

Article 64.

Continuing Care Retirement Communities.

§ 58-64-1. Definitions.

As used in this Article, unless otherwise specified:

- (1) Continuing care. – The furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under a contract approved by the Department in accordance with this Article effective for the life of the individual or for a period longer than one year. "Continuing care" may also include home care services provided or arranged by a provider of lodging at a facility to an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging.
- (2) Entrance fee. – A payment that assures a resident a place in a facility for a term of years or for life.
- (3) Facility. – The retirement community or communities in which a provider undertakes to provide continuing care to an individual.
- (4) Health-related services. – At a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.
- (4a) Home care services. – Defined in G.S. 131E-136.
- (5) Living unit. – A room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.
- (5a) Lodging. – A living unit as set forth in a contract approved by the Department in accordance with this Article.
- (6) Provider. – The promoter, developer, or owner of a facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents himself, herself, or itself as providing continuing care or "life care."
- (7) Resident. – A purchaser of, a nominee of, or a subscriber to, a continuing care contract.
- (8) Hazardous financial condition. – A provider is insolvent or in eminent danger of becoming insolvent. (1989, c. 758, s. 1; 1989 (Reg. Sess., 1990), c. 1024, s. 45; 1991, c. 720, ss. 2, 39; 1999-132, ss. 2.2, 2.3; 2010-128, s. 2.)

§ 58-64-5. License.

(a) No provider shall engage in the business of offering or providing continuing care in this State without a license to do so obtained from the Commissioner as provided in this Article. It is a Class 1 misdemeanor for any person, other than a provider licensed under this Article, to advertise or market to the general public any product similar to continuing care through the use of such terms as "life care", "continuing care", or "guaranteed care for life", or similar terms, words, or phrases. The licensing process may involve a series of steps pursuant to rules adopted by the Commissioner under this Article.

(b) The application for a license shall be filed with the Department by the provider on forms prescribed by the Department and within a period of time prescribed by the Department; and shall include all information required by the Department pursuant to rules adopted by it under this Article including, but not limited to, the disclosure statement meeting the requirements of this Article and other financial and facility development information required by the Department. The application for a license must be accompanied by an application fee of one thousand dollars (\$1,000).

(c) Upon receipt of the complete application for a license in proper form, the Department shall, within 10 business days, issue a notice of filing to the applicant. Within 90 days of the notice of filing, the Department shall enter an order issuing the license or rejecting the application.

(d) If the Commissioner determines that any of the requirements of this Article have not been met, the Commissioner shall notify the applicant that the application must be corrected within 30 days in such particulars as designated by the Commissioner. If the requirements are not met within the time allowed, the Commissioner may enter an order rejecting the application, which order shall include the findings of fact upon which the order is based and which shall not become effective until 20 days after the end of the 30-day period. During the 20-day period, the applicant may petition for reconsideration and is entitled to a hearing.

(e) Repealed by Session Laws 2003-193, s. 1, effective June 12, 2003.

(f) The Commissioner may, on an annual basis or on a more frequent basis if he deems it to be necessary, in addition to the annual disclosure statement revision required by G.S. 58-64-30, require every licensed provider to file with the Department any of the information provided by G.S. 58-64-5(b) for new licensure that the Commissioner, pursuant to rules adopted by him under this Article, determines is needed for review of licensed providers.

(g) The Commissioner may require a provider to: (i) provide the report of an actuary that estimates the capacity of the provider to meet its contractual obligation to the resident, or (ii) give consideration to expected rates of mortality and morbidity, expected refunds, and expected capital expenditures in accordance with standards promulgated by the American Academy of Actuaries, within the five-year forecast statements, as required by G.S. 58-64-20(a)(12). (1989, c. 758, s. 1; 1991, c. 196, ss. 1, 2; 2001-223, s. 22.1; 2003-193, ss. 1, 2; 2009-451, s. 21.9(a); 2010-128, s. 1.)

§ 58-64-7. Continuing care services without lodging.

