



**OFFICE OF COMMISSIONER OF INSURANCE**

COMMISSIONER OF INSURANCE • INDUSTRIAL LOAN COMMISSIONER • SAFETY FIRE COMMISSIONER

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LIMITED RISK ENTITIES  
GID-060-NT DEC2014

**CONTINUING CARE PROVIDER AND FACILITY ANNUAL STATEMENT**

Provider Name \_\_\_\_\_

D/B/A Facility Name \_\_\_\_\_

License Number \_\_\_\_\_ Fiscal Year Ended: \_\_\_\_\_

- This annual statement consists of three parts:
- PART I - THE PROVIDER - GENERAL INTERROGATORIES
  - PART II - THE FACILITY - GENERAL INTERROGATORIES
  - PART III - THE FACILITY - STATEMENT OF FINANCIAL CONDITION

**NOTICE** O.C.G.A. § 33-45-6 requires that annually, on or before May 1, a provider must file an annual statement as of the last day of the preceding calendar year or fiscal year of the provider. The required information must be filed on or before May 1 but not more than within 120 days after the last day of the fiscal year of the provider.

**GENERAL INFORMATION AND INSTRUCTIONS**

1. Responses must be typed.
2. Unanswered questions and blank lines or schedules will not be accepted. If no answers or entries are to be made, type "None", "Not Applicable", "N/A", or "-0-" in the space provided. ----- Do NOT leave a blank space.-----
3. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered.
4. DEFINITIONS: All terms used in this annual statement will have their general meaning except where specific statutory language applies under the provisions of O.C.G.A. § 33-34.

**Filing Fee: \$ 75 - Payable to "Commissioner of Insurance, State of Georgia"**

<b>PAYMENT REMITTANCE</b>	<b>ADDRESS TO REMIT BY MAIL:</b>	<b>Georgia Dept. of Insurance, Regulatory Services/Enforcement P.O. Box 935138, Atlanta, GA 31193-5138</b>
	Address To Remit By COURIER:	Wells Fargo Bank , Georgia Dept. of Insurance, Regulatory Services/Enforcement Lockbox 935138, 3585 Atlanta Ave., Hapeville, GA 30354

**DIRECTIONS FOR ATTESTING TO THIS ANNUAL STATEMENT**

- I. Each annual statement must contain an attestation as follows:
  - A. If the organization is a sole proprietorship, the annual statement must be sworn to by the sole proprietor.
  - B. If the organization is a limited partnership, the annual statement must be sworn to by the general partner(s).
  - C. If the organization is a partnership other than a limited partnership, the annual statement must be sworn to by the principal or managing partners.
  - D. If the organization is any other unincorporated entity, the annual statement must be sworn to by all of the responsible officers and/or directors.
  - E. If the organization is a corporation, the annual statement must be sworn to by the president and the secretary.
  - F. If the organization is a trust, the annual statement must be sworn to by all of the officers and trustees.

**NOTICE**

II. The following attestation form must be used. Submit one attestation for each person and attach additional attestation sheets if necessary.

**Regardless of the form of the organization, this annual statement must also be attested to by the Facility Administrator or Executive Director:**

**ATTESTATION**

I do solemnly swear or affirm that I am familiar with the Laws of Georgia relating to Continuing Care Providers; that all the foregoing information and documentary evidence submitted is true, complete and correct to the best of my knowledge and belief.

Company \_\_\_\_\_

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Print Title \_\_\_\_\_

<b>NOTARY</b>	Sworn to and Subscribed before Me this _____ day of _____, _____.	( Seal )
	In the County of _____, State of _____.	
	_____ (Notary Public)	_____ (My Commission Expires)

**PART I**

**THE PROVIDER – GENERAL INTERROGATORIES**  
**FOR THE FISCAL YEAR ENDED: \_\_\_\_\_**

**SPECIAL INSTRUCTIONS**  
**Complete PART I for the Provider ONLY.**

1. During this reporting period have any civil, criminal or administrative actions been taken or filed against the provider or any person affiliated, controlled or associated with the provider?  Yes  No  
 If —yes, fully explain and attach a copy of the complaint and final adjudication, if any. If no final adjudication has been made, explain the current status.

