

**SUPPLEMENTAL REPORTING FORM –  
ORGANIZATIONAL CLEARANCE CERTIFICATE HOLDERS  
NONPROFIT HOSPITAL ORGANIZATIONS**



STATE OF CALIFORNIA  
BOARD OF EQUALIZATION  
*www.boe.ca.gov*

This form is to be filed with BOE-278-OCC, Verification for Continued Eligibility of Organizational Clearance Certificate-Welfare and Veterans' Organization Exemption. When complete, submit this form and BOE-278-OCC to the Board of Equalization, County-Assessed Properties Division, PO Box 942879, Sacramento, CA 94279-0064 by the due date indicated on BOE-278-OCC.

NAME OF ORGANIZATION \_\_\_\_\_

BOE OCC NUMBER \_\_\_\_\_

CORPORATE ID NUMBER \_\_\_\_\_

MAILING ADDRESS (Number and Street) \_\_\_\_\_

MAILING ADDRESS cont. (City, State, Zip Code) \_\_\_\_\_

Accounting Period:  Calendar Year  Fiscal Year-ending \_\_\_\_\_

1. What were the organization's operating revenues (exclusive of gifts, endowments and grants-in-aid) for the following years? Was this information from your Internal Revenue Service Form 990 reporting?  Yes  No If yes, does your Form 990 reflect any amounts for disregarded entities (i.e., a limited liability company in which you are the sole member)?  Yes  No If yes, make adjustments to reflect only revenues for the Organizational Clearance Certificate holder - see instructions.

2005	2006	2007	2008

2. What were the organization's operating expenses (including depreciation based on cost of replacement and amortization of, and interest on indebtedness) for the following years? Was this information from your Form 990 reporting?  Yes  No If yes, does your Form 990 reflect any amounts for disregarded entities (i.e., a limited liability company in which you are the sole member)  Yes  No If yes, make adjustments to reflect only expenses for the Organizational Clearance Certificate holder - see instructions. If the depreciation reflected was not replacement cost, please indicate the method of depreciation used:  Straight line  Other (specify) \_\_\_\_\_

2005	2006	2007	2008

3. Do the organization's operating revenues exceed operating expenses by 10% or more of those expenses, defined as *surplus revenues* for any of the following years?  Yes  No If yes, identify the amount. (Calculate the amount in 3(a) below)

2005	2006	2007	2008

(a) Calculation of Surplus Revenues

	2005	2006	2007	2008
Net Operating Income (Revenue minus expenses from above)				
10% of Operating Expense				
Variance (positive indicates surplus)				

4. What were the organization's non-operating revenues and non-operating expenses?

	2005	2006	2007	2008
Non-Operating Revenues				
Non-Operating Expenses				

5. **Attach** to this form a copy of your certified/audited financial statements for the last four fiscal or calendar years. Also submit copies of IRS Form 990 for the last four years in electronic PDF format on CD.

6. If the organization had surplus revenues for any year, identified in question 3, did the organization use surplus revenues for debt retirement, plant or facility expansion, or reserve for operating contingencies?  Yes  No If yes, enter the total amount for such uses for each of the following years:

Year	Debt Retirement	Plant or Facility Expansion	Reserve for Operating Contingencies
2005			
2006			
2007			
2008			

7. **Attach** to this form a description of major plant or facility expansion projects; identifying the project location, scope and timeline for completion.

8. **Attach** to this form a list of properties upon which your organization claimed the welfare exemption with any of the 58 county assessors for the January 1, 2009 lien date. (*Identify address, county, Assessor's Parcel Number and its facility identification number with Office of Statewide Health Planning and Development.*)

9. Does the organization have a charity care policy and/or discount payment policy?  Yes  No If yes, provide an electronic copy of such policies. (If your organization has multiple hospitals and they have different policies, submit all policies and specify how they differ.) Does your organization have a community benefit plan?  Yes  No If yes, provide an electronic copy of your most recent community benefit plan. (If your organization has multiple hospitals and they have different plans, submit all plans.)