(a) A provider of continuing care who has obtained a license pursuant to this Article and desires to provide or arrange for continuing care services, including home care services, to an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging must submit the following to the Commissioner:

- (1) An application to offer continuing care services without providing lodging.
- (2) An amended disclosure statement containing a description of the proposed continuing care services that will be provided without lodging, including the target market, the types of services to be provided, and the fees to be charged.
- (3) A copy of the written service agreement, which must contain those provisions as prescribed in G.S. 58-64-25(b).
- (4) A summary of an actuarial report that presents the impact of providing continuing care services without lodging on the overall operation of the continuing care retirement community.
- (5) A financial feasibility study prepared by a certified public accountant that shows the financial impact of providing continuing care services without

lodging on the applicant and the continuing care retirement facility or facilities. The financial feasibility study shall include a statement of activities reporting the revenue and expense details for providing continuing care services without lodging, as well as any impact the provision of these services will have on operating reserves.

- (6) Evidence of the license required under Part 3 of Article 6 of Chapter 131E of the General Statutes to provide home care services, or a contract with a licensed home care agency for the provision of home care services to the individuals under the continuing care services without lodging program.

(b) A provider issued a start-up certificate for the provision of continuing care services without lodging must enter into binding written service agreements with subscribers to provide continuing care services without lodging.

(c) When providing the financial statements and five-year forecasts required by G.S. 58-64-20, a provider offering continuing care services without lodging must account for the related revenue and expenses generated from the provision of these services separate from the facility's on-site operation. (2010-128, s. 4.)

§ 58-64-10. Revocation of license.

(a) The license of a provider shall remain in effect until revoked after notice and hearing, upon written findings of fact by the Commissioner, that the provider has:

- (1) Willfully violated any provision of this Article or of any rule or order of the Commissioner;
- (2) Failed to file an annual disclosure statement or standard form of contract as required by this Article;
- (3) Failed to deliver to prospective residents the disclosure statements required by this Article;
- (4) Delivered to prospective residents a disclosure statement that makes an untrue statement or omits a material fact and the provider, at the time of the delivery of the disclosure statement, had actual knowledge of the misstatement or omission;
- (5) Failed to comply with the terms of a cease and desist order; or
- (6) Has been determined by the Commissioner to be in a hazardous financial condition.

(b) Findings of fact in support of revocation shall be accompanied by an explicit statement of the underlying facts supporting the findings.

(c) If the Commissioner has good cause to believe that the provider is guilty of a violation for which revocation could be ordered, the Commissioner may first issue a cease and desist order. If the cease and desist order is not or cannot be effective in remedying the violation, the Commissioner may, after notice and hearing, order that the license be revoked and surrendered. Such a cease and desist order may be appealed to the Superior Court of Wake County in the manner provided by G.S. 58-63-35. The provider shall accept no new applicant funds while the revocation order is under appeal. (1989, c. 758, s. 1.)

§ 58-64-15. Sale or transfer of ownership.

No license is transferable, and no license issued pursuant to this Article has value for sale or exchange as property. No provider or other owning entity shall sell or transfer ownership of the

facility, or enter into a contract with a third-party provider for management of the facility, unless the Commissioner approves such transfer or contract. (1989, c. 758, s. 1.)

§ 58-64-20. Disclosure statement.

(a) At the time of, or prior to, the execution of a contract to provide continuing care, or at the time of, or prior to, the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever occurs first, the provider shall deliver a current disclosure statement to the person with whom the contract is to be entered into, the text of which shall contain at least:

- (1) The name and business address of the provider and a statement of whether the provider is a partnership, corporation, or other type of legal entity.
- (2) The names and business addresses of the officers, directors, trustees, managing or general partners, any person having a ten percent (10%) or greater equity or beneficial interest in the provider, and any person who will be managing the facility on a day-to-day basis, and a description of these persons' interests in or occupations with the provider.
- (3) The following information on all persons named in response to subdivision (2) of this section:
 - a. A description of the business experience of this person, if any, in the operation or management of similar facilities;
 - b. The name and address of any professional service firm, association, trust, partnership, or corporation in which this person has, or which has in this person, a ten percent (10%) or greater interest and which it is presently intended shall currently or in the future provide goods, leases, or services to the facility, or to residents of the facility, of an aggregate value of five hundred dollars (\$500.00) or more within any year, including a description of the goods, leases, or services and the probable or anticipated cost thereof to the facility, provider, or residents or a statement that this cost cannot presently be estimated; and
 - c. A description of any matter in which the person (i) has been convicted of a felony or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property; or (ii) is subject to a currently effective injunctive or restrictive court order, or within the past five years, had any State or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, if the order or action arose out of or related to business activity of health care, including actions affecting a license to operate a foster care facility, nursing home, retirement home, home for aged, or facility subject to this Article or a similar law in another state.
- (4) A statement as to whether the provider is, or is not affiliated with, a religious, charitable, or other nonprofit organization, the extent of the affiliation, if any, the extent to which the affiliate organization will be responsible for the financial and contract obligations of the provider, and the provision of the Federal

- Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax.
- (5) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates, whether construction has begun, and the contingencies subject to which construction may be deferred.
 - (6) The services provided or proposed to be provided pursuant to contracts for continuing care at the facility, including the extent to which medical care is furnished, and a clear statement of which services are included for specified basic fees for continuing care and which services are made available at or by the facility at extra charge.
 - (7) A description of all fees required of residents, including the entrance fee and periodic charges, if any. The description shall include:
 - a. A statement of the fees that will be charged if the resident marries while at the facility, and a statement of the terms concerning the entry of a spouse to the facility and the consequences if the spouse does not meet the requirements for entry;
 - b. The circumstances under which the resident will be permitted to remain in the facility in the event of possible financial difficulties of the resident;
 - c. The terms and conditions under which a contract for continuing care at the facility may be canceled by the provider or by the resident, and the conditions, if any, under which all or any portion of the entrance fee or any other fee will be refunded in the event of cancellation of the contract by the provider or by the resident or in the event of the death of the resident prior to or following occupancy of a living unit;
 - d. The conditions under which a living unit occupied by a resident may be made available by the provider to a different or new resident other than on the death of the prior resident; and
 - e. The manner by which the provider may adjust periodic charges or other recurring fees and the limitations on these adjustments, if any; and, if the facility is already in operation, or if the provider or manager operates one or more similar continuing care locations within this State, tables shall be included showing the frequency and average dollar amount of each increase in periodic charges, or other recurring fees at each facility or location for the previous five years, or such shorter period as the facility or location may have been operated by the provider or manager.
 - (8) The health and financial condition required for an individual to be accepted as a resident and to continue as a resident once accepted, including the effect of any change in the health or financial condition of a person between the date of entering into a contract for continuing care and the date of initial occupancy of a living unit by that person.
 - (9) The provisions that have been made or will be made, including, but not limited to, the requirements of G.S. 58-64-33 and G.S. 58-64-35, to provide reserve funding or security to enable the provider to perform its obligations fully under contracts to provide continuing care at the facility, including the establishment

- of escrow accounts, trusts, or reserve funds, together with the manner in which these funds will be invested, and the names and experience of any individuals in the direct employment of the provider who will make the investment decisions.
- (10) Financial statements of the provider certified to by an independent public accountant as of the end of the most recent fiscal year or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 120 days prior to the date the disclosure statement is recorded, interim financial statements as of a date not more than 90 days prior to the date of recording the statement shall also be included, but need not be certified to by an independent certified public accountant.
 - (11) In the event the provider has had an actuarial report prepared within the prior two years, the summary of a report of an actuary that estimates the capacity of the provider to meet its contractual obligations to the residents.
 - (12) Forecasted financial statements for the provider of the next five years, including a balance sheet, a statement of operations, a statement of cash flows, and a statement detailing all significant assumptions, compiled by an independent certified public accountant. Reporting routine, categories, and structure may be further defined by regulations or forms adopted by the Commissioner.
 - (13) The estimated number of residents of the facility to be provided services by the provider pursuant to the contract for continuing care.
 - (14) Proposed or development stage facilities shall additionally provide:
 - a. The summary of the report of an actuary estimating the capacity of the provider to meet its contractual obligation to the residents;
 - b. Narrative disclosure detailing all significant assumptions used in the preparation of the forecasted financial statements, including:
 - 1. Details of any long-term financing for the purchase or construction of the facility including interest rate, repayment terms, loan covenants, and assets pledged;
 - 2. Details of any other funding sources that the provider anticipates using to fund any start-up losses or to provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care;
 - 3. The total life occupancy fees to be received from or on behalf of, residents at, or prior to, commencement of operations along with anticipated accounting methods used in the recognition of revenues from and expected refunds of life occupancy fees;
 - 4. A description of any equity capital to be received by the facility;
 - 5. The cost of the acquisition of the facility or, if the facility is to be constructed, the estimated cost of the acquisition of the land and construction cost of the facility;
 - 6. Related costs, such as financing any development costs that the provider expects to incur or become obligated for prior to the commencement of operations;
 - 7. The marketing and resident acquisition costs to be incurred prior to commencement of operations; and

