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Management of Continuing Care Facilities

Sec. 17b-533-1. Definitions

As used in Section 17b-533-1 to Section 17b-533-11, inclusive:

(a) **Continuing-care contract** means:

(1) An agreement pursuant to which a provider undertakes to furnish to a person not related by consanguinity or affinity to the provider, shelter and medical or nursing services or other health-related benefits for the life of a person or for a period in excess of one year, and which requires a present or future transfer of assets, or an entrance fee in addition to or instead of periodic charges, and the amount of the assets required to be transferred or the entrance fee is equal to or in excess of twenty thousand dollars.

(2) Notwithstanding the amount of assets or entrance fee, all contracts through which continuing-care is offered at a facility offering any “continuing-care contract” as hereinabove defined, shall be included in that definition.

(3) Contracts involving usual and customary leaseholds, and for conveyances of ownership interests, including condominiums, which are freely transferable and which constitute security for the purchaser’s payment, shall not be deemed to constitute continuing-care contracts.

(b) **Act** means P.A. 86-252, an Act concerning management of continuing-care facilities (C.G.S. Sec. 17a-360 et seq.)

(c) **Commissioner** means the commissioner on aging.

(d) **Committee** means the advisory committee established by the C.G.S. 17b-535.

(e) **Continuing care retirement community** means the actual or proposed site or sites at which services or care are to be provided in accordance with a continuing care contract.

(f) **Disclosure statement** means the documents required to be filed with the department by either by the Act, or these regulations, or provided to a prospective purchaser or resident.

(g) **Escrow Agent** means a financial institution authorized to conduct business in this State, which has a fiduciary relationship with a provider, for the purpose of meeting the requirements of the Act and of these regulations.

(h) **Legal representative** means an attorney, guardian, conservator, or any other person including a family member, designated by a resident or potential future resident as his or her representative.

(i) **Medical or nursing services or other health-related benefits** means services or benefits to which a resident becomes contractually entitled as a result of a transfer of assets, payment of the entrance fee or of the periodic charges, or purchased for a fee in addition to a transfer of assets, an entrance fee, or periodic charges. These services or benefits include the following when a facility or service is licensed pursuant to C.G.S. Sec. 19a-490, et seq.:

Hospital care;

Home health care by a Home Health Care Agency, or Homemaker-Home Health Aide Agency; and

Care in a Nursing Home, or priority access to a nursing home.

(j) **Offer** means an offer through either personal, telephone or mail contact or other communication directed to or received by a person at a location within this state as an inducement, solicitation, or attempt to encourage a person to enter into a continuing-care contract and shall include any paid advertisement published or

broadcast within this state, except for advertisements in periodicals where more than two-thirds of the circulation is outside this state.

The term "offer" shall not include marketing or feasibility studies, or any communication with an individual at the request of, or initiated by, that individual in regard to a continuing-care contract not intended to be performed within this state.

In regard to proposed facilities, the term "offer" shall not include options, or rights of first refusal involving consideration of one thousand dollars or less, provided that any such funds are (1) Either maintained in a passbook or equivalent account in the name of the prospective resident, or in an escrow account established with a financial institution solely for the purpose of holding such funds, (2) returnable to the individual upon demand, together with accrued interest thereon, by transfer of the passbook or otherwise, and the prospective resident is made fully aware of the foregoing provisions, by means which shall include contrasting, prominent type, setting forth the essence of these provisions in every option document.

(k) **Reasonable charge** means either the amount specified in a continuing-care contract or disclosure statement or, in the absence of being specified, a fee based upon actual costs in time, expense, overhead, etc. of selling or re-selling a continuing-care contract in regard to a specific dwelling unit at a facility.

(Effective January 31, 1996)

Sec. 17b-533-2. Registration; filing and acknowledgment

(a) (1) The commissioner, or the designee of the commissioner, shall acknowledge in writing the filing of a disclosure statement within ten business days of the date such statement is received if the disclosure statement, on its face, either meets the requirements of the Act, and these regulations, or contains only technical discrepancies. Such acknowledgment shall specify the fee which is due under Section 17b-533-10 (c) (2) of these regulations.

