Florida Office of Insurance Regulation

ANNUAL FINANCAL REPORT

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

ANNUAL FINANCIAL REPORT OF

_____

(Continuing Care Provider)

FOR

_____

(Continuing Care Facility)

TO THE
FLORIDA OFFICE OF INSURANCE REGULATION

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD ENDED

_____

GENERAL INFORMATION AND INSTRUCTIONS

The Florida Office of Insurance Regulation ("Office") issues a Certificate of Authority to the Provider, which is the legal entity that issues contracts for continuing care for a Facility, including residency agreements, reservation agreements, and waitlist agreements. Separate Certificates of Authority are issued for each Facility, which can result in a single Provider holding multiple Certificates of Authority and, therefore, submitting multiple reports for the same period. In addition to operating multiple Facilities, it is not unusual for Providers to engage in business other than providing continuing care in Florida. As a result, the Office requires financial information at the Provider and Facility level to evaluate the financial condition.

Further, many continuing care Providers are part of holding company structures through which they are affiliated with other Florida Providers through common ownership or control. These instructions are intended to clarify reporting requirements so that the Office has a clear understanding of the participants in the Florida market, regardless of organizational structure.

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.

2. 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.

3. Submit this form electronically via the Office's system at https://www.floir.com/iportal.

4. All questions and portions of this form must be completed in order for the filing to be considered complete—do not leave any items blank. For the financial statements, please ensure to enter 0 for numerical values and N/A for text responses, as appropriate, rather than leaving the field blank.

5. If additional explanations, supporting statements, documentation, or schedules are necessary, please upload them to the filing by attaching them as a Miscellaneous Document. Please add a label to the Miscellaneous Document that describes the attachment for ease of reference. Any attachments should be in a readable electronic format (i.e. Word, Excel, PDF, etc.).

6. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.

7. Financial Statements. Provide a Balance Sheet, Statement of Operations, and Statement of Cash Flows (collectively "Financial Statements") for both the Facility and the Provider. If operating the Facility is the Provider's only business, we would expect the Financial Statements for the Provider and Facility to be identical. If the Provider has more than one Facility or is engaged in other business in addition to operating the Facility, we would expect the Facility's Financial Statements to reflect the financial position and operations of the Facility as a sub-unit of the Provider and the Provider's Financial Statements to reflect the financial position of the Provider and all of its operations.

8. Minimum Liquid Reserves. Section 651.035, Florida Statutes, establishes minimum liquid reserve requirements that must be maintained by a Provider for each Facility. Minimum liquid reserve ("MLR") funds must be maintained in escrow or on deposit with the Department of Financial Services, Bureau of Collateral Management. MLR funds are recorded in Lines 6a and 11a of the Balance Sheet.

   In addition, Providers shall submit a schedule detailing MLR funding and accounts. Providers with financing on the Facility should complete SCHEDULE A and not SCHEDULE B. Providers without financing on the Facility should complete SCHEDULE B and not SCHEDULE A.

9. Escrow Statements. To document compliance with the Minimum Liquid Reserve Requirement, please upload escrow statements as a component of this filing. For the purpose of SCHEDULE A and SCHEDULE B, If a Provider uses a single MLR account for one or more of the Facility's MLR reserves, the Provider

should evenly apportion the funds between the appropriate reserve types for the purpose of completing the MLR schedule.

10. If a Provider owns more than one Facility, or if the Provider is affiliated through common ownership or control with additional Providers owning Facilities in Florida, please include a Provider Group Code on the cover page for the monthly, quarterly, and annual filings.

11. Obligated Groups. A Provider that is a member of an Obligated Group should complete SCHEDULE D and should not complete SCHEDULE C. A Provider that is not a member of an Obligated Group should complete SCHEDULE C and should not complete SCHEDULE D.

12. Before submitting this filing, please compare this report, the Minimum Liquid Reserve Calculation, and the audited financial statements to ensure that that all of the required filings are accurate and that amounts reported are consistent between documents.

ATTESTATION

This filing will not be considered complete unless it has been attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by the managing general partner.
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies of this page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

_____ _____
(Signature) (Title)

_____ _____
(Typed Name) (Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me this _____ day of _____, 20_____, by

_____, who is personally known to me or who has produced
(Name of Affiant)
_____ as identification.

_____
(Notary Stamp) (Signature of the Notary and Date Commission Expires)

_____ _____
(Signature) (Title)

_____ _____
(Typed Name) (Date)

State of _____
County of _____
The foregoing was sworn to and subscribed before me this _____ day of _____, 20_____, by

_____, who is personally known to me or who has produced
(Name of Affiant)
_____ as identification.

_____
(Notary Stamp) (Signature of the Notary and Date Commission Expires)

PROVIDER INFORMATION

Provider Name:_____

Provider Street Address:_____

City: _____ State:_____ Zip:_____

Phone: _____

Provider Mailing Address:_____

City: _____ State:_____ Zip:_____

Contact Name:_____

Contact Title:_____

Phone: _____ Ext: _____

Email Address:_____

Federal Employer Identification Number (FEIN):_____

1. Please select the type of organization that describes the Provider.

    - For-profit corporation
    - Not-for-profit corporation
    - General Partnership
    - Limited Partnership
    - Trust
    - Joint Venture
    - Limited Liability Company
    - Other: _____

2. Is the Provider affiliated with or sponsored by a not-for-profit organization?
    - Yes
    - No
    a. If yes, please provide the name of the affiliated or sponsoring organization. _____

3. Is the Provider affiliated with a religious organization?
    - Yes
    - No
    a. If yes, please provide the name of the religious organization. _____

4. Please provide the Florida Company Code of every CCRC in Florida for which the Provider is licensed pursuant to Chapter 651, Florida Statutes. Please separate Florida Company Codes with a comma.
    _____

5. Provide the following information regarding every CCRC owned or managed by the Provider.

Facility Name	**Location** *(select state)*	**Owned** *(check box if yes)*	**Managed** *(check box if yes)*

6. Does the Provider use a management company to manage this Facility?
   - o Yes
   - o No

   If yes, provide the following information:
   a. Name of the management company: _____
   b. Date of execution of the current management agreement: _____
   c. Expiration date of the current management agreement: _____
   d. Provide the information below regarding every CCRC owned or managed by the management company.