8. A description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health care services.

(15) Any other material information concerning the facility or the provider which, if omitted, would lead a reasonable person not to enter into this contract.

(b) The cover page of the disclosure statement shall state, in a prominent location and in boldface type, the date of the disclosure statement, the last date through which that disclosure statement may be delivered if not earlier revised, and that the delivery of the disclosure statement to a contracting party before the execution of a contract for the provision of continuing care is required by this Article but that the disclosure statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.

(c) A copy of the standard form of contract for continuing care used by the provider shall be attached to each disclosure statement.

(d) The Commissioner, by rules adopted by him under this Article, may prescribe a standardized format for the disclosure statement required by this section.

(e) The disclosure statement shall be in plain English and in language understandable by a layperson and combine simplicity and accuracy to fully advise residents of the items required by this section.

(f) The Department may require a provider to alter or amend its disclosure statement in order to provide full and fair disclosure to prospective residents. The Department may also require the revision of a disclosure statement which it finds to be unnecessarily complex, confusing or illegible. (1989, c. 758, s. 1; 1991, c. 196, s. 3; c. 720, s. 89; 1993, c. 452, s. 63; 2001-223, s. 22.2; 2003-193, ss. 3, 4, 5, 6.)

§ 58-64-25. Contract for continuing care; specifications.

(a) Each contract for continuing care shall provide that:

(1) The party contracting with the provider may rescind the contract within 30 days following the later of the execution of the contract or the receipt of a disclosure statement that meets the requirements of this section, and the resident to whom the contract pertains is not required to move into the facility before the expiration of the 30-day period; and

(2) If a resident dies before occupying a living unit in the facility, or if, on account of illness, injury, or incapacity, a resident would be precluded from occupying a living unit in the facility under the terms of the contract for continuing care, the contract is automatically canceled; and

(3) For rescinded or canceled contracts under this section, the resident or the resident's legal representative shall receive a refund of all money or property transferred to the provider, less (i) periodic charges specified in the contract and applicable only to the period a living unit was actually occupied by the resident; (ii) those nonstandard costs specifically incurred by the provider or facility at the request of the resident and described in the contract or any contract amendment signed by the resident; (iii) nonrefundable fees, if set out in the contract; and (iv) a reasonable service charge, if set out in the contract, not to

exceed the greater of one thousand dollars (\$1,000) or two percent (2%) of the entrance fee.

- (b) Each contract shall include provisions that specify the following:
- (1) The total consideration to be paid.
 - (2) Services to be provided.
 - (3) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or the general and economic welfare of the residents.
 - (4) The policies to be implemented if the resident cannot pay the periodic fees.
 - (5) The terms governing the refund of any portion of the entrance fee in the event of discharge by the provider or cancellation by the resident.
 - (6) The policy regarding increasing the periodic fees.
 - (7) The description of the living quarters.
 - (8) Any religious or charitable affiliations of the provider and the extent, if any, to which the affiliate organization will be responsible for the financial and contractual obligations of the provider.
 - (9) Any property rights of the resident.
 - (10) The policy, if any, regarding fee adjustments if the resident is voluntarily absent from the facility; and
 - (11) Any requirement, if any, that the resident apply for Medicaid, public assistance, or any public benefit program.
 - (12) The procedures for determining when the individual will transition to receiving lodging and health-related services in the event that a contract allows for the provision or arrangement of continuing care without lodging. (1989, c. 758, s. 1; 1991, c. 196, s. 4; 2010-128, s. 3.)

§ 58-64-30. Annual disclosure statement revision.

