Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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Chapter Three
An Empirical Survey of CCRCs II

RESIDENT POPULATION

Individuals who are attracted to, and become residents of, continuing care retirement communities have not yet been studied. Information collected through the survey questionnaire, however, sheds some light on demographic characteristics of CCRC resident populations, such as size and average age.

Each community was asked to provide its census of residents holding continuing care contracts and the total resident census for each level of care or service available in the community. These census figures, presented in Table 3–1, represent about half of the total number of continuing care retirement community residents in the country today.

Planners and developers of continuing care retirement communities, as well as many others, have wondered whether there is an optimum resident population size. There appears to be little consensus on this question. The distribution of CCRCs by resident population is relatively flat, as seen in Figure 3–1. The median continuing care resident population is 218; for all residents, the median is 245.

Communities have been getting larger over time. The data in Table 3–2 show a strong trend toward larger resident populations in newer communities.

One of the intriguing issues in continuing care is whether residents live longer because of the continuing care environment or because continuing care communities attract a population predisposed to good health and longevity. This question is beyond the range of this report.

TABLE 3–1
Resident Census by Level of Care

Living status	Continuing care contractholders		Total residents	
ILU	39,907	(n = 188)	40,827	(n = 191)
PCF	2,338	(n = 76)	2,954	(n = 81)
ICF	2,735	(n = 93)	4,118	(n = 99)
SNF	4,396	(n = 132)	6,810	(n = 144)
Other	538	(n = 12)	736	(n = 15)
Total	49,914		55,445	

FIGURE 3–1
Distribution by Total Number of Residents

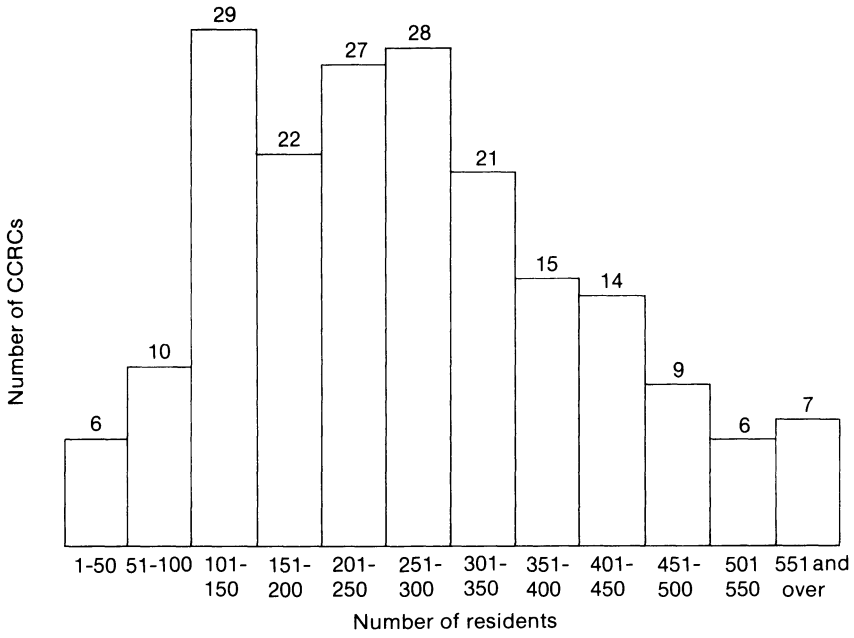

TABLE 3–2
Size of Resident Population by Age of Community

Size	All CCRCs	Pre-1960	1960–1969	1970–1979
100 and less	11.1%	13.9%	6.6%	11.9%
101–200	27.5	41.7	31.6	17.9
201–300	22.2	16.7	32.9	19.4
301 and more	30.9	25.0	26.3	46.3
No response	8.3	2.7	2.6	4.5
	100.0%	100.0%	100.0%	100.0%
Median size	245 res.	219 res.	250 res.	305 res.

Baseline data analyses indicate, however, that residents of continuing care retirement communities are among the "old-old" of the elderly population. More than half of CCRCs (52 percent) have an average resident age of 80 to 82 years or higher. Considering each level of service individually, average ages range up to over 85 for residents of intermediate nursing care.

Residents of:	Average age
Independent living units (n = 173)	80.2 years
Personal or domiciliary (n = 70)	84.2
Intermediate nursing care (n = 78)	85.4
Skilled nursing care (n = 115)	84.7

As one might expect, average resident age increases in a direct relationship to a community's age since a large majority of the first cohort of residents enter in their early to middle 70s and continue to live and age in the community for more than 10 years. There is a relationship between regions and community ages; thus, it is not surprising that the average resident age varies by region as well (see Table 3–3).

TABLE 3–3
Average Resident Age by Community Age and Geographic Region

	Community age				Region			
Average age	Total	Pre-1960	1960–1969	1970–1979	NE	NC	S	W
74 and below	7.8%	2.9%	5.5%	14.1%	3.7%	12.9%	23.5%	4.5%
74–77	8.2	0.0	1.4	20.3	11.1	11.4	7.8	0.0
78–81	36.2	14.7	35.6	45.3	55.6	31.4	29.5	31.8
82–85	40.7	61.8	50.7	18.8	25.9	32.9	39.2	54.5
86 and over	7.1	20.6	6.8	1.5	3.7	11.4	0.0	9.2
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

HEALTH CARE UTILIZATION

The most essential and expensive aspect of the package of services provided by continuing care retirement communities is health care. In order to study health care utilization among residents of CCRCs, two ratios were calculated for each community: health care ratio and nursing care ratio.

Definitions

Nursing care ratio: The number of residents receiving intermediate and skilled nursing care divided by the total number of residents, where resident is defined as an individual holding a continuing care contract.

Health care ratio: The number of residents receiving personal care, intermediate nursing care, and skilled nursing care divided by the total number of residents.

Nursing Care and Health Care Ratios

In general, when a community is newly opened, its resident population is relatively young and healthy. Over the years, this initial cohort of residents ages and grows increasingly frail, calling upon the various health care and health-related services provided by a continuing care retirement community. This relationship between health/nursing ratios and community age should be kept in mind for the following discussion.

