

Office of Insurance Regulation
Specialty Product Administration

**FLORIDA COMPANY
CODE:**

**FEDERAL EMPLOYER
IDENTIFICATION NUMBER:**

**ANNUAL REPORT
OF THE**

(Continuing Care Provider)

**TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA**

Specialty Product Administration
200 East Gaines Street
Tallahassee, FL 32399 - 0331

FOR CALENDAR YEAR ENDED

GENERAL INFORMATION AND INSTRUCTIONS

1. This report is very important and is a tool the Office of Insurance Regulation (the Office) uses to gauge the financial viability of your company. The financial information submitted is compiled into a financial spreadsheet which shows data accumulated from these reports. Financial viability ratios are computed from this information.
2. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
3. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
4. The Balance Sheet, Statement of Operations and the Statement of Cash flows must be prepared based on year-end amounts.
5. This form is submitted electronically. Adobe Reader version 7.0.5 or higher is required. If you do not have that version, please upgrade prior to downloading any forms, visit <http://www.adobe.com>.
6. When you downloaded this report, you were assigned a session key. This session key has an expiration date that was also assigned prior to downloading this form. **Please make sure you save or submit prior to this expiration date or all work up until the last save will be lost.**

This session will expire on:

Eastern Time

7. To assist you in completing this form click both "Highlight Fields" and "Highlight Required Fields" in the upper right hand corner of the report page. This will highlight the fields where you may enter data.
8. The report form will calculate all totals and pre-populate fields based upon your responses. Data cannot be entered into the total and pre-populated fields.
9. Please enter all numeric fields with numbers only (no commas, dashes, dollar signs, etc.) Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter "0" on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response. Additionally, certain Schedules and Exhibits provide the option "Check if N/A" if the information requested is not applicable to your company.
10. Line descriptions may not be altered or added. When in doubt where to place an item, show the item in an appropriate "Other" line and include a supplemental schedule describing the items listed in the "Other" category. Any item which is of an extraordinary nature should also be entered on an appropriate "Other" line.
11. To save or submit the data, buttons are provided on the last page of this report. Hit the ALT+s keys to go to the last page. By clicking the Save button, all data entered on the form will be saved to our website. **It is strongly recommended that you save your data periodically as you fill in this form.** You will receive a confirmation message once the data is successfully saved.
12. When you either save or submit the form, all data is checked for completeness and you will be notified if errors have occurred. When submitting data, you will be asked to correct these validation errors. Once the data is successfully submitted, you will no longer be able to enter data because this form will become read-only. **To update this information after you have already submitted the data, you will have to make an amendment to this form which is done through REFS.**
13. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered. This additional information should be in electronic format (i.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be uploaded and attached to the filing as a Miscellaneous Document through REFS.
14. If you have to mail additional information including the attestations, please include a copy of the cover page of the report so that we can properly match the mailed information to the correct report. Alternatively, you may submit a scanned PDF of the signed and notarized attestation page (see next page) as a Miscellaneous Document through REFS.

ATTESTATION

You can notarize this form electronically by entering the Notary Public, Commission Number and Expiration Date on the form prior to submitting electronically **OR** if you choose not to notarize electronically then print this page, complete and notarize, and mail it separately to the Office of Insurance Regulation.

NOTE: ATTESTATIONS SUBMITTED MANUALLY MUST HAVE ORIGINAL SIGNATURES. COPIES ARE NOT ACCEPTABLE.

- I. Regardless of the form of the organization, this report **must** be attested to by the Facility Administrator or Executive Director **AND** one of the following:
 - A. If the organization is a sole proprietorship, the report must be attested to by the owner.
 - B. If the organization is a corporation, the report must be attested to by both the President and Secretary of the Corporation.
 - C. If the organization is a limited partnership, the report must be attested to by the general partner.
 - D. If the organization is a partnership other than a limited partnership, the report must be attested to by all the partners. If the organization is a trust, the report must be attested to by all trustees and officers.

- II. As an insurer licensed to transact business in the state of Florida, I am familiar with the laws of Florida relating to continuing care contracts and do hereby certify under penalty of filing false or misleading documents pursuant to 817.2341, FS, or perjury pursuant to 837.06, FS, that the information reported provided herein is a full and true reporting of the requested information. This report is submitted for compliance with Chapter 651, FS.

