AMENDED IN ASSEMBLY MAY 24, 2013

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CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 975

Introduced by Assembly Members Wieckowski and Bonta

February 22, 2013

An act to amend Sections 127280, 127400, and 129050 of, to add Chapter 2.6 (commencing with Section 127470) to Part 2 of Division 107 of, and to repeal Article 2 (commencing with Section 127340) of Chapter 2 of Part 2 of Division 107 of, the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

AB 975, as amended, Wieckowski. Health facilities community benefits.

Existing law makes certain findings and declarations regarding the social obligation of private nonprofit hospitals to provide community benefits in the public interest, and requires these hospitals, among other responsibilities, to adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements. Existing law requires each private nonprofit hospital, as defined, to complete a community needs assessment, as defined, and to thereafter update the community needs assessment at least once every 3 years. Existing law also requires the hospital to file a report on its community

benefits plan and the activities undertaken to address community needs with the Office of Statewide Health Planning and Development. Existing law requires the statewide office to make the plans available to the public. Existing law requires that each hospital include in its community benefits plan measurable objectives and specific benefits.

This bill would declare the necessity of establishing uniform standards for reporting the amount of charity care and community benefits a facility provides to ensure that private nonprofit hospitals and nonprofit multispecialty clinics actually meet the social obligations for which they receive favorable tax treatment, among other findings and declarations.

This bill would require a private nonprofit hospital and nonprofit multispecialty clinic, as defined, by January 1, ~~2015~~ *2016*, to develop, in collaboration with the community, a community benefits statement, as specified, and a description of the process for approval of the community benefits statement by the hospital's or clinic's governing board, as specified. This bill would require the hospital or clinic, prior to adopting a community benefits plan, to complete a community needs assessment, as provided. The bill would authorize the hospital or clinic to create a community benefits advisory committee for the purpose of soliciting community input. This bill would require the hospital or clinic to make available to the public a copy of the assessment, file the assessment with the Office of Statewide Health Planning and Development, and update the assessment at least every 3 years.

This bill would also require a private nonprofit hospital and nonprofit multispecialty clinic, by April 1, ~~2015~~ *2016*, to develop a community benefits plan that includes a summary of the needs assessment and a statement of the community health care needs that will be addressed by the plan, and list the services, as provided, that the hospital or clinic intends to provide in the following year to address community health needs identified in the community health needs assessments. The bill would require the hospital or clinic to make its community health needs assessment and community benefits plan or community health plan available to the public on its Internet Web site and would require that a copy of the assessment and plan be given free of charge to any person upon request.

This bill would require a private nonprofit hospital or nonprofit multispecialty clinic, after April 1, ~~2015~~ *2016*, every 2 years to revise and submit its community benefits plan to the Office of Statewide Health Planning and Development, as specified, and would allow a hospital

or clinic under the common control of a single corporation or other entity to file a consolidated plan, as provided. The bill would require that the governing board of each hospital or clinic adopt the community benefits plan and make it available to the public, as specified.

This bill would require the Office of Statewide Health Planning and Development to develop and adopt regulations to prescribe a standardized format for community benefits plans, as provided, to provide technical assistance to help private nonprofit hospitals and nonprofit multispecialty clinics exempt from licensure comply with the community benefits provisions, to make public each community health needs assessment and community benefits plan and any comments received regarding those assessments and plans, and to ~~annually~~ calculate and make public the total value of community benefits provided by hospitals, *as specified*. This bill would authorize the Office of Statewide Health Planning and Development to assess a civil penalty, as provided, against any hospital or clinic that fails to comply with these provisions. This bill would make conforming changes.

Under existing law, patients with high medical costs who are at or below 350% of the federal poverty level are eligible to apply for participation under a hospital's charity care policy or discount care policy. A patient with high medical costs is defined as a patient who, among other things, does not receive a discounted rate from the hospital as a result of his or her third-party coverage.

This bill would delete that limitation from the definition of a patient with a high medical costs.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 127280 of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic, as defined in Section 128700, shall each

year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office pursuant to this chapter, Chapter 2.6 (commencing with Section 127470), or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Chapter 2.6 (commencing with Section 127470), and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

SEC. 2. Article 2 (commencing with Section 127340) of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code is repealed.

