~~(2) the activities of the Interagency Committee; and~~

~~(3) the status of services to seniors in the State.~~

§10–401.

(a) In this subtitle the following words have the meanings indicated.

(b) "Assisted living program" has the meaning stated in § 19-1801 of the Health - General Article.

(c) "Certified financial statement" means a complete audit prepared and certified by an independent certified public accountant.

(d) "Continuing care" means:

(1) continuing care in a retirement community; or

(2) continuing care at home.

(e) "Continuing care agreement" means an agreement between a provider and a subscriber to provide continuing care.

(f) (1) "Continuing care at home" means providing medical, nursing, or other health related services directly or by contractual arrangement:

(i) to an individual who is at least 60 years of age and not related by blood or marriage to the provider;

(ii) for the life of the individual or for a period exceeding 1 year; and

(iii) under a written agreement that requires a transfer of assets or an entrance fee notwithstanding periodic charges.

(2) "Continuing care at home" includes providing assistance with the physical maintenance of the individual's dwelling.

(g) "Continuing care in a retirement community" means providing shelter and providing either medical and nursing or other health related services or making the services readily accessible through the provider or an affiliate of the provider, whether or not the services are specifically offered in the written agreement for shelter:

(1) to an individual who is at least 60 years of age and not related by blood or marriage to the provider;

(2) for the life of the individual or for a period exceeding 1 year; and

(3) under one or more written agreements that require a transfer of assets or an entrance fee notwithstanding periodic charges.

(h) (1) "Contractual entrance fee refund" means a repayment of all or part of a subscriber's entrance fee to the subscriber or the subscriber's estate or designated beneficiary, as required by the terms of the continuing care agreement.

(2) "Contractual entrance fee refund" does not include a payment required under § 10-446 or § 10-448 of this subtitle.

(i) "Conversion" means converting a physical plant that provides housing or shelter into a facility if:

(1) the residential accommodations exist before a statement of intent is filed under § 10-409(b) of this subtitle; and

(2) at least 60% of the available residential accommodations of the facility owner were occupied during the two fiscal years prior to the filing of a statement of intent.

(j) "Deposit" means a portion of an entrance fee.

(k) (1) "Entrance fee" means a sum of money or other consideration paid initially or in deferred payments, that:

(i) assures a subscriber continuing care for the life of the subscriber or for a period exceeding 1 year; and

(ii) is at least three times the weighted average of the monthly cost of the periodic fees charged for independent living and assisted living units.

(2) "Entrance fee" includes a fee of similar form and application, regardless of title.

(3) "Entrance fee" does not include a surcharge.

(l) (1) "Expansion" means any single new capital addition to an existing facility that meets either of the following criteria:

(i) if independent or assisted living units are to be constructed, the number of units to be constructed is less than or equal to 25% of the number of existing independent and assisted living units; or

(ii) if independent or assisted living units are not to be constructed, the total projected cost exceeds the sum of:

1. 10% of the total operating expenses, less depreciation, amortization, and interest expense of the facility as shown on the certified financial statement for the most recent fiscal year for which a certified financial statement is available; and

2. the amount of the existing reserves properly allocable to, and allocated for, the expansion.

(2) "Expansion" does not include renovation and normal repair and maintenance.

(m) "Facility" means a physical plant in which continuing care in a retirement community is provided in accordance with this subtitle.

(n) "Financial difficulty" means current or impending financial conditions that impair or may impair the ability of a provider to meet existing or future obligations.

(o) "Governing body" means a board of directors, board of trustees, or similar group that ultimately directs the affairs of a provider, but whose members are not required to have an equity interest in the provider.

(p) (1) "Health related services" means services that are needed by a subscriber to maintain the subscriber's health.

(2) "Health related services" includes:

(i) priority admission to a nursing home or assisted living program; or

(ii) except for the provision of meals, assistance with the activities of daily living.

(q) "Person" includes a governmental entity or unit.

(r) "Processing fee" means a fee imposed by a provider for determining the financial, mental, and physical eligibility of an applicant for entrance into a facility.

(s) "Provider" means a person who:

(1) undertakes to provide continuing care; and

(2) is:

(i) the owner or operator of a facility; or

(ii) an applicant for or the holder of a preliminary, initial, or renewal certificate of registration.

(t) "Records" means information maintained by a provider for the proper operation of a facility under this subtitle.

(u) (1) "Renovation" means any single capital improvement to, or replacement of, all or part of an existing facility that will not increase the number of independent or assisted living units and for which the total projected cost exceeds the sum of:

(i) 20% of the total operating expenses, less depreciation, amortization, and interest expense of the facility as shown on the certified financial statement for the most recent fiscal year for which a certified financial statement is available; and

(ii) the amount of existing reserves properly allocable to, and allocated for, the renovation.

(2) "Renovation" does not include normal repair or maintenance.

(v) "Subscriber" means an individual for whom a continuing care agreement is purchased.

(w) (1) "Surcharge" means a separate and additional charge that:

(i) is imposed simultaneously with the entrance fee; and

(ii) may be required of some, but not all, subscribers because of a condition or circumstance that applies only to those subscribers.

(2) "Surcharge" does not include a second person entrance fee.

§10–402.

(a) (1) A continuing care at home provider is subject to each provision of this subtitle except Part II and §§ 10–446 and 10–448.

(2) A continuing care in a retirement community provider is subject to each provision of this subtitle except Part VI.

(b) (1) A continuing care operation that is subject to the provisions of this subtitle is not subject to:

(i) the Maryland Health Maintenance Organization Act under Title 19, Subtitle 7 of the Health – General Article;

(ii) except for § 15–603 of the Insurance Article, the Insurance Article;

(iii) Title 8 of the Real Property Article;

(iv) any county or municipal landlord–tenant law; or

(v) § 19–310.1 of the Health – General Article.

(2) If a provider contractually utilizes the services of a licensed home health agency or residential service agency and is not itself directly providing the type of services provided by a home health agency or residential service agency, the provider is not subject to Title 19, Subtitles 4 and 4A of the Health – General Article.

(3) Except as provided in paragraphs (1) and (2) of this subsection, a continuing care at home provider is subject to all other applicable licensing or certification requirements of State law.

(c) This subtitle does not apply to an agreement that is regulated as insurance under the Insurance Article.

(d) A provider that offers assisted living program services as part of a continuum of care in accordance with a continuing care agreement may:

(1) execute a separate assisted living resident agreement and a separate assisted living disclosure statement; or

(2) meet the requirements of §§ 10–425(c) and 10–444(e) of this subtitle.

(e) The liability of a provider to the Department of Health and Mental Hygiene under § 15–603 of the Insurance Article shall be limited to the amount of the refund that would be due to the subscriber if the subscriber were dismissed under § 10–448 of this subtitle at the time of enrollment in services provided by or paid wholly or partly by the Department of Health and Mental Hygiene.

§10–403.

(a) The Department shall:

(1) administer this subtitle;

(2) prepare and furnish all forms necessary or desirable under this subtitle;

(3) establish and collect reasonable filing fees to carry out this subtitle;

(4) adopt regulations necessary to enforce this subtitle; and

(5) prepare and distribute relevant public information and educational materials designed to advise individuals, institutions, and organizations of their rights and responsibilities under this subtitle.

(b) (1) Except as provided in paragraph (2) of this subsection, the Department shall make available to interested persons any information required to be provided to the Department under this subtitle and publicize the availability of the information.

(2) (i) A feasibility study filed under § 10-408 of this subtitle may not be disclosed until the Department issues an initial certificate of registration for the project.

(ii) Information required to be provided under § 10-434(b)(2) of this subtitle shall be disclosed only to the extent required under the Public Information Act.

§10–404.

Medical and nursing services and other health related services may be covered by an entrance fee or periodic charges or, at the option of the subscriber, may be purchased for an additional fee.

§10–405.

(a) In this section, "Fund" means the Continuing Care Fund.

(b) There is a Continuing Care Fund.

(c) The purpose of the Fund is to defray the costs of administering this subtitle.

(d) The Department of Aging shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) all fees collected under this subtitle;

(2) money appropriated in the State budget to the Fund;

(3) investment earnings of the Fund; and

(4) any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only for the purposes specified in this subtitle.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be paid into the Fund.

(i) Expenditures from the Fund may be made only in accordance with the State budget.

(j) Money expended from the Fund for administering this subtitle is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for administering this subtitle.

§10–407.

This part applies only to continuing care in a retirement community operations.

§10–408.

(a) A provider shall comply with the applicable provisions of §§ 10-409 through 10-415 of this subtitle before the provider may:

(1) offer continuing care in a retirement community;

(2) enter into or renew continuing care agreements;

(3) begin construction of a new facility;

(4) begin construction of an expansion to or renovation of an existing facility; or

(5) collect deposits for continuing care in this State.

(b) (1) A new capital addition to a facility that will result in the construction of a number of independent and assisted living units that is greater than 25% of the number of existing units is considered new development and is subject to §§ 10-409 through 10-411 of this subtitle.

(2) A new capital addition to a facility that does not involve the construction of independent or assisted living units and that does not meet the standard of § 10-401(l)(1)(ii) of this subtitle is not subject to review by the Department under §§ 10-409 through 10-415 of this subtitle.

(3) A capital improvement or replacement that does not meet the standard of § 10-401(w) of this subtitle is not subject to review by the Department under §§ 10-409 through 10-415 of this subtitle.

(c) A provider that has more than one facility offering continuing care shall make a separate application for each facility for preliminary, initial, and renewal certificates of registration.

§10–409.

(a) A provider may not collect deposits for continuing care or begin construction of a new facility until the Department approves a feasibility study.

(b) A person who intends to submit a feasibility study under subsection (c) of this section shall file with the Department a statement of intent to provide continuing care at least 30 days before the person submits the feasibility study to the Department.

(c) A feasibility study shall:

(1) be filed in a form satisfactory to the Department; and

(2) include at least the following information:

(i) a statement of the purpose of the proposed construction or conversion;

(ii) documentation of the financial resources of the provider;

(iii) a statement of the capital expenditures necessary to accomplish the project and the plan for acquiring the necessary capital;

(iv) a plan demonstrating the financial feasibility of the proposed project, including future funding sources;

(v) a study that demonstrates the market for the project;

(vi) an actuarial forecast reviewed by a qualified actuary;

(vii) a statement of the planned fee structure, including any proposed escalator or other automatic adjustment provision;

(viii) a description of the facility proposed to be used or being used for continuing care;

(ix) a copy of the proposed escrow and deposit agreements; and

(x) the form and substance of any proposed advertisement, advertising campaign, or promotional material for the facility that is available at the time of filing.

(d) The Department may approve a feasibility study if the Department determines that:

(1) the number of comprehensive care or assisted living beds in the facility for which licenses are required by the Department of Health and Mental Hygiene is not inconsistent with the State health plan;

(2) a reasonable financial plan has been submitted for developing and operating the project;

(3) a market for the facility appears to exist;

(4) a recognized authority prepared the feasibility study;

(5) the actuarial forecast supports the projections for the project;

(6) the Department has approved the escrow agreement and deposit agreement; and

(7) the approved escrow agreement is executed by the provider and the financial institution.

§10–410.

(a) A provider may collect deposits from prospective subscribers if:

(1) the Department has approved the provider's feasibility study; and

(2) funds collected are maintained in an escrow account.

(b) Each deposit agreement shall comply with the requirements of subsection (c) or (d) of this section.

(c) If a deposit agreement is used for a deposit on a unit for which the provider has not received written approval to withdraw deposits, the deposit agreement shall:

(1) state that all deposits and entrance fees will be held in escrow until:

(i) an initial certificate of registration for the unit is issued;

(ii) construction is completed;

(iii) a certificate of occupancy, or its equivalent, is issued by the local jurisdiction; and

(iv) the provider has the appropriate licenses or certificates from the Department of Health and Mental Hygiene, the Maryland Health Care Commission, and the Department;

(2) describe the disposition of any interest earned on deposits and entrance fees;

(3) state the amount of any processing fee and whether it will be refunded if the deposit agreement is canceled; and

(4) describe the disposition of the deposit if the deposit agreement is canceled before the continuing care agreement is executed.

(d) If a deposit agreement is used for a deposit on a unit for which the provider has received written approval to withdraw deposits, the deposit agreement shall:

(1) state that the provider may use all deposits and entrance fees at any time; or

(2) describe any applicable limitations on the use of deposits and entrance fees.

§10–411.

(a) A provider may not enter into a continuing care agreement until the Department issues a preliminary certificate of registration.

(b) An application for a preliminary certificate of registration shall be filed in a form satisfactory to the Department.