(2) If the commissioner determines that the disclosure statement, on its face, does not meet the requirements of the Act or these regulations, and will not be accepted for filing, written notification of that determination, stating the reasons therefor, will be given to the provider within ten business days of the date such statement is received. Such notification will not be accompanied by a return of the documents tendered.

(3) If neither an acknowledgment of filing nor notification of non-acceptance for filing is made within ten business days a provider may, until notification to the contrary, utilize the disclosure statement for the purposes of the Act.

(b) Upon notification that the disclosure statement has been accepted for filing, and that the required fee has been received pursuant to Section 17b-533-10 (c) of these regulations, the provider may use the disclosure statement for the purposes of the Act.

(c) (1) Upon notification that the disclosure statement submitted is not accepted for filing, the provider may not, until resolution of the discrepancies by acceptable amendment, appeal, litigation, agreement, or otherwise, use the disclosure statement for the purposes of the Act and, until such resolution, shall refrain from offering or entering into a continuing-care contract in this state, or with any resident of this state, or regarding any facility in this state, based upon the rejected disclosure statement.

(2) Use of a rejected disclosure statement for the purposes of the Act shall be grounds for an immediate request to the Attorney General by the commissioner for the initiation of appropriate legal action, including action to enjoin use of such a rejected disclosure statement.

(d) (1) Notwithstanding an acknowledgement of acceptance for filing, the commissioner may at any time thereafter review or investigate the information contained in any disclosure statements accepted for filing to determine accuracy and completeness thereof.

(2) (A) In the event that a subsequent review or investigation determines that any disclosure statement does not in fact meet the requirements of the Act and of these regulations, the commissioner shall forthwith notify the provider thereof, and the reasons therefor, but no penalties shall be assessed or sought for use of the defective disclosure statement for the period between an initial favorable acknowledgement and subsequent review and notice of discrepancies.

(B) In the event of such a subsequent determination, the commissioner may, in the case of technical or minor discrepancies, authorize continued use of the defective disclosure statement until the discrepancies can be conveniently corrected either by way of amendment or in a subsequent disclosure statement.

(C) (i) In the event discrepancies in the disclosure statement arise by reason of an untrue statement of material fact or failure to state a material fact then, on notification by the commissioner, the provider shall take such action as may be satisfactory to the commissioner to correct the disclosure statement and to notify prospective residents of changes therein.

(ii) In the event that a provider shall fail to take such action, or if it appears to the commissioner that the discrepancies were intentional, then the commissioner shall request the Attorney General to initiate appropriate legal action, including action to enjoin any use of the disclosure statement.

(Effective January 31, 1996)

Sec. 17b-533-3. Disclosure statements: form and content

(a) There shall be one disclosure statement for each facility.

(1) No representation shall be made on the cover page or elsewhere in any disclosure statement as to the validity of the disclosure statement, a period of time during which the disclosure statement remains valid or effective, or which in any manner indicates, infers, or represents that the disclosure statement is effective or valid.

(2) The disclosure statement must include a cover page, table of contents, and the information required by the Act and these regulations.

(3) In addition to such other items as a provider may wish to list therein, the Table of Contents must include the following headings, in prominent type, to identify where in the disclosure statement, or the continuing-care contract, the information required by the Act is located: (Numerical reference is to the subsections of C.G.S. Section 17b-522 (a).):

- NAME AND ADDRESS OF PROVIDER (1)
- OFFICERS, DIRECTORS, AND TRUSTEES (2)
- BUSINESS EXPERIENCE (3)
- JUDICIAL PROCEEDINGS (4)
- AFFILIATION (5)
- DESCRIPTION OF PROPERTY (6)
- BENEFITS INCLUDED (7)
- INTEREST ON DEPOSITS (8)
- TERMINATION OF CONTRACT (9)
- RIGHTS OF A SURVIVING SPOUSE (10)
- MARRIAGE OF A RESIDENT (11)

DISPOSITION OF PERSONAL PROPERTY	(12)
TAX CONSEQUENCES	(13)
RESERVE FUNDING - ESCROWS	(14)
FINANCIAL STATEMENTS	(15)
SOURCE OF FUNDS (if facility is not in operation)	(16)
PRO FORMA INCOME STATEMENTS	(17)
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(4) A disclosure statement may utilize a table of contents other than as set forth in subsection (3) if, when submitted for filing, the disclosure statement is accompanied by an index which cross-references the requirements of subsection (3) above with the table of contents in the disclosure statement.