SEC. 3. Section 127400 of the Health and Safety Code is amended to read:

127400. The following definitions apply for the purposes of this article:

(a) "Allowance for financially qualified patient" means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) (1) "Charity care" means the unreimbursed cost to a private nonprofit hospital or nonprofit multispecialty clinic of providing services to the uninsured or underinsured, as well as providing funding or otherwise financially supporting any of the following:

(A) Health care services or items on an inpatient or outpatient basis to a financially qualified patient with no expectation of payment.

(B) Health care services or items provided to a financially qualified patient through other nonprofit or public outpatient clinics, hospitals, or health care organizations with no expectation of payment.

(C) Community benefits, provided that the provision, funding, or financial support of those benefits is demonstrated to reduce community health care costs. For purposes of this subparagraph, "community benefits" means any of the following: vaccination programs and services for low-income families, *school health centers, as defined in Section 124174,* chronic illness prevention programs and services, nursing and caregiver training provided without assessment of fees or payment of tuition, home-based

health care programs for low-income families, or community-based mental health and outreach and assessment programs for low-income families. For purposes of this subparagraph, "low-income families" means families or individuals with income less than or equal to 350 percent of the federal poverty level.

(2) Charity care does not include any of the following:

(A) Uncollected fees or accounts written off as bad debt.

(B) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care.

(C) Contractual adjustments in the provision of health care services below the amount identified as gross charges or "chargemaster" rates by the health care provider.

(D) Any amount over 125 percent of the Medicare rate for the health care services or items provided on an inpatient or outpatient basis.

(E) Any amount over 125 percent of the Medicare rate for providing, funding, or otherwise financially supporting health care services or items with no expectation of payment provided to financially qualified patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(F) The cost to a nonprofit hospital of paying a tax or other governmental assessment.

(c) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(d) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (g) or a patient with high medical costs, as defined in subdivision (h).

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(e) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation.

(f) "Office" means the Office of Statewide Health Planning and Development.

(g) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

(h) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (c), ~~if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes,~~ *and who incurs* "high medical costs," ~~means any of~~ *which are defined as any of* the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital's charity care policy.

(i) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

SEC. 4. Chapter 2.6 (commencing with Section 127470) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

Chapter 2.6. Community Benefits

Article 1. Hospital Community Benefits

127470. (a) The Legislature finds and declares the following:

(1) Access to health care services is of vital concern to the people of California.

(2) Health care providers play an important role in providing essential health care services in the communities they serve.

(3) Notwithstanding public and private efforts to increase access to health care, the people of California continue to have significant unmet health needs. Studies indicate that as many as 6.9 million Californians are uninsured during a year.

(4) The state has a substantial interest in ensuring that the unmet health needs of its residents are addressed. Health care providers can help address these needs by providing charity care and community benefits to the uninsured and underinsured members of their communities.

(5) Hospitals have different roles in the community depending on their mission, governance, tax status, and articles of incorporation. Private hospitals that are investor owned and have for-profit tax status pay property taxes, corporate income taxes, and other taxes, such as unemployment insurance, on a different basis than nonprofit, district, or public hospitals. Nonprofit health facilities, including hospitals and multispecialty clinics, as described in subdivision (*l*) of Section 1206, receive favorable tax treatment by the government and, in exchange, assume a social obligation to provide charity care and other community benefits in the public interest.

(b) It is the intent of the Legislature in enacting this chapter to provide uniform standards for reporting the amount of charity care and community benefits provided to ensure that private nonprofit hospitals and multispecialty clinics operated by nonprofit corporations, as described in subdivision (*l*) of Section 1206, actually meet the social obligations for which they receive favorable tax treatment.

127472. The following definitions apply for the purposes of this chapter:

(a) "Community" means the service area or patient population for which a private nonprofit hospital or nonprofit multispecialty clinic provides health care services.

