

Chapter 93. Continuing Care Providers.

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Subchapter 1. Continuing Care Provider Regulation Act.

23-93-101. Title.

This chapter shall be known and may be cited as the "Continuing Care Provider Regulation Act".

23-93-102. Legislative intent - Applicability.

- (a) The General Assembly recognizes that continuing care communities have become an important and necessary alternative for the long-term residential, social, and health maintenance needs for many of the state's elderly citizens.
- (b) The General Assembly recognizes the need for full disclosure of important facts to an appropriate regulatory agency of the state. Accordingly, the General Assembly has determined that continuing care facilities should be regulated in accordance with the provisions of this chapter.
- (c)(1) The provisions of this chapter apply equally to for-profit and not-for-profit provider organizations.
- (2) The provisions of this chapter shall be the minimum requirements to be imposed

upon any person, association, or organization offering or providing continuing care as set forth in this chapter.

- (3) This chapter shall not apply to facilities duly authorized and licensed by the State of Arkansas as long-term care facilities providing nursing care.

23-93-103. Definitions.

As used in this chapter, unless the context otherwise requires:

- (1) "Commissioner" means the Insurance Commissioner;
- (2)(A) "Continuing care" means the furnishing of independent living units to individuals and either:
 - (i) Furnishing nursing care or personal care services pursuant to an agreement, whether the nursing care or personal care services are provided in the facility or in another setting designated by the agreement for providing continuing care to individuals; or
 - (ii) Requiring the payment of an entrance fee by an individual not related by consanguinity or affinity to the provider furnishing the living unit. Payments may be made by an entrance fee alone, an entrance fee and periodic payments, or by payment of fees for services.
- (B) Agreements to provide continuing care shall include agreements to provide care for any duration including agreements that are terminable by either party;
- (3) "Department" means the State Insurance Department;
- (4) "Entrance fee" means an initial or deferred transfer to a provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance of a specified individual as a resident in a facility which exceeds six (6) months' rental of the living unit. An accommodation fee, admission fee, or other fee of similar form and application shall be considered to be an entrance fee;
- (5) "Facility" means a place which provides continuing care;
- (6) "Living unit" means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one (1) or more identified individuals;
- (7) "Nursing care" means those services pertaining to the curative, restorative, and preventive aspects of nursing services that are performed by or under the supervision of a registered or licensed nurse. Nursing care does not include general health service such as nutritional counseling, exercise programs, or other preventive medicine techniques;
- (8) "Personal care services" means assistance with meals, dressing, movement, bathing, or other personal needs of maintenance or other direct supervision and oversight of the physical and mental well-being of a person. Personal care services does not include general health services such as nutritional counseling, exercise programs, or other preventive medicine techniques;
- (9) "Provider" means the owner or operator, whether a natural person, partnership, or other incorporated association, trust, or corporation whose owner or operator undertakes to provide continuing care for a fee, whether fixed or variable, for the period of care. The fee may be payable in lump sum, or lump sum and monthly

- maintenance charges, or in installments;
- (10) "Refund reserve" means the actuarially determined annual refund amount required to be maintained by a continuing care provider for service of its refund amounts during the next fiscal year of the facility;
 - (11) "Resident" means an individual entitled to receive continuing care in a facility; and
 - (12) "Solicit" means all actions of a provider in seeking to have individuals residing in this state pay an application fee and enter into a continuing care agreement by any means such as, but not limited to, personal, telephone, or mail communication or any other communication directed to and received by any individual in this state and any advertisements in any media distributed or communicated by any means to individuals in this state.

23-93-104. Violations.

- (a) Whenever it appears to the Insurance Commissioner that any person has engaged in, or is about to engage in, any act or practice constituting a violation of any provision of this chapter or any rule or order hereunder, the Insurance Commissioner may:
 - (1) Issue an order directed at that person requiring that person to cease and desist from engaging in the act or practice;
 - (2) Bring an action in any court which has appropriate jurisdiction to enjoin the acts or practices and to enforce compliance with this chapter or any of its rules or orders;
 - (3) Issue an order directed at that person to cease and desist from engaging in the act or practice and bring an action in any court which has appropriate jurisdiction to enjoin the acts or practices and to enforce compliance with this chapter or any of its rules and orders; or
 - (4) Issue an order assessing a monetary penalty of not more than one thousand dollars (\$1,000) for each violation against that person.
- (b) Upon a proper showing, a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted.

