

Continuing Care Retirement Center Addendum to Form AV-10

COUNTY: _____

TAX YEAR: _____

Full Name of Owner: _____

Facility Name: _____

Facility Address: _____

Phone Numbers: Home: (____) _____ Work: (____) _____ Cell: (____) _____

- YES NO Is the facility exempt from North Carolina income tax per Article 4 of Chapter 105 of the NC Statutes?
- YES NO Are all of the facility revenues, less operating and capital expenses, applied to providing uncompensated goods and services to the elderly and to the local community, or are applied to an endowment or a reserve for those purposes?
- YES NO Does the facility have an active program to generate funds through one or more sources such as gifts, grants, trusts, bequests, endowments, or an annual giving program to assist the retirement facility in serving persons who might not be able to reside there without financial assistance or subsidy?

- Does the facility serve all residents without regard to the resident's ability to pay?
- YES Attach all relevant documentation to support the claim. Complete the Affirmation section at the end of the form. You do not have to fill out the rest of the form.
- NO You must fill out the rest of the form.

I. RESIDENT REVENUE

Total Resident Revenue - As Disclosed in Most Recent Audited Financial Statement

(Includes all monthly service fees, fees for service charges, **amortized entry fee income for the year**, and any fees associated with living in the facility collected that would not otherwise be amortized into income for the year. **Excludes investment income, contributions and income from non-resident sources.**) Attach Relevant Sections of the Most Recent Audited Financial Statements.

(1) _____

II. CHARITY CARE

(A) Unreimbursed Health Care

(From Medicare/Medicaid or third party cost reports, internal resident assistance data **certified by the facility**, or audited financial statements that show amount of unreimbursed costs) Attach applicable pages of cost reports.

(a) _____

(B) Unreimbursed Housing and Services

(From internal assistance reports (Lyons software or spreadsheet) **certified by the facility**, and/or audited statements which show amount of unreimbursed costs, and/or as disclosed in most recent audited financial statement)

(b) _____

Total Charity Care

(Add lines a + b)

(2) _____

III. COMMUNITY BENEFITS

(Amounts claimed are to be taken from audited financial statements which either footnote the amount or disclose the amount in the statement of operations as a line item, and/or can be taken from documented receipt letters from entities receiving the service, donation or volunteer service, and/or as documented in the Lyons Software or **similar spreadsheet program**

certified by the facility. The amounts are limited to actual expenses incurred by the facility to perform the service or provide the donation.)

(A) Services

(Verifiable unreimbursed expenses incurred by the facility to provide health, recreation, community research, and education activities to the community at large, including the elderly – DOES NOT include resident volunteer time.)

(a) _____

(B) Charitable Donations

(Actual cash outlay or equivalent dollar amount of donated items originally acquired by the facility and documented in facility community benefit report (Lyons software or spreadsheet) and/or noted in audited financial statements.)

(b) _____

(C) Donated Volunteer Services

(Cost to the facility for allowing employees to volunteer in community service projects or organizations and/or actual unreimbursed facility material, space and volunteer time as documented based on wages paid by the facility for the volunteer during the service period/project.)

(c) _____

(D) Donations and Voluntary Payments to Government Agencies

(Amounts to be taken from receipted donations/payments from government agency receiving donation/payment when the facility would otherwise not have to pay the agency – goodwill.)

(d) _____

Total Community Benefits (Add lines a + b + c + d) (3) _____

Total Charity Care and Community Benefits (Add lines 2 + 3) (4) _____

IV. PERCENTAGE OF RESIDENT REVENUE PROVIDED IN CHARITY CARE

Percentage of Resident Revenue Provided in Charity Care (Divide line 4 by line 1, times 100) (5) _____%

ROUND DOWN to the next whole percentage. The exclusion is based on the minimum percentage of the facility's resident revenue that it provides in charity care to its residents. (6) _____%

V. EXCLUSION PERCENTAGE BASED ON PERCENTAGE OF RESIDENT REVENUE PROVIDED IN CHARITY CARE

<u>% of Revenue (from line 6)</u>	<u>Exclusion %</u>	
5%	100%	
4%	80%	
3%	60%	
2%	40%	
1%	20%	
Less than 1%	0%	EXCLUSION PERCENTAGE CLAIMED _____%

AFFIRMATION: I, the undersigned, declare under penalties of law that this addendum is true and correct as supported by the financial and facility records.

Signature of Owner: _____ Title: _____ Date: _____

The Tax Assessor may contact you for additional information after reviewing this addendum.