Overall, the distribution of CCRCs' health care and nursing care ratios is as follows:

Ratio	Nursing care ratio	Health care ratio
0% and N/R	12.3%	15.4%
1–5%	8.7	6.6
6–10%	16.3	13.3
11–15%	21.9	16.8
16–20%	13.8	17.3
21% and over	27.0	30.6
	100.0%	100.0%

Communities with higher ratios—for both health care and nursing care—are located predominantly in the North Central and Western regions. Since higher ratios are found in older communities and these two regions have relatively large, and equal, numbers of older communities, this finding is not surprising. A closer inspection shows that ratios are quite high among CCRCs in the North Central region and in the upper-middle range for Western region CCRCs.

Conversely, communities with lower ratios are clustered in the Southern region—where most of the new communities are being built—and in the Northeastern region, for a reason other than community age, since CCRCs in that region are evenly distributed with respect to community age. To analyze further the relationship between these ratios and various factors such as geographic region and management policy, the community age factor should be controlled; this analysis remains for future research.

Communities with extensive health care guarantees have lower nursing and health care ratios than communities with limited health care guarantees (see Table 3–4). Perhaps this finding indicates a successful effort on the part of CCRCs with extensive health care guarantees, responsible for a larger portion of residents' health care costs, to give residents appropriate and cost-effective care. These communities

TABLE 3–4
Nursing Care Ratio and Health Care Ratio by Health Care Guarantee

Median ratio	Health care guarantee		
	Extensive	Limited	All CCRCs
Nursing care	13.1%	22.3%	17.4%
Health care	15.6	25.8	20.2

have a financial incentive to monitor nursing care utilization carefully, while communities lacking this financial incentive have a higher proportion of residents receiving nursing care and health care.

The size of a community's resident population is also significantly related to the health care ratio: larger CCRCs have lower ratios, and smaller CCRCs have higher ratios. Since newer communities tend to be larger than older ones, this finding may be related to community age.

Policy on Moving Residents to Health Care

Overall, 45.4 percent of all communities have a management policy or contractual statement that specifies whether or not, and when, a resident must relinquish his or her apartment and move permanently to the health care facility; 52.2 percent do not have such a policy (2.4 percent = no response).

Among these communities (n = 94), most specify a certain time period or schedule for such a move, while other communities make these decisions on an informal, individual, or unspecified basis, as the data below show:[1]

After what period of time in HCC must a resident give up his/her ILU? (n = 94)	
1–30 days	7.4%
31–60 days	20.2
61–90 days	36.2
91–120 days	23.4
Over 120 days	2.2
No response	10.6

The existence of such a policy in a community is unrelated to the proportion of residents receiving health or nursing care. This finding is surprising, since a community with a low number of residents in its

[1] Responses include answers based on informal policies but not necessarily contractual provisions.

health care facility might be expected to have a policy encouraging residents to fill empty beds, while a community with a higher ratio—and therefore fewer beds available—might be expected to have a policy that discourages such moves. It is possible that this is, in fact, what occurs, but if so, it is done on an informal, selective basis. These figures show no difference in policy among CCRCs by health care ratio.

A definite trend is emerging among newer communities not to have a policy regarding permanent moves to a health care facility. Two thirds of CCRCs built prior to 1970 have such a policy, while only one third of those built since 1970 have one.

Outside Admission to Health Care

Continuing care retirement communities accept new residents at the personal care and nursing care levels as well as into their independent living units. Some of these outside admissions pay a per diem rate, while others are covered by a continuing care contract that lasts for more than one year.

Three quarters (75.4 percent) of CCRCs admit individuals from the outside community directly into their health care facility; 36.2 percent admit outside individuals into their personal care facility (only 40 percent of CCRCs have personal care facilities). Communities are much more likely to offer contracts that last for more than one year to persons becoming residents of personal care than to those admitted directly to health care, as these figures show:

Offer contract that lasts for more than one year for direct admissions to outside individuals to:		
Personal care facility (n = 75)	Yes	80.0%
	No or N/A	20.0
Health care center (n = 156)	Yes	44.9%
	No or N/A	55.1

Nursing Care Certification by Medicare and Medicaid

All CCRCs participate in the Medicare program in terms of their residents being protected against hospital costs, and most CCRCs require their residents to subscribe to Part B to cover physicians' costs. Medicare coverage of skilled nursing is extremely limited, however, and requirements for the facility are high, while Medicaid covers most long-term nursing care costs. CCRCs participate in the Medicare and Medicaid programs in about equal numbers: 54.6 percent are certified by Medicare, and 48.8 percent are certified by Medicaid (in both cases,

nonresponse = 5.5 percent). Yet the profiles of CCRCs participating in each of these programs are different, as shown in Table 3–5.

Communities participating in Medicare certification tend to have larger resident populations, are predominantly in the Northeastern re-

TABLE 3–5
Medicare and Medicaid Certification by Size, Region, Guarantee, and Age

	Percent CCRCs certified by Medicare	Percent CCRCs certified by Medicaid
All communities	54.6%	48.8%
Size		
100 and less	45.0	55.0
101–200	34.5	56.4
201–300	58.7	50.0
301–400	81.1	47.2
401 and over	80.0	52.0
Region		
Northeast	87.5	50.0
North Central	44.9	65.4
South	49.0	34.7
West	65.0	42.5
Health care guarantee		
Extensive	65.4	40.6
Limited	50.0	65.1
Age		
Before 1970	47.7	50.5
Since 1970	67.5	49.4

gion, offer extensive health care guarantees, are newer (built since 1970), have higher fees (total expected fees and entry fees), and have lower nursing and health care ratios. All of these factors are statistically significant.

In contrast, most of these same factors are significantly related, but in the opposite direction, to communities certified by the Medicaid program. Since the Medicaid program is administered at the state level, it is not surprising that regional variation appears. More of the communities in the North Central region are certified by Medicaid (65.4 percent) than of the communities in other regions, particularly in the South, where only 34.7 percent participate in the program. Medicaid certification does not vary by community age, so the difference between regions is probably due to interstate differences in Medicaid payment levels and certification procedures.

The fact that communities offering limited health care guarantees are more likely to be certified by the Medicaid program than are com-

munities with extensive health care guarantees supports the observation that residents of CCRCs with limited guarantees experience greater risk and health care cost, causing them to "spend down" their assets. Thus, these communities are likely to utilize the Medicaid program to a greater extent than the communities with extensive guarantees.