23-93-105. Rules and regulations.

The Insurance Commissioner shall have the authority to adopt, amend, or repeal such rules and regulations as are reasonably necessary for the enforcement of the provisions of this chapter.

23-93-106. Disclosure statement - Contents.

- (a) No later than sixty (60) days prior to the first solicitation of a contract to provide continuing care, the provider shall deliver an initial disclosure statement to the State Insurance Department. This statement shall contain all of the following information:
 - (1) The name and business address of the provider and a statement as to whether the provider is a partnership, corporation, or other type of legal entity;
 - (2) The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent (10%) or greater equity or

- beneficial interest in or of the provider, and a description of that person's interest in or occupation with the provider;
- (3) A statement as to whether the provider or any of its officers, directors, trustees, partners, managers, or affiliates, within ten (10) years prior to the date of application:
 - (A) Was convicted of a felony, a crime that if committed in Arkansas would be a felony, or any crime having to do with the provision of continuing care or providing of licensed nursing home care;
 - (B) Has been held liable or enjoined in a civil action by final judgment if the civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property;
 - (C) Had a prior discharge in bankruptcy or was found insolvent in any court action; or
 - (D) Had any state or federal licenses or permits suspended or revoked or had any state, federal, or industry self-regulatory agency commence an action against him and the result of the action;
 - (4) A statement as to:
 - (A) Whether the provider is or ever has been affiliated with a religious, charitable, or other nonprofit organization;
 - (B) The nature of the affiliation, if any;
 - (C) The extent to which the affiliate organization will be responsible for the financial and contract obligations of the provider; and
 - (D) The provision of the Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax;
 - (5) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates whether or not construction has begun, and the contingencies subject to which construction may be deferred;
 - (6) The services provided or proposed to be provided under contracts for continuing care at the facility, including the extent to which medical care is furnished. The disclosure statement shall clearly state which services are included in basic contracts for continuing care and which services are made available at or by the facility at extra charge;
 - (7) A description of all fees required of residents, including the entrance fee and periodic charges, if any. The description shall include the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on the adjustments, if any;
 - (8) A balance sheet of the provider, audited by a certified public accountant, and certified to by the provider, as of the end of the two (2) most recent fiscal years;
 - (9) A calculation of the actuarially required refund reserve showing the alternative bases upon which the calculation is made; and
 - (10) A copy of the standard form or forms of contract used by the provider which contain the minimum requirements of this chapter for continuing care contracts to be attached as an exhibit to each disclosure statement.

- (b) The provider shall file with the department annually, within four (4) months following the end of the provider's fiscal year, an annual disclosure statement. This statement shall contain the information required by this chapter for the initial disclosure statement, in addition to a financial statement as of the end of the provider's fiscal year, audited and certified by a certified public accountant.

23-93-107. Disclosure statement - Review.

- (a) The State Insurance Department shall review the filed disclosure document for the following:
 - (1) The completeness of the filing; and
 - (2) The manner and method of computing the reserve.
- (b) The Insurance Commissioner shall notify a provider of any deficiency in the filing within sixty (60) days from the date of filing. If the provider is notified of deficiencies in the filing, reasonable time shall be allowed to the provider to correct the deficiencies.
- (c) No provider may offer continuing care contracts to the public during the initial sixty-day filing period or during the period allowed to correct deficiencies noted by the commissioner.
- (d) All disclosure statements shall be made available at the facility and the office of the commissioner for inspection by the citizens of this state upon request. Each resident of a facility shall be informed of the availability of the statement annually.
- (e) Each disclosure statement shall clearly state that:
 - (1) A prospective or present resident shall rely solely upon the provider for the accuracy and completeness of the information contained in the disclosure statement; and
 - (2) No independent investigation of the accuracy of the information has been conducted by the commissioner.