(c) An application shall include at least the following information:

(1) the name and address of the facility and the name and address of any affiliate, parent, or subsidiary;

(2) the organizational structure and management of the provider, including:

(i) for a corporation or limited liability company, its name, the state in which it is incorporated or formed, and the name of the chief executive officer;

(ii) for a partnership, the names of the general partners, the state governing its formation, and the name of the primary individual responsible for managing it;

(iii) for an unincorporated association, the names of the members, the state governing its activities, and the name of the primary individual responsible for managing it;

(iv) for a partnership that has a corporation or limited liability company as one or more of its general partners, the name of each corporation or limited liability company, the state in which it is incorporated or formed, and the name of the chief executive officer;

(v) for a trust, the name of the trustee, the names of the owners of beneficial interests in the trust, the state governing it, and the name of the primary individual responsible for overseeing its activities;

(vi) the name and occupation of each officer, director, trustee, managing or general partner, and each person with a 10% or greater financial equity or beneficial interest in the provider and a description of the person's financial interest in or occupation with the provider;

(vii) the name and address of any entity in which a person identified in item (vi) of this paragraph has a 10% or greater financial interest and that is anticipated to provide goods, premises, or services with a value of $10,000 or more to the facility or provider in a fiscal year and a description of the goods, premises, or services and their anticipated cost to the facility or provider, which need not include salary, wage, or benefit information of employees of the provider; and

(viii) a statement whether the provider is qualified, or intends to qualify, as a tax exempt organization under the Internal Revenue Code;

(3) a copy of the corporate charter, partnership agreement, articles of association, membership agreement, trust agreement, or similar instrument or agreement governing the legal organization of the provider;

(4) (i) a certified financial statement of the provider for as many of the most recent fiscal years, not exceeding 3 years, for which certified financial statements are obtainable under generally accepted accounting principles; and

(ii) if the provider's fiscal year ended more than 90 days before the date the application is filed, an income statement, which need not be certified, covering the period between the end of the fiscal year and a date not more than 90 days before the date the application is filed;

(5) a statement of any affiliation with a religious, charitable, or other nonprofit organization, the extent of the affiliation, and the extent, if any, to which the affiliate organization will be responsible for the provider's financial and contractual obligations;

(6) a copy of the proposed continuing care agreement;

(7) a copy of any priority admission agreements between the provider and any health care provider for health related services;

(8) a statement of the current fee structure, including escalator or other automatic adjustment provisions;

(9) a statement of the role of any publicly funded benefit or insurance program in the financing of care;

(10) the form and substance of any advertisement, advertising campaign, or other promotional material for the facility that has not been previously submitted to the Department; and

(11) other reasonable and pertinent information that the Department requires.

(d) The Department shall issue a preliminary certificate of registration to a provider if:

(1) the feasibility study has been approved; and

(2) the Department determines that:

(i) the proposed continuing care agreement meets the requirements of §§ 10-444, 10-445, 10-446, and 10-448 of this subtitle;

(ii) all of the financial and organizational materials required to be submitted under subsection (c) of this section have been submitted to the Department; and

(iii) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead.

(e) If a preliminary certificate of registration is not issued within 6 months after the feasibility study is approved, or a longer time allowed by the Department for good cause shown, the provider shall refund all deposits and stop marketing continuing care under that application.

(f) A provider that plans to advertise before an initial certificate of registration is issued under § 10-412 of this subtitle shall submit to the Department the form and substance of any advertisement, advertising campaign, or other promotional material before it may be used.

§10–412.

(a) A provider may not provide continuing care until the Department issues an initial certificate of registration.

(b) An application for an initial certificate of registration shall be filed in a form satisfactory to the Department.

(c) An application shall include at least the following information:

(1) for a project other than a conversion, verification that continuing care agreements have been executed with subscribers for at least 65% of the independent living units and at least 10% of the total entrance fee for each contracted unit has been collected;

(2) for a conversion project, verification that at least 80% of the accommodations in the project that are not licensed as assisted living or comprehensive care beds are occupied or reserved in accordance with:

(i) leases;

(ii) continuing care agreements executed with subscribers who have paid a deposit that:

1. equals at least 10% of the total entrance fee; and

2. has been deposited by the provider under an escrow agreement approved by the Department; or

(iii) other appropriate contractual arrangements;

(3) verification that the provider has received a written commitment for permanent long-term financing; and

(4) if construction financing is required, verification that the provider has applied for the financing.

(d) (1) If requested by the permanent financing lender, the Department may issue a letter stating that the requirements of subsection (c)(1) of this section have been met.

(2) If requested by the construction lender, the Department may issue a letter stating that:

(i) the requirements of subsection (c)(1) and (3) of this section have been met; and

(ii) the initial certificate of registration will be issued on the closing of the construction loan.

(e) (1) The Department shall issue an initial certificate of registration to a provider if the Department determines that:

(i) the provider has a preliminary certificate of registration;

(ii) the provider has submitted the required documents;

(iii) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead;

(iv) for a project other than a conversion, continuing care agreements have been executed with subscribers for at least 65% of the independent living units and at least 10% of the entrance fee has been paid as a deposit for each contracted unit;

(v) for a conversion project, at least 80% of the accommodations in the project that are not licensed as assisted living or comprehensive care beds are occupied or reserved in accordance with:

1. leases;

2. continuing care agreements executed with subscribers who have paid a deposit that:

A. equals at least 10% of the total entrance fee; and

B. has been deposited by the provider under an escrow agreement approved by the Department; or

3. other appropriate contractual arrangements;

(vi) if construction financing is required, closing on the financing has occurred; and

(vii) the provider has a commitment for permanent long-term financing.

(2) The Department may issue the initial certificate of registration for a period not exceeding 18 months.

(f) A deposit held in escrow may not be used until:

(1) an initial certificate of registration has been issued;

(2) construction is completed;

(3) the provider has a certificate of occupancy or the equivalent from the appropriate local jurisdiction; and

(4) the provider has the appropriate licenses or certificates from the Department of Health and Mental Hygiene or the Department.

(g) If an initial certificate of registration is not issued within 24 months after the issuance of a preliminary certificate of registration, or a longer time allowed by the Department for good cause shown, the provider shall refund all deposits and stop offering continuing care under that application.

§10–413.

(a) (1) Each year, within 120 days after the end of a provider's fiscal year, the provider shall file an application for a renewal certificate of registration in a form satisfactory to the Department.

(2) A renewal application shall contain:

(i) any additions or changes to the information required by §§ 10-408 through 10-410 of this subtitle;

(ii) an audited financial statement for the preceding fiscal year prepared in accordance with an audit guide that the Department adopts;

(iii) an operating budget for the current fiscal year and a projected operating budget for the next fiscal year;

(iv) a cash flow projection for the current fiscal year and the next two fiscal years;

(v) a projection of the life expectancy and the number of residents who will require nursing home care;

(vi) an actuarial study reviewed by a qualified actuary and submitted every 3 years, unless the provider is exempted from the requirement for an actuarial study by regulations adopted by the Department exempting categories of providers that the Department determines have substantially limited long-term care liability exposure;

(vii) the form and substance of any proposed advertisement, advertising campaign, or other promotional material not previously submitted to the Department; and

(viii) any further information that the Department requires.

(b) (1) The Department may charge a late fee if the application and accompanying information are not received by the Department within 120 days after the end of the provider's fiscal year.

(2) Failure to file the required information within 90 days after the due date is a violation of this subtitle.

(c) The Department shall issue a renewal certificate of registration if the Department determines that:

(1) the required documents have been filed;

(2) any revised continuing care agreements meet the requirements of this subtitle;

(3) if the provider has been found to be in financial difficulty, the provider has complied with Part VII of this subtitle;

(4) when appropriate, the facility has been licensed or certified by the Department of Health and Mental Hygiene or the Department; and

(5) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted to the Department are not deceptive, misleading, or likely to mislead.

§10–414.

(a) A provider may not begin construction of a renovation until the provider receives written approval from the Department.

(b) (1) A provider shall file with the Department a request for approval for each renovation.

(2) At least 30 days before filing the request, the provider shall submit to the Department a written statement of intent to file a request for approval of a renovation.

(3) A request for approval of a renovation shall be in a form satisfactory to the Department.

(4) A request for approval shall include:

(i) a statement of the purpose of and need for the renovation;

(ii) a financial plan that demonstrates to the satisfaction of the Department that the renovation will not have an unreasonably adverse effect on the financial ability of the provider to provide continuing care in accordance with its continuing care agreements and this subtitle at the facility to be renovated and at the provider's other facilities in the State; and

(iii) any other information that the Department requires.

(c) The Department shall approve a renovation if the Department determines that the proposed renovation will not have an unreasonably adverse effect on the financial ability of the provider to provide continuing care in accordance with its continuing care agreements and this subtitle.

§10–415.

(a) A provider may not begin construction of an expansion until the provider receives written approval from the Department.

(b) (1) A provider shall file with the Department a request for approval for each expansion.

(2) At least 30 days before filing the request, the provider shall submit to the Department a written statement of intent to file a request for approval of an expansion.

(3) A request for approval of an expansion shall be in a form satisfactory to the Department.

(4) A request for approval shall include:

(i) a statement of the purpose of and need for the expansion;

(ii) if the expansion involves living units, a plan that demonstrates to the satisfaction of the Department that a market exists for the additional living units;

(iii) a financial plan that demonstrates to the satisfaction of the Department that the expansion will not have an unreasonably adverse effect on the financial ability of the provider to provide continuing care in accordance with its continuing care agreements and this subtitle at the facility to be expanded and at the provider's other facilities in the State; and

(iv) any other information that the Department requires.

(c) The Department shall approve an expansion and, if appropriate, issue a new certificate of registration if the Department determines that the proposed expansion will not have an unreasonably adverse effect on the financial ability of the provider to provide continuing care in accordance with its continuing care agreements and this subtitle.

§10–416.

(a) For cause, the Department may:

(1) deny a feasibility study approval; or

(2) deny, suspend, or revoke a preliminary, initial, or renewal certificate of registration.

(b) (1) Grounds for a denial, suspension, or revocation include:

(i) violation of this subtitle;

(ii) violation of a regulation the Department adopts under this subtitle;

(iii) misrepresentation; or

(iv) submission of a false financial statement.

(2) The Department shall set forth in writing its reasons for a denial, suspension, or revocation.

(c) Title 10, Subtitle 2 of the State Government Article governs the appeal of a denial, revocation, or suspension.

§10–419.

In this part, "net operating expenses" means the total operating expenses at each facility of a provider, less depreciation, amortization, unusual and infrequent expenses, changes in the obligation to provide future services, and changes in the fair market value of interest rate swap agreements not involving an exchange of funds.

§10–420.

(a) Interest expenses may be excluded from the calculation of net operating expenses for a fiscal year, if the provider funded a debt service reserve or other interest reserve under requirements imposed by a financial institution or under applicable financing documents, to the extent the reserve fund included amounts to cover interest for that fiscal year.

(b) (1) Except as otherwise provided in this part, a provider shall set aside for each facility subject to this subtitle operating reserves that:

(i) before January 1, 2023, equal 15% of the facility's net operating expenses for the most recent fiscal year for which a certified financial statement is available; and

(ii) beginning January 1, 2023, equal 25% of the facility's net operating expenses for the most recent fiscal year for which a certified financial statement is available.

(2) The provider shall keep the operating reserves in a reasonably liquid form in the judgment of the provider.

(3) Beginning January 1, 2014, the assets held by the provider as the operating reserves required under this subsection:

(i) except as provided in paragraph (4) of this subsection, shall be unrestricted cash and investments; and

(ii) may not:

1. be met with a line of credit; or

2. except as provided in paragraph (4) of this subsection, be hypothecated, pledged as collateral, or otherwise encumbered by the provider in any manner.

(4) Beginning January 1, 2014, the assets held by the provider as the operating reserves may be encumbered if:

(i) the assets are encumbered by contractual obligations undertaken before January 1, 2014, that have not materially changed since January 1, 2014; or

(ii) the assets are encumbered as part of a general security pledge of assets or similar collateralization that is part of the provider's long–term capital debt covenants included in the provider's long–term debt indenture or similar financial instrument but which remain available to the provider to pay operating expenses without substantial restrictions or limitations.

(c) (1) A provider shall meet the requirements of subsection (b) of this section within 10 full fiscal years after the date of its initial certificate of registration.

(2) A provider shall set aside at least 10% of the reserves required under subsection (b) of this section at the end of each fiscal year after the date of its initial certificate of registration, up to a total of 100% at the end of the 10th fiscal year.

(3) The Department may allow a provider to modify the minimum rate

required under paragraph (2) of this subsection or extend the time to meet the requirements of subsection (b) of this section if the modification is necessary to maintain the financial viability of the facility.

§10–421.

(a) (1) A provider shall compute operating reserves for each facility as of the end of the facility's most recent fiscal year.

(2) When a provider files an application for a renewal certificate of registration, the provider shall show compliance with operating reserve requirements by including with the application:

(i) a letter to the Department from a certified public accountant that states the amount set aside; or

(ii) a certified financial statement that states the amount set aside.

(b) A provider may apply toward the operating reserves required by § 10-420(b) of this subtitle any reserves, except debt service reserves, that are maintained under applicable financing document requirements if the reserves are available to the provider to meet the facility's operating expenses.

(c) For the purpose of computing a provider's operating reserves, investments held to the credit of the reserves shall be calculated at their market value as of the end of the provider's most recent fiscal year for which a certified financial statement is available.

§10–422.

(a) A provider shall notify the Department in writing immediately on the withdrawal of any amount from the funds available to satisfy the operating reserves required by § 10-420(b) of this subtitle.

(b) Within 30 days after making a withdrawal described in subsection (a) of this section, the provider shall submit to the Department a written plan for restoring the reserves to the level required by § 10-420(b) of this subtitle.

§10–423.

(a) For a facility that has not been the subject of a conversion and that has residents who are not parties to continuing care agreements, the provider shall calculate the amount of operating reserves required under § 10–420 of this subtitle based on the pro rata proportion of the net operating expenses as specified under subsection (b) of this section.

(b) The pro rata proportion of the net operating expenses equals the number of units in the facility for which the Department has issued a certificate of registration

divided by the total number of accommodations in the facility multiplied by the net operating expenses for the most recent fiscal year for which a certified financial statement is available.

§10–424.

(a) (1) A provider shall give without cost a disclosure statement for each facility for which the provider holds a preliminary, initial, or renewal certificate of registration:

(i) to a prospective subscriber before the earlier of payment of any part of the entrance fee or execution of a continuing care agreement; and

(ii) annually to any subscriber who requests a disclosure statement.