SERVICES AND SPECIAL FEATURES

A CCRC is a microcosm of a larger community, with most of the services needed for its residents' daily living provided on-site.

The survey instrument contained a list of the services that a CCRC might provide. However, it did not include questions to differentiate the extent of specific services (such as home health care, occupational therapy, physical exams, physical therapy, and prescription drug service) among communities. This type of analysis is necessary to compare health care delivery systems fairly and is an important area for future research. Questionnaire respondents were asked to check each item, indicating whether or not it was included in the basic fees and contract.[2] The information collected in this manner is presented in this section, together with the results from a smaller but similar list of special features. It is interesting to note that most services are either quite prevalent or rather unpopular, an indication of broad similarity among CCRCs, at least with respect to the selection of necessary and desirable services.

Services included in the basic contract and fees of at least 80 percent of CCRCs are: utilities, special diet, apartment cleaning, parking, kitchen appliances, replacement of apartment equipment, storage, emergency call system, and social services.

Conversely, 80 percent or more of CCRCs do not include in their contracts and fees services such as prescription drugs, therapy for psychiatric disorders, special duty nurses, dental care, podiatry, hearing aids, or membership in a health maintenance organization.

Table 3–6 summarizes 34 services in alphabetical order and shows percentages for each by several key factors: health care guarantee, region, and community age.

Categorized Services

The services listed in Table 3–6 were divided into three groups or types: medical, support/preventive health care, and services related to

[2] It should be noted that even though a service is not included in basic fees, it may be available from a community for an additional charge.

TABLE 3–6
Summary of Services: Percent of CCRCs Including Service in Fees

Services	All CCRCs	Guarantee	
		Ext.	Ltd.
Apartment cleaning	83.1%	91.6%	83.5%
Bed and bath linen	71.0	81.0	67.8
Community's own physician	32.4	45.9	17.6
Dental care	6.8	6.4	4.3
Emergency call system	88.9	94.5	90.7
Garages/carports	25.6	24.8	27.2
Health maintenance organization	4.3	5.5	2.2
Hearing aids	3.4	2.7	1.1
Home health care	28.5	41.1	16.3
Hospitalization	25.6	39.8	9.3
Illness or accident away from community	20.3	34.3	4.7
Kitchen appliances	84.1	88.1	79.3
Occupational therapy	36.3	50.0	23.0
Parking	85.5	84.4	85.9
Personal laundry facilities	78.7	85.3	79.1
Physical exams	26.1	38.5	10.1
Physical therapy	35.3	48.1	21.6
Podiatry	10.6	7.3	4.3
Prescription drugs	15.9	28.7	3.4
Private room in nursing care center	25.1	20.2	16.3
Recreational therapy	72.0	84.4	61.8
Referred specialist	23.7	30.3	9.8
Replacement of apartment equipment	86.0	88.9	80.4
Resident's physician	22.2	22.1	26.2
Social services	83.6	89.0	85.1
Special diet	83.6	92.5	81.6
Special duty nurses	9.2	11.9	5.4
Storage	81.5	87.1	72.3
Telephone	32.4	42.2	16.3
Therapy for psychiatric disorders	15.5	25.5	2.3
Tray service	56.5	73.3	43.2
Treatment for preexisting conditions	29.5	35.3	25.6
Transportation	72.5	84.9	57.4
Utilities	91.3	95.3	96.6

the physical plant or nonmedical. The breakdown for each category follows:

Medical	Supportive/preventive	Physical plant
Community's physician	Emergency call system	Utilities
Treatment for preexisting conditions	Special diet	Replacement of apartment equipment
Physical exams	Social services	Parking
Hospitalization	Transportation	Kitchen appliances
Referred specialist	Recreational therapy	Apartment cleaning
Resident's physician	Tray service	Storage
	Occupational therapy	

Region				Community age			
NE	NC	S	W	Pre-1960	1960–1969	1970–1979	1980–post
92.9%	82.9%	85.7%	97.9%	82.9%	97.2%	84.6%	80.0%
85.7	72.0	70.0	81.0	85.3	80.3	67.2	66.7
43.3	25.3	28.0	50.0	40.0	37.0	30.8	20.0
0.0	8.1	8.0	4.8	16.7	14.6	4.2	0.0
93.1	89.3	94.0	97.7	85.3	93.2	94.0	100.0
37.0	20.6	22.7	47.4	30.9	27.6	22.4	33.3
4.0	5.7	4.2	2.5	—	—	—	—
—	—	—	—	—	—	—	—
50.0	17.3	34.0	34.9	19.4	30.1	39.1	13.3
50.0	11.8	18.8	46.5	33.3	24.3	29.9	21.4
34.5	8.0	20.4	38.1	23.5	23.6	20.0	20.0
92.9	90.1	91.5	92.5	76.2	77.6	95.5	100.0
66.7	29.3	36.7	34.1	34.3	37.8	45.5	28.6
100.0	93.0	92.0	82.5	94.7	85.9	95.4	100.0
86.7	82.9	75.5	86.0	85.3	76.7	88.1	86.7
53.3	18.2	18.0	34.1	41.7	23.0	25.4	20.0
50.0	27.6	38.8	40.9	42.9	28.4	45.5	40.0
4.0	6.9	13.0	5.0	13.5	4.2	7.8	0.0
50.0	10.5	12.2	16.7	25.7	8.3	26.7	6.7
29.2	30.0	26.1	20.0	60.9	21.1	19.6	0.0
86.7	72.7	78.0	63.6	66.7	74.3	77.6	73.3
43.5	11.9	20.9	47.2	32.3	29.0	24.1	0.0
96.3	91.3	93.9	90.0	76.2	85.5	88.1	100.0
17.9	27.0	12.8	35.7	33.3	25.0	21.2	21.4
96.6	85.7	90.0	79.1	86.1	86.3	87.9	86.7
89.3	88.2	92.0	81.4	79.4	90.4	88.1	100.0
7.7	9.6	2.0	18.6	9.5	9.2	8.9	0.0
77.7	83.3	88.0	92.9	80.9	73.7	88.1	100.0
27.6	24.7	38.0	40.5	21.4	36.3	29.9	66.5
41.4	9.3	10.4	18.2	22.9	12.2	21.9	0.0
86.2	43.4	58.3	72.1	58.8	54.8	66.7	64.3
33.3	28.8	35.4	32.6	36.4	33.3	31.7	26.7
89.3	72.6	84.0	68.2	65.6	64.4	93.9	93.3
96.9	97.3	90.0	100.0	94.3	97.2	97.0	93.3