Facility Name	**Location** *(select state)*	**Owned** *(check box if yes)*	**Managed** *(check box if yes)*

7. Does the Provider pay commission to any officer, director, or salaried employee?
   - o Yes
   - o No

   a. If yes, please provide the following information.

Name	**Position**

8. Were debt service payments due for the Provider during the reporting period?
   - o Yes
   - o No
   a. If yes, for each lender, please provide the information below regarding the debt service payments due during the reporting period.

Lender(s)	**A** **Principal**	**B** **Interest**	**C** **Taxes**	**D** **Insurance**	**E** **Debt Service per Lender** *(Sum of A through D)*	**Payments Timely Made?** *(Select Yes or No)*
1.						
2.						
3.						
4.						
5.						
6. Total Debt Service						

9. Does the Provider have any balloon payments due on debt related to this Facility within 3 years of the period ended date of this filing?
   - o Yes
   - o No

   If yes, please provide the following:
   a. The amount of the balloon payment: _____
   b. Name of the lender: _____
   c. The due date for the balloon payment: _____

10. Upload an audited financial report for the Provider that meets the requirements of section 651.026(2)(b) and (c)(6), Florida Statutes.

FACILITY INFORMATION

Facility Name:_____

Facility Street Address:_____

City: _____ State:_____ Zip:_____

Phone: _____County: _____

Provider Mailing Address:_____

City: _____ State:_____ Zip:_____

Executive Director:_____

Phone: _____ Ext: _____

Email Address:_____

1. What is the estimated market value of the Facility? _____
2. What is the as of date for the estimated value provided above? _____
3. Provide the following information regarding all insurance coverage and upload proof of coverage as an attachment to this filing.

Insurer	Coverage Type	Coverage Limit	Deductible /Retention

4. Facility owned by: _____
5. Name of entity which the Facility or any part of Facility (ex. ground lease, building lease, etc.) is leased to: _____
6. Name of entity which the Facility or any part of Facility (ex. ground lease, building lease, etc.) is leased from: _____
7. If the Facility's records are not located on site, please provide the address where its records are located: _____

Please provide the following information regarding any units that have been added to the Facility during the reporting period (a certificate of occupancy has been issued) or are currently under construction.

For Assisted Living and Memory Care Units, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date in Line 9. Report the number of units that the Provider considers to be Memory Care Units as of the reporting date in Line 10. If the Provider does not make a distinction between Assisted Living and Memory Care or if a decision regarding whether the units will be used for Memory Care has not been made, please report all units as Assisted Living in Line 9 and enter 0s for Line 10.

	A Added	B Under Construction
8. Independent Living Units		
9. Assisted Living Units		
10. Memory Care Units		
11. Total Assisted Living (Line 9 + Line 10)		
12. Community Beds		
13. Sheltered Beds		
14. Total Skilled Nursing Beds (Line 12 +Line 13)		
15. Total Units (Sum of Lines 8, 11, and 14)		

16. Where any additional independent living/community common spaces constructed this year?
    - Yes
    - No

17. Was a new assisted living or memory care facility constructed during this year?
    - Yes
    - No

18. Was a new skilled nursing facility constructed during this year?
    - Yes
    - No

19. Did the Provider undertake a substantial renovation project for existing units?
    - Yes
    - No

20. Has the Provider remodeled or reconfigured the Facility to combine or otherwise permanently reduce the number of units?
    a. Yes
    b. No

21. Did the Provider incur any additional debt to related to construction costs?
    - Yes
    - No
    i. If yes, how much new debt was incurred? _____

If the Provider's plans for future construction projects at the Facility are publicly available, please provide the following information regarding any units that the Provider plans to add to the Facility in the next 3 years (3 years from the period ended date of this filing).

For Assisted Living and Memory Care Units, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date in Line 23. Report the number of units that the Provider considers to be Memory Care Units as of the reporting date in Line 24. If the Provider does not make a distinction between Assisted Living and Memory Care or if a decision regarding whether the units will be used for Memory Care has not been made, please report all units as Assisted Living in line 23 and enter zeroes for line 24.

	A Number of Units to Be Added
22. Independent Living Units	
23. Assisted Living Units	
24. Memory Care Units	
25. Total Assisted Living (Line 22 + Line 23)	
26. Community Beds	
27. Sheltered Beds	
28. Total Skilled Nursing Beds (Line 26 + Line 27)	
29. Total Units (Sum of Lines 22, 25, and 28)	

30. Does the Provider plan to construct any additional independent living/community common spaces to the Facility in the next three years?
    - Yes

- o No

31. Does the Provider plan to construct a new assisted living or memory care facility within the next 3 years?
    - o Yes
    - o No

32. Does the Provider plan to construct a new skilled nursing facility within the next 3 years?
    - o Yes
    - o No

33. Does the Provider plan to begin a substantial renovation project for existing units within the next 3 years?
    - o Yes
    - o No

34. Does the Provider plan to remodel or reconfigure the Facility to combine or otherwise permanently reduce the number of units within the next 3 years?
    - o Yes
    - o No

35. Does the Provider plan to incur any additional debt to related to construction costs within the next 3 years?
    - o Yes
    - o No.
    - a. If yes, how much new debt is estimated to be incurred? _____

36. Were debt service payments due specifically related to this Facility during the reporting period?
    - o Yes
    - o No

If yes, for each lender, please provide the following information regarding the Provider's debt service payments that were due during the reporting period.

Lender(s)	**A** **Principal**	**B** **Interest**	**C** **Taxes**	**D** **Insurance**	**E** **Debt Service per Lender** *(Sum of A through D)*	**Payments Timely Made?** *(Select Yes or No)*
37.						
38.						
39.						
40.						
41.						
42. Total Debt Service						

43. Does the Provider have any balloon payments due on debt related to this Facility within 3 years of the period ended date of this filing?
    - o Yes
    - o No

    If yes, please provide the following:
    - a. The amount of the balloon payment: _____
    - b. The name of the lender: _____
    - c. The due date for the balloon payment: _____

Facility Name:
Period Ending:

RESIDENTS' COUNCIL AND MEETING INFORMATION

1. Please provide the following information for the President, Chair, or person performing a similar function, of the Residents' Council or similar body:

    a. Name: _____

    b. Phone:_____

    c. Email Address: _____

2. Please provide the following information regarding the quarterly meetings required by section 651.085, Florida Statutes:

Date of Quarterly Meeting	**Date Notice of Quarterly Meeting Was Provided**	**Name & Title of Provider Representative(s) in Attendance**	**Monthly Fee Increases Discussed?** (select yes or no)	**Summary of Reasons for Fee Increase Provided in Writing?** (select yes or no)

FEES AND CHARGES

1. Please upload the fee schedules in affect as-of the period ended date of this filing in as Excel file or in readable PDF format. As applicable, please provide a fee schedule for each of the following:

    a. Entrance fees – continuing care contracts;
    b. Monthly maintenance fees – continuing care contracts;
    c. Fees charged for assisted living care;
    d. Fees charged for memory care; and
    e. Fees charged for skilled nursing care.