(a) Within 150 days following the end of each fiscal year, the provider shall file with the Commissioner a revised disclosure statement setting forth current information required pursuant to G.S. 58-64-20. The provider shall also make this revised disclosure statement available to all the residents of the facility. This revised disclosure statement shall include a narrative describing any material differences between (i) the forecasted statements of revenues and expenses and cash flows or other forecasted financial data filed pursuant to G.S. 58-64-20 as a part of the disclosure statement recorded most immediately subsequent to the start of the provider's most recently completed fiscal year and (ii) the actual results of operations during that fiscal year, together with the revised forecasted statements of revenues and expenses and cash flows or other forecasted financial data being filed as a part of the revised disclosure statement. A provider may also revise its disclosure statement and have the revised disclosure statement recorded at any other time if, in the opinion of the provider, revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 150 days prior to the date of delivery, shall be considered current for purposes of this Article or delivered pursuant to G.S. 58-64-20.

(b) The annual disclosure statement required to be filed with the Commissioner under this section shall be accompanied by an annual filing fee of one thousand dollars (\$1,000). (1989, c. 758, s. 1; 2003-193, s. 7; 2009-451, s. 21.9(b).)

§ 58-64-33. Operating reserves.

(a) A provider shall maintain after the opening of a facility: an operating reserve equal to fifty percent (50%) of the total operating costs of the facility forecasted for the 12-month period following the period covered by the most recent disclosure statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long-term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. If a facility maintains an occupancy level in excess of ninety percent (90%), a provider shall only be required to maintain a twenty-five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating reserve may be funded by cash, by invested cash, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies.

(b) A provider that has begun construction or has permanent financing in place or is in operation on the effective date of this section has up to five years to meet the operating reserve requirements.

(c) An operating reserve shall only be released upon the submittal of a detailed request from the provider or facility and must be approved by the Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal. (1991, c. 196, s. 5; c. 720, s. 89; 1993, c. 452, s. 64; 1993 (Reg. Sess., 1994), c. 678, s. 29; 1995, c. 193, s. 52; 2003-193, s. 8; 2004-203, s. 36.)

§ 58-64-35. Escrow, collection of deposits.

(a) Where escrow accounts are required by this Article, a provider shall establish an escrow account with (i) a bank, (ii) a trust company, or (iii) another independent person or entity agreed upon by the provider and the resident, unless such account arrangement is prohibited by the Commissioner. The terms of this escrow account shall provide that the total amount of any entrance fee, or any other fee or deposit that may be applied toward the entrance fee, received by the provider be placed in this escrow account. These funds may be released only as follows:

- (1) The first twenty-five percent (25%) of escrowed monies can be released when:
 - (i) the provider has presold at least fifty percent (50%) of the independent living units, having received a minimum ten percent (10%) deposit on the presold units;
 - (ii) the provider has received a commitment for any permanent mortgage loan or other long-term financing, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied; and
 - (iii) aggregate entrance fees received or receivable by the provider pursuant to binding continuing care contracts, plus the anticipated proceeds of any first mortgage loan or other long-term financing commitment are equal to not less than ninety percent (90%) of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus not less than ninety percent (90%) of

the funds estimated in the statement of cash flows submitted by the provider as that part of the disclosure statement required by G.S. 58-64-20, to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to continuing care contracts.

(2) The remaining seventy-five percent (75%) of escrowed monies can be released when:

- a. (i) the provider has presold a minimum of seventy-five percent (75%) of the independent living units, having received a minimum ten percent (10%) deposit on the presold units, or has maintained an independent living unit occupancy minimum of seventy-five percent (75%) for at least 60 days; (ii) construction or purchase of the independent living unit has been completed and an occupancy permit, if applicable, has been issued by the local government having authority to issue such permits; and (iii) the living unit becomes available for occupancy by the new resident; or
- b. the provider submits a plan of reorganization that is accepted and approved by the Commissioner.

(b) Upon receipt by the escrow agent of a request by the provider for the release of these escrow funds, the escrow agent shall approve release of the funds within five working days unless the escrow agent finds that the requirements of subsection (a) of this section have not been met and notifies the provider of the basis for this finding. The request for release of the escrow funds shall be accompanied by any documentation the fiduciary requires.