Do you intend to notarize this form electronically?

[Print this page](#)

<p>_____ (Typed Name)</p> <p>_____ (Signature)</p> <p>_____ (Title)</p> <p>Subscribed and sworn to before me</p> <p>This ____ day of _____, 20__</p> <p>Notary Public: _____</p> <p>Commission Number: _____</p> <p>Expiration Date: _____</p> <p><input type="checkbox"/> Personally Known or <input type="checkbox"/> Produced Identification</p> <p>_____ (Type of Identification Produced)</p>	<p>_____ (Typed Name)</p> <p>_____ (Signature)</p> <p>_____ (Title)</p> <p>Subscribed and sworn to before me</p> <p>This ____ day of _____, 20__</p> <p>Notary Public: _____</p> <p>Commission Number: _____</p> <p>Expiration Date: _____</p> <p><input type="checkbox"/> Personally Known or <input type="checkbox"/> Produced Identification</p> <p>_____ (Type of Identification Produced)</p>	<p>_____ (Typed Name)</p> <p>_____ (Signature)</p> <p>_____ (Title)</p> <p>Subscribed and sworn to before me</p> <p>This ____ day of _____, 20__</p> <p>Notary Public: _____</p> <p>Commission Number: _____</p> <p>Expiration Date: _____</p> <p><input type="checkbox"/> Personally Known or <input type="checkbox"/> Produced Identification</p> <p>_____ (Type of Identification Produced)</p>
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Company Name:

Year Ending:

**SECTION I
PROVIDER INFORMATION**

1. Furnish the Provider's:

Company Name: _____

Street: _____

City: _____ State/Prov: _____ Zip/Postal: _____

Phone: _____ Ext: _____ Fax: _____

Mailing Street: _____

City: _____ State/Prov: _____ Zip/Postal: _____

Contact Name: _____

Contact Title: _____

Phone: _____ Ext: _____ Fax: _____

Email Address: _____

Federal Employer Identification Number (FEIN): _____

2. A. Indicate the organizational structure of the Provider and attach the most current organizational chart:
(Check all appropriate answers)

- For Profit
- Not for Profit
- Corporation
- General Partnership
- Limited Partnership
- Trust
- Joint Venture
- Other

(Explain): _____

B. Is the Provider religiously affiliated?:

- Check if Yes

If Yes, please provide list of all affiliations:

Company Name:

Year Ending:

4. List the name and address of every CCRC in Florida for which the provider is licensed pursuant to Chapter 651, F.S.: (List one name and address per line)

5. A. List the name and address of every CCRC owned or managed by the provider in any state other than Florida: (List one name and address per line)

B. If a management company is utilized, list the name and address of every CCRC owned or managed by that management company in Florida: (Use one name and address per line)

In other states:

Company Name:

Year Ending:

6. Does the provider pay commission to any officer, director, or salaried employee?

Check if Yes

If yes, give Name and Title (List one name/title per line):

7. A. Based on the *provider's* indebtedness, give the following amounts due and identify the related lender(s) for this reporting period. (If different from Question 13, Page 8)

Debt Service Payment

Principal	_____	Taxes	_____
Interest	_____	Insurance	_____

Lender(s) (List one lender per line) (Enter N/A if not applicable):

B. Are all debt payments current for this period?

Check if Yes

8. If you currently use a management company, what is the expiration date of the agreement? _____

If the agreement was renewed during the reporting period, upload a copy via REFS.

**SECTION II
FACILITY INFORMATION**

9. Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ County: _____

Executive Director or Administrator: _____

Phone: _____ Ext: _____ Fax: _____

*** For other facility related address information, see questions 22 through 27**

10. A. Provide the estimated or actual market value of this facility:
Amount: _____ As of Date: _____

B. Amount of insurance coverage on this facility: _____

11. Have any additions or expansions to the original facility been made during this period? Check if Yes

If yes, describe the purpose of each structure including the number of living or nursing units added:

12. Are any phases under construction or to be constructed in the future? Check if Yes

If yes, describe the purpose of each structure including the number of living or nursing units added:

13. Based on the facility's financial condition, give the following amounts due and identify the related lender(s) for this reporting period:

Debt Service Payment

Principal _____ Taxes _____

Interest _____ Insurance _____

Lender(s) (List one lender per line)(Enter N/A if not applicable):

[Empty box for listing lenders]

14. A. Identify the President, or person performing a similar function, of the President's Council or similar body:

B. Provide the dates on which quarterly meetings were held during the reporting period:

15. A. Specify the range of entrance fees: from _____ to _____

2nd person fees: from _____ to _____

B. Specify the range of maintenance fees: from _____ to _____

2nd person fees: from _____ to _____

16. Provide a list of any changes or increases in fees for care or services during the reporting period: **(If there is not enough space provided below, please upload a separate document via REFS.)**

[Empty box for listing fee changes]

17. Specify the total number of INDIVIDUALS residing in this facility pursuant to:

A. Continuing Care Agreement: _____ C. Skilled Nursing-Community patients (non-CCRC): _____

B. Rental Agreement: _____ D. Total: _____ 0

18. Provide the average age of the resident population: _____

19. Do your continuing care residency contracts provide skilled nursing services? Check if Yes

If yes, check all appropriate answers:

A. On site or off site

B. Owned or by outside contractor

C. If contracted, name of entity: _____

D. Is contracted entity affiliated?: Check if Yes

E. **Upload a copy (via REFS) of the most recent license renewal and nursing home rating (Regardless of ownership)**

20. If skilled nursing facility is owned by provider, does it participate in either of the following:

Medicare: Check if Yes Annual Receipts _____

Medicaid: Check if Yes Annual Receipts _____

21. Does this facility require or arrange long-term care insurance, Medicare supplement insurance or similar types of insurance policies on behalf of the residents or the facility? Check if Yes

If yes, fully describe:

Company Name:

Year Ending:

22. Facility owned by:

Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
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23. Name of entity contracted to operate this facility: (A licensed CCRC provider who leases the facility from the owner)

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
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24. Name of company contracted to manage this facility:

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
----------------	------	----------------	------	-------------	-----------------	---------	-----	-------	--------------

25. Name of entity which facility or any part of facility (ex. ground lease, building lease, etc.) is leased TO:

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
----------------	------	----------------	------	-------------	-----------------	---------	-----	-------	--------------

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
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26. Name of entity which facility or any part of facility (ex. ground lease, building lease, etc.) is leased FROM:

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
----------------	------	----------------	------	-------------	-----------------	---------	-----	-------	--------------

Agreement Date	Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
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27. If the facility's records are not located on site, please indicate the location below:

Name	Street Address	City	State/Prov.	Zip/Postal Code	Phone #	Ext	Fax #	Contact Name
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**SECTION III
UNIT ANALYSIS**

Do not include units *permanently* utilized as something other than the categories below.

	(A) Currently Sold or Rented	(B) Unoccupied and Available to Market	(C) Unoccupied and Unavailable to Market or Reserved	(D) Total (A+B+C)
Continuing Care Units				
1. Independent Living Units	_____	_____	_____	_____
2. Assisted Living Units	_____	_____	_____	_____
3. Total Continuing Care Units	_____	_____	_____	_____
Rental Units				
4. Rental Units	_____	_____	_____	_____
Skilled Nursing Units				
5. Community Beds	_____	_____	_____	_____
6. Sheltered Beds	_____	_____	_____	_____
7. Total Skilled Nursing Units	_____	_____	_____	_____

UNIT SALES

Total CCRC Designated Units (From Line 3, Column D, Page 11): _____		
		Number
1.	Total CCRC units available beginning of this period: (Must agree to ending balance last period)	_____
2.	Plus units returned to inventory due to cancellation of sale, death, transfer, move-out, etc. this period:	_____
3.	Less CCRC units sold this period:	(_____)
4.	Less CCRC units removed from this period from inventory for renovation, rental or other purposes:	(_____)
5.	Total CCRC units available end of this period: (Item 1 + Item 2 - Item 3 - Item 4) Should agree to Line 3, Column B, Page 11	_____

WAITING LIST

	Number	Amount
1.	Deposits on hand beginning of this period:	_____
2.	Deposits received this period:	_____
3.	Less Deposits utilized or returned this period:	(_____) (_____)
4.	Net deposits on hand end of this period:	_____