23-93-108. Continuing care contracts - Minimum requirements.

- (a) A continuing care contract shall be written in clear and understandable language.
- (b) A continuing care contract shall, at a minimum:
 - (1) Describe the facility's admission policies, including age, health status, and minimum financial requirements, if any;
 - (2) Describe the health and financial conditions required for a person to continue to be a resident;
 - (3) Describe the circumstances under which the resident will be permitted to remain in the facility in the event of possible financial difficulties of the resident;
 - (4) List the total consideration paid, including donations, entrance fee, subscription fees, periodic fees, and other fees paid or payable. However, a provider cannot require a resident to transfer all his assets to the provider or community as a condition for providing continuing care, and the provider shall reserve his rights to charge periodic fees;
 - (5) Describe in detail all items of service to be received by the resident such as food, shelter, medical care, nursing care, personal care services, and other health

- services and the time period during which such services will be provided;
- (6) Provide, as an addendum to the contract, a description of items of service, if any, which are available to the resident but which are not covered in the entrance or monthly fee;
 - (7) Specify taxes and utilities, if any, that the resident must pay;
 - (8) Specify that deposits or entrance fees paid by or for a resident shall be held in trust in a cash escrow pursuant to this chapter;
 - (9) State the terms under which a continuing care contract may be cancelled by the resident or the provider and the basis for establishing the amount of refund of the entrance fee, if any;
 - (10) State the terms under which a continuing care contract is cancelled by the death of the resident and the basis for establishing the amount of refund, if any, of the entrance fee;
 - (11) State when fees will be subject to periodic increases and what the policy for increases will be;
 - (12) State the entrance fee and periodic fees that will be charged if the resident marries while living in the facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry;
 - (13) State the rules and regulations of the provider then in effect and state the circumstances under which the provider claims to be entitled to have access to the resident's unit;
 - (14) List the resident's and provider's respective rights and obligations as to any real or personal property of the resident transferred to or placed in the custody of the provider;
 - (15) Describe the living quarters purchased by or assigned to the resident;
 - (16) Provide under what conditions, if any, the resident may assign the use of a unit to another;
 - (17) Include the policy and procedure with regard to changes in accommodations due to an increase or decrease in the number of persons occupying an individual unit;
 - (18) State the conditions upon which the facility may sublet or relet a resident's unit;
 - (19) State what fee adjustments, if any, will be made in the event of voluntary absence from the facility for an extended period of time by the resident;
 - (20) Include the procedures to be followed when the provider temporarily or permanently changes the resident's accommodations, either within the facility or by transfer to a health facility;
 - (21) If the facility includes a nursing facility, describe the admissions policies and what will occur if a nursing facility bed is not available at the time it is needed;
 - (22) If the resident is offered a priority for nursing facility admission at a facility that is not owned by the continuing care facility, describe with which nursing facility the formal arrangement is made and what will occur if a nursing facility bed is not available at the time it is needed;
 - (23) Include the policy and procedures for determining under what circumstances a resident will be considered incapable of independent living and will require a

- permanent move to a nursing facility;
- (24) Specify the types of insurance, if any, the resident must maintain, including Medicare, other health insurance, and property insurance;
 - (25) Specify the circumstances, if any, under which the resident will be required to apply for Medicaid, public assistance, or any other public benefit programs;
 - (26) State that the provider has filed a disclosure statement with the department and state the contents of the disclosure statement required by § 23-93-106(a)(3); and
 - (27) State, in bold and conspicuous type, the following:

THIS CONTRACT IS GOVERNED BY THE CONTINUING CARE PROVIDER REGULATION ACT. THE PROVIDER HAS FILED A DISCLOSURE DOCUMENT WITH THE INSURANCE COMMISSIONER OF THE STATE OF ARKANSAS PRIOR TO OFFERING THIS CONTRACT. THE INSURANCE COMMISSIONER HAS NOT PASSED UPON THE VALIDITY OF THE INFORMATION FILED BY THE PROVIDER, DOES NOT MAKE ANY RECOMMENDATION WITH RESPECT TO THE FAIRNESS OF THE CHARGES MADE BY THE PROVIDER, HAS NOT CONDUCTED AN INDEPENDENT REVIEW OF THE FINANCIAL STRENGTH OF THE PROVIDER AND DOES NOT WARRANT THE ENFORCEABILITY OF ANY CONTRACT OFFERED BY THE PROVIDER. NO PROSPECTIVE RESIDENT SHOULD RELY UPON THE FACT THAT A FILING HAS BEEN MADE WITH THE COMMISSIONER IN MAKING THEIR DECISION. **EACH PROSPECTIVE RESIDENT SHOULD CONSULT HIS OWN LEGAL AND FINANCIAL ADVISERS PRIOR TO ENTERING INTO ANY CONTRACT WITH THE PROVIDER.**

23-93-109. Right to rescind contracts.

For a seven-day period beginning on the date a provider receives any payment from a prospective resident, a prospective resident shall have the right to rescind any contractual obligation into which he has entered and receive a full refund of any moneys transferred to the provider.

23-93-110. Misleading, etc., statements prohibited.

- (a) No provider shall make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement of any sort containing any assertion, representation, or untrue, deceptive, or misleading statement.
- (b) No provider shall file with the State Insurance Department or make, publish, disseminate, circulate, or deliver to any person or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or placed before the public any financial statement which does not accurately state its true financial condition.

23-93-111. Liquid refund reserve requirement.

- (a)(1) Each provider shall establish and maintain liquid refund reserves in an amount determined in accordance with this section;
- (2)(A) The refund reserve shall be equal to or shall exceed the actuarially determined annual refund amount as of the financial reporting date;
- (B) The actuarially determined annual refund amount shall be calculated upon both the actual experience of the facility and published industry norms;
- (C) The method which yields the greater sum shall determine the actuarially determined annual refund amount for the purposes of this section and § 23-93-106(a)(8).
- (b) The provider may satisfy the liquid reserve requirement by:
 - (1) Holding the reserve amount in an escrow account with a federally insured financial institution or institutions located and doing business in this state; or
 - (2) Purchasing a certificate of deposit from an Arkansas lending institution; or
 - (3) Investing in bonds, notes, warrants, and other evidences of indebtedness which are direct obligations of the United States of America held in the provider's name and held by the provider within the State of Arkansas; or
 - (4) Having the unqualified guaranty of an affiliated organization or individual, as evidenced by a written agreement, whose net worth as reported in its most recent financial statement audited by a certified public accountant and certified by the provider and filed with the State Insurance Department, which is equal to five (5) times the reserve amount or portion of the reserve amount to be satisfied by this method; or
 - (5) Any combination of the foregoing.
- (c) When requested by the Insurance Commissioner, the provider shall furnish all of the information relating to the amount of the reserve and the method used to maintain the reserve amount.

23-93-112. Escrow account required.

- (a)(1) The Insurance Commissioner shall require that the provider establish an interest-bearing escrow account with a financial institution authorized to do business in this state. Any entrance fees or payments received by the provider prior to the date the resident is permitted to occupy the living unit in the facility shall be placed in the escrow account.
- (2) Release of escrowed amounts to the provider shall be made as follows:
 - (A) For living units that have been previously occupied, at the time the new resident makes the first monthly payment; or
 - (B) For living units not previously occupied, at the earliest to occur of one (1) of the following:
 - (i) When aggregate fees received or receivable equal fifty percent (50%) of total entrance fees due at full occupancy, except that any entrance fee payments that are less than thirty-five percent (35%) of the amount due from a resident will not be counted;
 - (ii) When entrance fees plus the proceeds of any first mortgage or other long-

term loan in lieu of a first mortgage, plus other funds on hand, equal fifty percent (50%) of the total cost of the facility plus fifty percent (50%) of the start-up losses shown in the provider's application submitted under § 23-93-207; or

- (iii) When a permanent mortgage or other long-term loan commitment has been received and the mortgagee's commitment conditions prior to disbursement, other than completing construction and closing the purchase, have been satisfied.
- (b) If the funds in an escrow account and any interest earned on the funds are not released within thirty-six (36) months, or such greater time as may have been specified by the provider with the consent of the commissioner, then the funds shall be returned by the escrow agent to the persons who made the payment to the provider.
- (c) Nothing in this section shall require the escrow of any nonrefundable application fees charged to prospective residents.
- (d) An entrance fee held in escrow may be returned by the escrow agent at any time to the person or persons who paid the fee to the provider upon receipt by the escrow agent of notice from the provider that such person is entitled to a refund of the entrance fee.