(5) The disclosure statement may include the required information in any order, at the discretion of the provider, provided that the Table of Contents or separate index clearly sets forth the location of the required information.

(6) The disclosure statement shall be assembled into one document, except if a provider shall determine that financial and actuarial data can be more conveniently or logically combined into one separate document, then two documents may be submitted as the disclosure statement.

(b) A disclosure statement submitted to the department for filing may be accompanied by an actuarial certificate, signed by a member in good standing of the American Academy of Actuaries, stating that financial and actuarial projections have been made upon an actuarially sound basis in accordance with accepted actuarial principles. In that event, the initial requirements for filing in regard to actuarial soundness shall be deemed to have been met.

(c) (1) Actions initiated by the Attorney General against a provider in regard to non-compliance with the Act or these regulations shall, if not concluded, be affirmatively disclosed in disclosure statements filed subsequent to the initiation of such action by inclusion of a statement, under the heading JUDICIAL PROCEEDINGS, to the effect that such an action or actions have been instituted and are continuing. In such event, the provider shall initiate the filing of a revised disclosure statement not later than one (1) year from the date on which any such action is initiated.

(2) The requirements set forth in subsection (c) (1), above, may be waived by the commissioner upon application in writing by a provider, if the commissioner determines that the action or actions instituted arose by reason of the existence of a good faith dispute as to the scope or applicability of the Act or the regulations.

(3) If there are no proceedings to be reported under the heading JUDICIAL PROCEEDINGS, the disclosure statement shall contain an affirmative statement to that effect. Both the heading and this statement shall be omitted from the disclosure statement if the only disclosure required had been in regard to actions brought by the Attorney General, and the disclosure of such action had been waived pursuant to subsection (c) (2), above.

(d) If the manner in which periodic charges or other recurring fees may be adjusted is not set forth with specificity in the contract, by formula or otherwise, but rather indicates a general basis therefor, such as, "increases in taxes, and maintenance costs of the facility," then the disclosure statement shall include a statement to the effect that periodic charges (or other recurring fees) may be made

at the discretion of the provider. Such a statement shall be included under the heading "Entrance Fees/Periodic Charges."

(e) A disclosure statement for a continuing care retirement community at which any incident of ownership is or may be transferred in whole or in part shall meet the foregoing requirements, and in addition, the proposed documents which would transfer any incident of ownership shall be included under item "(21)."

(Effective January 31, 1996)

Sec. 17b-533-4. Escrow accounts

(a) No escrow agreement entered into pursuant to this section shall be deemed to meet the requirements of the Act or these regulations if it provides either for withdrawals contrary to the terms of the Act, or for changes in terms of the escrow agreement in regard thereto without prior notification to the commissioner of the proposed changes.

(b) Every escrow agreement shall contain, either in the original agreement, or in an amendment thereto, the requirement of prior notification to the commissioner as set forth in subsection (a), above.

(c) In the event the commissioner determines that an escrow agreement filed with the department does not meet the requirement of the Act and this section of the regulations, the commissioner may take such action as is consistent with the Act and these regulations.

(d) A provider may submit any existing or proposed escrow agreement to the department for an informal review. Notwithstanding either favorable or adverse comments thereon, such informal review or comments shall in no way be construed to be the position of the department, which can only be determined after such instrument is formally reviewed.

(Effective January 31, 1996)

Sec. 17b-533-5. Reserve fund escrow

(a) Upon written application by a provider, the commissioner may authorize a facility to maintain a reserve fund escrow or escrows in an amount less than required pursuant to the computation set forth in C.G.S. Sec. 17b-525, if the commissioner finds that the contractual liabilities of the provider and the best interests of the residents may be adequately protected by a reserve fund escrow or escrows in a lesser amount.