ENTRANCE FEE CASH SUMMARY REPORT

1. Total Entrance Fees Collected this period: (Include all initial entrance fee deposits and installments collected (\$):	_____	
	Number	Amount
2. Beginning Refunds Due	_____	_____
3. Refunds Incurred this Period	_____	_____
4. Refunds Paid this Period	(_____)	(_____)
5. Refunds Due End of Period (Please upload an aging breakdown on any balance due via REFS)	_____	_____
Refund Balances at End of Period (Aging)	Number	Amount
6. Less than 30 Days	_____	_____
7. 30 - 60 Days	_____	_____
8. 61 - 90 Days	_____	_____
9. 91 - 120 Days	_____	_____
10. * Over 120 Days	_____	_____
11. TOTAL (Must equal Line 5 above)	_____	_____
* Explanation required for Refunds over 120 days past due (limited to 1000 characters):		

Company Name:

Year Ending:

**BALANCE SHEET
ASSETS**

CURRENT ASSETS		
1.	Cash	_____
2.	Short-Term Investments with Maturity of 12 Months or Less	_____
3.	Accounts Receivable	_____
4.	Prepaid Expenses	_____
5.	Excess of MINIMUM LIQUID RESERVE funds	_____
6.	Other	_____
7.	TOTAL CURRENT ASSETS	_____
NON-CURRENT ASSETS		
8.	Restricted Assets whose use is limited:	
	a. Required Minimum Liquid Reserve (See Schedule B)	_____
	b. Other	_____
9.	Property, Plant and Equipment	_____
	a. Less Accumulated Depreciation (See Schedule A)	(_____)
10.	Long-Term Investments	_____
11.	Other	_____
12.	TOTAL NON-CURRENT ASSETS	_____
13.	TOTAL ASSETS	_____

**BALANCE SHEET (continued)
LIABILITIES**

CURRENT LIABILITIES		
14.	Accounts Payable	_____
15.	Accrued Expenses	_____
16.	Accrued Interest	_____
17.	Refunds Payable	_____
18.	Current Portion of Long-Term Debt:	
	a. On Facility	_____
	b. Other	_____
19.	Current Portion of Notes Payable	_____
20.	Other	_____
21.	TOTAL CURRENT LIABILITIES	_____
NON-CURRENT LIABILITIES		
22.	Unearned Entrance Fees	_____
23.	Long-Term Debt:	
	a. On Facility	_____
	b. Other	_____
24.	Notes Payable	_____
25.	Other	_____
26.	TOTAL NON-CURRENT LIABILITIES	_____
27.	TOTAL LIABILITIES	_____
FUND BALANCE		
28.	Beginning Fund Balance (Must agree with Line 31, Page 14 from prior year's report)	_____
29.	Excess / Deficit (Should equal Line 22, Page 16)	_____
30.	Other Contributions or Adjustments	_____
31.	TOTAL FUND BALANCE	_____
32.	TOTAL LIABILITIES AND FUND BALANCE	_____

STATEMENT OF OPERATIONS

REVENUES	
1. Earned Entrance Fees	_____
2. Health Care Center (Gross)	_____
3. Monthly Maintenance Fees	_____
4. Rental Revenues	_____
5. Other Income (Gross)	_____
6. TOTAL REVENUES	_____
EXPENSES	
7. Wages and Benefits	_____
8. Food Service	_____
9. Housekeeping	_____
10. Insurance:	
a. On Facility	_____
b. Other	_____
11. Interest:	
a. Long-Term Debt on Facility	_____
b. Other	_____
12. Leasehold Payments	_____
13. Maintenance	_____
14. Management Fees	_____
15. Marketing	_____
16. Medical Care	_____
17. Taxes:	
a. Property	_____
b. Other	_____
18. Other Expenses	_____
19. Amortization	_____
20. Depreciation	_____
21. TOTAL EXPENSES	_____
22. EXCESS / (DEFICIT)	_____