2. During this reporting period 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?  Yes  No  
 If —yes, fully explain and attach copies of all relevant documentation.

3. Does the provider pay commissions to any officer, director or salaried employee?  Yes  No  
 If —yes, fully explain.

PART II

THE FACILITY – GENERAL INTERROGATORIES  
FOR THE FISCAL YEAR ENDED: \_\_\_\_\_

SPECIAL INSTRUCTIONS

Complete a separate PART II for each facility owned or managed by the provider.

1. Facility is owned by: (Name) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City, State, Zip Code) \_\_\_\_\_  
(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_  
(E-Mail Address) \_\_\_\_\_

2. Facility is operated by: (Name) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City, State, Zip Code) \_\_\_\_\_  
(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_  
(E-Mail Address) \_\_\_\_\_

3. Facility is leased to: (Name) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City, State, Zip Code) \_\_\_\_\_  
(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_  
(E-Mail Address) \_\_\_\_\_

4. Facility is leased from: (Name) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City, State, Zip Code) \_\_\_\_\_  
(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_  
(E-Mail Address) \_\_\_\_\_

5. Facility's Books and Records are located at: (Name) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City, State, Zip Code) \_\_\_\_\_  
(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_  
(E-Mail Address) \_\_\_\_\_

6. Provide the name of the person on site who is responsible for the day to day financial operations of this facility:  
\_\_\_\_\_

7. During this reporting period has there been any new financing or refinancing of this facility?  Yes  No  
If yes, fully explain:  
\_\_\_\_\_

8. During this reporting period have there been any judgments, liens, or other encumbrances placed on this facility?  Yes  No  
If yes, fully explain:  
\_\_\_\_\_

9. Identify the President, or person performing a similar function, of the Resident's Council or similar body at this facility:  
\_\_\_\_\_

10. Does this facility utilize the services of an actuary?  Yes  No  
If yes, is the actuary an:  independent employee -or-  consultant?  
State the name, address, e-mail address, telephone number, and professional designation(s) of the actuary:  
\_\_\_\_\_

11. Are entrance fees the same in all cases?  Yes  No  
If —no, describe the plan by which the amount of the entrance fees are determined:  
\_\_\_\_\_

12. Explain how entrance fees are utilized:  
\_\_\_\_\_

13. Provide the following information regarding fees required of residents:  
A. Specify the range of entrance fees: From \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
Second person fees from \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
B. Specify the range of monthly maintenance fees: From \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
Second person fees from \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
C. Are any other fees required?  Yes  No  
If —yes, briefly describe each fee and specify the amount:  
\_\_\_\_\_

D. Attach a description of your schedule of fees and any other information furnished to prospective residents.

14. Specify the total number of persons residing in this facility pursuant to a:  
A. Continuing Care Agreement \_\_\_\_\_  
B. Rental Agreement \_\_\_\_\_  
C. Other \_\_\_\_\_ (Explain) \_\_\_\_\_  
D. Total \_\_\_\_\_ Please provide occupancy as a percentage → \_\_\_\_\_ %

15. Provide the average cost of care per resident. (Total expenses divided by total number of residents.)  
\_\_\_\_\_

16. State the name and title of the person responsible for marketing at the facility:  
\_\_\_\_\_

17. State the total amount of funds budgeted for marketing during this period and provide the actual amount expended.  
BUDGETED: \$ \_\_\_\_\_ ACTUAL: \$ \_\_\_\_\_

18. Check the types of health care offered or provided by this facility:  
 A. Personal Care or Assisted Living  
 B. Intermediate Care  
 C. Skilled Nursing Care

19. Does this facility possess a Georgia Certificate of Need issued by the State Health Planning Agency?  Yes  No  
If —yes, provide the Certificate of Need number:

20. Does this facility have a Skilled Nursing Facility?  Yes  No  
If —yes, check if:  on site  off site

Licensed under what name: \_\_\_\_\_

Owner and Operator: \_\_\_\_\_

Number of community beds: \_\_\_\_\_

Number of sheltered beds: \_\_\_\_\_

21. What is the debt financing source used for the facility?  
\_\_\_\_\_

22. Please provide debt maturity (if any)?  
\_\_\_\_\_

**PART III****THE FACILITY – STATEMENT OF FINANCIAL CONDITION****PART III INSTRUCTIONS FOR PART III - STATEMENT OF FINANCIAL CONDITION**