(b) The written application by the provider shall contain sufficiently detailed supporting information, including that relating to contracts, deposit agreements, and other material necessary to fully disclose to the commissioner the scope and status of such matters, and the basis for the application.

(c) Matters that will be considered by the commissioner in regard to the application include, but are not limited to, the following:

(1) Whether any separate fund which the provider wishes to have considered is maintained with an escrow agent pursuant to a written agreement;

(2) Whether the portion which would be withdrawn monthly from the reduced Section 17b-525 escrow without approval of the commissioner is substantially in accordance with the following formula:

$$\text{Portion Authorized to be Withdrawn monthly} = A/S \times 1/12$$

Where A = The reduced escrow amount; and

Where S = The statutory escrow amount.

(3) Whether the combined total amount proposed to be withdrawn from all such reserve or operating funds without the prior approval of the commissioner, does not exceed 1/12 of the combined amount of such funds.

(Effective January 31, 1996)

Sec. 17b-533-6. Annual filings

(a) A provider operating any facility located in this state shall file with the department the following financial and actuarial information pertaining to residents under continuing-care contracts for each facility located in this state and operated by the provider or by a manager under contract to the provider:

(1) The facility's current rate schedule;

(2) Residential turnover rates for the most recently completed fiscal year, and anticipated for the next five years;

(3) The projected average age of the residents for the next five years;

(4) Health-care utilization rates, including admission rates and days per one hundred residents by level of care for the most recently completed fiscal year, and anticipated for the next five years;

(5) Occupancy rates for the most recently completed fiscal year, and anticipated for the next five years;

(6) The number of Health care admissions pursuant to continuing-care contracts for the most recently completed fiscal year, and anticipated for the next five years;

(7) The days of care per year for the most recently completed fiscal year, and anticipated for the next five years;

(8) The number of permanent transfers to a facility that provides medical or nursing services or other health-related benefits for the most recently completed fiscal year;

(9) A statement of source and application of funds for the five-year period beginning the year of initial filing pursuant to C.G.S. section 17b-528 or subsequent filing pursuant to C.G.S. section 17b-528;

(10) Financial statements including certified current balance sheets and certified income statements, changes in financial position, and pro forma statements for the next five years as provided in C.G.S. section 17b-522, and either such information as is necessary to assess the actuarial soundness thereof or an actuarial certificate as provided below in subsection (i) (2) of this section;

(11) The basis for amortization assumptions for the provider's capital cost;

(b) The financial and actuarial information shall be filed annually, within one hundred fifty days following the end of the fiscal year of the provider. At the discretion of the provider, the first such statement may be filed simultaneously with the initial revised disclosure statement as set forth in section 17b-533-7 hereof.

(c) (1) If a provider is required to submit an annual financial and actuarial filing, a valid filing shall be supplemental to, and a prerequisite for, the continued effectiveness of a provider's latest disclosure statement on file with the department.

(2) In the event that an annual filing is not submitted as required, the provider's latest disclosure statement on file with the Department shall cease to be effective for the purposes of the Act, and such disclosure statement shall remain ineffective until the provider receives acknowledgement of the filing of the financial and actuarial information required by this section.

(d) The commissioner shall acknowledge in writing the filing of the financial and actuarial information within ten business days of the date it is received, if the

information either meets the requirements of the Act or contains only technical discrepancies.

(e) The commissioner shall set forth the initial determination of the department in conjunction with such acknowledgement, in the same manner as provided in section 17b-533-2 of these regulations regarding disclosure statements.

(f) If the commissioner determines that the information filed does not on its face meet the requirements of the Act or these regulations, and will not be accepted for filing, the provider shall be notified in writing within ten business days of receipt of the financial and actuarial information of such determination and the reasons therefor. Such notification will not be accompanied by return of the documents.

(g) If neither an acknowledgement of filing nor notification of non-acceptance for filing is made within ten business days, a provider may, until notification to the contrary, deem that the financial and actuarial information has been accepted for filing.

(h) Upon a determination that the financial and actuarial information will not be accepted for filing, the commissioner may notify the Office of the Attorney General of the deficiency and request that appropriate legal action be initiated to compel compliance with the Act, recover an appropriate fine therefor, or for such other relief as may be deemed appropriate; provided, that no such request shall be made for non-material technical discrepancies with respect to the Act or these regulations.