Please provide the following range of fees for continuing care contracts:

	A Lowest Fee	B Highest Fee
2. Entrance fee		
3. 2nd person entrance fee		
4. Monthly maintenance fee		
5. 2nd person maintenance fee		

6. How does the Provider apply the proceeds of entrance fees received? Please check all that apply:
    - o To pay down long-term debt
    - o To pay operating expenses
    - o To fund construction or renovation
    - o To pay resident refunds
    - o Other: _____

7. If the entrance fee is not the same in all cases, how is the amount of the entrance fee determined? Please check all that apply:
    - o Entrance fee varies by unit type
    - o Entrance fee changes based on market conditions or marketing promotions
    - o Entrance fee varies based on healthcare services provided
    - o Entrance fee varies based on services provided other than healthcare benefits (number of meals, housekeeping, etc.)
    - o Entrance fee varies based on whether a portion of the entrance fee is refundable regardless of the length of the resident's occupancy or if the entrance fee will amortize to 0% refundable
    - o Entrance fee varies based on timing of the refund payment
    - o Entrance fees vary by the age or health of the prospective resident
    - o Other: _____

Regardless of whether the change involves the basic rate or only those services available at additional cost the resident, please provide the following information:

8. Has the Provider changed or increased fees during the reporting period?
    - o Yes, fees increased, If so, by how much on average? a. _____%
    - o No, fees stayed the same
    - o No, fees decreased. If so, by how much on average? b. _____%

9. Has the Provider changed the scope of care or services during the reporting period?
    - o Yes, the provider provides a broader scope of care or services than last year
    - o Yes, the provider provides a narrower scope of care or services than last year
    - o No, the scope of care or services is the same as last year

10. Has the Provider changed the rates for care or services during the reporting period?
    - o Yes, the rates for care or services increased, If so, by how much on average? a. _____%
    - o Yes, the rates for care or services decreased. If so, by how much on average? b. _____%
    - o No, the rates for care or services stayed the same

RESIDENT COUNT

For each category below, specify the total number of individuals at this Facility as of the end of the reporting period. Continuing care at-home residents should not be included in lines 1 through 4.

Level of Care	**A** **Pursuant to a Continuing Care Contract**	**B** **Without a Continuing Care Contract**
1. Independent Living		
2. Assisted Living and Memory Care		
3. Skilled Nursing		
4. Total (Sum of Lines 1, 2 and 3)		

5. Please specify how many individuals have contracted with the Provider pursuant to a continuing care at-home contract for this Facility: _____

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

CONTINUING CARE CONTRACTS

Using the definitions below, please complete the following table regarding the number of continuing care contracts in force at this Facility. Please provide the number of the Provider's in force continuing care contracts that fit in each category. Choose the best fit using the definitions below.

Type A or "Extensive" or Life Care" Contracts: continuing care contracts that provide lifetime access to independent living and assisted living or skilled nursing care with little or no increase in the monthly fee as the result of moving to a higher level of care.

Type B or "Modified" Contracts: continuing care contracts that offer a less extensive health care benefit than Type A contracts, but more benefits than a fee-for-service contract. Type B contracts may provide for a slightly discounted rate for assisted living or skilled nursing care, a limited period of assisted living or skilled nursing care, or a set amount of funds to be credited toward charges for assisted living or skilled nursing care. If residents exhaust their healthcare credit or remain at a higher level of care for a greater period of time than the number of days established in their continuing care contract, they pay a stated daily rate for care.

Type C or "Fee-for-Service" Contracts: continuing care contracts that grant residents exclusive or priority access to assisted living or skilled nursing care, but do not provide any discounts for assisted living or skilled nursing care. Residents at a higher level of care are charged the stated daily rate.

Traditional Refund Clause: a clause in a Type A, Type B, or Type C continuing care contract whereby the resident's entrance fee amortizes down to a 0% refund of the entrance fee based on months of occupancy by the resident.

Refundable Clause : a clause in a Type A, Type B, or Type C continuing care contract that provides the resident with a right to a refund of a specified percentage their entrance fee regardless of the number of months of occupancy, subject to terms and conditions.

	A **Traditional Refund Clause**	**B** **Refundable Clause**
1. Type A		
2. Type B		
3. Type C		

Please provide the following information regarding the Provider's refund liability for this Facility.

	A **Current Reporting Period**	**B** **Previous Annual Reporting Period**
4. Contractual liability for refundable entrance Fees		
5. Contractual refund obligations assuming all contracts were terminated		

6. Please provide the OIR Form Filing Numbers for the continuing care contracts that the Provider has not discontinued writing at this Facility. Please separate each form filing number with a comma.

_____
_____
_____

7. Is the estimated present value of the net cost of future services and use of facilities less than the deferred revenue from entrance fees?
    - o Yes
    - o No

    a. If the estimated present value of the net cost of future services and use of facilities exceeds the deferred revenue from entrance fees, has the Provider recorded a liability representing the obligation to provide future services and use of facilities to residents?
        - o Yes
        - o No
        - o Not Applicable

    b. If a liability was recorded, what is the amount of the liability representing the obligation to provide future services and use of facilities? _____

ASSISTED LIVING/MEMORY CARE AND SKILLED NURSING INFORMATION

Skilled Nursing

1. Do the Provider's continuing care contracts provide for skilled nursing services?
   - Yes
   - No

   If yes, please provide the following:
   1. The name of the skilled nursing provider _____
   2. Is the skilled nursing provider an affiliate of the Provider?
      - Yes
      - No

2. Does the Provider offer continuing care at-home contracts that provide for skilled nursing services?
   - Yes
   - No

3. How are these services provided? Select all that apply.
   - On site at a Facility owned by the Provider
   - On site at a facility owned by an affiliate
   - On site by an unaffiliated provider
   - Off site by at a Facility owned by the Provider
   - Off site at a facility owned by an affiliate
   - Off site by an unaffiliated provider