Does the organization maintain cost information for medical care for charity care (free care) provided to patients?  Yes  No If yes, enter the total cost of care according to the organization's cost calculations; enter the accounts (number and description) used to record such costs. (Note: Cost information should be consistent with the IRS Schedule H method or the best available method. Identify the method of cost calculation:  IRS Schedule H method,  Catholic Health Association Guidelines,  other - describe.) You may submit additional information on how cost calculations were made. If IRS Schedule H method was used and it was not based on a cost accounting system, describe and explain why such system was not used.

Account:				Total
2005				
2006				
2007				
2008				

10. Does the organization's hospital(s) provide medical care to Medicare, Medi-Cal or county indigent program recipients?  Yes  No  
 If yes, provide the following information for each year: (Attach supplementary schedules, if necessary.)

(a) Enter the total amount of contractual adjustments for the organization's hospital(s) in accordance with the Office of Statewide Health Planning and Development's uniform accounting and reporting system requirements for California hospitals.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

(b) Enter the total amount received by the organization's hospital(s) for care to such patients.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

(c) Does the organization maintain cost information for care provided to such patients?  Yes  No  
 If yes, enter the total cost of care according to the organization's cost calculations. (Note: Cost information should be consistent with the IRS Schedule H method or the best available method. Identify the method of cost calculation:  IRS Schedule H method,  Catholic Health Association Guidelines,  other - describe.) You may submit additional information on how cost calculations were made. If IRS Schedule H method was used and it was not based on a cost accounting system, describe and explain why such system was not used.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

11. Does the organization's hospital provide medical care for which discounted payments were received from patients for care (other than Medicare, Medi-Cal or county indigent program recipients)?  Yes  No  
 If yes, provide the following information:

(a) Enter the accounts (number and description) used to record such discounted payments and the associated amounts received for medical care for each year.

Account:				Total
2005				
2006				
2007				
2008				

(b) Enter the total charge amount prior to discount for each year.

Account:				Total
2005				
2006				
2007				
2008				

(c) Does the organization maintain cost information for medical care for which discounted payments were received from patients, excluding Medicare, Medi-Cal or county indigent program recipients?  Yes  No If yes, enter the total cost of care according to the organization's cost calculations. (Note: Cost information should be consistent with the IRS Schedule H method or the best available method. Identify the method of cost calculation:  IRS Schedule H method,  Catholic Health Association Guidelines,  other - describe.) You may submit additional information on how cost calculations were made. If IRS Schedule H method was used and it was not based on a cost accounting system, describe and explain why such system was not used.

Account:				Total
2005				
2006				
2007				
2008				

12. Did the organization's hospital(s) incur bad debt expense for medical care provided to patients during any of the specified years?  Yes  No If yes, enter the hospital(s) total bad debt expense for medical care to such patients? (If the bad debt expense is known for uninsured patients versus underinsured patients, please specify. Otherwise, report in total.)

Year	Uninsured Patients	Underinsured Patients	Total
2005			
2006			
2007			
2008			

13. Identify the provisions in your charity care or discount payment policy that address debt collection policies and practices. Does your organization use a collection agency for debt collection of unpaid medical services?  Yes  No If yes, furnish a copy of the written agreement with the agency, which is required by the Health and Safety Code (Article 3 Hospital Fair Pricing Policies); and submit any information provided to debt collection agencies that outline the practices they must employ for debt collection.

If your organization used a collection service for any of the specified years, provide the following information:

(a) Enter the number of delinquent accounts, debt amount and total collected.

Year	No. Delinquent Accounts	Debt Amount	Total Collected
2007			
2008			

- (b) Enter the number of liens filed for delinquent accounts, the amount collected from liens, and the total amount expended to collect delinquent accounts.

Year	No. of Liens on Delinquent Accounts	Total Amount of Liens Collected	Total Amount Expended to Collect Such Debt
2007			
2008			

14. Did the organization's hospital(s) participate in any joint venture (of which the organization is a partner or shareholder) with another entity during any of the specified years?  Yes  No If yes, enter the total number of joint ventures for each year and attach a description identifying the entities involved and the organization's interest held in such entity.