(i) (1) Required financial and actuarial information shall be filed in one document which shall consist of a cover page, a table of contents, and the information in such order as may be convenient for the provider; provided, that the table of contents adequately identifies by number, words, or both, the material included in the filing for ready comparison with the information required by the Act and these regulations.

(2) Any filing under this section which is accompanied by an actuarial certificate signed by a member in good standing of the American Academy of Actuaries stating that the financial and actuarial projections have been made on an actuarially sound basis in accordance with accepted actuarial principles shall be deemed to have met the initial requirements for filing in regard to actuarial soundness.

(j) Notwithstanding acknowledgement of acceptance for filing, the commissioner may at any time thereafter review and investigate the financial and actuarial information filed pursuant to this section to determine the accuracy and completeness thereof.

(Effective January 31, 1996)

Sec. 17b-533-7. Disclosure statements: revisions

(a) Within one hundred fifty days following the end of the first fiscal year of a provider in which a registration is filed, and if that registration has not been withdrawn, a provider shall file a revised disclosure statement.

(b) Subsequent to the mandatory submission of the first revision of its disclosure statement, a provider need only initiate the filing of such revised disclosure statements as it deems necessary to prevent a disclosure statement from containing a material misstatement of fact or from omitting a material fact required to be stated therein. Filings of optional disclosure statements shall be accompanied by a written statement from the provider setting forth why it deemed such a revision to be necessary.

(c) Acknowledgement of filing or rejection of revised disclosure statements, shall be in the same manner as set forth in Section 17b-533-2 of these regulations.

(d) The form and content of revised disclosure statements shall be the same as set forth in Section 17b-533-3 of these regulations.

(e) Notwithstanding an acknowledgement of acceptance for filing, the commissioner may at any time thereafter review and investigate the information contained in revised disclosure statements accepted for filing to determine accuracy and completeness thereof.

(f) In the event that a subsequent review determines that a revised disclosure statement does not in fact meet the requirements of the Act and of these regulations then the commissioner may take such actions as are set forth in Section 17b-533-2 (d) (2).

(Effective January 31, 1996)

Sec. 17b-533-8. Investigations

(a) Investigations, inquiries, and investigatory hearings as are deemed necessary by the commissioner to develop information for the use of the department may be conducted for the following purposes:

(1) To determine whether any person has violated any provision of the Act or of these regulations, relating to registration, disclosure, or escrow provisions relating to continuing-care contracts;

(2) To aid in the enforcement of the Act, including the regulations promulgated pursuant thereto; and

(3) To aid in the prescribing of regulations by the commissioner.

(b) (1) Notice of investigatory hearings shall be given in such manner and to such persons as appropriate in order to afford adequate, timely knowledge of the proceeding to any person specifically affected thereby; provided, that in hearings pertaining to providers or continuing-care contracts in general, no general notifications to all providers need be made.

(2) Notice of investigatory hearing shall provide for a hearing date not less than ten calendar days from the date of mailing the notice. The hearing date may be changed by the commissioner, for good cause shown, upon the request of any person.

(3) The commissioner, or any presiding officer authorized by the commissioner to conduct any inquiry, investigation or hearing shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any investigatory hearing ordered by the commissioner, the commissioner or such presiding officer having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or having appeared in obedience thereto, refuses to answer any pertinent question put to him by the commissioner or by the presiding officer or to produce any records and papers pursuant thereto, the commissioner or the presiding officer as the commissioner's agent may apply to the superior court for Hartford county or for the county wherein the person resides or wherein the business has been conducted, or to any judge or said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

(4) Any person subpoenaed to attend a hearing may be accompanied by an attorney and may, not less than five days prior to such hearing, request that a transcript of the hearing be made by an official stenographer or court reporter.

(5) It shall be the sole responsibility of any person desiring a copy of a hearing transcript to obtain a copy from the reporter or stenographer.