(2) A provider shall submit its initial disclosure statement to the Department for review at least 45 days before giving the statement to any prospective subscriber.

(b) (1) A provider shall revise the disclosure statement annually and file it with the Department within 120 days after the end of the provider's fiscal year.

(2) The Department shall review the disclosure statement solely to ensure compliance with § 10-425 of this subtitle.

(c) (1) An amended disclosure statement is subject to each requirement of this subtitle.

(2) A provider shall file an amended disclosure statement with the Department when it is delivered to a subscriber or prospective subscriber.

§10–425.

(a) A disclosure statement shall include:

(1) a table of contents;

(2) the name, address, and description of the facility and the identity of the owner or owners of the facility and the land on which it is located;

(3) the name and address of the provider and of any parent or subsidiary;

(4) the organizational structure and management of the provider, including:

(i) for a corporation or limited liability company, its name, the state in which it is incorporated or formed, and the name of the chief executive officer;

(ii) for a partnership, the names of the general partners, the state

governing its formation, and the name of the primary individual responsible for managing it;

(iii) for an unincorporated association, the names of the members, the state governing its activities, and the name of the primary individual responsible for managing it;

(iv) for a partnership that has a corporation or limited liability company as one or more of its general partners, the name of each corporation or limited liability company, the state in which it is incorporated or formed, and the name of the chief executive officer;

(v) for a trust, the name of the trustee, the names of the owners of beneficial interests in the trust, the state governing it, and the name of the primary individual responsible for overseeing its activities; and

(vi) a statement whether the provider is qualified, or intends to qualify, as a tax–exempt organization under the Internal Revenue Code;

(5) the name and occupation of each officer, director, trustee, managing or general partner, and each person with a 10% or greater equity or beneficial interest in the provider, and a description of the person's financial interest in or occupation with the provider;

(6) the name and address of any entity in which a person identified in item (5) of this subsection has a 10% or greater financial interest and that is anticipated to provide goods, premises, or services with a value of $10,000 or more to the facility or provider in a fiscal year and a description of the goods, premises, or services and their anticipated cost to the facility or provider, which need not include salary, wage, or benefit information of employees of the provider;

(7) a description of any matter in which an individual identified in item (5) of this subsection:

(i) has been convicted of a felony or pleaded nolo contendere to a felony charge, if the felony involved fraud, embezzlement, fraudulent conversion, or misappropriation of property;

(ii) has been held liable or enjoined in a civil action by final judgment, if the civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation as a fiduciary;

(iii) has been subject to an effective injunctive or restrictive order of a court of record in an action that arose out of or related to business activity or health care, including an action that affected a license to operate a facility or service for senior, impaired, or dependent persons; or

(iv) in the past 10 years, had a state or federal license or permit

suspended or revoked because a governmental unit brought an action that arose out of or related to business activity or health care, including an action that affected a license to operate a facility or service for senior, impaired, or dependent persons;

(8) a description of the provider's form of governance and the composition of its governing body, and a statement that the provider will satisfy the requirements of §§ 10–426 and 10–427 of this subtitle;

(9) if the provider has a governing body, a description of the process used by the provider to:

(i) select a subscriber member of its governing body; and

(ii) satisfy the requirements of § 10–427(a) of this subtitle.

(10) a statement of any affiliation of the provider with a religious, charitable, or other nonprofit organization, and the extent of the organization's responsibility for the financial and contractual obligations of the provider;

(11) if the facility will be managed on a day–to–day basis by a person other than an individual who is directly employed by the provider, the name of the proposed manager or management company and a description of the business experience of the manager or company in operating or managing similar facilities;

(12) a copy of the most recent certified financial statement obtainable under generally accepted accounting principles;

(13) a description of the long–term financing for the facility;

(14) a cash flow forecast for the current and the next two fiscal years;

(15) a description of any activity related to a renovation, expansion, or new development during the preceding fiscal year or proposed for the current fiscal year;

(16) a description of:

(i) the steps that have been or will be taken to comply with the operating reserve requirements under § 10–420(b) of this subtitle; and

(ii) the provider's investment policy related to the required reserves, including how often and by whom the reserve fund investment is reviewed;

(17) a description of the financial arrangements that the provider has made, if any, to address the renewal and replacement of the buildings and improvements at the facility, such as the establishment of a renewal and replacement fund;

(18) if the facility has not reached 85% occupancy of its independent living units, a summary of the feasibility study;

(19) if applicable, a description of the conditions under which the provider may be issued an initial certificate of registration and may use escrowed deposits;

(20) a description of all basic fees, including entrance fees, fees for health related services, and periodic fees that the provider collects from subscribers, and the amount and frequency of any fee changes during the previous 5 years or, if the facility has been in operation less than 5 years, for each year of operation;

(21) a summary of the basic services provided or proposed to be provided at the facility under the continuing care agreement, including the extent to which health related services are provided, that clearly states which services are indicated in the agreement as included in the basic fee and which services are or will be made available at or by the facility at an extra charge;

(22) if applicable, a statement that it is the provider's policy to impose a surcharge on some, but not all, subscribers because of a condition or circumstance that applies only to those subscribers and that the surcharge is not part of the entrance fee refund required under § 10–448 of this subtitle;

(23) a description of the role of any resident association;

(24) a description of the internal grievance procedure;

(25) if the provider offers a continuing care agreement that promises a contractual entrance fee refund after occupancy, a statement whether the portion of the entrance fee to be refunded is held in trust or escrow for the subscriber after occupancy, and if so held, a description of where and how the funds are held;

(26) if the provider offers an extensive agreement, the following statement: "If you have a long–term care insurance policy, request your advisors to review the policy and the continuing care agreement to determine whether there are potential areas of duplication or areas where benefits can be coordinated.";

(27) a statement that the provider will amend its disclosure statement whenever the provider or the Department considers an amendment necessary to prevent the disclosure statement from containing:

(i) a material misstatement of a fact required by this section to be stated in the disclosure statement; or

(ii) an omission of a material fact required by this section to be stated in the disclosure statement; and

(28) any other material information about the facility or the provider that the Department requires or that the provider wishes to include.

(b) The disclosure statement shall contain a cover page that states, in a prominent location and type face:

(1) the date of the disclosure statement; and

(2) that the issuance of a certificate of registration does not:

(i) constitute approval, recommendation, or endorsement of the facility by the Department; or

(ii) evidence or attest to the accuracy or completeness of the information in the disclosure statement.

(c) (1) This subsection applies to a provider that:

(i) has a continuing care agreement that includes a provision to provide assisted living program services; and

(ii) does not execute a separate assisted living agreement.

(2) In addition to any other requirement of this section, the disclosure statement shall contain the following information about the assisted living program:

(i) the name and address and a description of each facility that the provider operates;

(ii) a statement regarding the relationship of the provider to other providers or services if the relationship affects the care of the resident;

(iii) a description of any special programming, staffing, and training provided by the program for individuals with particular needs or conditions such as cognitive impairment;

(iv) notice of:

1. the availability of locks for storage;

2. the availability of locks for the subscriber's room;

3. the security procedures that the provider will implement to protect the subscriber and the subscriber's property; and

4. the provider's right, if any, to enter a subscriber's room;

(v) a statement of the obligations of the provider, the subscriber, or the subscriber's agent for:

1. arranging or overseeing medical care;

2. monitoring the subscriber's health status;

3. purchasing or renting essential or desired equipment and

supplies; and

4. ascertaining the cost of and purchasing durable medical equipment;

(vi) an explanation of the assisted living program's complaint or grievance procedure; and

(vii) notice of any material changes in the assisted living program.

(3) The provider shall:

(i) give to each subscriber annually and without cost revisions to the disclosure statement provisions under paragraph (2) of this subsection;

(ii) ensure that each subscriber or the subscriber's agent initials the revised disclosure statement to acknowledge the revisions; and

(iii) make copies of the initialed disclosure statements available for inspection by the Department of Health and Mental Hygiene under Title 19, Subtitle 18 of the Health - General Article.

§10–426.

(a) At least once a year, each provider shall hold a meeting open to all of the provider's subscribers.

(b) At the meeting, an authorized officer of the provider shall:

(1) summarize the provider's operations, significant changes from the previous year, and goals and objectives for the next year; and

(2) answer subscribers' questions.

§10–427.

(a) (1) If a provider has a governing body, at least one of the provider's subscribers shall be a full and regular member of the governing body.

(2) If the provider owns or operates more than three facilities in the State, the governing body shall include at least one of the provider's subscribers for every three facilities in the State.

(3) Subject to paragraph (4) of this subsection, a member of the governing body who is selected to meet the requirements of this subsection shall be a subscriber at a facility in the State and be selected according to the same general written standards and criteria used to select other members of the governing body.

(4) The governing body shall confer with the resident association at each

of the provider's facilities before the subscriber officially joins the governing body.

(5) The Secretary may waive the requirements of this subsection for a provider in the process of decertifying as a provider, if the Secretary determines that there are no subscribers willing and able to serve on the governing body.

(b) (1) If a provider does not have a governing body, the provider shall appoint a select committee of its officers or partners to meet at least twice a year with the resident association at each of its facilities to address concerns of the subscribers and to ensure that the opinions of subscribers are relayed to all officers or partners of the provider.

(2) If a facility does not have a resident association, the committee shall meet with a reasonable number of representatives, not required to exceed fifteen, that the subscribers elect.

(c) As determined by the provider's governing body, the provider shall make available to subscribers either the nonconfidential portions of the minutes of each meeting of the governing body or a summary of the nonconfidential portions of the minutes, within 1 month of approval of the minutes.

§10–428.

(a) A provider shall establish an internal grievance procedure to address a subscriber's grievance.

(b) The internal grievance procedure shall at least:

(1) allow a subscriber or group of subscribers collectively to submit a written grievance to the provider;

(2) require the provider to send a written acknowledgment to the subscriber or group of subscribers within 5 days after receipt of the written grievance;

(3) require the provider to assign personnel to investigate the grievance;

(4) give a subscriber or group of subscribers who file a written grievance the right to meet with management of the provider within 30 days after receipt of the written grievance to present the grievance; and

(5) require the provider to respond in writing within 45 days after receipt of the written grievance regarding the investigation and resolution of the grievance.

(c) (1) Within 30 days after the conclusion of an internal grievance procedure established under this section, a subscriber, group of subscribers, or provider may seek mediation through one of the Community Mediation Centers in the State or another mediation provider.

(2) If a provider, subscriber, or group of subscribers seeks mediation under paragraph (1) of this subsection:

(i) the mediation shall be nonbinding; and

(ii) the provider, subscriber, or group of subscribers may not be represented by counsel.

§10–429.

A provider shall make readily available to its subscribers for review at the facility:

(1) copies of all materials that the provider submits to the Department that are required to be disclosed under the Public Information Act; and

(2) a copy of the most recent finalized budget of the facility.

§10–430.

All marketing materials, including disclosure statements, that state that part or all of the entrance fee is or may be refundable shall include a conspicuous disclaimer that states at least the following: "Carefully read the continuing care agreement for the conditions that must be satisfied before the provider is required to pay the entrance fee refund.".

§10–432.

(a) (1) Subsection (b)(2) of this section does not apply to a transfer of ownership or control of a person that owns or controls a facility, if:

(i) the transfer is part of a business reorganization; and

(ii) the same person or persons holding the right to control or holding a majority of ownership before the business reorganization will retain, directly or indirectly, the right to control or a majority of ownership, respectively, after the business reorganization.

(2) The provider shall notify the Department and the facility's subscribers 30 days before any reorganization described in paragraph (1) of this subsection.

(b) Unless the Department approves the sale or transfer in accordance with §§ 10–433 through 10–435 of this subtitle:

(1) except for the grant of a mortgage or deed of trust to an unrelated third party, a provider that holds a preliminary, initial, or renewal certificate of registration may not sell or otherwise transfer, directly or indirectly, ownership of a facility or any ownership interest in a facility; and

(2) a person with an ownership interest in or a right to control

the provider, through governing body appointments or contractual or similar arrangements, may not sell or otherwise transfer, directly or indirectly, the right to control or more than 50% of the ownership of a person that owns or controls a facility.

(c) Any series of sales or other transfers described in subsection (b) of this section that occur in a 12–month period shall be aggregated for purposes of this section and §§ 10–433 through 10–435 of this subtitle.

§10–433.

(a) (1) At least 90 days before the proposed effective date of a sale or other transfer, a provider subject to § 10-432(b) of this subtitle shall file with the Department a statement of intent to transfer ownership or control.

(2) At least 65 days before the proposed effective date of the sale or other transfer, a provider subject to § 10-432(b) of this subtitle and any proposed new provider shall give written notice of the proposed sale or other transfer, including notice of the place and time of the meeting required by § 10-434(b) of this subtitle, to the subscribers of the affected facility and the Department.