2005	2006	2007	2008

15. Did the organization's hospital(s) provide funds, grants, or non-cash assistance including, but not limited to, supplies, materials, equipment, or medical services, to a public and/or non-related nonprofit tax exempt entity which operates health care facilities (hospitals, community clinics, etc.) serving lower-income patients during any of the specified fiscal years?  Yes  No If yes, enter the total contribution amount, according to the hospital's cost calculations and attach a description identifying the entities involved and what was contributed.

2005	2006	2007	2008

16. Attach to this form an organizational chart that identifies all legal entities related to and/or affiliated with the organization holding the Organizational Clearance Certificate. List the full names of the entities and complete street addresses.

17. Did your organization own and operate one or more outpatient clinics (clinics providing psychiatric services to children and/or multispecialty clinics described in Health and Safety Code section 1206, subdivision (1)), which receive the welfare exemption from property taxation under Revenue and Taxation Code sections 214?  Yes  No If yes, enter the total number of outpatient clinics providing services and attach a list of clinics, including the clinic's full name, complete street address and type of clinic. (Note: Provide information based welfare exemption claim filings for the January 1, 2009 lien date. *(Identify address, county, Assessor's Parcel Number.)*)

Total number of outpatient clinics \_\_\_\_\_

18. Enter the total compensation for the three most highly-compensated executives of the hospital organization for each of the following years. Attach a separate schedule that identifies the amounts of each of the 3 compensation components that are included on the organization's annual Form 990, *Return of Organization Exempt From Income Tax*.

NAME			
2005			
2006			
2007			
2008			

NAME OF PERSON TO CONTACT FOR ADDITIONAL INFORMATION *(Please Print)* \_\_\_\_\_

TITLE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ TELEPHONE NUMBER  
(      )

**INSTRUCTIONS FOR SUPPLEMENTAL REPORTING FORM –  
ORGANIZATIONAL CLEARANCE CERTIFICATE HOLDERS –  
NONPROFIT HOSPITAL ORGANIZATIONS**

**FILING OF FORM**

This form is to be filed as a supplemental schedule with BOE-278-OCC, *Verification for Continued Eligibility of Organizational Clearance Certificate-Welfare and Veterans' Organization Exemption*; which was mailed to your organization to verify and update our information. Form BOE-278-OCC must be completed and filed with the Board to maintain eligibility for your *Organizational Clearance Certificate*. When complete, send claim form BOE-278-OCC and this Supplemental Reporting Form to the County-Assessed Properties Division's Exemption Section at the address listed on page 1 of this form. If you have any questions, you may contact the Exemption Section at 916-445-3524.

**1. OPERATING REVENUES**

State the organization's amount of operating revenues (exclusive of gifts, endowments and grants-in-aid) for each year. Note: The amounts reported should reflect only those of the organization holding the Organizational Clearance Certificate (corporation, foundation, community chest, funds, or limited liability company); amounts for disregarded entities reported for purposes of Internal Revenue Service Form 990 should be excluded.

**2. OPERATING EXPENSES**

State the organization's amount of operating expenses for each year. (Expenses include depreciation based on cost of replacement and amortization of, and on indebtedness.) Note: The amounts reported should reflect only those of the organization holding the Organizational Clearance Certificate (corporation, foundation, community chest, funds, or limited liability company); amounts for disregarded entities reported for purposes of Form 990 should be excluded.

**3. SURPLUS REVENUES**

An organization must not be organized or operated for profit in order to continue to qualify for an Organizational Clearance Certificate and the welfare exemption. Hospitals are not deemed to be organized or operated for profit, if, their operating revenues (exclusive of gifts, endowments and grants-in-aid) did not exceed operating expenses by an amount equivalent to ten percent of those operating expenses during the immediately preceding fiscal year. (See Revenue and Taxation Code section 214, subdivision (a)(1).) However, surplus revenues may be used for specific purposes, such as debt retirement, expansion of plant and facilities or reserve for operating contingencies without disqualifying for the exemption.