(c) If, as the result of an investigation, inquiry, or investigatory hearing conducted for the purposes set forth in the Act and these regulations, the commissioner deter-

mines that any provider has violated any provision of the Act, the commissioner may, without further action, request the attorney general to seek a temporary or permanent injunction and such other relief as may be appropriate to enjoin such provider from continuing such violation or violations.

(Effective January 31, 1996)

Sec. 17b-533-9. Receivership: rehabilitation, and liquidation

(a) The commissioner shall give not less than five calendar days written notice to a provider or a facility of an intention to request the Attorney General to apply for an order appointing a receiver to rehabilitate or liquidate a facility.

(b) Such notice shall be sent by certified mail, return receipt requested, or delivered personally to the business or other office of the provider at the facility, or elsewhere within the state, in which event an affidavit of service shall be executed.

(c) Such notice shall include a summary of the basis for the action, and the date on which the commissioner will request the Office of the Attorney General to initiate action, together with the following statement:

YOU MAY REQUEST A HEARING
ON THIS MATTER NOT LATER THAN
(one day prior to the date on which
the commissioner is to take action.)

SUCH A REQUEST MUST BE IN WRITING.

FAILURE TO REQUEST SUCH A HEARING WILL
RESULT IN LEGAL ACTION FOR THE APPOINTMENT
OF A RECEIVER TO REHABILITATE OR LIQUIDATE YOUR FACILITY.

(d) (1) A request for a hearing must be in writing, and shall be delivered to the commissioner.

(2) The provider or the facility may propose a date for the hearing which shall not be more than ten days from the date of the request, and may also request that a verbatim transcript be made of the proceeding, and that all testimony be taken under oath.

(3) Such request for a hearing shall specify the names of attorneys who will represent the facility.

(4) The commissioner shall, not more than 3 business days after receiving the request, notify the facility of the time and date of the hearing, which shall not be less than five business days from the date of the request.

(5) The commissioner shall, not more than 5 business days from the close of the hearing, make a determination which shall be communicated to the facility, and if appropriate simultaneously request the Attorney General to initiate action.

(6) Notwithstanding the foregoing limitations on the commissioner in regard to requesting action to have a receiver appointed, the commissioner may request the Office of the Attorney General to initiate such other action as the Attorney General may deem appropriate in the circumstance.

(Effective January 31, 1996)

Sec. 17b-533-10. Miscellaneous

(a) Continuing-care:

A determination by the department that an arrangement in regard to existing or prospective shelter, and medical or nursing services or other health-related benefits constitutes a continuing care contract and the site or sites at which provision of

services and benefits is made constitutes a continuing care retirement community, will be made after consideration of the following guidelines:

(1) The resident's right to occupy shelter does not solely constitute either an ownership interest, or a usual and customary leasehold;

(2) There are specific commitments for present or future medical or nursing services or other health-related benefits;

(3) A present or future transfer of assets is required, a specific part of which may be applicable to the obligation to provide medical or nursing services or other health-related benefits, and part of which may be applicable to the obligation to provide shelter;

(4) There are periodic charges or a part thereof which may be applicable to the obligation to provide medical or nursing services or other health related benefits;

(5) There are limited rights to transfer shelter to another person whether or not to or through the provider, or no such rights of transfer at all;

(6) There may be, in the event of the departure or death of a resident subsequent to the occupation of the shelter, limitations on return to a resident or his estate of any advance payments or transfers of funds made by him.

(7) The provision of qualifying medical or nursing services or other health related benefits is a condition of occupancy of any residential unit.

(b) **Filing of documents:** (1) Three copies of disclosure statements, financial and actuarial data, and any other documents or information required to be filed, shall be submitted by certified mail, return receipt requested, or delivered by hand to the Department on Aging, 175 Main Street, Hartford, CT 06106, Attn: Office of the Commissioner.

(2) All documents shall, upon receipt by the Department, be date stamped on the cover page and on one inside page.

(3) (A) A date-stamped receipt shall be given for any documents hand delivered, but such a receipt shall not constitute "acknowledgement" within the meaning of the Act.

(B) Any receipt shall also specify the name of the provider, and shall identify the documents delivered.

