

ANNUAL STATEMENT

Of

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(CONTINUING CARE PROVIDER)

D/B/A

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(FACILITY NAME)

LICENSE NUMBER: \_\_\_\_\_

FISCAL YEAR ENDED: \_\_\_\_\_, 20\_\_\_\_

- 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. This annual statement consists of three parts: Part I – The Provider – General Interrogatories; Part II – The Facility - General Interrogatories; and Part III – The Facility – Statement of Financial Condition.
2. Responses must be typed.
3. 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.
4. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered.
5. 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.

ATTESTATION

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.

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

**NOTICE!**

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

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

\_\_\_\_\_  
Company

\_\_\_\_\_  
Signature of Affiant

\_\_\_\_\_  
Name (typewritten)

\_\_\_\_\_  
Title (typewritten)

Sworn to and Subscribed before Me

This \_\_\_\_\_ day of \_\_\_\_\_

20\_\_\_\_.

(Seal)

\_\_\_\_\_  
NOTARY PUBLIC

**PART I**

**THE PROVIDER – GENERAL INTERROGATORIES**

**FOR THE FISCAL YEAR ENDED:**

\_\_\_\_\_ ,20\_\_\_\_\_

**SPECIAL INSTRUCTIONS**

Complete PART I for the Provider ONLY.

**PART I**

**THE PROVIDER – GENERAL INTERROGATORIES**

**FOR THE FISCAL YEAR ENDED: \_\_\_\_\_, 20 \_\_\_\_\_**

**COMPLETE THE FOLLOWING FOR THE PROVIDER ONLY:**

1. Furnish the Provider's:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Mailing Address)

\_\_\_\_\_  
(Street address, if different from above)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Title)

( ) / ( ) /  
\_\_\_\_\_  
(Telephone Number/Fax Number/E-mail Address)

\_\_\_\_\_  
(Provider's Federal Tax I. D. Number)

2. Indicate the Organizational Structure of the Provider:

A. \_\_\_\_\_ Corporation: \_\_\_\_\_ For Profit \_\_\_\_\_ Not-for-Profit

B. \_\_\_\_\_ General Partnership

C. \_\_\_\_\_ Limited Partnership

D. \_\_\_\_\_ Trust

E. \_\_\_\_\_ Unincorporated Association

F. \_\_\_\_\_ Other (Explain):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Attach a list of names, phone numbers, e-mail addresses, residence and business addresses of all officers, directors, partners, and administrators. Include any person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of the facility. If such person has been appointed, elected, nominated, or designated during this report period, place an asterisk (\*) in front of that person's name:

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4. List the name and address of each facility in Georgia for which the provider is licensed as the "Provider" pursuant to the provisions of O.C.G.A. § 33-45 and state whether or not the facility is owned or managed by the provider. Also, complete PART II and PART III for each facility listed.

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5. List the name and address of each facility owned or managed by the provider in any State other than Georgia.

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6. List and briefly describe business operations of the provider other than those listed in Items 4 and 5 above.

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- 7.A. State whether or not the provider is affiliated with any religious, not-for-profit, or proprietary organization, or management entity.

ANSWER: \_\_\_\_\_ If "yes", explain the extent to which the affiliate organization will be responsible for the financial or contractual obligations of the provider as well as any provisions for exemption from payment of federal income tax for either the provider or the affiliate. Also provide an organizational chart.

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B. Describe any change in status with respect to the information required to be filed; for example, any change in organizational structure or method of doing business.

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C. 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?

ANSWER: \_\_\_\_\_ 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.

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D. 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?

ANSWER: \_\_\_\_\_ If "yes", fully explain and attach copies of all relevant documentation.

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E. Does the provider pay commissions to any officer, director or salaried employee?

ANSWER: \_\_\_\_\_ If "yes, fully explain.

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8. **PROVIDE AUDITED FINANCIAL STATEMENTS FOR THE PROVIDER AS FOLLOWS:**

Attach a separately bound copy of the audited financial statements of the provider for the current and prior fiscal year. **Compilations or reviews are not acceptable.** The financial statements must be prepared on a consolidated basis in accordance with generally accepted accounting principles and audited by an independent certified public accountant. The financial statements must contain the following:

- A. The accountant's opinion;
- B. A Balance Sheet;
- C. A Statement of Income and Expenses;

D. A Statement of Equity or Fund Balances;

E. A Statement of Changes in Financial Position;

NOTE: In 1987, the Financial Accounting Standards Board (“FASB”), The organization that establishes generally accepted accounting principles (“GAAP”), withdrew the Statement of Changes in Financial Position in response to a definite trend toward the cash format for presenting this statement and replaced it with the Statement of Cash Flows.