(b1) Release of any escrowed funds that may be due to the subscriber or resident shall occur upon: five working days' notice of death, nonacceptance by the facility, or voluntary cancellation. If voluntary cancellation occurs after construction has begun, the refund may be delayed until a new subscriber is obtained for that specific unit, provided it does not exceed a period of two years.

(c) If the provider fails to meet the requirements for release of funds held in this escrow account within a time period the escrow agent considers reasonable, these funds shall be returned by the escrow agent to the persons who have made payment to the provider. The escrow agent shall notify the provider of the length of this time period when the provider requests release of the funds.

(d) Facilities that currently meet the seventy-five percent (75%) presales or the seventy-five percent (75%) occupancy requirements, as outlined in subdivision (a)(2) of this section, are not required to escrow entrance fees, unless otherwise required by the Commissioner. (1989, c. 758, s. 1; 1991, c. 196, s. 6, c. 720, s. 8, c. 761, ss. 11, 12.)

§ 58-64-40. Right to organization.

(a) A resident living in a facility operated by a provider licensed under this Article has the right of self-organization, the right to be represented by an individual of the resident's own choosing, and the right to engage in concerted activities to keep informed on the operation of the facility in which the resident resides or for other mutual aid or protection.

(b) The board of directors or other governing body of a provider or its designated representative shall hold semiannual meetings with the residents of each facility operated by the provider for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Upon request of the most representative residents' organization, a member of the governing body of the provider, such as a board member, a general partner, or a

principal owner shall attend such meetings. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents. (1989, c. 758, s. 1; 1999-132, s. 2.4; 2001-223, s. 22.3; 2003-193, s. 9.)

§ 58-64-45. Supervision, rehabilitation, and liquidation.

(a) If, at any time, the Commissioner determines, after notice and an opportunity for the provider to be heard, that:

- (1) A portion of an entrance fee escrow account required to be maintained under this Article has been or is proposed to be released in violation of this Article;
- (2) A provider has been or will be unable, in such a manner as may endanger the ability of the provider, to fully perform its obligations pursuant to contracts for continuing care, to meet the forecasted financial data previously filed by the provider;
- (3) A provider has failed to maintain the escrow account required under this Article; or
- (4) A provider is bankrupt or insolvent, or in imminent danger of becoming bankrupt or insolvent;

the Commissioner may commence a supervision proceeding pursuant to Article 30 of this Chapter or may apply to the Superior Court of Wake County or to the federal bankruptcy court that may have previously taken jurisdiction over the provider or facility for an order directing the Commissioner or authorizing the Commissioner to rehabilitate or to liquidate a facility in accordance with Article 30 of this Chapter.

(b) The definition of "insolvency" or "insolvent" in G.S. 58-30-10(13) shall not apply to providers under this Article. Rules adopted by the Commissioner shall define and describe "insolvency" or "hazardous financial condition" for providers under this Article. G.S. 58-30-12 shall not apply to facilities under this Article.

(c) If, at any time, the Court finds, upon petition of the Commissioner or provider, or on its own motion, that the objectives of an order to rehabilitate a provider have been accomplished and that the facility or facilities owned by, or operated by, the provider can be returned to the provider's management without further jeopardy to the residents of the facility or facilities, the Court may, upon a full report and accounting of the conduct of the provider's affairs during the rehabilitation and of the provider's current financial condition, terminate the rehabilitation and, by order, return the facility or facilities owned by, or operated by, the provider, along with the assets and affairs of the provider, to the provider's management.

(d), (e) Repealed by Session Laws 1995 (Regular Session, 1996), c. 582, s. 3.

(f) In applying for an order to rehabilitate or liquidate a provider, the Commissioner shall give due consideration in the application to the manner in which the welfare of persons who have previously contracted with the provider for continuing care may be best served.

(g) An order for rehabilitation shall be refused or vacated if the provider posts a bond, by a recognized surety authorized to do business in this State and executed in favor of the Commissioner on behalf of persons who may be found entitled to a refund of entrance fees from the provider or other damages in the event the provider is unable to fulfill its contracts to provide continuing care at the facility or facilities, in an amount determined by the Court to be equal to the reserve funding that would otherwise need to be available to fulfill such obligations. (1989, c. 758, s. 1; 1995 (Reg. Sess., 1996), c. 582, s. 3; 2003-193, s. 10.)