4. Upload a copy of the nursing provider's most recent license renewal and nursing home rating.

If the skilled nursing facility is owned by the Provider, does it participate in the following:

5. Medicare
   - Yes. If yes, Annual Receipts _____
   - No
6. Medicaid
   - Yes. If yes, Annual Receipts _____
   - No

Assisted Living/Memory Care

7. Do the Provider's continuing care contracts provide for assisted living or memory care services?
   - Yes
   - No

   If yes, please provide the following:
   a. The name of the assisted living provider. _____
   b. Is the assisted living provider an affiliate of the Provider?
      - Yes
      - No

8. Does the Provider offer continuing care at-home contracts that provide for assisted living or memory care services?
   - Yes
   - No

9. How are these services provided? Select all that apply.
   - On site at a Facility owned by the Provider
   - On site at a facility owned by an affiliate
   - On site by an unaffiliated provider
   - Off site by at a Facility owned by the Provider
   - Off site at a facility owned by an affiliate
   - Off site by an unaffiliated provider

10. Upload a copy of the assisted living provider's most recent license renewal.

11. Does this facility require long-term care insurance, Medicare supplement insurance, or similar types of insurance policies on behalf of the residents or the facility? Check all that apply.
    - No
    - Long-term care insurance
    - Medicare supplement insurance
    - Other: a. _____

12. Does this facility arrange long-term care insurance, Medicare supplement insurance, or similar types of insurance policies on behalf of the residents or the facility? Check all that apply.
    - No
    - Long-term care insurance
    - Medicare supplement insurance
    - Other: a. _____

Facility Name:
Period Ending:

UNIT ANALYSIS

Please complete the table below regarding the units at the Facility. For the purposes of completing the Unit Analysis, please refer to the descriptions below.

Continuing Care Units: Units, other than Skilled Nursing Units, occupied by or to be occupied by at least one continuing care contract holder. Units that are *Available to Market and Unsold* or *Unavailable to Market* should be reported in this section, rather than the Rental Units section, unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Assisted Living and Memory Care Units**:** For lines 2, 7 and 15, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date. For lines 3, 8, and 16, please report the number of units that the Provider considers to be Memory Care Units as of the reporting date. If the Provider does not make a distinction between Assisted Living and Memory Care, please report all units as Assisted Living in lines 2, 7, and 15, and enter 0s for lines 3, 8, and 16.

Rental Units**:** Rental Units are those occupied by individuals who are not continuing care contract holders. *Available to Market and Unsold* and *Unavailable to Market Units* should be reported as Continuing Care Units unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Skilled Nursing Units: Community Beds refers to Skilled Nursing Units occupied by or available to individuals who are not continuing care contract holders. Sheltered Beds refers to Skilled Nursing Units occupied by or available only to continuing care contract holders.

Other Continuing Care Contracts: This section refers to continuing care contract holders residing at a location that is not operated by the Provider. Line 14 refers to individuals with continuing care at-home contracts that are not currently residing at the Facility. Lines 15 through 19 refer to continuing care or continuing care at-home contract holders residing at a location that is not operated by the Provider.

	A Occupied or Sold	**B Available to Market and Unsold**	**C Unavailable to Market**	**D Reserved by Prospective Residents**	**E Total (A+B+C+D)**
Continuing Care Units					
1. Independent Living Units					
2. Assisted Living					
3. Memory Care					
4. Total Assisted Living (Line 2 + Line 3)					
5. Total Continuing Care Units (Line 1 + Line 4)					
Rental Units					
6. Independent Living Rental					
7. Assisted Living Rental					
8. Memory Care Rental					
9. Total Assisted Living Rental (Line 7 + Line 8)					
10. Total Rental Units (Line 6 + Line 9)					
Skilled Nursing Units					
11. Community Beds					
12. Sheltered Beds					
13. Total Skilled Nursing Beds (Line 11 + Line 12.)					
Other Continuing Care Contracts					
14. Independent Living					
15. Assisted Living					
16. Memory Care					

17. Total Assisted Living (Line 15 + Line 16)					
18. Skilled Nursing					
19. Total Other Continuing Care Contracts (Sum of Lines 14, 17, and 18)					
20. Total of All Units (Sum of Lines 5, 10, 13, and 19)					

UNIT SALES

	Number
1. Total CCRC units available beginning of this period:	
2. Plus units returned to inventory due to cancellation of sale, death, transfer, move-out, etc. this period:	
3. Plus units added during this period:	
4. Less CCRC units sold this period:	**( )**
5. Less CCRC units removed from inventory for renovation, rental, or other purposes during this period:	**( )**
6. Total CCRC units available end of this period: *(Sum of lines 1, 2, and 3, minus lines 4 and 5)*	

WAITING LIST

Complete the table below regarding waiting list deposits. A waiting list deposit is any payment made by or on behalf of a prospective resident to a Provider in return for a preferential right to subscribe to a continuing care agreement.

	A Number	**B 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: *(Sum of lines 1 and 2, minus line 3)*		

RESERVATION DEPOSITS

A reservation deposit is a payment made by or on behalf of a prospective resident for the purpose of reserving a specific unit in a Facility.

		A Number	B 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: *(Sum of lines 1 and 2, minus line 3)*		

Facility Name:
Period Ending:

ENTRANCE FEE CASH SUMMARY REPORT

1.	Total Entrance Fees Collected this period: (Include all initial entrance fee deposits and installments collected):		
		A Number	**B Amount**
2.	Beginning Refunds Due		
3.	Refunds Incurred this Period		
4.	Refunds Paid this Period	**( )**	**( )**
5.	Refunds Due End of Period *(Sum of lines 2 and 3, minus line 4)*		
Refund Balances at End of Period (Aging)		**A Number**	**B 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 agree with Line 5 above)** *(Sum of lines 6 through 10)*		

12. Please provide an explanation for any refunds that are unpaid but have been due for more than 120 days.
_____
_____
_____
_____

13. For refunds paid during this reporting period for contracts terminated by residents, please provide the average number of days from the time a resident's contract was terminated and their unit was vacated until the date their refund was issued. _____

PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	**(** **)**
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF OPERATIONS

