



**Florida Office of Insurance Regulation**

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**MONTHLY FINANCIAL REPORT**

**FLORIDA COMPANY CODE:**

**FLORIDA PROVIDER GROUP CODE:**

**FEDERAL EMPLOYER IDENTIFICATION NUMBER:**

**MONTHLY FINANCIAL REPORT OF**

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(Continuing Care Provider)

**FOR**

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(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**

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Facility Name:  
Period Ending:

## 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.flair.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.

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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 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.

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### ATTESTATION

This filing will not be considered complete unless it has 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
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies the 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 by means of  physical presence or  online notarization, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_, who is personally  
(Name of Affiant)  
known to me or who has produced \_\_\_\_\_ 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 by means of  physical presence or  online notarization, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_, who is personally  
(Name of Affiant)  
known to me or who has produced \_\_\_\_\_ as identification.

(Notary Stamp)

\_\_\_\_\_  
(Signature of the Notary and Date Commission Expires)

Facility Name:  
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**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.

	<b>A Occupied or Sold</b>	<b>B Available to Market and Unsold</b>	<b>C Unavailable to Market</b>	<b>D Reserved by Prospective Residents</b>	<b>E Total (A+B+C+D)</b>
<b>Continuing Care Units</b>					
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)					
<b>Rental Units</b>					
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)					
<b>Skilled Nursing Units</b>					
11. Community Beds					
12. Sheltered Beds					
13. Total Skilled Nursing Beds (Line 11 + Line 12)					
<b>Other Continuing Care Contracts</b>					
14. Independent Living					
15. Assisted Living					
16. Memory Care					

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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)					

**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: \_\_\_\_\_

Facility Name:  
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**PROVIDER FINANCIAL STATEMENTS  
 BALANCE SHEET – ASSETS**

<b>CURRENT ASSETS</b>		
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	
<b>9.</b>	<b>TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)</b>	
<b>NON-CURRENT ASSETS</b>		
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	
<b>15.</b>	<b>TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)</b>	
<b>16.</b>	<b>TOTAL ASSETS (Line 9 plus Line 15)</b>	

Facility Name:  
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**PROVIDER FINANCIAL STATEMENTS  
 BALANCE SHEET – LIABILITIES**

<b>CURRENT LIABILITIES</b>		
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.	<b>TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)</b>	
<b>NON-CURRENT LIABILITIES</b>		
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.	<b>TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)</b>	
31.	<b>TOTAL LIABILITIES (Line 24 plus Line 30)</b>	
<b>NET ASSETS (DEFICIT) / EQUITY</b>		
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.	<b>TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)</b>	
36.	<b>TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)</b>	



Facility Name:  
 Period Ending:

**PROVIDER FINANCIAL STATEMENTS  
 PROVIDER STATEMENT OF OPERATIONS**

<b>REVENUES</b>	
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.	<b>TOTAL REVENUES (Sum of Lines 4 through 10)</b>
<b>EXPENSES</b>	
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

Facility Name:  
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26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	<b>TOTAL EXPENSES (Sum of Lines 12 through 26)</b>	
<b>OTHER INCOME (EXPENSE)</b>		
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.	<b>CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS)</b> (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:  
 Period Ending:

**PROVIDER FINANCIAL STATEMENTS  
 PROVIDER STATEMENT OF CASH FLOWS**

<b>A. OPERATING ACTIVITIES</b>	
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>B. INVESTING ACTIVITIES</b>	
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)
<b>C. FINANCING ACTIVITIES</b>	
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)

Facility Name:  
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<b>D.</b>	<b>Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)</b>	
<b>E.</b>	<b>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)</b>	
<b>F.</b>	<b>Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)</b>	

Facility Name:  
 Period Ending:

**FACILITY FINANCIAL STATEMENTS  
 BALANCE SHEET – ASSETS**

<b>CURRENT ASSETS</b>	
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
<b>9.</b>	<b>TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)</b>
<b>NON-CURRENT ASSETS</b>	
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
<b>15.</b>	<b>TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)</b>
<b>16.</b>	<b>TOTAL ASSETS (Line 9 plus Line 15)</b>

Facility Name:  
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**FACILITY FINANCIAL STATEMENTS  
 BALANCE SHEET – LIABILITIES**

<b>CURRENT LIABILITIES</b>		
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.	<b>TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)</b>	
<b>NON-CURRENT LIABILITIES</b>		
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.	<b>TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)</b>	
31.	<b>TOTAL LIABILITIES (Line 24 plus Line 30)</b>	
<b>NET ASSETS (DEFICIT) / EQUITY</b>		
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.	<b>TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)</b>	
36.	<b>TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)</b>	

Facility Name:  
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**FACILITY FINANCIAL STATEMENTS  
 FACILITY STATEMENT OF OPERATIONS**

<b>REVENUES</b>	
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.	<b>TOTAL REVENUES (Sum of Lines 4 through 10)</b>
<b>EXPENSES</b>	
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

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26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	<b>TOTAL EXPENSES (Sum of Lines 12 through 26)</b>	
<b>OTHER INCOME (EXPENSE)</b>		
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.	<b>CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS)</b> <b>(Line 11 minus the sum of Lines 26 through 30)</b>	



Facility Name:  
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**FACILITY FINANCIAL STATEMENTS  
 FACILITY STATEMENT OF CASH FLOWS**

<b>A. OPERATING ACTIVITIES</b>	
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>B. INVESTING ACTIVITIES</b>	
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)
<b>C. FINANCING ACTIVITIES</b>	
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)

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<b>D.</b>	<b>Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)</b>	
<b>E.</b>	<b>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)</b>	
<b>F.</b>	<b>Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)</b>	

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## 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

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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.
- Yes  
 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.
- Yes  
 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.
- Yes  
 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.
- Residents or prospective residents (refunds)
  - Health care providers
  - Prescription drug vendors
  - Food vendors
  - Lenders
  - Employees
  - Contract employees or consultants
  - Construction, maintenance, or similar companies
  - Insurers
  - Local, state, or federal government entities (taxes, fees)
  - Other:
14. Has the Provider closed on any new financing, additional financing, or refinancing since the last filing submission?
- Yes  
 No

Facility Name:  
Period Ending:

## 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 begins 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.
    - 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
<b>1. Debt Service Reserve</b>		
a. DFS		
Escrow Accounts:		
b.		
c.		
Total Trustee Held Debt Service Reserve Funds:		
d.		
e.		
<b>2. Total Debt Service Reserve (Sum of Lines 1a through 1c)</b>		
<b>3. Operating Reserve</b>		
a. DFS		
Escrow Accounts		
b.		
c.		
<b>4. Total Operating Reserve (Line 3a + 3b)</b>		
<b>5. Renewal &amp; Replacement Reserve</b>		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
<b>6. Total Renewal and Replacement Reserve (Sum 5a through 5d)</b>		
<b>7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)</b>		

Facility Name:  
Period Ending:

## 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.  $(\text{number of months since property taxes were paid}) \times 1.b =$  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 begins 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.

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