(b) (1) The written notice to the Department required under subsection (a)(2) of this section shall include:

(i) the name and address of the existing provider and any proposed new provider and the office of each to which comments may be sent under § 10-434 of this subtitle;

(ii) the name and address of the affected facility;

(iii) the organizational structure and management of the provider and the facility after the proposed sale or other transfer is completed, including:

1. if the provider is to be a corporation or limited liability company, its name, its state of incorporation or formation, and the name of the chief executive officer;

2. if the provider is to be a partnership, the names of the general partners, the state governing its formation, and the name of the primary individual responsible for managing it;

3. if the provider is to be an unincorporated association, the names of the members, the state governing its activities, and the name of the primary individual responsible for managing it;

4. if the provider is to be a trust, the trustee's name, the names of the owners of beneficial interests in the trust, the state that governs it, and the name of the primary individual responsible for overseeing its activities;

5. if the provider is to be a partnership that has a corporation or limited liability company as one or more of its general partners, the name of each corporation or limited liability company, its state of incorporation or formation, and the name of its chief executive officer; and

6. the name and occupation of each officer, director, trustee, general partner, principal, and each person who will have a 10% or greater equity or beneficial interest in the provider or in a person that owns or controls the provider;

(iv) a copy of the corporate charter, partnership agreement, articles of association, membership agreement, or trust agreement that will govern the legal organization of the provider after the sale or transfer;

(v) a statement of any affiliation with a religious, charitable, or other nonprofit organization after the proposed sale or transfer and the extent, if any, of the affiliate organization's responsibility for the financial and contractual obligations of the provider;

(vi) the name and address of any business or professional entity in which a person identified in item (iii)6 of this paragraph has a 10% or greater financial interest and that is likely to provide goods, premises, or services with a value of $10,000 or more a year to the facility or provider after the sale or transfer, and a description of the goods, premises, or services;

(vii) the name of the proposed manager or management company that will manage the day-to-day operations of the facility after the sale or other transfer, and a description of the business experience of the manager or company in operating or managing similar facilities;

(viii) a description of any matter in which a person identified in item (iii)6 of this paragraph:

1. has been convicted of a felony or pleaded nolo contendere to a felony charge, if the felony involved fraud, embezzlement, fraudulent conversion, or misappropriation of property;

2. has been held liable or enjoined in a civil action by final judgment, if the civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation as a fiduciary;

3. was subject to an effective injunctive or restrictive order of a court of record in an action that arose out of or related to business activity or health care, including an action that affected a license to operate a facility or service for senior, impaired, or dependent persons; or

4. within the past 10 years, had a state or federal license or permit suspended or revoked because of an action brought by a governmental unit arising out of or relating to business activity or health care, including actions affecting

a license to operate a facility or service for senior, impaired, or dependent persons;

(ix) a financial plan provided by the entity that will be the provider after the proposed sale or other transfer is completed in a form reasonably acceptable to the Department that demonstrates the projected effects of the sale or transfer on the financial operations of the provider and the facility, including any obligations of the provider to make payments in connection with the sale or transfer from the financial resources of the provider or the facility; and

(x) a statement by the entity that will be the provider after the proposed sale or transfer is completed that demonstrates that the sale or transfer is not likely to have an unreasonably adverse effect on:

1. the provider's financial stability; or

2. the provider's capacity to perform its continuing care agreement obligations to subscribers.

(2) In addition to the information required to be provided under paragraph (1) of this subsection, a provider subject to § 10-432(b) of this subtitle and any proposed new provider shall provide to the Department any other information that the Department requires to evaluate the proposed transaction.

(3) On request, the existing provider and any proposed new provider shall give to a subscriber of the affected facility the information included in the written notice to the Department under paragraph (1) of this subsection.

§10–434.

(a) Within 15 days after the notice required under § 10-433(a)(2) of this subtitle is given, subscribers may submit to the existing provider, any proposed new provider, and the Department written questions and comments about the proposed sale or transfer.

(b) (1) Within 25 days after the notice required under § 10-433(a)(2) of this subtitle is given, representatives of the existing provider and any proposed new provider shall hold a meeting with not more than 15 representatives chosen by the subscribers of the affected facility to discuss the proposed sale or transfer.

(2) The subscriber representatives shall give their names and addresses to the existing provider, any proposed new provider, and the Department.

(3) Representatives of the Department may attend the meeting.

(c) Within 10 days after the meeting required under subsection (b) of this section, subscribers may submit to the existing provider, any proposed new provider, and the Department additional written comments about the proposed sale or transfer.

§10–435.

(a) (1) After reviewing the information required by §§ 10-433 and 10-434 of this subtitle, the Department shall determine whether the sale or transfer satisfies the standard for approval set forth in subsection (b) of this section.

(2) The Department shall make the determination within 50 days after the date of the notice required under § 10-433(a)(2) of this subtitle unless extended by the Department for good cause.

(3) The Department shall notify the existing provider, any proposed new provider, and the subscriber representatives in writing of the determination and the reasons for it and, if applicable, that the Department intends to transfer the certificate of registration to the new provider.

(b) The Department shall approve a sale or other transfer of ownership or control unless the Department determines that the sale or transfer is likely to have an unreasonably adverse effect on:

(1) the financial stability of the provider; or

(2) the capacity of the provider to perform continuing care agreement obligations to subscribers.

(c) (1) In accordance with Title 10, Subtitle 2 of the State Government Article, the provider may appeal the Department's decision on the proposed sale or transfer.

(2) A person other than the provider may not appeal the Department's decision or be a party in interest to the proceedings.

(3) The Department shall give prompt notice of any appeal and of any decision issued in the appeal to the subscriber representatives.

(d) A sale or other transfer of ownership or control subject to this section and §§ 10-432 through 10-434 of this subtitle may not be completed until 15 days after the later of:

(1) the day the Department issues the notice required under subsection (a)(3) of this section of its decision to approve the sale or transfer; or

(2) if an appeal is taken under subsection (c) of this section, the day the administrative law judge issues a decision to allow the sale or transfer.

§10–436.

(a) This section does not apply to:

(1) a transaction undertaken under a contractual obligation in effect on

October 1, 1996;

(2) a transaction made in the ordinary course of business of operating a facility;

(3) a refund under a contract entered into in the ordinary course of business;

(4) a transfer of cash, securities, or other investment property in connection with an ordinary investment transaction;

(5) a grant of a mortgage, deed of trust, or security interest to an unrelated third party;

(6) a transaction involving an easement, right-of-way, road widening, or similar conveyance for the benefit of a public body or a utility;

(7) a transaction made for an expansion or renovation; or

(8) any other sale, transfer, or other disposition exempted by the Department by regulation.

(b) (1) A provider that holds a preliminary, initial, or renewal certificate of registration may not sell, transfer, or otherwise dispose of more than 10% of its total assets in any 12-month period unless the Department approves the sale, transfer, or disposition in accordance with §§ 10-437 and 10-438 of this subtitle.

(2) A provider may not sell, transfer, or otherwise dispose of assets equal to or less than 10% of its total assets if the sale, transfer, or disposition is likely, according to standards set by regulation, to have an unreasonably adverse effect on:

(i) the financial stability of the provider; or

(ii) the capacity of the provider to perform its obligations under its continuing care agreements.

(3) Determinations of total assets shall be based on the provider's latest certified financial statements available at the time the sale, transfer, or other disposition is made.

§10–437.

(a) A provider subject to § 10-436(b)(1) of this subtitle shall:

(1) at least 60 days before the sale, transfer, or other disposition, file with the Department a statement of intent to sell, transfer, or otherwise dispose of assets; and

(2) at least 30 days before the sale, transfer, or other disposition, give

written notice to the Department of the proposed sale, transfer, or other disposition of assets.

(b) The statement of intent required to be filed with the Department under subsection (a)(1) of this section shall include:

(1) identification of each asset to be sold, transferred, or otherwise disposed of;

(2) if the provider is subject to § 10-436(b)(1) of this subtitle because of a series of sales, transfers, or other dispositions that have exceeded cumulatively 10% of its total assets, identification of each asset that has been sold, transferred, or disposed of; and

(3) the reason for the sale, transfer, or other disposition identified in item (1) of this subsection.

(c) The notice to the Department required under subsection (a)(2) of this section shall include:

(1) a statement that demonstrates that the proposed sale, transfer, or other disposition is not likely to have an unreasonably adverse effect on:

(i) the financial stability of the provider; or

(ii) the capacity of the provider to perform its obligations under its continuing care agreements; and

(2) any other information that the Department requires.

§10–438.

(a) (1) After reviewing the information required by § 10-437 of this subtitle, the Department shall determine whether the sale, transfer, or other disposition satisfies the standard for approval set forth in subsection (b) of this section.

(2) The Department shall make its determination and notify the provider in writing within 25 days after the date of the notice required by § 10-437(a)(2) of this subtitle, unless extended by the Department for good cause.

(3) If the Department does not approve the proposed sale, transfer, or other disposition, the Department shall include the reasons for its determination in the written notice to the provider.

(b) The Department shall approve the sale, transfer, or other disposition of assets unless it determines that the sale, transfer, or disposition is likely to have an unreasonably adverse effect on:

(1) the financial stability of the provider; or

(2) the capacity of the provider to perform its obligations under its continuing care agreements.

(c) (1) By regulation, the Department shall adopt reasonable objective financial standards for a proposed sale, transfer, or other disposition of assets.

(2) If the Department determines that the provider has met the objective financial standards, the Department shall approve the proposed sale, transfer, or other disposition of assets.

(3) If the Department determines that the provider has not met the objective financial standards, the Department may approve a proposed sale, transfer, or other disposition of assets if it satisfies the requirements set forth in subsection (b) of this section.

(d) (1) In accordance with Title 10, Subtitle 2 of the State Government Article, the provider may appeal the Department's decision on the proposed sale, transfer, or other disposition of assets.

(2) A person other than the provider may not appeal the Department's decision or be a party in interest to the proceedings.

(e) A sale, transfer, or other disposition of assets subject to this part may not be completed until 5 days after the later of:

(1) the day the Department issues the notice required under subsection (a)(2) of this section of its decision to approve the sale, transfer, or other disposition; or

(2) if an appeal is taken under subsection (d) of this section, the day the administrative law judge issues a decision to allow the sale, transfer, or other disposition of assets.

§10–439.

A provider whose facility has been the subject of a conversion may not terminate or fail to renew a lease for an accommodation in order to enter into a continuing care agreement for that accommodation.

§10–440.

(a) A provider may not remove a record or asset of the provider related to the operation of a facility or the provision of services under a continuing care agreement from the State unless the Department consents in writing.

(b) Consent shall be based on the provider's submission of satisfactory evidence that the removal:

(1) will facilitate and make the operations of the provider more economical; and

(2) will not diminish the service or protection to be given to the provider's subscribers in the State.

§10–441.

(a) The Department may:

(1) inspect a facility that offers continuing care;

(2) examine the facility's books and records; and

(3) audit or observe a service provided under a continuing care agreement.

(b) If all or part of a facility is subject to licensure by the Department of Health and Mental Hygiene, the Department shall coordinate its inspections under this section with the Department of Health and Mental Hygiene to avoid duplication.

§10–443.

The provisions of Part IV of this subtitle are in addition to, and not in lieu of, other applicable laws.

§10–444.

(a) Except as provided in subsection (b)(25) of this section, a requirement of this section does not apply to any continuing care agreement entered into before the effective date of the requirement.

(b) In a form acceptable to the Department, each continuing care agreement shall:

(1) show the total consideration paid by the subscriber for continuing care, including the value of all property transferred, donations, entrance fees, subscriptions, monthly fees, and any other fees paid or payable by or on behalf of a subscriber;

(2) specify all services that are to be provided by the provider to each subscriber, such as food, shelter, medical care, nursing care, or other health related services, including in detail all items that each subscriber will receive, and whether the items will be provided for life or for a designated time period;

(3) designate the classes of subscribers according to types of payment plans;

(4) subject to subsection (c) of this section, describe the procedures to be followed by the provider when the provider temporarily or permanently changes the subscriber's accommodations within the facility or transfers the subscriber to another

health facility;

(5) describe the policies that will be implemented if the subscriber becomes unable to pay the monthly fees;

(6) state the policy of the provider concerning changes in accommodations and the procedure to implement that policy if the number of persons occupying an individual unit changes;

(7) provide in clear and understandable language, in boldface type, and in the largest type used in the body of the agreement:

(i) the terms governing the refund of any portion of the entrance fee if the provider discharges the subscriber or the subscriber cancels the agreement; and

(ii) whether monthly fees, if charged, will be subject to periodic increases;

(8) state the terms under which an agreement is canceled by the death of the subscriber;

(9) provide that charges for care paid in advance in a lump sum may not be increased or changed for the duration of the agreed–upon care;

(10) state that the provider represents that the subscriber has received, at least two weeks before signing the agreement:

(i) the current version of the written rules of the provider;

(ii) the continuing care agreement form, with the attachments, exhibits, and addenda; and

(iii) the current disclosure statement, with the attachments, exhibits, and addenda;

(11) describe the living quarters;

(12) if applicable, state the conditions under which a subscriber may assign a unit for the use of another individual;

(13) state the provider's religious or charitable affiliations and the extent, if any, to which the affiliate organization is responsible for the provider's financial and contractual obligations;

(14) state the subscriber's and provider's respective rights and obligations concerning:

(i) use of the facility; and

(ii) any real and personal property of the subscriber placed in the provider's custody;

(15) state that subscribers have the right to organize and operate a subscriber association at the facility and to meet privately to conduct business;

(16) state that there is an internal grievance procedure to address a subscriber's grievance;

(17) state the fee adjustments, if any, that will be made if the subscriber is voluntarily absent from the facility for an extended period of time;

(18) specify the circumstances, if any, under which the subscriber will be required to apply for Medicaid, Medicare, public assistance, or any public benefit program and whether the facility participates in Medicare or medical assistance;

(19) state that the subscriber received a copy of the latest certified financial statement at least two weeks before signing the agreement and that the subscriber has reviewed the statement;

(20) state that the subscriber acknowledges reviewing all of the terms of the entrance fee refund clauses and provisions contained in the continuing care agreement;

(21) provide that, on request, the provider will make available to the subscriber any certified financial statement submitted to the Department;

(22) if applicable, describe the conditions under which the provider may be issued an initial certificate of registration and the conditions under which the provider may use escrowed deposits, and state the amount of the subscriber's deposit;

(23) state that fees collected by a provider under the terms of a continuing care agreement may only be used for purposes set forth in the agreement;

(24) include one of the following model statements or a substantially similar statement:

(i) "The provider agrees that, for as long as the subscriber's continuing care agreement remains in effect, the provider shall only use fees paid by the subscribers of the community for purposes directly related to the construction, operation, maintenance, or improvement of the community.";

(ii) "The provider does not currently use fees paid by subscribers of the community for purposes other than those directly related to the construction, operation, maintenance, or improvement of the community, but the provider reserves the future right to use fees paid by subscribers of the community for purposes unrelated to the construction, operation, maintenance, or improvement of the community."; or

(iii) "The provider may use fees paid by subscribers of the community

for purposes unrelated to the construction, operation, maintenance, or improvement of the community, including for the furtherance of the provider's corporate mission, to distribute profits, or to benefit an affiliated community.";

(25) allow a subscriber to designate a beneficiary to receive any refundable portion of the entrance fee that is owed due to the death of the subscriber on or after the date of occupancy, if the designation is:

(i) in writing;

(ii) witnessed by at least two competent witnesses;

(iii) not contingent; and

(iv) specified in percentages and accounts for 100% of the refund due;

(26) state the funeral and burial services, if any, that the provider will provide;

(27) contain a table of contents;

(28) if the provider offers a continuing care agreement that promises a contractual entrance fee refund after occupancy, state whether the portion of the entrance fee to be refunded is held in trust or escrow for the subscriber after occupancy, and if so held, state where and how the funds are held;

(29) if the payment of a contractual entrance fee refund after occupancy is conditioned on the reoccupancy or recontracting of the subscriber's unit, state that the provider agrees to make reasonable efforts to satisfy the condition; and

(30) contain the following statement in boldface type and in the largest type used in the agreement: "A preliminary certificate of registration or certificate of registration is not an endorsement or guarantee of this facility by the State of Maryland. The Maryland Department of Aging urges you to consult with an attorney and a suitable financial advisor before signing any documents.".