REVENUES		
1.	Resident Service Fees	
2.	Healthcare Fees	
3.	Rental Revenues	
4.	Total Resident Revenues (Sum of Lines 1 through 3)	
5.	Amortization of Earned Entrance Fees	
6.	Investment Income, Net	
7.	Realized Gains (Losses) from Investments	
8.	Unrealized Gains (Losses) from Investments	
9.	Net Assets Released from Restrictions (This must agree with Line 29)	
10.	Other Income	
11.	**TOTAL REVENUES (Sum of Lines 4 through 10)**	
EXPENSES		
12.	Resident Services	
13.	Dietary Services	
14.	Housekeeping, Maintenance and Utilities	
15.	Insurance:	
	a. On Facility	
	b. Other	
16.	Interest:	
	a. Long-Term Debt on Facility	
	b. Other	
17.	Leasehold Payments	
18.	General and Administrative	
19.	Management Fees	
20.	Marketing	
21.	Healthcare Services	
22.	Taxes:	
	a. Property	
	b. Other	
23.	Other Expenses	
24.	Amortization	
25.	Depreciation	

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	**TOTAL EXPENSES (Sum of Lines 12 through 26)**	
OTHER INCOME (EXPENSE)		
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	**CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)**	

Facility Name:
Period Ending:

PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF CASH FLOWS

A. OPERATING ACTIVITIES		
1.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3.	Cash Provided (Used) by Operations:	
a.	Entrance Fees Received	
b.	Entrance Fee Refunds Paid	( )
c.	Earned Entrance Fees	( )
d.	Depreciation	
e.	Amortization	
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)	
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES		
1.	Change in Investments and Assets Limited as to Use	
2.	Purchase of Property and Equipment	
3.		
4.		
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES		
1.	Repayment of Long Term Debt	( )
2.	Entrance Fees Refunded	
3.		
4.		
5.		
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

D.	**Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)**	
E.	**Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)**	
F.	**Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)**	

FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	**(** **)**
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES

CURRENT LIABILITIES		
17.	Accounts Payable	
18.	Accrued Expenses	
19.	Accrued Interest	
20.	Current Portion of Entrance Fee Refunds Payable	
21.	Current Portion of Long-Term Debt:	
	a. On Facility	
	b. Other	
22.	Current Portion of Notes Payable	
23.	Other Short Term Liabilities	
24.	**TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)**	
NON-CURRENT LIABILITIES		
25.	Long-Term Debt:	
	a. On Facility	
	b. Other	
26.	Notes Payable	
27.	Refundable Entrance Fees	
28.	Deferred Revenue from Entrance Fees	
29.	Other Long Term Liabilities	
30.	**TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)**	
31.	**TOTAL LIABILITIES (Line 24 plus Line 30)**	
NET ASSETS (DEFICIT) / EQUITY		
32.	Beginning Net Assets (Deficit) / Equity	
33.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34.	Other Contributions or Adjustments	
35.	**TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)**	
36.	**TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)**	

FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF OPERATIONS

REVENUES		
1.	Resident Service Fees	
2.	Healthcare Fees	
3.	Rental Revenues	
4.	Total Resident Revenues (Sum of Lines 1 through 3)	
5.	Amortization of Earned Entrance Fees	
6.	Investment Income, Net	
7.	Realized Gains (Losses) from Investments	
8.	Unrealized Gains (Losses) from Investments	
9.	Net Assets Released from Restrictions (This must agree with Line 29)	
10.	Other Income	
11.	**TOTAL REVENUES (Sum of Lines 4 through 10)**	
EXPENSES		
12.	Resident Services	
13.	Dietary Services	
14.	Housekeeping, Maintenance and Utilities	
15.	Insurance:	
	a. On Facility	
	b. Other	
16.	Interest:	
	a. Long-Term Debt on Facility	
	b. Other	
17.	Leasehold Payments	
18.	General and Administrative	
19.	Management Fees	
20.	Marketing	
21.	Healthcare Services	
22.	Taxes:	
	a. Property	
	b. Other	
23.	Other Expenses	
24.	Amortization	
25.	Depreciation	

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	**TOTAL EXPENSES (Sum of Lines 12 through 26)**	
OTHER INCOME (EXPENSE)		
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	**CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)**	

Facility Name:
Period Ending:

FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF CASH FLOWS

A. OPERATING ACTIVITIES		
2.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3.	Cash Provided (Used) by Operations:	
a.	Entrance Fees Received	
b.	Entrance Fee Refunds Paid	( )
c.	Earned Entrance Fees	( )
d.	Depreciation	
e.	Amortization	
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)	
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES		
1.	Change in Investments and Assets Limited as to Use	
2.	Purchase of Property and Equipment	
3.		
4.		
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES		
1.	Repayment of Long Term Debt	( )
2.	Entrance Fees Refunded	
3.		
4.		
5.		
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

D.	**Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)**	
E.	**Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)**	
F.	**Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)**	

EXHIBIT A – INTERROGATORIES

For any "Yes" responses, please upload and explanation and any required documentation into the filing. The supporting documentation should be uploaded as a Miscellaneous Document. Please label the documentation appropriately for ease of reference when reviewing the filing.

1. If the Provider is a limited partnership, has the general partner changed since the last filing submission?
   - Yes
   - No

2. Has any individual or entity assumed ownership or possession of or control over 10% or more of the Provider, a controlling company of the Provider, or the Provider's assets, based on the balance sheet from the most recent audited financial report filed with the Office, since the last filing submission?
   - Yes
   - No

3. Have there been any other changes in the officers, directors, shareholders of the Provider since the last filing submission?
   - Yes
   - No

4. Have there been any changes to managers of or management company for the Facility, including the Executive Director, Facility Administrator, or equivalent position, since the last filing submission?
   - Yes
   - No

5. Have there been any changes to the Provider's organizational structure since the last filing submission?
   - Yes
   - No

6. Have there been any changes to the Provider's organizational documents since the last filing submission? Organizational documents include but are not limited to: articles of incorporation, by-laws, partnership agreement, articles of association, trust agreement, etc.
   - Yes
   - No

7. Have any judgments or fines been entered against the Provider since the last filing submission?
   - Yes
   - No

8. With respect to any business operations of the Provider, have any bankruptcy, delinquency, receivership, foreclosure or loan default proceedings been initiated since the last filing submission?
   - Yes
   - No

9. Is the Provider out of compliance with any terms, conditions, or covenants established in lending agreements for long-term financing?
   - Yes
   - No

