 40th year, and each preceding year, as specified in paragraph (9), by the annual turnover, as specified in paragraph (6), until the total of the annual turnovers used in the calculations equals the total number of units in the continuing care retirement community.

(11) The projected refund liability shall be the sum of the products obtained pursuant to paragraph (10), multiplied by the rate of refund for the seventh year of residency, specified by current continuing care contracts, multiplied by the percentage of current continuing care contracts which specify this rate of refund. The projected refund liability amount shall be calculated for each rate, if existing continuing care contracts specify several rates.

(12) The projected refund liability, or the aggregate of these liabilities, if several rates are obtained pursuant to paragraph (11), may be reduced by the value of the land used for the continuing care retirement community, inflated to the 40th year of operation, as determined pursuant to paragraph (4), if the provider agrees to a lien pursuant to Section 1793.15 to secure this commitment.

(13) Calculate the present value of the projected refund liability at the current rate of interest for new 30-year treasury bonds. The result is the required refund reserve.

(e) Any entity which holds a certificate of authority, provisional certificate of authority, or permit to sell deposit subscriptions on or before September 23, 1986, shall be exempted from the refund reserve requirement established by this section, if the entity has an equity balance of five times the amount of the refund reserves calculated pursuant to subdivision (c).

(1) The equity balance shall be verified by one or more of the following means:

(A) The “stockholders’ equity,” or equivalent amount, as reflected on the most recent Form 10K (which may be on a consolidated basis or on a consolidated and combined basis) filed with the Securities and Exchange Commission.

(B) The “total fund balance of net worth,” or equivalent amount, as reflected on Form 990 or Form 990-PF filed with the Internal Revenue Service.

(C) The “total net worth,” or equivalent amount, as reflected on the most recent Form 109 filed with the Franchise Tax Board.

(2) The amount of the requirement for the equity balance shall be revised annually pursuant to this section.

(3) Compliance shall be based on review, by the department, of financial statements prepared in accordance with generally accepted accounting principles, accompanied by an unqualified opinion by a certified public accountant.

(4) If the equity balance is determined by the department to be less than the required amount, the provider or other entity assuming responsibility shall deposit, in a form satisfactory to the department, an amount equal to the refund reserve required within 60 days.

(f) All continuing care retirement communities offering refundable entrance fees that are not secured by cash reserves, except those facilities that were issued a certificate of authority prior to May 31, 1995, shall clearly disclose this fact in all marketing materials and continuing care contracts.

(Amended by Stats. 1995, Ch. 920, Sec. 48. Effective January 1, 1996.)