23-93-113. Statutory lien.

In the event of the bankruptcy or receivership of the provider resulting from the financial difficulties of the provider, the residents of the facility shall have a statutory lien on the real and personal property of the facility. This lien shall be subordinate to liens of record prior to the date of a filing of a petition in bankruptcy or petition for receivership, but shall be superior to all other creditors.

23-93-114. Investigations and examinations.

- (a) The State Insurance Department may conduct any investigation or examination deemed necessary by the Insurance Commissioner for the public health, safety, and welfare of a resident or potential resident of a facility. In addition, the department may conduct any investigation or examination deemed necessary by the commissioner in response to a written complaint filed by a resident or prospective resident, or if it appears from the filings required by this chapter that the solvency of the facility is in question, or to determine whether any provision of this chapter or any rule or order has been violated.
- (b) The commissioner may conduct any investigation in person or direct any department employee to act on his behalf. For any on-site investigation, the expenses incurred, including compensation of any department examiner, shall be paid by the facility being investigated. For the purposes of this section, the provisions of § 23-61-206 shall apply.
- (c) The commissioner may conduct a financial examination. The commissioner may utilize department examiners or he may retain independent certified public accountants to conduct the examination. Each facility being examined shall pay the department the expenses incurred pursuant to § 23-61-206. The cost of any retained accountants shall not be in excess of the amount that could be charged for department

examiners.

- (d) When the services of an actuary are deemed necessary in any investigation or examination, the commissioner may retain an independent actuary with those expenses being paid by the facility.
- (e) The commissioner or any officer designated by the commissioner may administer oaths and affirmations, issue subpoenas, hear testimony, and take evidence in reference to any investigation or examination conducted pursuant to this chapter.

Subchapter 2. Licensing.

23-93-201. Definitions.

As used in this subchapter:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Department" means the State Insurance Department;
- (3) "Entrance fee" means a payment that assures a resident a place in a facility for a term of years or for life;
- (4) "Facility" means a place which provides life care;
- (5) "Hazardous financial condition" means a provider is insolvent or in imminent danger of becoming insolvent;
- (6) "Life care" means continuing care as defined in § 23-93-103(2), except that no additional charges are made for nursing care or personal care services beyond those charged all residents of the facility who are not receiving nursing care or personal care services;
- (7) "Living unit" means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one (1) or more identified individuals;
- (8)(A) "Nursing care" means those services pertaining to the curative, restorative, and preventive aspects of nursing services that are performed by or under the supervision of a registered or licensed nurse.
 - (B) "Nursing care" does not include general health service such as nutritional counseling, exercise programs, or other preventive medicine techniques;
- (9)(A) "Personal care services" means assistance with meals, dressing, movement, bathing, or other personal needs of maintenance or other direct supervision and oversight of the physical and mental well-being of a person.
 - (B) "Personal care services" does not include general health services such as nutritional counseling, exercise programs, or other preventive medicine techniques;
- (10) "Provider" means the owner or operator, whether a natural person, partnership, or other incorporated association, trust, or corporation whose owner or operator undertakes to provide life care for a fee, whether fixed or variable, for the period of care. The fee may be payable in lump sum, or lump sum and monthly maintenance charges, or in installments;
- (11) "Refund reserve" means the actuarially determined annual refund amount

required to be maintained by a life care provider for service of its refund amounts during the next fiscal year of the facility;

- (12) "Resident" means an individual entitled to receive life care in a facility; and
- (13) "Solicit" means all actions of a provider in seeking to have individuals residing in this state pay an application fee and enter into a life care agreement by any means, such as, but not limited to, personal, telephone, or mail communication, or any other communication directed to and received by any individual in this state, and any advertisements in any media distributed or communicated by any means to individuals in this state.