(b) "Community benefits" means the unreimbursed goods, services, and resources provided by a private nonprofit hospital or nonprofit multispecialty clinic that addresses community-identified health needs and concerns, particularly for people who are uninsured, underserved, or members of a vulnerable population. Community benefits include, but are not limited to, charity care, as defined in Section 127400, the cost of community health improvement services and community benefit operations, *the cost of school health centers, as defined in Section 124174,* and the cost of health professions education, subsidized health services for vulnerable populations, research, contributions to community groups, and community building activities.

(c) "Community benefits plan" means the written document prepared for annual submission to the office that includes, but is not limited to, a description of the activities that the private nonprofit hospital or nonprofit multispecialty clinic has undertaken to address identified community needs within its mission and financial capacity, and the process by which the hospital or clinic develops the plan in consultation with the community.

(d) "Community health needs assessment" means the process by which the private nonprofit hospital or nonprofit multispecialty clinic identifies, for its primary service area as determined by the hospital or clinic, unmet community needs.

(e) "Discounted care" means the cost for medical care provided consistent with Article 1 (commencing with Section 127400) of Chapter 2.5.

(f) "Free care" means the unreimbursed cost for medical care for a patient who cannot afford to pay for care provided consistent with Article 1 (commencing with Section 127400) of Chapter 2.5.

(g) "Nonprofit multispecialty clinic" means a clinic as described in subdivision (*l*) of Section 1206.

(h) "Office" means the Office of Statewide Health Planning and Development.

(i) "Private nonprofit hospital" means a private nonprofit acute care hospital operated or controlled by a nonprofit corporation, as defined in Section 5046 of the Corporations Code, that has been determined to be exempt from taxation under the Internal Revenue

Code. For purposes of this chapter, "private nonprofit hospital" does not include any of the following:

(1) A district hospital organized and governed pursuant to the Local Health Care District Law (Division 23 (commencing with Section 32000)).

(2) A rural general acute care hospital, as defined in subdivision (a) of Section 1250.

(3) A children's hospital, as defined in Section 10727 of the Welfare and Institutions Code.

(4) A multispecialty clinic operated by a for-profit hospital, regardless of its net revenue.

(j) "Underserved and vulnerable population" means a population that has disproportionate unmet health-related needs, such as a high prevalence of one or more health conditions or concerns, and that has limited access to timely, quality health care.

127473. A private nonprofit hospital or a nonprofit multispecialty clinic that reports community benefits to the community shall report on those community benefits in a consistent and comparable manner to all other private nonprofit hospitals and nonprofit multispecialty clinics.

127474. A private nonprofit hospital or a nonprofit multispecialty clinic shall make its community health needs assessment and community benefits plan or community health plan available to the public on its Internet Web site. A copy of the assessment and plan shall be given free of charge to any person upon request.

Article 2. Community Benefits Statement, Community Needs Assessment, and Community Benefits Plan

127475. (a) Private nonprofit hospitals and nonprofit multispecialty clinics shall provide community benefits to the community.

(b) By January 1, ~~2015~~ *2016*, each private nonprofit hospital and each nonprofit multispecialty clinic shall develop, in collaboration with the community, all of the following:

(1) A community benefits statement that describes the hospital's or clinic's commitment to developing, adopting, and implementing a community benefits program. The hospital's or clinic's governing board shall document that it has reviewed the clinic's

organizational mission statement and considered amendments to it that would better align that organizational mission statement with the community benefits statement.

(2) A description of the process for approval of the community benefits statement by the hospital's or clinic's governing board, including a declaration that the board and administrators of the hospital or clinic shall be responsible for oversight and implementation of the community benefits plan. The board may establish a community benefits implementation committee that shall include members of the board, senior administrators, and community stakeholders.

(3) A community health needs assessment pursuant to Section 127476 that evaluates the health needs and resources of the community it serves.

(c) By April 1, ~~2015~~ *2016*, a private nonprofit hospital or nonprofit multispecialty clinic shall develop, in collaboration with the community, a community benefits plan pursuant to Section 127477 designed to achieve all of the following outcomes:

(1) Access to health care for members of underserved and vulnerable populations.

(2) The addressing of essential health care needs of the community, with particular attention to the needs of members of underserved and vulnerable populations.

(3) The creation of measurable improvements in the health of the community, with particular attention to the needs of members of underserved and vulnerable populations.