State the amount of surplus revenues for each year by using the calculation in 3a.

**4. OPERATING AND NON-OPERATING EXPENSES**

State the organization's amount of non-operating revenues and non-operating expenses for each year.

**5. FINANCIAL STATEMENTS AND FORM 990**

Submit a copy of certified financial statements (balance sheet and operating statement) of the organization. If the nature of any item of income or expense is not clear from the account name, further information indicating the nature of the account should be appended. Submit an electronic copy in PDF format of Form 990, and applicable schedules filed with the Internal Revenue Service for the last 4 years. (Note: If 2008 financial statements or Form 990 is not yet available, please forward this information when it becomes available.)

**6. USE OF SURPLUS REVENUES**

If the organization had surplus revenues, as calculated in 3, identify the amounts used for debt retirement, plant or facility expansion, or reserve for operating contingencies for each year.

- **Debt Retirement** - Funds required by external sources to be used to meet debt service charges and the retirement of indebtedness on plant assets.
- **Facility Expansion** - The addition of land and/or improvements to a coordinated group of fixed assets – land, buildings, machinery, and equipment constituting a plant.
- **Reserve for Operating Contingencies** - A segregation of retained earnings evidenced by the creation of a subordinate account to meet unforeseen financial needs due to emergencies and changing medical needs.

**7. PLANT OR FACILITY EXPANSION**

Provide a description of major plant or facility expansion projects; identifying the project location, scope and timeline for completion. Report projects where construction has started or is about to start, where seismic retrofitting is required but the Office of Statewide Health Planning and Development's review or permitting process is not complete (e.g., building a new hospital, addition of parking structure, addition of hospital wing, conversion to neonatal unit). Additionally, identify any future projects where plans have been developed. (Note: if you had surplus revenues in question 3 and indicated use for plant or facility expansion in question 6, please furnish documentation on such projects, e.g., project plan, Board of Directors approvals, estimated cost of construction.)

**8. PROPERTIES CLAIMED FOR EXEMPTION**

Provide a listing of properties upon which your organization is claiming the welfare exemption; identifying the property location (physical address, city, county and Assessor's Parcel Number.) For any acute care facilities also provide the Office of Statewide Health Planning and Development's facility identification number.

**9. CHARITY CARE POLICY, DISCOUNT PAYMENT POLICY, AND COMMUNITY BENEFIT PLAN**

Identify whether your organization has a charity care and/or discount payment policy. If so, provide a copy of the organization's charity care and discount payment policy on a disk in PDF format. If your organization has multiple hospitals, indicate whether each facility has different policies. Provide a copy of the organization's most recent community benefit plan on a disk in PDF format. Provide the cost for charity care (free care) provided to patients according to the organization's cost calculations; identify the accounts (number and description) used to record such costs. (Cost of such care is to be reported using Internal Revenue Service Form 990 Schedule H method or best available method. Identify method used – Schedule H, Catholic Health Association Guidelines, or other. Explain method used.)

**10. MEDICAL CARE PROVIDED**

Indicate whether the organization's hospital provides medical care to Medicare, Medi-Cal or county indigent program recipients for each year. If yes, provide the amount of contractual adjustments in accordance with the Office of Statewide Health Planning and Development's uniform accounting and reporting system requirements for California hospitals; the amount received for such care; and cost of such care. (Cost of such care is to be reported using Internal Revenue Service Form 990 Schedule H method or best available method. Identify method used – Schedule H, Catholic Health Association Guidelines, or other. Explain method used.)

**11. DISCOUNTED PAYMENTS FOR MEDICAL CARE**

Indicate whether the organization's hospital provides medical care for which discounted payments were received from patients for care, excluding Medicare, Medi-Cal or county indigent program recipients for each year. If yes, identify the accounts (number and description) used to record discounted payment data; the amounts received for such care; and cost of such care according to the organization's cost calculations. (Cost of such care is to be reported using Internal Revenue Service Form 990 Schedule H method or best available method. Identify method used – Schedule H, Catholic Health Association Guidelines, or other. Explain method used.)