23-93-202. Continuing Care Provider Act - Applicability.

- (a) In addition to the provisions of this subchapter, life care providers shall be subject to the provisions of the Continuing Care Provider Regulation Act, § 23-93-101 et seq.
- (b) No life care provider shall be established, conducted, or maintained in this state without obtaining a license from the Insurance Commissioner, except, life care providers established prior to August 13, 1993, shall be licensed without application or payment of a fee.

23-93-203. License not transferable - Limitation on contracts.

- (a) No license is transferable, and no license issued pursuant to this subchapter has value for sale or exchange as property.
- (b) No provider or other owning entity shall sell or transfer ownership of the facility, or enter into a contract with a third-party provider for management of the facility, unless the State Insurance Department approves such transfer or contract.

23-93-204. Issuance of license.

The State Insurance Department shall issue a license upon its affirmative determination that all of the following requirements have been met:

- (1) The provider can fulfill its obligation under the life care contract if the resident complies with the terms of the offer;
- (2) There is reasonable assurance that all proposed improvements can be completed as represented;
- (3) The provider, its officers, and principals have not been convicted of a crime in this state, the United States, or any other state or foreign country within the past ten (10) years, the seriousness of which in the opinion of the department warrants the denial of a permit;
- (4) The provider, its officers, and principals have not been subject to any permanent injunction or final administrative order restraining a false or misleading plan involving a facility disposition, the seriousness of which in the opinion of the department warrants the denial of a permit; and
- (5) The disclosure statement requirements of § 23-93-101 et seq. have been satisfied.

23-93-205. Violations.

- (a) The license of a provider shall remain in effect until revoked after notice and

hearing, upon written finding of fact by the State Insurance Department, that the provider has:

- (1) Willfully violated any provision of this subchapter, or any regulation promulgated thereunder;
 - (2) Failed to file an annual disclosure statement or standard form of contract as required by § 23-93-101 et seq.;
 - (3) Delivered to a prospective resident a disclosure statement that makes an untrue statement or omits a material fact, and the provider, at the time of the delivery of the disclosure statement, had actual knowledge of the misstatement or omission;
 - (4) Failed to comply with the terms of a cease and desist order issued pursuant to § 23-93-104; or
 - (5) Has been determined by the department to be in a hazardous financial condition.
- (b) Findings of fact in support of revocation shall be accompanied by an explicit statement of the underlying facts supporting the finding.

23-93-206. Fees.

- (a)(1) An application for a license shall consist of a statement containing the items set forth in this subchapter, together with a filing fee in the amount of four hundred dollars (\$400) plus forty dollars (\$40.00) per living unit made payable to the Treasurer of State.
- (2) In the event living units are added during the application process, an additional fee of forty dollars (\$40.00) per living unit shall be paid.
- (b)(1) Upon receipt of the complete application for a license, the State Insurance Department shall, within ten (10) business days, issue a notice of filing to the applicant.
- (2) Within ninety (90) days of the notice of filing, the department shall enter an order issuing the license or rejecting the application.
- (c)(1) If the Insurance Commissioner determines that any of the application requirements have not been met, the commissioner shall notify the applicant that the application must be corrected within thirty (30) days in those particulars designated by the commissioner.
- (2)(A) If the requirements are not met within the time allowed, the commissioner may enter an order rejecting the application, which order shall include the finding of fact upon which the order is based and which shall not become effective until twenty (20) days after the end of the thirty-day period.
- (B) During the twenty-day period, the applicant may petition for reconsideration and is entitled to a hearing.
- (d) If a facility is accredited by a process approved by the commissioner as substantially equivalent to the requirements of this subchapter, then the facility shall be deemed to have met the requirements of this subchapter and the commissioner shall issue a license to the facility.

23-93-207. Application.