Medical

Illness or accident away from community
Prescription drugs
Therapy for psychiatric disorders
Podiatry*
Special duty nurses*
Dental care*

Supportive/preventive

Physical therapy
Home health care
Health maintenance organization*
Hearing aids*

Physical plant

Personal laundry facilities
Bed and bath linen
Telephone
Garages/carports
Private room in nursing care center

* Included in basic fees for less than 10 percent of cases and therefore not included in the percentage totals and averages tabulated.

Health Care Guarantee/Service Analysis

One of the hypotheses tested by this preliminary analysis is that CCRCs offering extensive health care guarantees are more likely than those with limited guarantees to provide supportive/preventive health care–related services to residents of independent living units, thereby reducing health care utilization. While by no means conclusive, and offered in this report primarily as a basis for future research, a review of the data presented in Table 3–7 indicates that the hypothesis is

TABLE 3–7
Type of Services by Health Care Guarantee

	Average percent of CCRCs		
Service type	**Extensive**	**Limited**	**Differential**
Medical	33.4%	12.1%	21.3%
Supportive/preventive	73.0	54.5	18.5
Physical plant	71.7	64.1	7.6

correct. Overall, an average of 73.0 percent of CCRCs with extensive health care guarantees have supportive/preventive services, compared to an average of 54.5 percent of CCRCs with limited health care guarantees. This differential is particularly strong in comparisons with the services of tray service, occupational therapy, physical therapy, and home health care.

The difference between the two groups of CCRCs with respect to medical services was expected since, by definition, medical and health care is included in contracts offering extensive health care and is generally not included in contracts providing limited health care.

The relative similarity between the two groups of CCRCs on physical plant and facilities provided indicates that, except for the extent to which communities cover the cost of health care incurred by residents holding continuing care contracts, continuing care retirement communities constitute a unique and discrete group and provide a standard package of services.

Regional Variation in Services Offered

Overall, communities in the Northeastern and Western regions include more services as part of their basic fees; CCRCs in the Northeast are particularly high in providing services categorized as supportive, while CCRCs in the West are slightly higher in providing medical services. Communities in the North Central region generally have the same physical plant services that other communities have but are underrepresented on services classified as supportive and medical. CCRCs in

the Southern region are low in providing physical plant services, most notably personal laundry facilities and bed and bath linen, and in covering the cost of a resident's own physician. These differences are shown in Table 3–8.

TABLE 3–8
Type of Services by Region

	Northeast	North Central	South	West
Service type				
Medical	40.8%	16.8%	19.7%	35.5%
Supportive/preventive	78.7	58.5	67.3	63.6
Physical plant	74.8	70.7	70.3	75.5

Markets in each region influence to some extent what services are expected and provided in CCRCs, and this is reflected in the data presented. Furthermore, to the extent that regions are related to community age, regional variations reflect differences in the cost of construction and capital over time.

Community Age/Service Analysis

Based on the data presented in Table 3–6, some services are becoming more prevalent, whereas others are diminishing and are not as likely to be included in contracts and fees offered by new communities. Among the services declining in coverage are bed and bath linen, apartment cleaning, community's or resident's physician, referred specialist, treatment for preexisting conditions, and special duty nurses (the last four of which are costly medical or medical-related services). Services that have been added by newer communities are parking facilities, kitchen appliances, replacement of apartment equipment, storage, and emergency call system.

The picture drawn by these data forms a *W* or up-and-down line rather than a smooth slope. Communities in the pre-1960 group are nonstandard and have a multitude of backgrounds, histories, and patterns of services. CCRCs built in the early 1960s, without the benefit of Medicare, individually covered many of the items later covered by that program. Communities built in the late 1960s and early 1970s often structured their service package around the Medicare program and, therefore, are more likely to include many of the listed services in their fees and contracts. Communities built since 1975 have had to deal with higher construction and health care costs. More important, those built since 1980 or currently under construction are facing the possibility of cutbacks in Medicare and other programs in addition to higher costs

and have reduced the range of services provided by continuing care contracts (more services are provided on an "a la carte" basis).

Fees and Service Package

An index, called the *total expected fee index,* was developed to more fairly compare fees among CCRCs which vary their combination of monthly and entry fees. This index is a present value combination of the total anticipated entry fee and monthly fees to be paid by an individual resident in his or her lifetime.[3]

Total Expected Fee Definition

Total expected fee is the total anticipated dollars to be paid by an average resident. The index is equal to the entry fee paid by the resident plus 12 times the monthly fee times the resident's expected lifetime.

TEF = Entry fee
+ 12 times ILU monthly fee times resident's life expectancy

In the following analysis, one-bedroom fees are used; however, fees and fee plans of continuing care retirement communities are presented in detail in the *1982 Reference Directory of Continuing Care Retirement Communities*.[4]

Using the "total expected fees" variable as a measure of a community's relative fee structure, each of the services was analyzed to determine which services are related to fees, or which services are added when fees are higher. Not unexpectedly, the services classified as "medical" are marginally related, as are three services from the other two categories. Services related to higher fees—both entry and monthly—are: tray service, bed and bath linen, physical exams, hospitalization, illness away from the community, physical therapy, therapy for psychiatric disorders, and the community's physician. A few services are related to either high entry fees or high monthly fees but not both. For example, personal laundry facilities are related to entry fees since they are a capital expenditure, whereas apartment cleaning, prescription drugs, and occupational therapy are significant only with respect to the level of monthly fees. Several services, for example, trans-

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[3] It should be noted that the version of the TEF index used in this report is biased toward limited health care guarantees since it is based on apartment monthly fees and does not reflect changes in monthly fees after transfer to the health care center. Hence, TEF indices for limited-guarantee contracts that charge lower apartment monthly fees will typically be lower than the indices for extensive guarantees.