10. Since the last filing submission, have any administrative actions been initiated against any of the following:
    - the Provider or any of its officers, directors, or controlling persons;
    - any affiliates of the Provider;
    - the managers or management company of the Facility, including the Executive Director, Facility Administrator, or equivalent position; or
    - any entity providing shelter, nursing care, or personal services pursuant to the Provider's continuing care contracts.

    o Yes
    o No

11. Since the last filing was submitted, have any of individuals described below been convicted of or pled nolo contendere to a crime, other than a minor traffic violation:
    - any officer, director, or controlling person of the Provider; or
    - any managers of the Facility, including the Executive Director, Facility Administrator, or equivalent positions; or
    - any employees or principals of the Facility's management company performing roles similar to those listed above.
      o Yes
      o No

12. During the reporting period or at any time since the last filing submission, has the Provider failed to pay its obligations as they come due in the normal course of business? For the purposes of this question, "the normal course of business" is defined as the time agreed upon by the involved parties.
    o Yes
    o No

13. If the answer is yes to item 12, please select all applicable creditor types that the Provider was or is unable to pay timely.

    o Residents or prospective residents (refunds)
    o Health care providers
    o Prescription drug vendors
    o Food vendors
    o Lenders
    o Employees
    o Contract employees or consultants
    o Construction, maintenance, or similar companies
    o Insurers
    o Local, state, or federal government entities (taxes, fees)
    o Other:

14. Has the Provider closed on any new financing, additional financing, or refinancing since the last filing submission?
    o Yes
    o No

EXHIBIT B – DETAILED LISTING OF THE ASSETS MAINTAINED IN THE MINIMUM LIQUID RESERVES

Please complete and upload the Exhibit B spreadsheet to provide the detailed listing of the assets maintained in the minimum liquid reserves, as required by Section 651.026, Florida Statutes.

EXHIBIT C – PROPERTY, PLANT, AND EQUIPMENT HAVING AN ORIGINAL COST OF $25,000 OR GREATER

Please complete and upload the Exhibit C spreadsheet to provide the information about Property, Plant, and Equipment having an original cost of $25,000 or greater, as required by Section 651.026, Florida Statutes. Please note that one sheet in Exhibit C must be completed for Property, Plant, and Equipment Used in Providing Continuing Care, and one sheet must be completed for Property, Plant, and Equipment Not Used in Providing Continuing Care.

EXHIBIT D – 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/siteDocuments/OfficeDirector.pdf.

Name	**Title/Position**	**Ownership Percentage**	**New** *(select yes or no)*	**Date of Change**

Facility Name:
Period Ending:

EXHIBIT E – 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, select “Yes” in the "New" column provided.

Legal Name	State of Domicile	FEIN	Ownership Percentage	New *(select yes or no)*	Date of Change

SCHEDULE A – MINIMUM LIQUID RESERVES FOR FACILITIES WITH FINANCING

- Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE B.

- Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE B and are not required to complete this schedule.

1. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve ("MLR") Calculation, Form OIR-A3-477, ("MLR Calculation") filed for the Provider's current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider's Annual Report is due, which is 181 days after the end of the Provider's fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year beings 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider's annual statement is due, which is 180 days after the last day of the Provider's fiscal year.

2. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider's minimum liquid reserves.

    a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.

    b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1b, 1c, 3b, 3c, 5e, or 5f, as applicable.

    c. If the Provider comingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 6510.033, Florida Statutes, the Provider may allocate the balance(s) between Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable. However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.

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    d. If the Provider has a debt service reserve established pursuant to a trust indenture or mortgage lien on the facility, it may be included in Lines 1d and 1e if the Provider has filed the documents specified in Section 651.035(1)(b), Florida Statutes, with the Office. The sum of Lines 1dB and 1eB cannot exceed the Allowable Amount specified in Column 74, Schedule VII, number 74 of the Minimum Liquid Reserve Calculation,

3. Funds included in the Provider's MLR are recorded in Lines 6a and 11a of the Facility's Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility's Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
Total Trustee Held Debt Service Reserve Funds:		
d.		
e.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Sum of Lines 3a and 3b)		
5. Renewal & Replacement Reserve		
a. (Less any approved withdraw for which the Provider is making timely repayments)		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5d)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

SCHEDULE B – MINIMUM LIQUID RESERVES FOR FACILITIES WITHOUT FINANCING

- Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE A.

- Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE A and are not required to complete this schedule.

1. Calculating the Debt Service Reserve - Tax Reserve Requirement
    a. Annual Property Tax Liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3)
    b. 1.a /12 = Monthly Tax Reserve Deposit Amount
    c. Date the Property Taxes were paid:
    d. (number of months since property taxes were paid) x 1.b = Line 1A below.

2. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve ("MLR") Calculation, Form OIR-A3-477, ("MLR Calculation") filed for the Provider's current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider's Annual Report is due, which is 181 days after the end of the Provider's fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year beings 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider's annual statement is due, which is 180 days after the last day of the Provider's fiscal year.

3. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider's minimum liquid reserves.

    a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.

    b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable.

    c. If the Provider comingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 6510.033, Florida Statutes, the Provider may allocate the balance(s) between Lines However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.

4. Funds included in the Provider's MLR are recorded in Lines 6a and 11a of the Facility's Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility's Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Sum of Lines 3a and 3b)		
5. Renewal & Replacement Reserve		
a. (Less any approved withdraw for which the Provider is making timely repayments)		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5e)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:
Period Ending:

SCHEDULE C – ANNUAL CALCULATION OF FINANCIAL AND OPERATING RATIOS

If the Provider has long-term debt on the Facility and the structure of such debt establishes an Obligated Group, complete SCHEDULE D instead of this schedule.

Preliminary Questions:

1. Has the Provider reached stabilized occupancy?

   - o Yes
   - o No

2. Has the time projected to achieve stabilized occupancy, as reported in the last feasibility study required by the Office as part of an application filing under s. 651.0215, s. 651.023, s. 651.024, or s. 651.0246, elapsed?

   - o Yes
   - o No

   a. If yes, on what date was the Provider projected to reach stabilized occupancy? _____

I. Days Cash on Hand

1. Please complete the schedules below. Assets are recorded on the Facility Balance Sheet, and Expenses are recorded on the Facility Statement of Operations. Amounts reported below should match the Financial Statements' lines referenced and the amounts reported in the audited financial statements submitted by the Provider with this Annual Report. Lines 1 through 13 will prepopulate based on the Facility Financial Statements in this filing. If the Provider overwrites any of the prepopulated totals, please submit an explanation of the discrepancy.

