Florida Office of Insurance Regulation

SALES AND FINANCIAL REPORT FOR A NON-OPERATIONAL FACILITY

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

SALES AND FINANCIAL REPORT FOR A NON-OPERATIONAL FACILITY FILED BY

_____

(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.

Facility Name:
Period Ending:

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)

Facility Name:
Period Ending:

UNIT RESERVATIONS

The line 1 amount field should equal the amount you would receive if all units were sold. The line 3 amount field should equal the full entrance fee amount for each unit sold, not just the deposit amount.

Total Reservations for CCRC Units:		
	Number	**Amount**
1. Total CCRC units available for sale, beginning of this period:		
2. Plus CCRC units returned to inventory due to:		
a. Cancellation of Reservation		
b. Death		
c. Other		
d. Total		
3. Less CCRC units reserved during this period:	( )	( )
4. Total CCRC units available for sale, end of this period: (Line 1 + Line 2d - Line 3)		

Facility Name:
Period Ending:

UNIT RESERVATIONS (At-Home)

The line 1 amount field should equal the amount you would receive if all units were sold. The line 3 amount field should equal the full entrance fee amount for each unit sold, not just the deposit amount.

Total CCRC At-Home Contracts:		
	Number	**Amount**
1. Total continuing care at-home contracts available for sale, beginning of this period:		
2. Plus continuing care at-home contracts returned to inventory due to:		
a. Cancellation of Reservation		
b. Death		
c. Other		
d. Total		
3. Less continuing care at-home contracts reserved during this period:	( )	( )
4. Total continuing care at-home contracts available for sale, end of this period: (Line 1 + Line 2d - 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 ($):		
	Number	**Amount**
2. Beginning Refunds Due		
3. Refunds Incurred this Period		
4. Refunds Paid this Period	( )	( )
5. Refunds Due End of Period **(Please provide an aging breakdown on any balance due)**		
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):**

Facility Name:
Period Ending:

ENTRANCE FEE/RESERVATION FEE
RECONCILIATION OF ESCROW STATEMENT

1.	Beginning Balance: (Should agree to ending balance for prior period)		
2.	Add:		
	a. Sales Deposits		
	b. Interest Earned		
	c. Other (Explain, limited to 100 characters)		
	d. Total		
3.	Less:		
	a. Refunds	( )	
	b. Interest Withdrawal	( )	
	c. Escrow Agent Fee	( )	
	d. Other (Explain, limited to 100 characters)	( )	
	e. Total		( )
4.	Ending Balance per Reconciliation		
5.	Ending Balance per Escrow Statement **(Attach copy of Escrow Statement supporting balance)**		
6.	Difference (Provide detailed explanation below, limited to 1000 characters)		

Form OIR-A3-1245
Rev.: 9/19
Rule 69O-193.005