F. A Statement of Cash Flows; and

G. Notes to the financial statements considered customary or necessary for full disclosure or adequate understanding of the financial statements, financial condition, and operation.

**PART II**

**THE FACILITY – GENERAL INTERROGATORIES**

**FOR THE FISCAL YEAR ENDED**

\_\_\_\_\_ ,20\_\_\_\_\_

**SPECIAL INSTRUCTIONS**

Complete a separate PART II for each facility listed in PART I, Interrogatory 4., page 7.

**PART II – THE FACILITY**

**FOR THE FISCAL YEAR ENDED:** \_\_\_\_\_, 20\_\_\_\_\_

**COMPLETE THE FOLLOWING GENERAL INTERROGATORIES:**

1. License Number: \_\_\_\_\_

2. Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City and County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Administrator: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

3. Facility is owned by: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Phone Number) (Fax Number)

\_\_\_\_\_  
(E-Mail Address)

4. Facility is operated by: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Phone Number) (Fax Number)

\_\_\_\_\_  
(E-Mail Address)

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

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

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

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

9. During this reporting period has there been any new financing or refinancing of this facility?  
ANSWER: \_\_\_\_\_ If "yes", fully explain: \_\_\_\_\_  
\_\_\_\_\_

10. During this reporting period have there been any judgments, liens, or other encumbrances placed on this facility?

ANSWER: \_\_\_\_\_ If "yes", fully explain:

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

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12. Does this facility utilize the services of an actuary?

ANSWER: \_\_\_\_\_ If "yes", is the actuary an employee or independent consultant? State the name, address, e-mail address, telephone number, and professional designation(s) of the actuary:

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13. Are entrance fees the same in all cases?

ANSWER: \_\_\_\_\_ If "no", describe the plan by which the amount of the entrance fees are determined:

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14. Explain how entrance fees are utilized:

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15. 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?

ANSWER: \_\_\_\_\_ If "yes", briefly describe each fee and specify the amount:

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

E. Have any changes in the scope of care and services or any increases in fees for care and services occurred in the last year?

ANSWER: \_\_\_\_\_ If "yes", explain:

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16. 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 \_\_\_\_\_

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

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18. State the name and title of the person responsible for marketing at the facility:

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19. State the total amount of funds budgeted for marketing during this period and provide the actual amount expended.

BUDGETED: \$ \_\_\_\_\_ ACTUAL: \$ \_\_\_\_\_

20. 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

21. Does this facility participate in either of the following:

A. Medicare program \_\_\_\_\_ yes \_\_\_\_\_ no

B. Medicaid program \_\_\_\_\_ yes \_\_\_\_\_ no

If "yes", fully explain the level of participation:

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22. Does this facility possess a Georgia Certificate of Need issued by the State Health Planning Agency?

ANSWER: \_\_\_\_\_ If "yes", provide the Certificate of Need number: \_\_\_\_\_

23. Does this facility have a Skilled Nursing Facility?

ANSWER: \_\_\_\_\_ If "yes", \_\_\_\_\_ on site or \_\_\_\_\_ off site

Licensed under what name:

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Owner and Operator:

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Number of community beds \_\_\_\_\_, sheltered beds \_\_\_\_\_

**PART III**

**THE FACILITY – STATEMENT OF FINANCIAL CONDITION**

**FOR THE FISCAL YEAR ENDED:**

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**PART III**  
**STATEMENT OF FINANCIAL CONDITION**  
**INSTRUCTIONS FOR PART III**

**COMPLETE THIS PART AS INSTRUCTED BELOW FOR EACH FACILITY LISTED IN PART I, INTERROGATORY 4., PAGE 7.**

**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.

7. Attach a separately bound copy of the audited financial statements of each facility for the current and prior fiscal year. **Compilations or reviews are not accepted.** The financial statements must be in accordance with generally accepted accounting principles and audited by an independent certified public accountant. The financial statements must contain the following:

- A. The accountant's opinion;
- B. A Balance Sheet;
- C. A Statement of Income and Expenses;
- D. A Statement of Equity or Fund Balances;
- E. A Statement of Changes in Financial Position;

NOTE: In 1987, the Financial Accounting Standards Board ("FASB"), the Organization that establishes generally accepted accounting principles ("GAAP"), withdrew the Statement of Changes in Financial Position in response to a definite trend toward the cash format for presenting this statement and replaced it with the Statement of Cash Flows.

- F. A Statement of Cash Flows; and
- G. Notes to the financial statements considered customary or necessary for full disclosure or adequate understanding of the financial condition and operation.