[4] Howard E. Winklevoss and Alwyn V. Powell, *1982 Reference Directory of Continuing Care Retirement Communities* (Philadelphia: Human Services Research, Inc., 1982). This report provides a brief overview of data collected on fees charged by CCRCs in the aggregate.

portation and emergency call system, are more likely to be included in contract fees by CCRCs with fees in the middle range.

Number of Meals

Although all communities serve meals to residents, usually in one or more central dining rooms, CCRCs are divided into two essentially equal groups with respect to the number of meals that are included in standard fees:

Number of meals included in standard fee schedule	
Three meals a day	50.3%
One meal per day	27.1
Two meals per day	5.3

Table 3–9 presents the results of three cross-tabulations performed to determine whether communities including three meals differ from

TABLE 3–9
Number of Meals by Community Age, Size, and Guarantee

	Percent of CCRCs/Number of meals included			
	All CCRCs	One meal (n = 55)	Two meals (n = 10)	Three meals (n = 102)
Community age				
Before 1970	57%	31%	30%	77%
Since 1970	34	62	70	15
No response	9	7	0	8
	100%	100%	100%	100%
Resident population				
Less than 200	38%	33%	30%	43%
201–400	39	38	30	44
401 and over	12	13	40	9
No response	11	16	0	4
	100%	100%	100%	100%
Health care guarantee				
Extensive	53%	54%	70%	53%
Limited	45	46	30	45
No response	2	0	0	2
	100%	100%	100%	100%

those including just one meal a day with regard to the factors of community age, resident population size, and health care guarantee. The factors of resident population size and health care guarantee do not differentiate among communities on the number of meals included in fees. However, the factor of community age shows a strong trend away from three meals a day among newer communities. In many communi-

ties, residents can choose from among several meal plans or options, and fees are adjusted accordingly.

Special Features

Some of the special features and amenities that continuing care retirement communities were hypothesized to have were listed in the survey instrument, and respondents were asked to check whether or not their community had them. These responses are presented in Table 3–10.

TABLE 3–10
Special Features

Feature on premises	Percent CCRC with feature
Religious services	95.2%
Beauty salon	94.7
Garden space	90.8
Residents' association	89.4
Master TV antenna	88.9
Barber	78.3
Guest facilities	73.4
Hiking trails	42.0
Fireplaces	38.2
Bank	19.3
Swimming pool	16.4
Pharmacy	15.5

No further analysis was done to determine what kinds of CCRCs tend to have certain features; this remains for future research. There is consensus on most of the items, with two exceptions—hiking trails and fireplaces, both of which are tied to a community's setting and type of construction. Although these were not listed as special features, it is known that many CCRCs have a gift shop and/or a convenience store where residents can purchase food and household items. Other features common to most CCRCs may also be missing from the list.

MANAGEMENT AND FINANCIAL POLICIES

The process of managing a continuing care retirement community is complex, challenging, and becoming increasingly sophisticated. This section does not purport to cover the multitude of issues, policies, and concerns that properly come under the heading "Management." Several specific topics were targeted in the survey questionnaire, and the results are presented in this section. These topics are: purchased management services, aggregate expenses, financial statements, admission policies, and residents' role in decision making.

Purchased Management Services

In response to the explosive growth and the increased complexity of the continuing care industry, companies have been formed to provide services to CCRCs. Of particular interest was the purchase of management services by communities: how many and what kinds of CCRCs purchase such services? The survey data show that about one third (36.3 percent) of communities purchase management services (including health care management) from another organization;[5] 61.8 percent of CCRCs do not and are, presumably, self-managed (1.9 percent = no response/not applicable).

More than half (56 percent) of communities purchasing management services (n = 75) do so from a proprietary or for-profit corporation; 42.7 percent purchase such services from nonprofit organizations (1.3 percent = not applicable). Thus, approximately 40 nonprofit CCRCs, or one fifth of the total CCRCs surveyed (n = 207), are managed by a proprietary firm. Communities with a lower percentage of residents receiving health care, in the middle range of fees, with larger resident populations, and/or built before 1970 are representative of the group that purchases management services. These CCRCs also are less likely to offer extensive health care guarantees.

Aggregate Expenses

Detailed financial information was not collected from communities, but most communities responded to a question regarding expenses, as follows.

Aggregate expense values	Average		Per capita	
Departmental expenses	$2,171,710	(n = 151)	$7,929	(n = 147)
Depreciation expense	297,204	(n = 149)	1,038	(n = 145)
Interest expense*	361,436	(n = 136)	1,425	(n = 133)
Mortgage reduction	146,897	(n = 108)	560	(n = 105)
Capital expenditures	170,255	(n = 125)	751	(n = 125)

* In some cases, this value was not listed separately but was included with depreciation expense.

Financial Statements

Virtually all communities (93.7 percent) have external financial statements prepared by independent certified public accountants (CPAs); the remaining 6.3 percent either gave no response or considered the question not applicable.

Slightly more than one third (37.2 percent) of communities prepare and use internal management statements that differ from external fi-

[5] It could not be determined whether communities managed by their sponsoring/affiliated body are counted among those that purchase management services. We assume they are included if a management fee is paid to the sponsoring organization.

nancial statements; in 54.6 percent of CCRCs these statements are the same (6.3 percent = no response; 1.9 percent = not applicable).

Communities differ on the question of whether to use external or internal statements in determining fee increases, and some use another method entirely, as the following figures indicate.[6]

What financial statements are used to determine fee increases?	
External statements	42.0%
Internal statements	57.0
None used	1.9
Other	15.0

Admission Policies

Over the years, communities have developed fairly standard admission policies for new entrants. Most communities (90.8 percent and 94.2 percent, respectively) require potential residents to have a physical examination and to be of certain minimum age, usually 65 years. A large number (70 percent) require minimum levels of assets; two thirds (65.7 percent) require a minimum monthly income; and more than half (57.5 percent) require medical insurance coverage. Neither a religious requirement nor a maximum age requirement is imposed by most communities (87 percent and 89.4 percent, respectively, do not impose these requirements). Since individuals generally enter communities at the independent living unit level, it is not surprising that most communities (81.6 percent) impose health requirements.