(c) A subscriber's accommodations may be changed only to protect the health or safety of the subscriber or the general and economic welfare of other residents.

(d) A continuing care agreement may contain, in a form acceptable to the Department, any other appropriate provision to effectuate the purpose of the agreement.

(e) (1) This subsection applies if:

(i) a provider's continuing care agreement includes a provision to provide assisted living program services; and

(ii) the provider does not execute a separate assisted living agreement.

(2) In addition to any other requirement of this section, the continuing care agreement shall include the following provisions concerning the assisted living program:

(i) a statement of the level of care that the assisted living program is licensed to offer;

(ii) a description of the procedures to be followed by the provider for notifying the subscriber of the level of care the subscriber needs if the subscriber transfers to an assisted living program;

(iii) a statement indicating the options available to a subscriber if the subscriber's level of care, after admission to an assisted living program, exceeds the level of care for which the provider is licensed;

(iv) based on a sample list of assisted living program services that the Department of Health and Mental Hygiene maintains, a statement of which services are provided by the assisted living program and which services are not;

(v) a statement of the obligations of the provider and the subscriber or the subscriber's agent for handling the subscriber's finances;

(vi) a statement of the obligations of the provider and the subscriber or the subscriber's agent for disposition of the subscriber's property on the subscriber's discharge or death; and

(vii) the applicable rate structure and payment provisions covering:

1. all rates to be charged to the subscriber, including:

A. service packages;

B. fee-for-service rates; and

C. any other nonservice-related charges;

2. criteria to be used for imposing additional charges to provide additional services, if the subscriber's service and care needs change;

3. payment arrangements and fees, if known, for third-party services not covered by the continuing care agreement, but arranged for by the subscriber, the subscriber's agent, or the assisted living program;

4. identification of the persons responsible to pay all fees and charges and a clear indication of whether the person's responsibility is or is not limited

to the extent of the subscriber's funds;

5. a provision for notice at least 45 days before any rate increase, except for an increase necessitated by a change in the subscriber's medical condition; and

6. fair and reasonable billing and payment policies.

§10–445.

(a) (1) (i) If a provider's feasibility study has been approved under § 10–409 of this subtitle, the Department, within 120 days after receipt of a continuing care agreement or any other related agreement submitted by a provider, shall determine whether the agreement complies with the requirements of this subtitle.

(ii) At any time during the review process, the Department may submit comments to or request additional information from the provider to determine whether the agreement complies with the requirements of this subtitle and other applicable law.

(iii) If the Department submits comments or a request for additional information under subparagraph (ii) of this paragraph, the 120–day review period under subparagraph (i) of this paragraph is suspended.

(iv) On receipt of any requested information or modifications to the agreement necessitated by the Department's comments under subparagraph (iii) of this paragraph, the Department, within the number of days remaining in the 120–day review period, shall:

1. complete its review to determine whether the agreement meets the requirements of this subtitle and other applicable law identified by the Department in accordance with subparagraph (ii) of this paragraph; and

2. approve or disapprove the agreement.

(v) 1. If the Department does not approve the agreement, the Department shall notify the provider in writing, including citations to the specific provisions of law that the Department determined were not complied with in the agreement.

2. A provider may appeal the disapproval of an agreement under subparagraph (iv) of this paragraph under the provisions of Title 10, Subtitle 2 of the State Government Article.

(2) If the Department does not act within 120 days, the agreement is deemed approved.

(b) The provider shall maintain the continuing care agreement at the facility

and make it available for inspection by the Department of Health and Mental Hygiene under Title 19, Subtitle 18, of the Health – General Article and Title 10, Subtitle 3 of the Health – General Article.

(c) If a provider is seeking approval for a modification to an approved continuing care agreement or other related agreement, the Department shall limit its review to:

(1) the section of the agreement being modified and any sections directly affected by the modification; and

(2) any section of the agreement that may have been affected by a change in the law or a regulation that was enacted after the Department approved the agreement.

(d) If the continuing care agreement is not an extensive agreement or a modified agreement and the provider uses a separate assisted living agreement:

(1) the provider is not required to submit the assisted living agreement or any requests for modifications to the Department for approval; and

(2) (i) the provider shall state in its continuing care agreement that, if the subscriber wishes to transfer to assisted living, the subscriber will be required to sign an additional separate agreement for assisted living services that will not be approved by the Department for compliance with legal requirements or coordination with the continuing care agreement; and

(ii) the provider may include a provision in its continuing care agreement stating that assisted living contracts and services are regulated by the Office of Health Care Quality within the Department of Health and Mental Hygiene.

(e) If the continuing care agreement is not an extensive agreement or a modified agreement and the provider uses a separate comprehensive care agreement:

(1) the provider is not required to submit the comprehensive care agreement or any requests for modifications to the Department for approval; and

(2) (i) the provider shall state in its continuing care agreement that, if the subscriber wishes to transfer to comprehensive care, the subscriber will be required to sign an additional separate agreement for comprehensive care services that will not be approved by the Department for compliance with legal requirements or coordination with the continuing care agreement; and

(ii) the provider may include a provision in its continuing care agreement stating that comprehensive care facilities contracts and services are regulated by the Office of Health Care Quality within the Department of Health and Mental Hygiene.

§10–446.

(a) A subscriber may rescind a continuing care agreement for any reason before the date of occupancy by the subscriber.

(b) (1) A continuing care agreement is automatically canceled if, before the date of occupancy:

(i) the subscriber dies;

(ii) the provider determines that the subscriber is ineligible for admission to the facility; or

(iii) the subscriber terminates the continuing care agreement because of a substantial change in the subscriber's physical, mental, or financial condition.

(2) Within 30 days after a continuing care agreement is canceled under this subsection, the subscriber or the subscriber's legal representative shall receive a full refund of all money paid to the provider, less:

(i) a processing fee approved by the Department; and

(ii) any special additional costs incurred by the provider due to modifications in the structure or furnishings of the unit specifically requested by the subscriber, if:

1. the costs do not exceed the costs of modification and the reasonable costs of restoration actually incurred by the provider; and

2. the costs were set forth in writing in a separate addendum to the agreement signed by the subscriber.

(c) (1) If the subscriber rescinds the continuing care agreement within 90 days after entering into the agreement and before the date of occupancy for any reason other than the reasons specified in subsection (b)(1) of this section, the provider shall refund the amount described in subsection (b)(2) of this section to the subscriber or the subscriber's legal representative within 30 days after the date of rescission.

(2) If the subscriber rescinds the continuing care agreement more than 90 days after entering into the agreement and before the date of occupancy for any reason other than the reasons specified in subsection (b)(1) of this section, the provider may retain up to 25% of the subscriber's entrance fee deposit.

(d) (1) A subscriber may rescind a continuing care agreement at any time if a term of the agreement violates this subtitle and the subscriber is injured by the violation.

(2) The subscriber is entitled to treble damages for extensive injuries

arising from a violation.

(e) (1) An applicant for admission to a facility who withdraws the application before executing a continuing care agreement shall receive a refund of all money paid to the provider except a processing fee approved by the Department.

(2) The refund shall be paid within 60 days after the applicant withdraws the application.

§10–447.

(a) (1) In this section the following words have the meanings indicated.

(2) "Extensive agreement" means a continuing care agreement under which the provider promises to provide residential facilities, meals, amenities, and long-term care services in a licensed assisted living program or comprehensive care program:

(i) for as long as the subscriber needs the services; and

(ii) for no increase in the subscriber's entrance fee or periodic fees, except for an adjustment to account for increased operating costs caused by inflation or other factors unrelated to the individual subscriber.

(3) "Modified agreement" means a continuing care agreement:

(i) under which the provider promises to provide residential facilities, meals, amenities, and a limited amount of long-term care services in a licensed assisted living program or comprehensive care program:

1. for as long as the subscriber needs the services; and

2. for no increase in the subscriber's entrance fee or periodic fees, except for an adjustment to account for increased operating costs caused by inflation or other factors unrelated to the individual subscriber; and

(ii) that provides that long-term care services in a licensed assisted living program or comprehensive care program beyond the limited amount of services to be provided under item (i) of this paragraph will be provided at a per diem, fee-for-service, or other agreed-upon rate.

(b) (1) A provider shall provide the assisted living services a subscriber needs in accordance with paragraph (2) of this subsection if:

(i) the subscriber's continuing care agreement is an extensive or modified agreement that promises the provider will provide assisted living services; and

(ii) the provider does not have an assisted living bed available at the facility when the subscriber needs the promised care.

(2) The provider shall provide assisted living services required under paragraph (1) of this subsection to a subscriber:

(i) at the same rate the subscriber would pay if an assisted living bed were available; and

(ii) at the provider's option:

1. in the subscriber's independent living unit; or

2. in a nearby licensed assisted living facility.

(c) (1) A provider shall provide the comprehensive care services a subscriber needs in accordance with paragraph (2) of this subsection if:

(i) the subscriber's continuing care agreement is an extensive or modified agreement that promises the provider will provide the subscriber with comprehensive care services if the subscriber needs them; and

(ii) the provider does not have a comprehensive care bed available when the subscriber needs the promised care.

(2) The provider shall provide the services required under paragraph (1) of this subsection:

(i) at the same rate the subscriber would pay if a comprehensive bed were available; and

(ii) at the provider's option:

1. in the subscriber's independent or assisted living unit; or

2. in a nearby licensed comprehensive care facility.

§10–448.

(a) A continuing care agreement may not allow dismissal or discharge of the subscriber from the facility providing care before the agreement expires unless:

(1) the provider has just cause for the dismissal or discharge; and

(2) the provider gives the subscriber at least 60 days' advance notice.

(b) If a provider terminates a subscriber's continuing care agreement for just cause, the provider shall pay the subscriber a refund calculated in accordance with subsection (c) of this section, within 60 days after the later of:

(1) the date of dismissal or discharge; or

(2) the date the subscriber vacates the unit.

(c) (1) The subscriber's refund shall equal the entrance fee divided by the subscriber's years of expected lifetime at admission, multiplied by the subscriber's years of expected lifetime at dismissal or discharge.

(2) A subscriber's years of expected lifetime at admission and at dismissal or discharge shall be computed based on the appropriate tables most recently published by the U.S. Department of Health and Human Services at the time of dismissal or discharge.

§10–449.

(a) A continuing care agreement shall allow a subscriber to terminate the agreement by giving a written termination notice to the provider.

(b) If a continuing care agreement is terminated by the subscriber's election or death within the first 90 days of occupancy, the provider shall pay any contractual entrance fee refund within 30 days after the earlier to occur of:

(1) the recontracting of the subscriber's unit by:

(i) another subscriber for whom an entrance fee has been paid; or

(ii) another party who is not a subscriber; or

(2) the later to occur of:

(i) the 90th day after the date the written termination notice is given or the date of death; or

(ii) the day the independent living units at the facility have operated at 95% of capacity for the previous 6 months.

(c) If a continuing care agreement is terminated by the subscriber's election or death after the first 90 days of occupancy, the provider shall pay any contractual entrance fee refund within 60 days after the subscriber's death or the effective date of termination, if on the date of death or at any time between the date the written termination notice is given and the effective date of termination:

(1) the subscriber resides in a unit at a higher level of care than the level of care in which the subscriber resided on initially entering the facility; and

(2) the last unit in which the subscriber resided at the initial level of care on entering the facility has been occupied by or reserved for another subscriber who has paid an entrance fee.

(d) This section does not prohibit a provider from requiring that a subscriber's unit be vacated before any contractual entrance fee refund is paid as a result of the subscriber's election to terminate a continuing care agreement.

§10–450.