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**RECOMMENDED OPERATING RESERVE WORKSHEET**

FOR PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_

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

**BALANCE SHEET  
(NOT-FOR-PROFIT)**

**AS OF \_\_\_\_\_ 20\_\_\_\_\_**

**CURRENT ASSETS**

CASH		\$ _____
SHORT TERM INVESTMENTS		_____
ACCOUNTS RECEIVABLE		_____
INVENTORIES		_____
PREPAID EXPENSES		_____
OTHER		_____
TOTAL CURRENT ASSETS		_____

**NON – CURRENT ASSETS**

PLANT, PROPERTY, EQUIPMENT		
LAND		\$ _____
BUILDING	\$ _____	
FIXED EQUIPMENT	_____	
MOVEABLE EQUIPMENT	_____	
LESS ACCUMULATED DEPRECIATION	_____	
OTHER		_____
TOTAL NON – CURRENT ASSETS		_____
 TOTAL ASSETS		 \$ _____

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**CURRENT LIABILITIES**

OPERATING RESERVE \$ \_\_\_\_\_

ACCOUNTS PAYABLE \_\_\_\_\_

ACCRUED INTEREST \_\_\_\_\_

ACCRUED SALARIES \_\_\_\_\_

TAXES PAYABLE \_\_\_\_\_

DEPOSITS AND REFUNDS PAYABLE \_\_\_\_\_

CURRENT PORTION OF LONG – TERM DEBT

A. ON FACILITY \$ \_\_\_\_\_

B. OTHER \_\_\_\_\_

CURRENT PORTION OF NOTE PAYABLE \_\_\_\_\_

OTHER \_\_\_\_\_

TOTAL CURRENT LIABILITIES \$ \_\_\_\_\_

**NON – CURRENT LIABILITIES**

DEFERRED ENTRANCE FEE REVENUE \$ \_\_\_\_\_

LONG – TERM DEBT \_\_\_\_\_

A. ON FACILITY \$ \_\_\_\_\_

B. OTHER \_\_\_\_\_

NOTES PAYABLE \_\_\_\_\_

OTHER \_\_\_\_\_

TOTAL NON – CURRENT LIABILITIES \$ \_\_\_\_\_

FUND BALANCE \_\_\_\_\_

TOTAL LIABILITIES AND FUND BALANCE \$ \_\_\_\_\_

License Number

Facility Name

**STATEMENT OF OPERATIONS  
(NOT-FOR-PROFIT)**

**FOR THE PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_**

**REVENUES:**

ENTRANCE FEE REVENUE	\$ _____
MONTHLY MAINTENANCE FEES	_____
RENTAL REVENUES	_____
OTHER INCOME	_____
TOTAL REVENUES	\$ _____

**EXPENSES:**

WAGES AND BENEFITS	\$ _____
FOOD SERVICE	_____
INSURANCE:	
A. ON FACILITY	\$ _____
B. OTHER	_____
INTEREST:	
A. LONG-TERM DEBT ON FACILITY	_____
B. OTHER	_____
MEDICAL CARE	
TAXES:	
A. PROPERTY	_____
B. OTHER	_____
OTHER EXPENSES	_____
TOTAL EXPENSES	\$ _____
EXCESS REVENUES OVER EXPENSES (DEFICIT)	\$ <u>_____</u>

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**FUND BALANCE  
(NOT-FOR-PROFIT)**

BEGINNING FUND BALANCE \$ \_\_\_\_\_

EXCESS OF REVENUE OVER EXPENSES (DEFICIT) \_\_\_\_\_

OTHER CONTRIBUTIONS \_\_\_\_\_

ENDING FUND BALANCE \$ \_\_\_\_\_

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**BALANCE SHEET  
(CORPORATION)**

AS OF \_\_\_\_\_, 20\_\_\_\_

**CURRENT ASSETS**

CASH		\$ _____
SHORT TERM INVESTMENTS		_____
ACCOUNTS RECEIVABLE		_____
INVENTORIES		_____
PREPAID EXPENSES		_____
OTHER		_____
TOTAL CURRENT ASSETS		_____

**NON – CURRENT ASSETS**

PLANT, PROPERTY, EQUIPMENT		
LAND		\$ _____
BUILDING	\$ _____	
FIXED EQUIPMENT	_____	
MOVEABLE EQUIPMENT	_____	
LESS ACCUMULATED DEPRECIATION	_____	
OTHER		_____
TOTAL NON – CURRENT ASSETS		_____
 TOTAL ASSETS		 \$ _____