Communities requiring minimum monthly income and minimum assets have similar characteristics. These communities tend to have been built during the period 1970 to 1979 and are perhaps more wary of inflation. In spite of this, the fee variable (total expected fees) is not related significantly to communities having these financial requirements.

Communities that require medical insurance coverage upon admission are larger, have higher fees, and offer extensive health care guarantees (as shown in Table 3–11). Their health care ratios are in the middle range. The medical insurance requirement does not vary by community age.

Outside Admission to Nursing Care

Among the communities studied, 75.4 percent admit patients other than those holding continuing care contracts to their nursing care facilities. Such outside admissions are hypothesized to be influenced by two related factors: (1) the nursing care ratio and (2) the number of years a community has been open (community age). Older communities have

[6] More than one response was recorded for this question in some cases.

TABLE 3–11
Medical Insurance Requirement by Health Care Guarantee (supplementary to Medicare)

Medical insurance required	Health care guarantee	
	Extensive	Limited
Yes	76.0%	44.2%
No	24.0	55.8

higher nursing care ratios because their resident populations have aged, while newer communities have healthier resident populations and lower nursing care ratios. These newer communities generate additional income by taking outside admissions into their new, largely unfilled, nursing care facilities.[7]

The data in Table 3–12 support this conclusion. Communities built before 1970 are less likely to admit outside residents, while all new

TABLE 3–12
Outside Admissions by Community Age

Percent outside admissions to total census	Pre-1960	1960–1969	1970–1979	1980–post
0%	54.3%	59.5%	26.2%	54.5%
1–20%	28.6	32.4	58.5	0.0
21–40%	5.7	5.4	7.7	27.3
41–60%	5.7	2.7	1.5	9.1
61% and over	5.7	0.0	6.1	9.1

communities have outside admissions to their nursing facilities. A regional variation exists with respect to outside admissions: CCRCs in the Northeast are more likely, those in the West much less likely, to have them.

More surprising is the finding that the size of a community is not related to its policy or practice on taking outside admissions. This may imply that communities are building the correct number of nursing beds for their resident populations.

Residents' Role in Decision Making

Residents of continuing care retirement communities participate in decision-making processes in both formal and informal ways. Resident

[7] This change over time often poses a problem to CCRC developers in obtaining a certificate of need for nursing care beds when one must show that the surrounding geographic area (usually the Health Services Area) can support the additional beds.

associations are active in 89.4 percent of CCRCs, and in almost 20 percent at least one resident serves as a member of the board of directors.

Most resident associations are fairly well organized and sophisticated, reflecting the generally higher levels of education and socioeconomic status among continuing care residents. A resident association usually has an executive committee or a representative council and many standing committees that meet more frequently to carry out much of the work of the association. With such broad-based participation, it is not unusual to find that over half of all the residents in a community are involved in the decision making at some level.

Resident associations are somewhat less prevalent among communities built prior to 1960. In the past two decades, there has been a trend toward and a demand for greater resident participation and accountability. This trend is evident among the younger residents of newer communities.

Residents' access to financial statements, in connection with their role as investors/consumers, is an issue within the continuing care field. Consequently, questions regarding this topic were included in the survey instrument. Residents have access to external financial statements in 82.6 percent of CCRCs; they have access to internal management statements in 45.9 percent of CCRCs. Residents in communities built before 1970 are less likely to have such access, perhaps because they lack a resident association or other formal organization to work with community managers.

CAPITAL FINANCING

Continuing care retirement communities have obtained construction financing in different ways and through various sources. Responses to a fixed-choice question regarding financing methods show that CCRCs primarily have used conventional mortgages, entry fees, charitable gifts and donations, FHA-insured mortgages, and tax-exempt revenue bonds.

What financing methods were used for construction:*

Conventional mortgage	54.1%
FHA-insured mortgage	14.5
Private taxable bonds	4.8
Tax-exempt revenue bonds	15.5
Public taxable bonds	1.9
Gifts and donations	30.4
Entry fees	33.8
Other	11.6

* These values double-count instances in which the stated method is used in combination with another method.

Obviously, as the economic climate and mortgage markets have changed over the years, the sources of construction financing have also changed. It is not surprising, therefore, to learn that communities built since 1980 have turned away from a heavy dependence on conventional mortgages and entry fees and toward tax-exempt revenue bonds.

Changes in federal laws have also affected construction financing methods. In 1959, Congress enacted the National Housing Act, which established the Section 231 program of FHA-insured mortgages for housing for the elderly. Thus, many communities built in the early 1960s have FHA-insured mortgages. In 1964, however, new regulations were written which excluded the use of Section 231 in conjunction with accommodation or entrance fees, and consequently none of the communities built after that year have FHA-insured mortgages. These communities turned to the conventional mortgage lenders in large numbers for construction monies.

Communities built prior to 1960 are much more likely to have used only entry fees to construct their facilities. Older CCRCs used conventional mortgage money in combination with other funds, primarily entry fees or gifts and donations. Many of the older CCRCs evolved from homes established during the late 19th century and the early 20th century by individuals leaving property and bequests to private foundations expressly for the purpose of caring for and housing indigent, aged people, usually women. These endowments were often used as seed money for the new facilities which became continuing care retirement communities in the 1960s.

The type of construction financing varies by geographic region. In part, this is related to the ages of communities, but some other interesting findings emerge as well. For example, CCRCs in the Western region are much more likely to have used FHA-insured mortgages or entry fees (alone) because many of these communities were built and opened in the early 1960s, when these sources were available and it was practical to use them. The Northeastern and North Central regions have similar patterns of growth through the 1960s and 1970s, but very few, if any, CCRCs in the Northeast obtained FHA-insured mortgages, preferring conventional mortgage money instead, whereas CCRCs in the North Central region used both conventional mortgages and FHA-insured mortgages in combination with other financing and shunned the use of conventional mortgages alone. The Southern region, the location of most communities built in the past two years or currently under construction, is associated with a high use of tax-exempt revenue bonds, both as a sole funding source and in combination with other sources. Tables 3–13 and 3–14 present the data illustrating these trends. (The values in these tables are the number of CCRCs using a specific financing method.)