(c) **Annual fees:** (1) Each provider having an accepted disclosure statement or an accepted revised disclosure statement on file with the department shall pay an annual fee equal to twenty four dollars (\$24.00) multiplied by the number of residential units at the facility to which the disclosure statement applies. Said fee shall be paid not later than five business days after the first day of January in each year, and shall be accompanied by a signed letter from the provider specifying the number of residential units at the facility. Acknowledgment, in writing, of receipt of the required fee shall be promptly issued by the department. If the fee is not paid as herein set forth, the disclosure statement for the facility shall cease to be effective for the purposes of the act until the provider has received the department's written acknowledgment of payment of the fee.

(2) **Initial disclosure statements:** An initial disclosure statement submitted for filing shall not be accompanied by any fee. Acknowledgment by the commissioner of acceptance for filing in accordance with Section 17b-533-2 (a) (1) of these regulations shall specify the amount of the fee which is due, based on the formula set forth in (1) above. Notwithstanding acknowledgment of acceptance for filing, the disclosure statement shall not be effective for purposes of the act until notification to the provider from the department that the required fee has been received.

(d) **Fiscal year:** (1) When an initial disclosure statement is filed, the provider shall state the fiscal year of the provider either in the transmission letter, or on the cover page of the disclosure statement.

(2) In the event a provider changes its fiscal year it shall notify the commissioner thereof. The commissioner may, on such terms and conditions in regard to required filings as the commissioner deems appropriate, require interim filings or bridge reports.

(e) **Informal reviews:** (1) A provider may, at any time, seek the informal advice or views of the department in regard to any matter pertaining to the provisions of the Act or these regulations, but in no event shall any views given or advice rendered informally by the department be deemed binding on actions or determinations of the department which may subsequently be undertaken or rendered in a formal determination.

(2) Actions taken by a provider in good faith reliance or informal advice shall not be subject to any penalty, or action by the commissioner other than as may be necessary to provide for full disclosure.

(Effective January 31, 1996)

Sec. 17b-533-11. Advisory committee

(a) The name of the committee established by the Act shall be

THE CONTINUING-CARE ADVISORY COMMITTEE.

(b) The committee shall have the following purposes:

(1) To assist the commissioner in the various reviews and the registration functions to be performed under the Act and these regulations;

(2) To report to commissioner on developments in the field of continuing-care;

(3) To report to the commissioner any special problems in the field of continuing care;

(4) To recommend changes in relevant statutes, and these regulations; and

(5) To advise on any other matters referred to the committee by the commissioner.

(c) The committee shall be composed of not more than twelve (12) members.

(1) In the event a vacancy occurs on the committee by virtue of death, resignation, inability to serve, or termination by the commissioner, any such vacancy shall be filled by the commissioner for the balance of the unexpired term.

(2) Members of the committee may be re-appointed to additional terms, without limitation.

(d) The advisory committee shall be comprised of professionals such as accountants, actuaries, insurance representatives, representatives of the continuing-care industry, and may include residents of continuing-care facilities and others knowledgeable in the field of continuing-care and familiar with the provisions of the Act. Members of the committee shall be appointed in accordance with the provisions of C.G.S. Section 4-9a.

(1) The commissioner may seek recommendations for membership on the committee from any individual, business entity, association or group, in order to meet the requirements for membership established by the Act.

(e) Meetings of the committee shall be held at such times and places as may be established by the commissioner, with the advice of the chairman.

(1) The committee shall meet at least four (4) times in each calendar year, with at least one meeting in each quarter, if possible.

(2) The commissioner may as deemed necessary, or upon a request in writing from a majority of members, call additional meetings.

(3) Meetings shall be attended by the commissioner, or the designee of the commissioner.

(4) (A) The agenda for regularly scheduled meetings must be approved by the commissioner, and such agendas shall be submitted to the commissioner by the chairman for approval.

(B) The agenda for any special or additional meetings shall be prepared by the commissioner.

(C) Meetings of the committee shall be conducted in accordance with all applicable provisions of the Freedom of Information Act.

(f) Staff support for the committee shall be provided by the department, by such individuals as may be designated by the commissioner to perform such functions.

(g) The committee shall remain in existence until terminated by act of the General Assembly.

(Effective January 31, 1996)