CRITERIA FOR DETERMINING THE ALLOWANCE OF 651.035 (4)(b), FLORIDA STATUTES

STATE OF FLORIDA
OFFICE OF INSURANCE REGULATION

For the period beginning _____, 20____ and ending _____, 20____.

A MULTI-FACILITY PROVIDER MUST COMPLETE AND SUBMIT A SEPARATE FORM AND ALL SUPPORTING SCHEDULES THEREUNDER FOR EACH FACILITY FOR WHICH IT IS THE PROVIDER.

NOTE: THIS FORM AND ALL SUPPORTING SCHEDULES ARE REQUIRED TO BE FILED EACH YEAR 60 DAYS PRIOR TO SUBMITTING THE MINIMUM LIQUID RESERVE CALCULATION.

Complete the following for each facility:

1. Facility file number: _____

2. Name and address of Facility: _____

3. Name and address of Provider: _____

4. Provider's Federal ID Number: _____

5. Provider's fiscal year end: _____

6. Name, address, title and telephone number of person or persons designated as a contact person regarding this form:

I. **General** (Please answer 2 – 5, yes or no)

(1) Attach a copy of a certified statement from the board, stating the policies regarding a runoff position, the date this policy was effective and whether it will terminate.

(2) Currently and for the past five years, has the provider been in compliance with Chapter 651, Florida Statutes (FS)? _____

(3) Has the provider or any management company, administrator or similar persons, currently or in the past five years, had any civil, criminal, or administrative actions taken or filed against him or any person affiliated, controlled, or associated with the provider? _____

(4) Currently, and for the past five years, has the provider or any person affiliated, controlled, or associated with the provider been the subject of or initiated any bankruptcy or similar proceedings, voluntary or involuntary, with respect to any of the business operations of the provider? _____

(5) Currently are there any unresolved complaints or actions against the provider? _____

II. **Financial** (Please answer all yes or no)
Currently and for the past five years:

(1) Has the provider and the facility maintained a positive net worth? _____

(2) Does your total long-term debt per unit exceed your capital cost per unit? _____

(3) Does the ratio of the provider's and the facility's capital cost exceed the long-term debt by 2 times? _____

(4) Have all refunds due CCRC residents been paid timely? _____

III. **Outstanding CCRC Contracts**

(1) Give the total number of CCRC residents and the total number of non-CCRC residents currently residing at the facility: _____ CCRC _____ Non-CCRC

(2) List for each CCRC resident currently under contract, their name, present age, life expectancy and where they are located in the facility by level of care. (example: ILU, AL, SNF)

(3) For each resident listed in (2) above, briefly identify the refund provision as stated in their contract and the current liability to each.

IV. **Sales and Marketing**

(1) For the past 36 months, what has been the turnover rate on the average each month?
_____

(2) As of the month end prior to this request, how many units are unoccupied, but available for sale? _____

(3) As of the month end prior to this request, how many units are unoccupied, but not available for sale? _____

V. **Resident Meetings**

(1) Do you have a resident's council for CCRC residents? _____

(2) How often are resident's council meetings held? _____

(3) Attach a copy of the minutes from the most recent resident's council meeting.

VI. **Costs of Providing Contract Benefits**

(1) What is the amount of your last audited Obligation to Provide Future Services?

_____

(2) Provide the calculations from which the answer to VI. (1), was derived.

I _____, of _____ , an insurer licensed to transact business in the state of Florida, 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 624.3101, FS, or perjury pursuant to 837.06, FS, that the information reported above is a full and true reporting of the requested information. This report is submitted for compliance with Chapter 651, FS.

_____(Typed Name)

_____(Signature)

_____(Title)

Signed Before Me

This ____ day of _____, 20____

(Seal)

_____NOTARY PUBLIC

Personally known _____ ,
or produced identification _____

Type of identification produced

_____