TABLE 3–13
Construction Financing by Community Age

Financing method	Total	Year contract first offered: Pre-1960	1960–1969	1970–1979	1980–post
Conventional mortgage					
Alone	46	3	18	25	0
In combination	66	12	30	20	4
FHA-insured mortgage					
Alone	18	2	13	2	1
In combination	13	2	6	5	0
Tax-exempt revenue bonds					
Alone	10	1	6	4	5
In combination	20	2	7	8	3
Entry fees					
Alone	4	2	1	1	0
In combination	62	9	26	20	7

TABLE 3–14
Construction Financing by Regional Location

Financing method	Region: Northeast	North Central	South	West
Conventional mortgage				
Alone	12	12	13	9
In combination	9	34	11	16
FHA-insured mortgage				
Alone	0	5	4	10
In combination	1	7	2	4
Tax-exempt revenue bonds				
Alone	2	5	4	0
In combination	1	10	8	2
Entry fees				
Alone	0	2	1	2
In combination	9	28	15	13

Regionally and over time, the data show a steady use of entry fees in whole or in combination with other sources of construction financing. Generally, lenders require developing CCRCs to secure a certain percentage of entrance fee commitments so as to demonstrate the community's feasibility; typically, 30–50 percent of all units are required. Total reliance upon entry fees for construction funding, however, has decreased steadily in the past decade.

RESERVES

Data provided by CCRCs on the types of reserves they hold and preliminary analyses of these data by several factors—community age, geographic location, type of health care guarantee, level of fees, and source of initial capital—are presented in this section. Five types of reserves are discussed: debt service, equipment replacement, health care, financial aid, and contingency funds.

Debt Service Reserve

About half (49.3 percent, n = 207) of the CCRCs surveyed hold reserves for debt service, making this the most frequently held reserve. Generally, these debt service reserves are required by loan covenants and management policy; in some states, they are required by regulation or statute.

Whether a community is likely to hold debt service reserves is related to the community's age and to its source of construction financing, as one might expect (see Table 3–15). It is not related to geographic region or health care guarantee.

TABLE 3–15
Debt Service Reserve by Community Age and Source of Capital

	Community age				Primary source of capital		
Debt service reserve	Pre-1960	1960–1969	1970–1979	1980–post	Conventional mortgage	FHA-insured mortgage	Tax-exempt revenue bond
Yes	32%	64%	73%	92%	64%	55%	97%
No	68	36	27	8	36	44	3

Equipment Replacement Reserve

With respect to the factors of community age, health care guarantee, and capital financing, there is no significant difference between CCRCs with building and equipment replacement reserves and those without such reserves. A geographic variation exists, however, with CCRCs in the Western region more likely, communities in the North Central region less likely, to have a reserve for equipment replacement. Communities with fees in the middle range are more likely to have reserves for equipment replacement than are communities with either high or low fees. (See Table 3–16.)

TABLE 3–16
Equipment Replacement Reserve by Region

Equipment reserve	NE	NC	S	W
Yes	54%	42%	62%	74%
No	46	58	38	26

Health Care Reserve

The need to establish health care reserves to fund the liability of future health care costs for current residents is a recent development in the continuing care field and remains an open question. Of the seven types of reserves included in the survey instrument, communities are least likely to have a health care reserve; 18.4 percent responded affirmatively (n = 38). Three quarters of these do so as a result of management or board policy; one tenth do so in accordance with state regulations. California, Colorado, Florida, Arizona, and Minnesota have some form of reserve requirement in their legislation or regulations regarding CCRCs.

One might assume that communities offering extensive health care guarantees would be more likely to establish health care reserves since they pay a larger share of residents' future medical costs and assume greater risk. It is surprising, therefore, to learn that not only is the relationship between these factors statistically insignificant but that the actual percentages show a tendency toward the opposite relationship (see Table 3–17).

TABLE 3–17
Health Care Reserve by Health Care Guarantee

Health care reserve	Extensive	Limited
Yes	30%	25%
No	70	75

A geographic difference exists among CCRCs on this issue as well.[8] Among the communities (n = 38) with health care reserves, 39.5 percent are in the Western region, 28.9 percent in the North Central region, 18.4 percent in the South, and 13.2 percent in the Northeastern region.

[8] Related to California, requirements for reserves under which state-approved mortality tables must be used to calculate a CCRC's health care liability.

TABLE 3–18
Health Care Reserve by Community Age

Health care reserve	Pre-1960	1960–1970	1970–1980	1980–post
Yes	8%	28%	34%	12%
No	92	72	66	88

As Table 3–18 shows, communities opened between 1960 and 1980 are more likely to have health care reserves than are those built either before 1960 or, more important, since 1980 (though this group includes CCRCs under construction which have not yet had the opportunity to establish such a reserve). These figures indicate a trend toward health care reserves.

Financial Aid Reserve

Of the communities surveyed, 44 percent (n = 91) hold reserve funds for financial aid to residents who become unable to pay some or all of the fees charged, a practice almost wholly due to management and/or board policy.

Residents of communities offering limited health care guarantees are more exposed financially and, presumably, more likely to need assistance over the long term. However, these communities are not more likely than other CCRCs to hold reserves for financial aid to residents (see Table 3–19).

TABLE 3–19
Financial Aid Reserve by Health Care Guarantee

Financial aid reserve	Extensive	Limited
Yes	62%	58%
No	38	42

The factors of community age, type of capital financing, and geographic location are not related to financial aid reserves. CCRCs with higher health care ratios tend to have reserves for financial aid, as do CCRCs with fees at either the high or low ends of the scale. Those with fees in the middle range are less likely to have assistance reserves.

Contingency Reserve

Seventy-nine communities (or 38.2 percent of all the CCRCs studied) hold a reserve fund for contingencies as a matter of management or

board policy. Some of these communities (7.6 percent) stated that state regulation was their reason for holding a reserve for contingencies. As might be expected, CCRCs with fees at the low end of the scale hold reserves for contingencies.