Assets	**Balance as of the Reporting Date**
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10 and 11b-d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of 1 through 6)	

2. Please complete the schedules below. Line items should match the Annual Financial Statements and the Audited Financial Statements submitted by the Provider with this Annual Report.

Expenses	**Total as of the Reporting Date**
8. Operating Expenses (Line 27)	
9. (Depreciation) (Line 25)	( )
10. (Amortization) (Line 24)	( )
11. (Other Noncash Expenses) (Line 26)	( )
12. Adjusted Expense Total (Sum of Lines 8 through 11)	
13. Days Cash on Hand Denominator (Line 12 divided by 365)	

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____

4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?

   - o Yes
   - o No

a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Legal Name of Issuing Entity	**Demand Note** (select yes or no)	**Parental Guarantee** (select yes or no)	**Amount**	**Filing ID**

b. Please provide the total amount of all demand notes issued by the parent. _____

c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.

5. Do lenders require the Provider to maintain a minimum number of Days Cash on Hand pursuant to the Provider's financing agreements?

   - o Yes
   - o No

   a. If yes, what is the number of days cash on hand required. _____

   b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Days Cash on Hand as of the reporting date. _____

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living/memory care units, and skilled nursing beds in a Facility divided by the total number of units and beds in that Facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The Facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____

2. Please select the basis on which occupancy percentage was calculated:

    - o On a daily basis—average of 365
    - o On a weekly basis—average of 52
    - o On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

3 Do lenders require the Provider to maintain an occupancy ratio pursuant to the Provider's financing agreements?

- o Yes
- o No

    a. If yes, what is the required occupancy ratio? _____

    b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's occupancy as of the reporting date. _____

III. Debt Service Coverage Ratio

1. Does the Provider have debt on the Facility?

   - o Yes
   - o No

2. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Expenses	Total as of the Reporting Date
1. Total Expenses (Line 27)	
2. (Interest Expense on Debt Facility) (Line 16)	( )
3. (Depreciation) (Line 25)	( )
4. (Amortization) (Line 24)	( )
5. (Other Noncash Expenses) (Line 26)	( )
6. Adjusted Expense Total (Sum of Lines 1 through 5)	

3. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Revenues	Total as of the Reporting Date
7. Total Revenues (Line 11)	
8. (Earned Entrance Fees) (Line 5)	( )
9. (Other Noncash Revenue) (Line 8)	( )
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9)	( )
11. Gross Entrance Fees (Line 3a)	
12. (Refunds Paid) (Sum of Lines 3b and C2)	( )
13. Adjusted Revenue Total (Sum of Lines 7 through12)	

4. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Debt Service	Total for the 12-Month Period Ending on the Reporting Date
14. Principal (Line 42A, page 10)	
15. Interest (Line 42B, page 10)	
16. Debt Service Denominator (Sum of Lines 14 and 15)	

3. Debt Service Coverage Ratio ((Line 13 above minus Line 6 above) divided by Line 16 above) = _____

4. Do lenders require the Provider to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?

   - o Yes
   - o No

   a. If yes, what is the required debt service coverage ratio. _____

   b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Debt Service Coverage Ratio as of the reporting date. _____

IV. Additional Information Regarding Financial and Operating Ratios

	Lender Requirement	Lender Calculation	Statutory Requirement	Provider's Ratio	Meets Threshold (*the form will prepopulate with yes or no based on the information provided)*
Days Cash on Hand	*(Populate with Line 5a. Page 43 or NA)*	*(Populate with Line 5b, Page 41 or NA)*	100	*(Populate with Line 3, Page 42)*	
Occupancy	*(Populate with Line 3a, Page 44 or NA)*	*(Populate with Line 3b, Page 44 or NA)*	80%	*(Populate with Line 1, Page 44)*	
Debt Service Coverage Ratio	*(Populate with Line 6, Page 45 or NA)*	*(Populate with Line 6b, Page 45 or NA)*	1.20:1	*(Populate with Line 4, Page 45)*	

1. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has occurred. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.

2. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
    a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
    b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.

SCHEDULE D – OBLIGATED GROUPS

ANNUAL CALCULATION OF FINANCIAL AND OPERATING RATIOS AND SUPPORTING FINANCIAL INFORMATION FOR OBLIGATED GROUPS

Use this schedule, not SCHEDULE C, if the Provider has long-term debt on the Facility and the structure of such debt establishes an Obligated Group.

1. Provide the Florida Company Code for all Facilities in the Obligated Group who hold Certificates of Authority issued by the Office below, separated by commas.
   _____
   _____
   _____
   _____

2. List all other entities that are members of the Obligated Group.
   _____
   _____
   _____
   _____

3. Complete Schedules D(1) and D(2). The Provider must make available all necessary records to verify the information reported in this schedule.

4. The first time this Schedule is completed upload financing documents evidencing the members of Obligated Group, terms and conditions of the financing, any bond covenants or other necessary lender requirements, and other documents as necessary to evidence the financing transaction as an attachment to this filing.

5. If any of the terms and conditions of the financing change after the initial filing, please upload any revised documents, amendments, etc. to as an attachment to the this filing.

6. Has the lender determined that the Obligated Group is out of compliance with any terms, conditions, or covenants of its financing agreement?

   - o Yes
   - o No

   a. If Yes, please upload a document explaining the issue and the steps the Obligated Group is taking to come into compliance.