An act, agreement, or statement by a subscriber or by an individual purchasing care for a subscriber under an agreement to furnish care to the subscriber is not a valid waiver of any provision of this subtitle intended for the benefit or protection of the subscriber or the individual purchasing care for the subscriber.

§10–453.

This part applies only to continuing care at home operations.

§10–454.

(a) The Department shall adopt regulations that:

(1) set standards for continuing care at home providers; and

(2) provide for the certification of continuing care at home providers and the annual renewal of certificates of registration.

(b) In addition to the provisions required under subsection (a) of this section, the regulations adopted by the Department shall, at a minimum:

(1) provide for and encourage the establishment of continuing care at home programs;

(2) for an individual who is employed by or under contract with a continuing care at home provider and who will enter a subscriber's home to provide continuing care at home services:

(i) set minimum requirements;

(ii) require a criminal history records check, if the individual will have routine, direct access to a subscriber; and

(iii) require the provider to screen and verify the individual's character references;

(3) establish standards for the renewal of certificates of registration;

(4) establish standards for entrance fees, deposits, and the number of executed agreements necessary to begin operations;

(5) establish conditions for the release of deposits and entrance fees from escrow accounts;

(6) establish standards for when and how a subscriber or provider may rescind a continuing care at home agreement before continuing care at home services are provided to the subscriber;

(7) allow a subscriber to rescind a continuing care at home agreement at any time if the terms of the agreement violate this subtitle; and

(8) establish that a provider may terminate an agreement or discharge a subscriber only for just cause and establish procedures to carry out the termination or discharge.

§10–455.

(a) A provider may not collect deposits to provide continuing care at home services until the Department approves a feasibility study.

(b) A provider that intends to develop a continuing care at home program and provide continuing care at home services shall file a statement of intent with the Department at least 30 days before submitting the feasibility study required under this section.

(c) A feasibility study shall:

(1) be filed in a form satisfactory to the Department; and

(2) include at least the following information:

(i) a statement of the purpose of the program and the need for the proposed services;

(ii) documentation of the financial resources of the provider;

(iii) a plan demonstrating the financial feasibility of the proposed program, including future funding sources;

(iv) an actuarial forecast that has been reviewed by a qualified actuary;

(v) a study demonstrating the proposed market for the program;

(vi) the form and substance of any proposed advertisements, advertising campaigns, or other promotional materials for the program that is available at the time of filing;

(vii) a detailed statement of the covered services; and

(viii) any other information that the Department requires.

(d) The Department shall approve a feasibility study filed under this section if

the Department determines that:

(1) the proposed use of new or existing health facilities is not inconsistent with the State health plan;

(2) a reasonable financial plan has been developed to provide continuing care at home services, including the number of agreements to be executed before beginning operations and the criteria to release funds from escrow;

(3) a market for the continuing care at home program appears to exist;

(4) the feasibility study was prepared by a recognized authority;

(5) the provider has submitted all proposed advertisements, advertising campaigns, and other promotional materials for the program;

(6) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead;

(7) the actuarial forecast supports the market for the program;

(8) the approved escrow agreement and deposit agreement state the conditions for the release of deposits and entrance fees from escrow;

(9) a copy of the escrow agreement executed by the provider and the financial institution has been filed with the Department; and

(10) any other information requested by the Department has been submitted and approved.

§10–456.

(a) A provider may collect deposits from prospective subscribers if:

(1) the Department has approved the provider's feasibility study; and

(2) the provider maintains the funds collected in an escrow account.

(b) Deposits collected under subsection (a) of this section shall be held in escrow until:

(1) the provider has been issued a certificate of registration under § 10-458 of this subtitle; or

(2) a later time that the Department may set by regulation.

§10–457.

(a) A provider may not enter into an agreement to provide continuing care at home services until the Department issues a preliminary certificate of registration to the provider.

(b) An application for a preliminary certificate of registration shall:

(1) be filed in a form satisfactory to the Department; and

(2) include at least the following information:

(i) a copy of the proposed continuing care at home agreement, which shall include the following statement set forth in print no smaller than the largest type used in the body of the agreement:

"A certificate of registration is not an endorsement or guarantee of this continuing care at home provider by the State of Maryland. The Maryland Department of Aging urges you to consult an attorney and a suitable financial advisor before signing any documents.";

(ii) the form and substance of any proposed advertisements, advertising campaigns, or other promotional material for the program that is available at the time of filing the application and that has not been filed previously with the Department; and

(iii) any other information that the Department requires.

(c) The Department shall issue a preliminary certificate of registration to a provider if the Department determines that:

(1) the proposed continuing care at home agreement is satisfactory;

(2) the provider has submitted all proposed advertisements, advertising campaigns, and other promotional materials for the program;

(3) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead;

(4) the information and documents submitted with the feasibility study under § 10-455 of this subtitle are current and accurate or have been updated to make them accurate; and

(5) the provider has submitted any other information that the Department requests.

§10–458.

(a) A provider may not provide continuing care at home services until the Department issues a certificate of registration to the provider.

(b) An application for a certificate of registration shall:

(1) be filed in a form satisfactory to the Department; and

(2) include at least the following information:

(i) verification that the required number of agreements has been executed and the corresponding deposits collected;

(ii) the form and substance of any proposed advertisements, advertising campaigns, or other promotional material for the program that are available at the time of filing and that have not been filed previously with the Department;

(iii) verification that any other license or certificate required by other appropriate State units has been issued to the provider; and

(iv) any other information that the Department requires.

(c) The Department shall issue a certificate of registration to a provider if the Department determines that:

(1) the information and documents submitted with the feasibility study and application for a preliminary certificate of registration are current and accurate or have been updated to make them accurate;

(2) the required number of agreements has been executed and the corresponding deposits collected;

(3) any other license or certificate required by other appropriate State units has been issued to the provider;

(4) the provider has submitted all proposed advertisements, advertising campaigns, and other promotional materials for the program;

(5) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead; and

(6) the provider has submitted any other information that the Department required.

(d) If a provider intends to advertise before the Department issues a certificate of registration under subsection (c) of this section, the provider shall submit to the

Department any advertisement, advertising campaign, or other promotional materials before using it.

(e) If a certificate of registration is not issued to a provider within 24 months after the Department approves a feasibility study, or a longer time allowed by the Department for good cause shown, the provider shall refund all deposits collected and stop offering continuing care at home services under that application.

§10–459.

(a) (1) Each year, within 120 days after the end of a provider's fiscal year, the provider shall file an application for a renewal certificate of registration with the Department.

(2) An application shall:

(i) be filed in a form satisfactory to the Department; and

(ii) contain any reasonable and pertinent information that the Department requires.

(b) The Department shall issue a renewal certificate of registration if the Department determines that:

(1) all required documents have been filed and are satisfactory;

(2) any revised agreements for continuing care at home services meet the Department's requirements;

(3) the proposed use of new or existing health facilities is not inconsistent with the State health plan;

(4) the provider has submitted all proposed advertisements, advertising campaigns, and other promotional materials for the program; and

(5) the form and substance of all advertisements, advertising campaigns, and other promotional materials submitted are not deceptive, misleading, or likely to mislead.

§10–460.

(a) For cause, the Department may:

(1) deny a feasibility study approval; or

(2) deny, suspend, or revoke a preliminary, initial, or renewal certificate of registration.

(b) (1) Grounds for a denial, suspension, or revocation include:

(i) violation of this subtitle;

(ii) violation of a regulation the Department adopts under this subtitle;

(iii) misrepresentation; or

(iv) submission of a false financial statement.

(2) The Department shall set forth in writing its reasons for a denial, suspension, or revocation.

(c) Title 10, Subtitle 2 of the State Government Article governs the appeal of a denial, revocation, or suspension.

§10–463.

In this part, "Committee" means the Financial Review Committee established in § 10-464 of this subtitle.

§10–464.

There is a Financial Review Committee in the Department.

§10–465.

(a) (1) The Committee consists of seven members appointed by the Secretary.

(2) Of the seven members:

(i) two shall be knowledgeable in the field of continuing care;

(ii) two shall be certified public accountants;

(iii) one shall be from the financial community; and

(iv) two shall be consumer members.

(3) In appointing the consumer members, the Secretary shall give a preference to subscribers of continuing care facilities.

(b) (1) The term of a member is 3 years.

(2) The terms of members are staggered as required by the terms provided for members on October 1, 2007.

(3) A member may serve consecutive terms.

(c) The Committee shall elect its chair.

(d) A member:

(1) may not receive compensation as a member of the Committee; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) A member is immune from civil liability as provided in § 5-514 of the Courts Article.

(f) A member may not participate in a review of a provider's financial condition if that member has an interest, as defined under the Maryland Public Ethics Law in § 5–101 of the General Provisions Article, in the provider.

(g) The deliberations of the Committee and communications between the Department and the Committee, including recommendations of the Committee, shall be confidential.

§10–466.

(a) (1) The Department may refer to the Committee for its consideration:

(i) a provider's application for a renewal certificate of registration after review by the Department; or

(ii) a finding of possible financial difficulty, at any time.

(2) The Department shall provide to the Committee any materials the Department considers necessary.

(b) (1) The Committee shall review the referral from the Department and may request additional information from the Department.

(2) Except as provided in subsection (c) of this section, within 45 days after receipt of a referral, the Committee shall notify the Department in writing whether the Committee recommends that the Department:

(i) find the provider in financial difficulty; and

(ii) find that the financial difficulty, if any, includes a significant risk of financial failure in accordance with § 10-469 of this subtitle.

(3) In making a recommendation to the Department, the Committee shall state the reason for the recommendation.

(c) (1) The Committee may request from the Secretary one 30-day extension of the deadline under subsection (b)(2) of this section.

(2) The Secretary may grant or deny the extension.

§10–467.

(a) Within 25 days after receipt of the Committee's recommendations, the Department shall consider the recommendations and make a final determination of whether financial difficulty exists and, if so, whether there is a significant risk of financial failure in accordance with § 10-469 of this subtitle.

(b) If the Department determines that the provider is in financial difficulty it shall immediately notify the provider by certified mail, return receipt requested, and inform the provider whether the Department has determined that there is a significant risk of financial failure.

(c) The provider shall:

(1) advise its subscribers of the Department's determination in a meeting to be held by the provider with representatives of the subscribers;

(2) hold the meeting within 10 days after the provider's receipt of notice from the Department; and

(3) advise the Department of the date, time, and location of the meeting.

§10–468.

(a) (1) A provider notified of financial difficulty by the Department shall prepare and submit to the Department for its approval a 5-year financial plan to correct the causes of the financial difficulty.

(2) The financial plan shall be submitted within 60 days after receipt of notification.

(3) The provider may request one 30-day extension from the Secretary.

(4) The Secretary may grant or deny the extension.

(b) (1) The Department shall respond to the provider within 60 days after receipt of the proposed financial plan.

(2) The Department may:

(i) work with the provider to establish the financial plan; and

(ii) consult with the Committee before approving the financial plan.

(c) (1) On approval, the financial plan shall be implemented.

(2) The provider shall make available to its subscribers copies of its approved financial plan.

(d) The provider shall:

(1) submit to the Department an annual progress report for the term of its financial plan; and

(2) revise its financial plan if the Department determines that revisions are necessary.

(e) The Department may withhold the renewal certificate of registration or withdraw a preliminary, initial, or renewal certificate of registration if:

(1) the provider does not prepare a financial plan;

(2) the provider is unwilling or unable to prepare a financial plan;

(3) the financial plan is inadequate to correct the current or impending financial condition that necessitated the financial plan; or

(4) the provider fails to implement the financial plan.

§10–469.

The Department may determine that there exists a significant risk of the financial failure of a provider based on one or more of the following findings or circumstances:

(1) the provider has failed to meet loan covenants that give a lender or a bond trustee the option to exercise remedies on its collateral;

(2) an actuarial report has been provided to the Department reflecting significant underfunding of future liabilities that are unlikely to be readily addressed;

(3) there is a significant shortfall by the provider in maintaining required reserves for a significant period of time;

(4) a significant balloon payment or future loan payment will become due within the next 12 months and the provider is unable to demonstrate that it will obtain a modification from its lender, have the resources to make the payment, or have the ability to refinance;

(5) there has been a significant decline in the occupancy rate that is likely to have a material adverse financial impact on the provider;

(6) there has been a material adverse change in debt service coverage ratio for an extended period of time that reduces the ratio to less than 1.0;

(7) there has been a significant decline in days cash on hand that is unrelated to additions to property, plant, and equipment or other community enhancements and that could result in an inability to pay obligations of the provider as they become due;

(8) there has been a significant increase in the operating ratio, adjusted for unrealized gains and losses on investments, that could result in the inability of the provider to meet its obligations; or

(9) the refusal or inability of the provider to provide accurate information or data required to be submitted to the Department under this subtitle and related regulations.

§10–472.

(a) In this part the following words have the meanings indicated.

(b) "Creditor" means a person with a claim against a provider.

(c) "Delinquency proceeding" means a proceeding under this subtitle to liquidate, rehabilitate, reorganize, or conserve a provider.

(d) "General assets" means:

(1) all property that is not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class of persons;

(2) to the extent that property of a provider is specifically encumbered, the amount of the property or its proceeds that exceeds the amount necessary to discharge the encumbrance; and

(3) assets held in trust and assets held on deposit for the security or benefit of all subscribers and creditors in the United States.

(e) "Receiver" includes a conservator, rehabilitator, and liquidator.

(f) (1) "Secured claim" means a claim that:

(i) is secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; or

(ii) has become a lien on specific assets through judicial process.

(2) "Secured claim" does not include a special deposit claim or a claim against general assets.

(g) (1) "Special deposit claim" means a claim secured by a deposit required by law for the security or benefit of a limited class of persons.