§ 58-64-46. Receiverships; exception for facility beds.

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds for a facility owned by, or operated by, the provider, if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the provider or (ii) the welfare of persons who have previously contracted with the provider or may contract with the provider, may be best served by the addition of adult care home beds. (1999-219, s. 2; 2003-193, s. 11.)

§ 58-64-50. Investigations and subpoenas.

(a) The Commissioner may make such public or private investigations within or outside of this State as necessary (i) to determine whether any person has violated or is about to violate any provision of this Article, (ii) to aid in the enforcement of this Article, or (iii) to verify statements contained in any disclosure statement filed or delivered under this Article.

(b) For the purpose of any investigation or proceeding under this Article, the Commissioner may require or permit any person to file a statement in writing, under oath or otherwise, as to any of the facts and circumstances concerning the matter to be investigated.

(c) For the purpose of any investigation or proceeding under this Article, the Commissioner or his designee has all the powers given to him for insurance companies. He may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records deemed relevant or material to the inquiry, all of which may be enforced in the Superior Court of Wake County. (1989, c. 758, s. 1.)

§ 58-64-55. Examinations; financial statements.

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a provider offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the provider examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference. (1989, c. 758, s. 1; 1995, c. 193, s. 53; 1999-132, s. 11.9; 2003-193, s. 12.)

§ 58-64-60. Contracts as preferred claims on liquidation.

In the event of liquidation of a provider, all contracts for continuing care executed by the provider shall be deemed preferred claims against all assets owned by the provider; provided, however, such claims shall be subordinate to the liquidator's cost of administration or any secured claim. (1989, c. 758, s. 1; 1995 (Reg. Sess., 1996), c. 582, s. 4; 2003-193, s. 13.)

§ 58-64-65. Rule-making authority; reasonable time to comply with rules.

(a) The Commissioner is authorized to promulgate rules to carry out and enforce the provisions of this Article.

(b) Any provider who is offering continuing care may be given a reasonable time, not to exceed one year from the date of publication of any applicable rules promulgated pursuant to this Article, within which to comply with the rules. (1989, c. 758, s. 1; 2003-193, s. 14.)

§ 58-64-70. Civil liability.

(a) A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 58-64-20 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the provider violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.

(b) Liability under this section exists regardless of whether the provider had actual knowledge of the misstatement or omission.

(c) A person may not file or maintain an action under this section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(c), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

(d) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation. (1989, c. 758, s. 1; 1995, c. 193, s. 54; 2003-193, s. 15.)

§ 58-64-75. Criminal penalties.

Any person who willfully and knowingly violates any provision of this Article is guilty of a Class 1 misdemeanor. The Commissioner may refer such evidence as is available concerning violation of the Article or of any rule or order hereunder to the Attorney General or a district attorney who may, with or without such reference institute the appropriate criminal proceedings under this Article. Nothing in this Article limits the power of the State to punish any person for any conduct that constitutes a crime under any other statute. (1989, c. 758, s. 1; 1993, c. 539, s. 469; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-64-80. Advisory Committee.

There shall be a nine member Continuing Care Advisory Committee appointed by the Commissioner. The Committee shall consist of at least two residents of facilities, two representatives of LeadingAge North Carolina, one individual who is a certified public accountant and is licensed to practice in this State, one individual skilled in the field of architecture or engineering, and one individual who is a health care professional. (1989, c. 758, s. 1; 1999-132, s. 2.5; 2015-281, s. 8.)

§ 58-64-85. Other licensing or regulation.

(a) Nothing in this Article affects the authority of the Department of Health and Human Services or any successor agency otherwise provided by law to license or regulate any health service facility or domiciliary service facility.

(b) Facilities and providers licensed under this Article that also are subject to the provisions of the North Carolina Condominium Act under Chapter 47C of the General Statutes shall not be subject to the provisions of Chapter 39A of the General Statutes, provided that the facility's declaration of condominium does not require the payment of any fee or charge not otherwise provided for in a resident's contract for continuing care, or other separate contract for the provisions of membership or services. (1991, c. 720, s. 1; 1997-443, s. 11A.118(a); 2011-196, s. 13.)