Facility Name:
Period Ending:

SCHEDULE D(1) – OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	**(** **)**
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES

CURRENT LIABILITIES		
17.	Accounts Payable	
18.	Accrued Expenses	
19.	Accrued Interest	
20.	Current Portion of Entrance Fee Refunds Payable	
21.	Current Portion of Long-Term Debt:	
	a. On Facility	
	b. Other	
22.	Current Portion of Notes Payable	
23.	Other Short Term Liabilities	
24.	**TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)**	
NON-CURRENT LIABILITIES		
25.	Long-Term Debt:	
	a. On Facility	
	b. Other	
26.	Notes Payable	
27.	Refundable Entrance Fees	
28.	Deferred Revenue from Entrance Fees	
29.	Other Long Term Liabilities	
30.	**TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)**	
31.	**TOTAL LIABILITIES (Line 24 plus Line 30)**	
NET ASSETS (DEFICIT) / EQUITY		
32.	Beginning Net Assets (Deficit) / Equity	
33.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34.	Other Contributions or Adjustments	
35.	**TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)**	
36.	**TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)**	

Facility Name:
Period Ending:

OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF OPERATIONS

REVENUES		
1.	Resident Service Fees	
2.	Healthcare Fees	
3.	Rental Revenues	
4.	Total Resident Revenues (Sum of Lines 1 through 3)	
5.	Amortization of Earned Entrance Fees	
6.	Investment Income, Net	
7.	Realized Gains (Losses) from Investments	
8.	Unrealized Gains (Losses) from Investments	
9.	Net Assets Released from Restrictions (This must agree with Line 29)	
10.	Other Income	
11.	**TOTAL REVENUES (Sum of Lines 4 through 10)**	
EXPENSES		
12.	Resident Services	
13.	Dietary Services	
14.	Housekeeping, Maintenance and Utilities	
15.	Insurance:	
	a. On Facility	
	b. Other	
16.	Interest:	
	a. Long-Term Debt on Facility	
	b. Other	
17.	Leasehold Payments	
18.	General and Administrative	
19.	Management Fees	
20.	Marketing	
21.	Healthcare Services	
22.	Taxes:	
	a. Property	
	b. Other	
23.	Other Expenses	
24.	Amortization	
25.	Depreciation	

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	**TOTAL EXPENSES (Sum of Lines 12 through 26)**	
OTHER INCOME (EXPENSE)		
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	**CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)**	

Facility Name:
Period Ending:

OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF CASH FLOWS

A. OPERATING ACTIVITIES		
1.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3.	Cash Provided (Used) by Operations:	
a.	Entrance Fees Received	
b.	Entrance Fee Refunds Paid	( )
c.	Earned Entrance Fees	( )
d.	Depreciation	
e.	Amortization	
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)	
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES		
1.	Change in Investments and Assets Limited as to Use	
2.	Purchase of Property and Equipment	
3.		
4.		
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES		
1.	Repayment of Long Term Debt	( )
2.	Entrance Fees Refunded	
3.		
4.		
5.		
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

D.	**Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)**	
E.	**Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)**	
F.	**Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)**	

SCHEDULE D(2) – ANNUAL OBLIGATED GROUP FINANCIAL AND OCCUPANCY RATIOS

If the Provider has long-term debt on the Facility and the structure of such debt does not establish an Obligated Group, please complete SCHEDULE C instead of this schedule.

I. Days Cash on Hand

1. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Assets	**Balance as of the Reporting Date**
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10 and 11b through 11d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of Lines 1 through 6)	

2. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Expenses	**Total as of the Reporting Date**
8. Operating Expenses (Line 27)	
9. (Depreciation) (Line 25)	( )
10. (Amortization) (Line 24)	( )
11. (Other Noncash Expenses) (Line 26)	( )
12. Adjusted Expense Total (Sum of Lines 8 through 11)	
13. Days Cash on Hand Denominator (Line 12 divided by 365)	

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____

4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?

   - o Yes
   - o No

   a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Legal Name of Issuing Entity	**Demand Note** (select yes or no)	**Parental Guarantee** (select yes or no)	**Amount**	**Filing ID**

b. Please provide the total amount of all demand notes issued by the parent. _____

c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.

5. Do lenders require the Obligated Group to maintain a minimum number of Days Cash on Hand pursuant to its financing agreements?

   - o Yes
   - o No

   a. If yes, what is the number of days cash on hand required. _____

   b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Days Cash on Hand as of the reporting date. _____

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living/memory care units, and skilled nursing beds in a Facility divided by the total number of units and beds in that Facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The Facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____

2. Please select the basis on which occupancy percentage was calculated:

    - o On a daily basis—average of 365
    - o On a weekly basis—average of 52
    - o On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

3 Do lenders require the Obligated Group to maintain an occupancy ratio pursuant to the Obligated Group's financing agreements?

- o Yes
- o No

a. If yes, what is the required occupancy ratio? _____

b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Occupancy as of the reporting date. _____

III. Debt Service Coverage Ratio

1. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Expenses	Total as of the Reporting Date
1. Total Expenses (Line 27)	
2. (Interest Expense on Debt Facility) (Line 16)	( )
3. (Depreciation) (Line 25)	( )
4. (Amortization) (Line 24)	( )
5. (Other Noncash Expenses) (Line 26)	( )
6. Adjusted Expense Total (Sum of Lines 1 through 5)	

2. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Revenues	Total as of the Reporting Date
7. Total Revenues (Line 11)	
8. (Earned Entrance Fees) (Line 5)	( )
9. (Other Noncash Revenue) (Line 8)	( )
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9)	( )
11. Gross Entrance Fees (Line 3a)	
12. (Refunds Paid) (Lines 3b plus Line C2)	( )
13. Adjusted Revenue Total (Sum of Lines 7 through 12)	

3. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Debt Service for Obligated Group	Total for the 12-Month Period Ending on the Reporting Date
14. Principal	
15. Interest	
16. Debt Service Denominator (Sum of Lines 14 and 15)	

4. Debt Service Coverage Ratio ((Line 13 above minus Line 6 above) divided by Line 16 above) = _____

5. Do lenders require the Provider to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?

   - o Yes
   - o No

   a. If yes, what is the required debt service coverage ratio. _____

6. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Debt Service Coverage as of the reporting date. _____

IV. Additional Information Regarding Financial and Operating Ratios

	Lender Requirement	Lender Calculation	Statutory Requirement	Provider's Ratio	Meets Threshold (*the form will prepopulate with yes or no based on the information provided and statutory requirements)*
Days Cash on Hand	*(Populate with Line 5a, Page 55 or NA)*	*(Populate with Line 5b, Page 55 or NA)*	100	*(Populate with Line 3, Page 54)*	
Occupancy	*(Populate with Line 3a, Page 56 or NA)*	*(Populate with Line 3b, Page 56 or NA)*	80%	*(Populate with Line 1, Page 56)*	
Debt Service Coverage Ratio	*(Populate with Line 5a, Page 57 or NA)*	*(Populate with Line 5b, Page 57 or NA)*	1.20:1	*(Populate with Line 4, Page 57)*	

3. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has Occurred. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.

4. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
    a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
    b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.

1. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has Occurred. For a Provider that is a member of an Obligated Group, the Obligated Group's days cash on hand and debt service coverage ratio will be used. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.

2. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.