**COMPLETE THIS PART AS INSTRUCTED BELOW FOR EACH FACILITY LISTED IN PART I, INTERROGATORY 4. IF THIS REPORT DOES NOT CONTAIN THE INFORMATION ASKED FOR IN THE BLANKS, OR IS NOT PREPARED IN ACCORDANCE WITH THESE INSTRUCTIONS, IT CANNOT BE ACCEPTED.**

**GENERAL INFORMATION AND INSTRUCTIONS FOR PART III:**

1. The reporting date and the license number of the facility must be typed or stamped on all pages.
2. Unanswered questions and blank lines will not be accepted. If no answers or entries are to be made, type “None”, “Not Applicable”, “N/A” or “-0-” in the space provided. Do not leave a blank space.
3. Any item which is of an extraordinary nature should be entered as a special item and adequately described.
4. Additional supporting statements or schedules may be added. The additions should be properly cross-referenced to the item being answered. (Example --“Balance Sheet” Line 7).
5. The Attestation must be signed by the appropriate person.
6. The Georgia Insurance Department strongly recommends each facility hold an operating reserve for the protection of its residents. The RECOMMENDED OPERATING RESERVE WORKSHEET should be completed by all facilities regardless of their reserve policy. This worksheet provides further explanation of the calculation of this reserve.

License Number \_\_\_\_\_ Facility Name \_\_\_\_\_

**RECOMMENDED OPERATING RESERVE WORKSHEET**

**FOR THE FISCAL YEAR ENDED:** \_\_\_\_\_

**OPERATING RESERVE:**

A. Projected principal and interest payments due over the next twelve month period on all mortgage loans and/or other long term financing on the facility: \$ \_\_\_\_\_

B. 30% of the projected operating costs for the next twelve month period: \$ \_\_\_\_\_

**TOTAL RECOMMENDED OPERATING RESERVE (A + B)** \$ \_\_\_\_\_

**RESERVES BEING HELD BY YOUR FACILITY:** \$ \_\_\_\_\_

License Number \_\_\_\_\_ Facility Name \_\_\_\_\_

**UNIT ANALYSIS**

**FOR THE PERIOD ENDED** \_\_\_\_\_

(A)	(B)	(C)	(D)
OCCUPIED	UNOCCUPIED AND AVAILABLE FOR SALE	UNOCCUPIED BUT NOT AVAILABLE FOR SALE DUE TO RENOVATION OR REPAIR	TOTAL OF (A) + (B) + (C)

**CONTINUING CARE UNITS**

- 1. Total number of independent living units:
- 2. Total number of assisted living units:
- 3. Total number of all continuing care units:


**RENTAL UNITS**

- 1. Total number of rental units:

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**SKILLED NURSING UNITS:**

- 1. Total number of community nursing beds:
- 2. Total number of sheltered nursing beds:
- 3. Total number of skilled nursing beds:


License Number \_\_\_\_\_ Facility Name \_\_\_\_\_

### UNIT SALES

FOR THE PERIOD ENDED \_\_\_\_\_

**TOTAL FACILITY DESIGNATED UNITS**  
(PAGE 15, LINE 3, COLUMN D)

- 1. Total facility units available for sale at the beginning of this period \_\_\_\_\_
- 2. Facility units sold during this period: \_\_\_\_\_
- 3. Facility units removed from inventory for renovation or rental purposes: \_\_\_\_\_
- 4. Units returned to inventory due to cancellation of sale, death, transfer, move-out, etc.: \_\_\_\_\_
- 5. Total facility units available for sale at the end of this period:  
(Line 1 – Line 2 – Line 3 + Line 4) \_\_\_\_\_

### PART II – B WAITING LIST SUMMARY

	<u>Number</u>	<u>Amount</u>
1. Waiting list deposits on hand at the beginning of this period:	_____	\$ _____
2. Waiting list deposits received this period:	_____	\$ _____
3. Waiting list deposits utilized or returned this period:	_____	\$ _____
4. Net waiting list deposits on hand at the end of this period: (Line 1 + Line 2 – Line 3)	_____	\$ _____