The application for a license shall contain the following documents and information:

- (1)(A) An appointment of an Arkansas resident to serve as the registered agent for the provider shall be filed with the State Insurance Department. Thereafter the registered agent shall be authorized to receive service of any lawful process in any proceeding arising under this subchapter against the provider or his or her agents.
- (B) On and after January 1, 2003, all licensed life care providers shall file with the Insurance Commissioner a designation of an Arkansas resident as an agent for service of legal process, and the commissioner shall maintain a listing in conformity with § 23-63-301 et seq.;
- (2) The states or other jurisdictions, including the federal government, in which an application for certification or similar documents for the subject facility have been or will be filed and any order, judgment, or decree entered in connection therewith by the regulatory authorities in each of the jurisdictions or by any court or administrative body thereof;
- (3) The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent (10%) or greater equity or beneficial interest in the provider and a description of that person's interest in or occupation with the provider;
- (4)(A)(i) Copies of the articles of incorporation, with all amendments thereto, if the provider is a corporation;
- (ii) Copies of all instruments by which the trust is created or declared, if the provider is a trust; and
- (iii) Copies of the articles of partnership or association and all other organization papers, if the provider is organized under another form.
- (B) In the event the provider is not the legal title holder to the property upon which the facility is or is to be constructed, the above documents shall be submitted for both the provider and the legal title holder;
- (5) A legal description by metes and bounds or other acceptable means of the lands to be certified, and the relationship of such lands to existing streets, roads, and other improvements, together with a map showing the proposed or actual facility and showing the dimensions of the living units as available, except for living units that are completed and available for inspection. The map shall be drawn to scale, signed, and sealed by a licensed professional engineer or land surveyor;
- (6) Copies of the deed or other instrument establishing title of the provider and a title search, title report, or title certificate, or a binder or policy issued by a licensed title insurance company;
- (7) A statement concerning any litigation, orders, judgments, or decrees which might affect the offering;
- (8) A statement that the life care agreements will be offered to the public and entered into without regard to marital status, sex, race, creed, or national origin or, if not, any legally permissible restrictions on purchase that will apply;
- (9) A statement of the present conditions of physical access to the facility, and the existence of any material adverse conditions that affect the facility that are known, should be known, or are readily ascertainable;
- (10) Copies of all contracts and agreements which the resident may be required to execute;

- (11) In the event there is or will be a blanket encumbrance affecting the facility or a portion thereof, a copy of the document creating it and a statement of the consequences upon a resident of a failure of the person bound to fulfill the obligations under which the instrument and the manner in which the interest of the resident is to be protected in the event of such eventuality;
- (12) One (1) copy of the proposed disclosure statement required under § 23-93-106;
- (13) A current financial statement of the provider and any related predecessor, parent, or subsidiary company including, but not limited to, a current profit and loss statement and balance sheet audited by an independent public accountant;
- (14) A statement concerning any adjudication of bankruptcy during the last five (5) years against the provider, its predecessor, parent, or subsidiary company, and any principal owning more than ten percent (10%) of the interests in the facility at the time of the filing of the application for certification. This requirement shall not extend to limited partners or those whose interests are solely those of investors;
- (15) Copies of all easements and restrictions, whether of record or not;
- (16) A statement as to the status of compliance with all the requirements of all laws, ordinances, and regulations of governmental agencies having jurisdiction over the construction, permitting, and licensing of the facility, together with copies of all necessary federal, state, county, and municipal approvals;
- (17) A statement that neither the provider nor any of its officers or principals have ever been convicted of a crime in this state or a foreign jurisdiction and that the provider has never been subject to any permanent injunction or final administrative order restraining a false or misleading promotional plan involving continuing care facility disposition, or, if so, copies of all pleadings and orders in regard thereto;
- (18) A projected annual budget for the facility for the next five (5) years or such lesser time as the department allows;
- (19) Copies of market studies, if any, prepared on behalf of the provider concerning the feasibility of the project;
- (20) An affidavit, signed by the provider, that the contents of the application are true and accurate and made in good faith; and
- (21) Such other additional information as the department may require in individual cases after review of an application for certification to assure full and fair disclosure.