STATEMENT OF CASH FLOWS

A. OPERATING ACTIVITIES	
1. Net Income (From Line 22, Page 16, Statement of Operations)	_____
2. Adjustments to reconcile Net Income to Net Cash provided by operations:	
a. Gross Entrance Fees Received	_____
b. Refunds Paid	(_____)
c. Earned Entrance Fees	(_____)
d. _____	_____
e. _____	_____
f. _____	_____
g. _____	_____
h. _____	_____
i. _____	_____
j. _____	_____
k. _____	_____
l. Total Operations Adjustments (Sum of Line 2(a) - Line 2(k))	_____
3. Total Operating Adjustments (Sum of Line 1 and Line 2(l))	_____
B. INVESTING ACTIVITIES	
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. Total Investing Activities	_____
C. FINANCING ACTIVITIES	
1. Total Gross Debt Principal Paid	(_____)
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. Total Financing Activities	_____
D. Increase (Decrease) in Cash (Sum of A.3. & B.5. & C.6.)	_____
E. Cash at Beginning of Period (Must agree with prior year's ending cash)	_____
F. Cash at End of Period (Sum of D & E. Must agree to Line 1, Page 14)	_____

Company Name:

Year Ending:

SCHEDULE A

1. Property Plant and Equipment Used To Furnish Or Provide Continuing Care *

Asset	Date Acquired	Actual Cost	Depreciation to Date
Total			

2. Property Plant and Equipment Not Used To Furnish Or Provide Continuing Care *

Asset	Date Acquired	Actual Cost	Depreciation to Date
Total			

* Include only items having an original cost of \$25,000 or more.

Company Name:

Year Ending:

SCHEDULE B

1. Complete a listing of the information detailed below for all assets maintained in the Minimum Liquid Reserve.

Asset	Date Acquired	Actual Cost	Market Value
Total			

2. Are all Minimum Liquid Reserve assets invested in compliance with the requirements of Part II Chapter 625, F.S.? Check if No

If No, identify which assets do not comply and provide an explanation of the circumstances surrounding their purchase and holding (limited to 1000 characters),

Company Name:

Year Ending:

**SCHEDULE C-1
LIST OF OFFICERS/DIRECTORS AND KEY PERSONNEL**

Complete the following for all officers, directors, partners, members, and facility executive director/administrators. Include shareholders and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such person and/or shareholder has been appointed, elected, nominated, designated or has been added to this list during this report period, place a check in the "New" column provided. If required biographical information has not been previously submitted on those checked, please refer to the instructions provided at <http://www.floir.com/pdf/OfficeDirector.pdf>.

Name	Position/Title	Residence Address	City	State/ Prov.	Zip/Postal Code	Date of Birth	%	New
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
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								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>

Company Name:

Year Ending:

**SCHEDULE C-2
LIST OF COMPANIES**

Complete the following for all companies and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such company has been added to this list during this report period, place a check in the "New" column provided.

Name	Business Address	City	State/ Prov.	Zip/Postal Code	FEIN	%	New
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
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							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>

Company Name:

Year Ending:

INVOICE

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
CONTINUING CARE RETIREMENT COMMUNITY
LIFE CARE PROVIDER ANNUAL REPORT:**

Name of Company: _____

FEIN: _____

Street Address: _____

City, State and Zip Code: _____

Phone Number: _____

Mailing Address (If different from Street Address)

Street Address: _____

City, State and Zip Code: _____

1. Make check payable to the Office of Insurance Regulation and **mail check and invoice only to:**
Office of Insurance Regulation
Bureau of Financial Services
Post Office Box 6100, Tallahassee
Florida 32314-6100

2. **IF YOU ARE MAILING IN THE ANNUAL REPORT:**
 Attach a copy of the check and the invoice to the report. The completed annual report, Form OIR-A3-470 should be submitted to:
 Florida Department of Financial Services - Office of Insurance Regulation
 Bureau of Specialty Insurers - Continuing Care Section
 200 E. Gaines Street, Larson Building
 Tallahassee, Florida 32399-0331

	B/T	CY/TL	F/T	AMOUNT
Annual Filing Fee	C	12/23	F	\$100.00

Print this page

SAVE/SUBMIT PAGE

Save - Use this button to save your data to our server. **It is strongly recommended that you save your data periodically as you fill in this form.** You can still save your data even if you have validation errors appear below.

Submit Final - Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. **Once you successfully submit the form data, you can no longer make changes.**

The session key will expire on:

Eastern Time

Save

Submit Final