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**CURRENT LIABILITIES**

OPERATING RESERVE \$ \_\_\_\_\_

ACCOUNTS PAYABLE \_\_\_\_\_

ACCRUED INTEREST \_\_\_\_\_

ACCRUED SALARIES \_\_\_\_\_

TAXES PAYABLE \_\_\_\_\_

DEPOSITS AND REFUNDS PAYABLE \_\_\_\_\_

CURRENT PORTION OF LONG – TERM DEBT

    A. ON FACILITY \$ \_\_\_\_\_

    B. OTHER \_\_\_\_\_

CURRENT PORTION OF NOTE PAYABLE \_\_\_\_\_

DIVIDENDS PAYABLE \_\_\_\_\_

OTHER \_\_\_\_\_

TOTAL CURRENT LIABILITIES \$ \_\_\_\_\_

**NON – CURRENT LIABILITIES**

DEFERRED ENTRANCE FEE REVENUE \$ \_\_\_\_\_

LONG – TERM DEBT \_\_\_\_\_

    A. ON FACILITY \$ \_\_\_\_\_

    B. OTHER \_\_\_\_\_

NOTES PAYABLE \_\_\_\_\_

OTHER \_\_\_\_\_

TOTAL NON – CURRENT LIABILITIES \$ \_\_\_\_\_

CAPITAL STOCK \_\_\_\_\_

PAID IN AND CONTRIBUTED CAPITAL \_\_\_\_\_

RETAINED EARNINGS \_\_\_\_\_

TOTAL LIABILITIES AND STOCKHOLDERS EQUITY \$ \_\_\_\_\_

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**STATEMENT OF OPERATIONS  
(CORPORATION)**

**FOR THE PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_**

**REVENUES:**

ENTRANCE FEE REVENUE	\$ _____
MONTHLY MAINTENANCE FEES	_____
RENTAL REVENUES	_____
OTHER INCOME	_____
TOTAL REVENUES	\$ _____

**EXPENSES:**

WAGES AND BENEFITS	\$ _____
FOOD SERVICE	_____
INSURANCE:	
A. ON FACILITY	\$ _____
B. OTHER	_____
INTEREST:	
B. LONG-TERM DEBT ON FACILITY	_____
B. OTHER	_____
MEDICAL CARE	
TAXES:	
A. PROPERTY	_____
B. OTHER	_____
OTHER EXPENSES	_____
TOTAL EXPENSES	\$ _____
NET INCOME (LOSS)	\$ <u>_____</u>

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Facility Name

**STATEMENT OF RETAINED EARNINGS  
(CORPORATION)**

BEGINNING BALANCE	\$ _____
NET INCOME (LOSS)	_____
OTHER CONTRIBUTIONS	_____
DEDUCTIONS	_____
ENDING BALANCE	\$ <u>_____</u>



License Number

Facility Name

UNIT ANALYSIS

FOR PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_\_

(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 PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_\_

TOTAL FACILITY DESIGNATED UNITS  
(PAGE 28, 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)	_____	\$ <u>_____</u>

License Number

Facility Name

SCHEDULE A

PROPERTY, PLANT AND EQUIPMENT USED TO FURNISH OR PROVIDE CONTINUING CARE\*

Description / Location	Name and Address of Mortgagee	Amount of Payment / Rate of Interest	Date Acquired	Actual Cost	Accumulated Depreciation
TOTALS					

Description / Location	Net Book (Depreciated) Value	Appraised Value And Date of Appraisal	Mortgage Balance Due	Insurance Coverage	Net Equity (Appraised Value less Encubrances)
TOTALS					

\*Include only items having an original cost of \$25,000 or more.

License Number

Facility Name

SCHEDULE B

PROPERTY, PLANT AND EQUIPMENT **NOT** USED TO FURNISH OR PROVIDE CONTINUING CARE\*

Description / Location	Name and Address of Mortgagee	Amount of Payment / Rate of Interest	Date Acquired	Actual Cost	Accumulated Depreciation
TOTALS					

Description / Location	Net Book (Depreciated) Value	Appraised Value and Date of Appraisal	Mortgage Balance Due	Insurance Coverage	Net Equity (Appraised Value less Encumbrances)
TOTALS					

\*Include only items having an original cost of \$25,000 or more.

License Number

Facility Name

ENTRANCE FEE REFUND SUMMARY REPORT

FOR THE PERIOD ENDED \_\_\_\_\_, 20\_\_\_\_\_

Total Entrance Fees Collected this Period \$ \_\_\_\_\_  
(Please include all entrance fee deposits and installments collected.)

Refunds due beginning of Period		Refunds incurred this Period		Refunds paid this Period		Refunds due at end of Period*	
Number	\$ Amount	Number	\$ Amount	Number	\$ Amount	Number	\$Amount

\*Please provide an Aging Breakdown on this balance.

30 – 60 Days Old	60 – 90 Days Old	90 – 120 ** Days Old	TOTAL
\$ _____	\$ _____	\$ _____	\$ _____

\*\*Explanation required.