**12. BAD DEBT**

Indicate whether the organization's hospital incurred bad debt expense for each year. If yes, provide the amount of bad debt in accordance with the Office of Statewide Health Planning and Development's uniform accounting and reporting system requirements for California hospitals.

**13. COLLECTION SERVICES**

Indicate the specific provisions in your charity care or discount payment policy that disclose your debt collection policies and the effective date of such policies. Indicate whether your organization uses a collection agency for debt collection of unpaid medical services. Submit copies of all written agreements with collection agencies and any information you provide to such agencies to assist them in determining whether individuals from whom they are attempting to collect may qualify for charity care or discounted payment under the hospital's policies.

If your organization used a collection service for the specified years, provide the number of delinquent accounts, total debt amount and total amount collected. Identify the number of liens on delinquent accounts, the amount collected from liens, and the cost incurred for collection of such delinquent accounts.

- **Collection Service** – includes, but not limited to, an affiliated or unaffiliated debt collection firm, attorney, or any other type of outside collection service used by the hospital to collect delinquent accounts for medical services, whether or not the account was assigned, transferred or sold to the collection service, and whether or not, the hospital entered into a contract for this service. (It does not include any internal accounts receivable or billing departments.)

**14. JOINT VENTURES**

Indicate whether the organization participated in any joint venture with a nonprofit or for-profit entity during any of the specified years. If yes, list the entities involved (including the name of the entity, whether it is for-profit or nonprofit, description of primary activity of the entity, the organization's profit % or stock ownership %, officers, directors, trustees, or key employee's profit % or stock ownership %, physicians' profit % or stock ownership%).

**15. ASSISTANCE TO NON-RELATED ENTITY**

Indicate whether the organization provided funds, grants or non-cash assistance to unrelated nonprofit or public health care facilities serving indigent patients; and provide the amount contributed according to the hospital's cost calculations. Provide a description of what was contributed and entities involved.

**16. AFFILIATED ENTITIES**

Provide an organization chart that identifies all legal entities related to and/or affiliated with your organization (the Organizational Clearance Certificate holder). Provide the full name of the entity, its location (street address, city), and tax exempt status (nonprofit or for-profit).

## 17. MULTISPECIALTY CLINICS

Indicate whether the organization owned and operated one or more outpatient clinics (clinics providing psychiatric services to children and/or multispecialty clinics described in Health and Safety Code section 1206, subdivision(l)), which receive the welfare exemption from property taxation under Revenue and Taxation Code section 214 for the January 1, 2009 lien date. If yes, provide the total number of outpatient clinics providing services and attach a list of clinics. (*Identify the clinic's full name, complete street address and type of clinic.*)

- **Outpatient Clinics** –There are two types of outpatient clinics, whether or not patients are admitted for an overnight stay or longer, eligible for the welfare exemption under the hospital purpose of section 214, including a clinic that provides psychiatric services for emotionally disturbed children and a nonprofit multispecialty clinic. Health & Safety Code section 1206, subdivision (l) defines multispecialty clinic as a clinic operated by a nonprofit tax-exempt organization, which provides health care, health education, and conducts medical research through a group of 40 or more physicians and surgeons who are independent contractors representing not less than 10 board-certified specialties and not less than two-thirds of whom practice on a full-time basis at the clinic. The multispecialty clinic may consist of a single outpatient clinic or multiple clinics operated as a unified single integrated clinic in the aggregate. (Further information on outpatient clinics qualifying for the welfare exemption is available in Assessors' Handbook, Section 267, *Welfare, Church, and Religious Exemptions*, located on the Board's website at: <http://www.boe.ca.gov/proptaxes/pdf/ah267.pdf>)

## 18. EXECUTIVE COMPENSATION

Provide the total compensation for the three most highly-compensated executives of the hospital organization. For each executive, identify the amounts for each component as reported in the organizations IRS Form 990; (1) compensation, (2) contribution to employee benefit plans and deferred compensation, (3) expense accounts and other allowances.