Summary of Reserves

The five states that have regulations regarding CCRC reserves, particularly California and Colorado, require reserves in specified amounts. These regulations could be construed to cover several of the areas discussed in this section. More detailed information must be collected and analyzed before conclusions can be drawn regarding the types and amounts of reserves that CCRCs hold. However, some research questions for future study are raised by these preliminary findings. For example, why are communities with contracts offering extensive health care guarantees not holding reserves, especially health care reserves, in larger numbers? Should more communities with limited health care guarantees establish financial aid reserves? What other funding mechanisms are in place to meet the financial needs of residents who outlive their assets?

SUMMARY PROFILE AND TRENDS

No prototype of a continuing care retirement community exists. The heterogeneity among communities, documented in this book, results from the efforts of continuing care providers to create alternative styles and combinations of housing and services for older people to choose from. However, a fairly consistent, recognizable, and commercially viable "product" has emerged from the convergence of the ideas and practices of many independent sources and from the numerous trials, errors, and successes of many dedicated individuals and organizations. The following discussion summarizes the characteristics unique to continuing care retirement communities.

Organization and Physical Plant

Almost all CCRCs are owned and operated by nonprofit organizations, and many are sponsored by or affiliated with a religious organization or body. The median age of all identified CCRCs is 14 years, where age means the number of years since the community first offered a continuing care contract to a resident. Most of the older communities are located in the Western (primarily California) and the North Central regions of the United States, while the Sun Belt, or Southern region, is

the location of many communities recently opened or under construction.

Communities have an average of 165 independent living units (ILUs) and have two or three levels of care on-site in addition to the ILUs: personal care, intermediate nursing care, and/or skilled nursing care. There are two styles of communities: campus and high-rise.

Contracts and Fees

Two kinds of payments are made by residents of CCRCs: entry fees and monthly fees. Entry fees are set according to the type and size of living unit. Throughout the past 25 years, part or all of the entry fees have been used to finance construction of the physical plant. Increases in entry fees have kept pace with recent inflation; the average increase for the period June 30, 1980, to July 2, 1981, was 12 percent.

Most communities have no limits on the monthly fees they can charge, and these fees, too, have risen with inflation; for the same 1980–81 period, the average increase was 10.4 percent. Financial aid is available in most communities to assist residents who outlive their assets. Communities with lower monthly fees (presumably including those with limits on rate increases) are more likely to participate in the Medicaid program than are communities with higher monthly fees. Communities that offer a limited health care guarantee to residents (causing residents to assume more of the financial burden and risk) are also more likely to participate in the Medicaid program. Very few, if any, residents have been asked to leave a community because of depletion of funds.

Contracts are generally mutually terminable by either the resident or the community, and refunds on entry fees, usually prorated, are given upon death or voluntary withdrawal. No consensus exists among CCRCs, however, on refund schedules of payment.

Residents

Typically, 90–100 percent of the residents in any particular community hold continuing care contracts. Communities (primarily new ones) also admit individuals without contracts directly into the health care facility, and some offer continuing care contracts to individuals entering personal care units.

The median number of continuing care contractholders in a CCRC is 218; the median total resident population is 245. Communities serve the relatively healthy "old-old"; the average of residents in independent living units is 80.2 years, and that of residents of intermediate nursing care units is 85.4 years. Board-based resident associations are active in most CCRCs.

Services Included in Fees

Communities in the Northeastern and Western regions include larger packages of services than do CCRCs in other locations. Three types of services were analyzed: services having to do with the physical plant or daily living, supportive or preventive health care services, and medical or medical-related services. Communities are fairly consistent in offering physical plant services but differ in the latter two categories depending on the health care guarantee of the continuing care contract offered. Communities offering extensive health care guarantees, and therefore assuming more of the risk and cost of medical care, are more likely to include and provide supportive/preventive services as part of the basic fee.

Services included in the fees of a typical continuing care retirement community are: utilities, special diet, apartment cleaning, parking, kitchen appliances, replacement of apartment equipment, storage, emergency call system, and social services.

Services not included in the fees of most communities are: prescription drugs, therapy for psychiatric disorders, special duty nurses, dental care, podiatry, and hearing aids.

Reserves

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

Trends

Continuing care retirement communities are constantly evolving in response to new markets (i.e., younger, consumer-oriented, and more educated residents), new economic climates as reflected in increased capital costs and new financing mechanisms, changes in public program appropriations and regulations, the long-term experience of continuing care providers, and the application of new technology. Some of the key trends emerging from the survey data are:

A move toward larger resident populations and communities.

Growth within the industry; new communities are under construction, particularly in the Sun Belt areas, and more than a third of the existing communities plan additions to their physical plants in the next two years.

Tax-exempt revenue bonds have replaced conventional mortgages and other sources of construction financing as the primary source of capital for CCRCs, but this could change if Congress changes

the law regarding industrial bonds or if mortgage market interest rates decline.

Continuing care contracts are becoming more carefully defined and mutually terminable. There is a trend toward extending the period for refunds upon death but making them contingent upon reoccupation of the unit, and there is a trend away from allowing a probationary period in the contract.

Admission policies are becoming more standardized and include a physical examination, minimum age requirements, and minimum assets and income.

A trend exists toward holding reserves in accordance with management policies, particularly debt service and health care reserves.

Several trends indicate support for the hypothesis that continuing care retirement communities reduce health care utilization. Communities with extensive health care guarantees have lower health care and nursing care ratios, while communities with limited health care guarantees have higher ratios. Among newer communities, there is a trend away from having a set policy regarding a resident's permanent move to the health care facility, enabling these communities to make such decisions on a case-by-case basis and thus to maintain each person at the most appropriate, cost-effective, and independent level of care. CCRCs with extensive health care guarantees (and lower health care ratios) do not hold reserves for health care in greater proportion than CCRCs with limited guarantees and higher health care ratios, perhaps signaling the success of the extensive guarantees in keeping the lid on health care utilization and costs.

Communities are moving away from including three meals a day in their fees and toward including one meal a day, an example of a general shift toward greater flexibility and choice for residents.

Newer communities are dropping some services and picking up others in greater number than older communities. Among the services not included by newer communities in their basic fees and contracts are: bed and bath linen, apartment cleaning, community's or resident's own physician, referred specialists, treatment for preexisting conditions, and special duty nurses. Services being included in basic fees by newer communities are typically those related to the physical plant, such as parking, kitchen appliances, storage, emergency call system, and replacing apartment equipment. ■