(2) "Special deposit claim" does not include a claim against general assets.

(h) "Transfer" means:

(1) the sale or other direct or indirect disposition of property or an interest in property;

(2) the fixing of a lien on property or an interest in property; or

(3) the retention of a security title to property delivered to a debtor.

§10–473.

Notwithstanding any other provision of law and subject to § 10-493 of this subtitle, a delinquency proceeding is the exclusive method of liquidating, rehabilitating, reorganizing, or conserving a provider.

§10–474.

The Secretary, deputy secretary, special deputy secretary, or any person acting as receiver in a rehabilitation, liquidation, or conservation of a provider as a result of a court order shall have the same immunity from liability that the Maryland Insurance Commissioner, deputy commissioner, special deputy commissioner, or any person acting as receiver in a rehabilitation, liquidation, or conservation of an insurer would have under § 5-410 of the Courts Article.

§10–475.

(a) (1) This subsection applies even if a paper or instrument is not:

(i) executed by the Secretary or a deputy, employee, or attorney of record of the Secretary; and

(ii) connected with the commencement of an action or proceeding by or against the Secretary or with the subsequent conduct of the action or proceeding.

(2) Subject to subsection (b) of this section, the Secretary may not be required to pay to a public officer in the State a fee for filing, recording, or issuing a transcript or certificate or for authenticating a paper or instrument that relates to the exercise by the Secretary of a power or duty of the Secretary under this subtitle.

(b) (1) The Secretary or deputy secretary, when acting as receiver or ancillary receiver under this subtitle, shall pay all court costs out of the assets of the provider before any distribution to creditors or termination of rehabilitation.

(2) In all cases, court costs and those specified in subsection (a) of this section shall:

(i) be charged in the accounts of the Secretary to the court; or

(ii) be paid by the provider as a condition of termination of the action or proceeding.

§10–476.

(a) (1) In a delinquency proceeding in which the Secretary has been appointed receiver, the Secretary may:

(i) appoint one or more special deputy secretaries to act for the Secretary; and

(ii) employ counsel, clerks, and assistants.

(2) Compensation of the special deputies, counsel, clerks, and assistants and all expenses of taking possession of the provider and of conducting the delinquency proceeding shall be:

(i) set by the Secretary, subject to approval by the court; and

(ii) paid out of the assets or funds of the provider.

(3) Within the limits of duties imposed on a special deputy concerning a delinquency proceeding, the special deputy:

(i) has all powers given to the receiver; and

(ii) in the exercise of those powers, is subject to all the duties imposed on the receiver concerning the delinquency proceeding.

(b) In a civil proceeding filed against a special deputy secretary appointed under this subtitle, the special deputy secretary is entitled to representation by the Attorney General as specified in Title 12, Subtitle 3, Part II of the State Government Article.

§10–477.

(a) The Circuit Court of Baltimore City:

(1) has exclusive original jurisdiction over delinquency proceedings; and

(2) may issue all necessary and proper orders to carry out this subtitle.

(b) If service is made in accordance with the Maryland Rules or other applicable law, a court with subject matter jurisdiction over an action brought under this subtitle also has jurisdiction over:

(1) an officer, director, manager, trustee, organizer, promoter, or attorney in fact of a provider against which a delinquency proceeding has been commenced, in an action resulting from or incidental to the person's relationship with the provider;

(2) a person that, at the time of or after commencement of the delinquency proceeding, held or was in control of assets in which the receiver claims an interest on behalf of the provider, in an action concerning the assets of the provider; and

(3) a person obligated to the provider in any way, in an action on or incidental to the obligation.

(c) The venue of all delinquency proceedings is in Baltimore City.

§10–478.

(a) The Secretary shall commence a delinquency proceeding against a provider by applying to the court for an order that directs the provider to show cause why the court should not grant the relief requested.

(b) (1) The court may consider an application for commencement of a delinquency proceeding only if the application is filed by the Secretary in the name of the State.

(2) After a hearing under the terms of the show cause order, the court:

(i) shall grant or deny the application; and

(ii) may order other relief as the nature of the case and the interests of the creditors, stockholders, members, subscribers, or the public may require.

§10–479.

(a) The Secretary may apply to the court for an order that directs the Secretary to conserve or rehabilitate a provider, if the provider:

(1) is a provider for which the Department has made a determination of significant risk of financial failure under Part VII of this subtitle;

(2) has refused to submit to the Secretary or a deputy or examiner of the Secretary, for reasonable examination, any of the property, books, records, accounts, or affairs of the provider, or of a subsidiary or related company of the provider within the provider's control;

(3) has concealed or removed its assets or records;

(4) has willfully violated its charter, articles of incorporation, a State law, or an order of the Secretary;

(5) after reasonable notice, has failed promptly and effectively to terminate the employment, status, and influence over the management of the provider of a person that has executive authority in fact over the provider and has refused to be examined under oath about the affairs of the provider in the State or elsewhere;

(6) has been or is the subject of an application for appointment of a receiver, trustee, custodian, sequestrator, or similar fiduciary of the provider or its property in an action that was not filed under this subtitle, regardless of whether the

appointment:

(i) has been made;

(ii) may deny the courts of the State jurisdiction; or

(iii) may prejudice an orderly delinquency proceeding under this subtitle;

(7) has consented to the order for conservation or rehabilitation through a majority of its directors, stockholders, members, or subscribers;

(8) has failed to pay a final judgment rendered against it in the State on a continuing care agreement issued or assumed by the provider, within 60 days after the latest of:

(i) the day on which the judgment became final;

(ii) the day on which the time for taking an appeal expired; or

(iii) the day on which an appeal was dismissed before final termination;

(9) after examination by the Secretary, is found to be in a condition in which further transaction of its business will be hazardous to its subscribers, bondholders, creditors, or the public;

(10) has failed to remove a person that has executive authority in fact over the provider after the Secretary has found that person to be dishonest or untrustworthy in a manner that may affect the business of the provider;

(11) has reasonable cause to know, or should have known, that there has been:

(i) embezzlement of funds from the provider;

(ii) wrongful sequestration or diversion of assets of the provider;

(iii) forgery or fraud that affects the provider; or

(iv) other illegal conduct in, by, or with respect to the provider;

(12) is controlled directly or indirectly by a person that the Secretary finds to be untrustworthy; or

(13) has failed to file a financial report required by law within the time allowed by law and, after written demand by the Secretary, has failed to give an immediate and adequate explanation.

(b) (1) If the appointment of the Secretary as receiver is not then in effect, and even if no previous order has directed the Secretary to rehabilitate a provider, the Secretary may apply to the court for an order that appoints the Secretary as receiver and that directs the Secretary to liquidate the provider if the provider:

(i) has not done business for at least 1 year;

(ii) is a provider determined to have a significant risk of financial failure under Part VII of this subtitle and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute an action or proceeding to liquidate its business or affairs, to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this title;

(iii) is doing business in a fraudulent manner; or

(iv) is in a condition in which further rehabilitation efforts on any grounds specified in subsection (a) of this section appear to be useless.

(2) If at any time during a rehabilitation proceeding the Secretary determines that further efforts to rehabilitate the provider would be useless, the Secretary may apply to the court for an order of liquidation.

§10–480.

(a) (1) An order to rehabilitate a provider shall:

(i) appoint the Secretary as rehabilitator;

(ii) direct the Secretary:

1. to take possession of the property of the provider and conduct the business of the provider under the general supervision of the court; and

2. to take action the court directs to remove the causes and conditions that have made rehabilitation necessary;

(iii) vest title to all property of the provider in the rehabilitator; and

(iv) require the rehabilitator to make accountings to the court that:

1. are at intervals as the court specifies in its order, but not less frequently than two times each year; and

2. include the opinion of the rehabilitator about the likelihood of success of the rehabilitation.

(2) Issuance of an order of rehabilitation:

(i) does not constitute an anticipatory breach of any contract of the

provider; and

(ii) is not grounds for retroactive revocation or retroactive cancellation of a contract of the provider, unless the rehabilitator revokes or cancels the contract.

(b) (1) Subject to paragraph (2) of this subsection, the Secretary, or an interested person on due notice to the Secretary, may apply to the court at any time for an order that:

(i) terminates a rehabilitation proceeding; and

(ii) allows the provider to resume possession of its property and the conduct of its business.

(2) An order under this subsection may not be issued unless, after a hearing, the court determines that the purposes of the rehabilitation proceeding have been fully accomplished.

(c) (1) An order to liquidate the business of a provider shall direct the Secretary promptly to:

(i) take possession of the property of the provider;

(ii) liquidate the business of the provider;

(iii) deal with the property and business of the provider in the name of the Secretary or in the name of the provider, as the court directs; and

(iv) notify each creditor that may have a claim against the provider to present the creditor's claim.

(2) The Secretary may apply for, and the court may issue, an order to dissolve the corporate existence of a provider:

(i) on application of the Secretary for an order to liquidate the provider; or

(ii) at any time after the court has granted the order of liquidation.

(d) An order to conserve the assets of a provider shall require the Secretary promptly to take possession of and conserve the property of the provider in the State, subject to further direction by the court.

§10–481.

(a) In this section, "appointed receiver" means a person, other than the Secretary, that the court appoints as a conservator, rehabilitator, or receiver under this section.

(b) (1) On motion of the court or the Secretary, the court may issue an order that appoints or substitutes a person other than the Secretary as conservator, rehabilitator, or receiver:

(i) on initial application by the Secretary for an order to appoint the Secretary as conservator, rehabilitator, or receiver under this subtitle; or

(ii) at any time during the course of a conservatorship, rehabilitation, or receivership under this subtitle.

(2) An appointed receiver has the same powers and duties that the Secretary has under this subtitle as conservator, rehabilitator, or receiver.

(c) (1) In addition to any other report required by the court, the court shall require an appointed receiver at least quarterly to file with the Secretary and court a report about:

(i) the status of the conservatorship, rehabilitation, or receivership; and

(ii) the activities of the appointed receiver since the last report filed under this paragraph.

(2) The report required under paragraph (1) of this subsection at a minimum shall include:

(i) information of the character required by Title 13 of the Maryland Rules that applies to receivers generally;

(ii) any other information necessary to provide a complete report on the financial affairs and condition of the conservatorship, rehabilitation, or receivership;

(iii) a complete account of all efforts by the appointed receiver since the last report:

1. to sell or dispose of the remaining business or assets of the provider; or

2. to otherwise bring to a prompt conclusion the conservatorship, rehabilitation, or receivership; and

(iv) copies of any actuarial or other evaluations of the business and assets under the control of the appointed receiver.

(3) The report shall be audited unless for good cause the court waives the audit.

(d) Subject to any protective order that the court considers appropriate, information filed under seal shall be provided to the Secretary.

(e) The appointed receiver shall give the Secretary full access to all documents and records related to the conservatorship, rehabilitation, or receivership that are in the possession of the appointed receiver.

(f) The Secretary may be a party to a conservatorship, rehabilitation, or receivership for which there is an appointed receiver.

(g) (1) Subject to approval of the court, the Secretary may negotiate for sale of all or part of the assets or business of the provider placed in conservatorship, rehabilitation, or receivership.

(2) The appointed receiver:

(i) shall cooperate fully in any sales negotiation under paragraph (1) of this subsection; and

(ii) may object to the terms of a sale of the assets or business of the provider that results from the negotiation.

(3) After notice and an opportunity to be heard, the court may limit the efforts of the Secretary to undertake or continue negotiations for the sale of the assets or business of the provider if the negotiations would impair the ability of the appointed receiver to engage in similar negotiations or discharge other responsibilities.

(h) (1) If the Secretary determines that an appointed receiver is not adequately discharging the duties and responsibilities of the position, the Secretary may file with the court an application that seeks to discharge the appointed receiver and to appoint the Secretary as conservator, rehabilitator, or receiver or to appoint another receiver.

(2) If the Secretary establishes by a preponderance of the evidence that grounds exist for discharge of an appointed receiver, the court shall grant the application of the Secretary to discharge the appointed receiver and to appoint the Secretary as conservator, rehabilitator, or receiver or to appoint another receiver.

§10–482.

Within 15 days after appointment as receiver or conservator for a provider against which a delinquency proceeding has been commenced, the receiver or conservator shall notify each subscriber of the provider, by letter or other means approved by the court, of the commencement of the delinquency proceeding and of the possibility that the continuing care agreement of the subscriber may be canceled.

§10–483.

An appeal may be taken to the Court of Special Appeals from:

(1) an order that grants or refuses rehabilitation, liquidation, or conservation; and

(2) any other order in a delinquency proceeding that has the character of a final order as to the particular part of the delinquency proceeding covered by the order.

§10–484.

(a) To facilitate the rehabilitation, liquidation, conservation, or dissolution of a provider under this subtitle, the Secretary, subject to the approval of the court, may:

(1) borrow money;

(2) execute, acknowledge, and deliver notes or other evidences of indebtedness for the loan;

(3) secure the repayment of the loan by the mortgage, pledge, assignment, or transfer in trust of all or part of the property of the provider; and

(4) take any other action necessary and proper to consummate the loan and to provide for its repayment.

(b) The Secretary is not obligated personally or in an official capacity to repay a loan made under this section.

§10–485.

(a) Whenever under this subtitle a receiver is to be appointed in a delinquency proceeding for a provider, the court shall:

(1) appoint the Secretary as receiver; and

(2) order the Secretary promptly to take possession of the assets of the provider and to administer the assets under the orders of the court.

(b) Beginning on the date of issuance of an order that directs the Secretary to rehabilitate or liquidate a provider, the Secretary as receiver is vested by operation of law with title to and may take possession of all of the property, contracts, rights of action, books, and records of the provider, wherever located.

(c) The filing of the order that directs possession to be taken, or a certified copy of the order, in an office where instruments affecting title to property are required to be filed provides the same notice as would be provided by a deed, bill of sale, or other evidence of title that is so filed.

(d) (1) The Secretary as receiver shall administer properly all assets that come into the possession or control of the Secretary.

(2) If considered desirable to protect the assets, the court at any time may require a bond from the Secretary or deputy secretary.

(3) On taking possession of the assets of a provider and subject to the direction of the court, the Secretary immediately shall:

(i) conduct the business of the provider; or

(ii) take action authorized by this subtitle to rehabilitate, liquidate, or conserve the affairs or assets of the provider.

§10–486.

(a) During pendency of a delinquency proceeding for a provider, an attachment, garnishment, execution, or similar action or proceeding may not be commenced or maintained in a court of this State against the provider or its assets.

(b) A lien obtained or an action or proceeding prohibited by subsection (a) of this section is void as against any rights arising in the delinquency proceeding, if the lien was obtained or the action or proceeding commenced within 4 months before or at any time after commencement of a delinquency proceeding.

§10–487.

(a) A transfer of or lien on the property of a provider is voidable if the transfer or lien is:

(1) made or created within 4 months before the issuance of a show cause order under this subtitle;

(2) made or created with the intent to give a creditor a preference or to enable the creditor to obtain a greater percentage of the debt than another creditor of the same class; and

(3) accepted by the creditor having reasonable cause to believe that the preference will occur.

(b) Each director, officer, employee, stockholder, member, subscriber, and any other person acting on behalf of a provider that is concerned in a voidable transfer under subsection (a) of this section and each person that, as a result of the voidable transfer, receives any property of the provider or benefits from the voidable transfer:

(1) is personally liable; and

(2) shall account to the Secretary.

(c) The Secretary as receiver in a delinquency proceeding may:

(1) avoid a transfer of or lien on the property of a provider that a creditor, stockholder, subscriber, or member of the provider might have avoided; and

(2) recover the transferred property or its value from the person that received it unless that person was a bona fide holder for value before the date of issuance of a show cause order under this subtitle.

§10–488.

(a) (1) The Secretary shall deposit moneys collected in a delinquency proceeding in a State or national bank, savings bank, or trust company.

(2) Deposits made by the Secretary under paragraph (1) of this subsection have priority of payment equal to any other priority specified by the banking laws of this State if the depository:

(i) is an institution organized and supervised under the laws of this State; and

(ii) becomes insolvent or liquidates voluntarily or involuntarily.

(3) The Secretary may deposit all or part of the moneys collected in a national bank or trust company as a trust fund.

(b) To the extent that an investment or account is insured by the Federal Deposit Insurance Corporation, the Secretary may invest in shares of or deposits in a savings and loan association or building and loan association.

§10–489.

(a) (1) If on issuance of an order of liquidation under this subtitle or at any time during a liquidation proceeding the provider is not clearly solvent, the court, after notice it considers proper and a hearing, shall issue an order that the provider is an impaired provider.

(2) Notwithstanding any previous notice given to creditors, after issuance of an order under paragraph (1) of this subsection, the Secretary shall notify each person that may have a claim against the provider that the claim is forever barred unless the person files the claim with the Secretary at a place and within the time specified in the notice.

(3) The time specified in the notice:

(i) shall be as set by the court for filing claims; but

(ii) may not be less than 6 months after issuance of the order that

the provider is an impaired provider.

(4) The notice shall be given in the manner and for the reasonable period of time that the court orders.

(b) (1) Each claimant shall set forth in reasonable detail:

(i) the amount of the claim or the basis on which the amount can be determined;

(ii) the facts on which the claim is based; and

(iii) any priority asserted by the claimant.

(2) Each claim shall:

(i) be verified by the affidavit of the claimant or a person authorized to act on behalf of the claimant who has knowledge of the facts; and

(ii) be supported by any documents that may be material to the claim.

(3) Each claim shall be filed with the receiver in the State on or before the last date specified under this subtitle for filing of claims.

(c) The receiver shall:

(1) report a claim to the court:

(i) within 10 days after receiving the claim; or

(ii) within an additional period set by the court for good cause shown; and

(2) recommend in the report action to be taken on the claim.

(d) (1) On receipt of the report of the receiver, the court shall:

(i) set a time for hearing the claim; and

(ii) direct the claimant or receiver to give notice as the court determines to each person that appears to the court to be interested in the claim.

(2) The notice given in accordance with this subsection shall:

(i) specify the time and place of the hearing; and

(ii) state concisely:

1. the amount and nature of the claim;

2. any priority asserted by the claimant; and

3. the recommendation of the receiver about the claim.

(e) (1) At the hearing specified under subsection (d) of this section:

(i) each person with an interest in the claim may appear; and

(ii) the court shall issue an order in which the court allows in part, or disallows the claim.

(2) An order under this subsection is a final order subject to appeal.

§10–490.

(a) In this section, "preferred claim" means a claim that is given priority of payment from the general assets of a provider under the laws of the State or the United States.

(b) (1) The first $500 of compensation or wages owed to an officer or employee of a provider for services rendered within 3 months before the commencement of a delinquency proceeding against the provider shall be paid before payment of any other debt or claim.

(2) Subject to paragraph (3) of this subsection, the Secretary may pay the compensation required to be paid under this subsection as soon as practicable after commencement of the delinquency proceeding.

(3) At all times, the Secretary shall reserve funds that the Secretary believes are sufficient for expenses of administration.

(4) The priority required under this subsection is instead of any other similar priority that may be authorized by law as to wages or compensation.

(c) Priority over all other claims in a liquidation proceeding, other than claims for wages specified in subsection (b) of this section, expenses of administration, and taxes, shall be given to claims by subscribers that arise from continuing care agreements with the provider, including claims to the statutory refund required by § 10-448 of this subtitle.

(d) (1) The owner of a secured claim against a provider for which a receiver has been appointed in this State or another state may:

(i) surrender the security and file the claim as a general creditor; or

(ii) have the claim discharged by resort to the security.

(2) If the owner of a secured claim has the claim discharged by resort to the security, any deficiency shall be treated as a claim against the general assets of the

provider on the same basis as the claims of unsecured creditors.

(3) The amount of a deficiency is conclusive if adjudicated by a court of competent jurisdiction in a proceeding in which the receiver has been given notice and an opportunity to be heard.

(4) If the amount of a deficiency is not conclusive, the amount shall be determined in a delinquency proceeding in the State.

§10–491.

(a) (1) Subject to paragraph (2) of this subsection, contingent and unliquidated claims may not share in a distribution of the assets of a provider that has been adjudicated to be an impaired provider by an order issued under this subtitle.

(2) If properly presented, a contingent and unliquidated claim shall be considered and may be allowed to share if:

(i) the claim becomes absolute against the provider on or before the last day for filing claims against the assets of the provider; or

(ii) there is a surplus and the liquidation is subsequently conducted on the basis that the provider is solvent.

(b) (1) Except as provided in paragraph (2) of this subsection, a claim of a person that has a secured claim may not be allowed at a sum greater than the difference between:

(i) the value of the claim without security; and

(ii) the value of the security itself on:

1. the date of issuance of the liquidation order; or

2. another date set by the court for determining rights and liabilities as provided in subsection (c) of this section.

(2) If the claimant surrenders the security to the Secretary, the claim shall be allowed in the full amount for which it is valued.

(c) Subject to the provisions of this subtitle on the rights of claimants holding contingent claims, and unless otherwise directed by the court, the rights and liabilities of a provider and creditors, stockholders, members, subscribers, and other persons interested in the estate of the provider are fixed on the date on which the order that directs the liquidation of the provider is filed in the office of the clerk of the court that issued the order.

§10–492.

(a) Except as provided in subsection (b) of this section, in all cases of mutual debts and credits between a provider and another person in connection with a delinquency proceeding, the debts and credits shall be offset and the balance only shall be allowed or paid.

(b) An offset may not be allowed in favor of another person if:

(1) on the date of issuance of a liquidation order or otherwise, as specified in § 10-491(c) of this subtitle, the obligation of the provider to the person would not entitle the person to share as a claimant in the assets of the provider; or

(2) the obligation of the provider to the person was purchased by or transferred to the person for use as an offset.

§10–493.

If a provider is the subject of a bankruptcy or receivership action, the claims of subscribers shall be administered in accordance with § 10-490(c) of this subtitle for the purpose of any legal action in conjunction with the bankruptcy or receivership.

§10–496.

(a) A person may not maintain or operate a facility offering continuing care without having obtained an initial or renewal certificate of registration.

(b) A person may not disseminate prohibited advertising or promotional materials.

(c) A person may not provide false registration information to the Department.

(d) (1) A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 6 months or a fine not exceeding $1,000 or both.

(2) Each violation of this subtitle constitutes a separate offense.

§10–497.

(a) The Secretary may impose a civil money penalty against a provider for an action or inaction that violates this subtitle or any regulation adopted by the Department under this subtitle.

(b) (1) Before imposing a civil money penalty under subsection (a) of this section, the Department shall issue a notice of violation to the provider.

(2) The notice shall state:

(i) when the provider must submit a plan of correction that is acceptable to the Department;

(ii) when each identified violation must be substantially corrected, which may not be less than 30 days; and

(iii) that failure to submit an acceptable plan of correction as required under item (i) of this paragraph or to correct an identified violation may result in an order imposing a civil money penalty under subsection (d) of this section.

(c) If at the expiration of the time set forth in the notice required under subsection (b) of this section the Department determines a violation has not been corrected, the Secretary may:

(1) extend the time in which the violation must be corrected; or

(2) impose a civil money penalty under subsection (d) of this section.

(d) (1) The Secretary may impose a civil money penalty not exceeding $5,000 for each violation.

(2) In setting the amount of a civil money penalty under this section, the Secretary shall consider the following factors:

(i) the number, nature, and seriousness of the violations;

(ii) the degree of risk to the health, life, or physical or financial safety of the subscribers caused by the violations;

(iii) the efforts made by the provider to correct the violations;

(iv) whether the amount of the proposed civil money penalty will jeopardize the financial ability of the provider to continue operating; and

(v) other factors as justice may require.

(3) If a civil money penalty is imposed under this section, the Department shall issue an order stating:

(i) the basis on which the order is made;

(ii) each regulation or statute violated;

(iii) each civil money penalty imposed and the total amount of the civil money penalty imposed; and

(iv) the manner in which the amount of the civil money penalty was calculated.

(4) (i) The Department shall provide written notice to a provider of the imposition of a civil money penalty.

(ii) The notice shall be served on the provider by certified mail and shall include the order and a statement on how to file an administrative appeal.

(5) If a civil money penalty is imposed under this section, the provider has the right to appeal from the order in accordance with Title 10, Subtitle 2 of the State Government Article.

(e) (1) A provider shall pay a civil money penalty to the Department within 10 days after the provider receives a final order imposing the civil money penalty.

(2) An order imposing a civil money penalty is final when the provider has exhausted all opportunities to contest the civil penalty in accordance with Title 10, Subtitle 2 of the State Government Article.

(3) If a provider does not comply with this section, the Department may file a civil action to recover the penalty.

(4) The Department shall deposit all civil money penalties collected under this section into the General Fund.

§10–498.

(a) (1) Any subscriber injured by a violation of this subtitle may bring an action for equitable relief or an action for damages in any court of general jurisdiction.

(2) In an action described in paragraph (1) of this subsection, the court may award reasonable attorney's fees to a subscriber in whose favor a judgment is entered.

(b) The Department may bring an action for an appropriate temporary restraining order or injunction for a violation of this subtitle.

§10–499.

(a) The Department may use the receivership provisions of Part VIII of this subtitle to protect the interests of subscribers in:

(1) the substantial advance payments subscribers have made in the form of entrance fees and, when applicable, periodic fees, for future continuing care without necessarily having any ownership in or control of the provider or the facility;

(2) the insurance aspects of continuing care agreements, as applicable; and

(3) the continued delivery of services committed to under continuing care

agreements.

(b) The Department may petition for the appointment of a receiver:

(1) if there is a threat of immediate closure of a facility;

(2) if the provider is not honoring its contracts with its subscribers;

(3) to prohibit the improper diversion of the provider's assets and records from the facility or the State; or

(4) if the Department has made a determination of a significant risk of financial failure in accordance with §§ 10-467 and 10-469 of this subtitle.

(c) The Department may petition for the appointment of a receiver before the provider files a plan of correction.

(d) The receiver may rehabilitate, conserve, or liquidate as provided by the order of appointment and Part VIII of this subtitle.

~~§10–501.~~

~~(a) In this part the following words have the meanings indicated.~~

~~(b) "Capital equipment" means essential fixed equipment and furnishings with an expected useful life of at least 15 years.~~

~~(c) (1) "Cost" means all expenses incident to the construction, acquisition, conversion, renovation, or improvement of a project.~~

~~(2) "Cost" includes:~~

~~(i) the cost to acquire any interest in real or personal property in connection with a project;~~

~~(ii) the cost of financial, technical, professional, engineering, and legal services in connection with a project whether the expenses are incurred before or after any bond, note, or other evidence of indebtedness or obligation is issued by the State to finance the project;~~

~~(iii) the cost of development of a senior citizen activities center master plan; and~~

~~(iv) the cost of plans, specifications, surveys, estimates of costs and revenues, feasibility or practicability reports, machinery, equipment, and administrative expenses, and other expenses that are necessary and incident to the financing authorized for the project.~~

~~(d) "Grant" means a grant from the State under the Program.~~