127476. (a) Prior to adopting a community benefits plan, a private nonprofit hospital or nonprofit multispecialty clinic shall complete a community needs assessment that evaluates the health needs and resources of the community served by the hospital or clinic that is designed to achieve the outcomes specified in subdivision (c) of Section 127475.

(b) In conducting its community health needs assessment, a private nonprofit hospital or nonprofit multispecialty clinic shall solicit comments from and meet with local government officials, including representatives of local public health departments. A private nonprofit hospital or nonprofit multispecialty clinic shall also solicit comments from and meet with health care providers, registered nurses, community groups representing, among others, patients, labor, seniors, and consumers, and other health-related

organizations. Particular attention shall be given to persons who are themselves underserved and who work with underserved and vulnerable populations. Particular attention shall also be given to identifying local needs to address racial and ethnic disparities in health outcomes. A private nonprofit hospital or nonprofit multispecialty clinic may create a community benefits advisory committee for the purpose of soliciting community input.

(c) In preparing its community health needs assessment, a private nonprofit hospital or nonprofit multispecialty clinic shall use available public health data. A private nonprofit hospital or nonprofit multispecialty clinic may collaborate with other facilities and health care institutions in conducting community health needs assessments and may make use of existing studies in completing their own needs assessments.

(d) Prior to completing a community health needs assessment, a private nonprofit hospital or nonprofit multispecialty clinic shall make available to the public a copy of the assessment for review and comment.

(e) A community health needs assessment shall be filed with the office. A private nonprofit hospital or a nonprofit multispecialty clinic shall update its community needs assessment at least every three years.

127477. (a) By April 1, ~~2015~~ *2016*, a private nonprofit hospital or nonprofit multispecialty clinic shall develop a community benefits plan that conforms with this chapter.

(b) In developing a community benefits plan, a private nonprofit hospital or nonprofit multispecialty clinic shall solicit comments from and meet with local government officials, including representatives of local public health departments. A private nonprofit hospital or nonprofit multispecialty clinic shall also solicit comments from and meet with health care providers, community groups representing, among others, patients, labor, seniors, and consumers, and other health-related organizations. Particular attention shall be given to persons who are themselves underserved, who work with underserved and vulnerable populations, and who work with populations at risk for racial and ethnic disparities in health outcomes.

(c) A community benefits plan shall include, at a minimum, all of the following:

(1) A summary of the needs assessment and a statement of the community health care needs that will be addressed by the plan.

(2) A list of the services the private nonprofit hospital or nonprofit multispecialty clinic intends to provide in the following year to address community health needs identified in the community health needs assessments. The list of services shall be categorized under the following:

(A) Charity care, as defined in subdivision (b) of Section 127400.

(B) Other community benefits, including community health improvement services and community benefit operations, health professions education, subsidized health services, research, and contributions to community groups.

(C) Community building activities targeting underserved and vulnerable populations.

(3) A description of the target community or communities that the plan is intended to benefit.

(4) An estimate of the economic value of the community benefits that the private nonprofit hospital or nonprofit multispecialty clinic intends to provide.

(5) A summary of the process used to elicit community participation in the community health needs assessment and community benefits plan design, and a description of the process for ongoing participation of community members in plan implementation and oversight, and a description of how the assessment and plan respond to the comments received by the private nonprofit hospital or nonprofit multispecialty clinic from the community.

(6) A list of individuals, organizations, and government officials consulted during the development of the plan.

(7) A description of the intended impact on health outcomes attributable to the plan, including short- and long-term measurable goals and objectives.

(8) Mechanisms to evaluate the plan’s effectiveness.

(9) The name and title of the individual responsible for implementing the plan.

(10) The names of individuals on the private nonprofit hospital’s or nonprofit multispecialty clinic’s governing board.

(11) If applicable, a report on the community benefits efforts of the preceding year, including the amounts and types of

community benefits provided, in a manner to be prescribed by the office; a statement of the plan's impact on health outcomes, including a description of the private nonprofit hospital's or nonprofit multispecialty clinic's progress toward meeting its short- and long-term goals and objectives; and an evaluation of the plan's effectiveness.

(d) A private nonprofit hospital or nonprofit multispecialty clinic may also report on bad debts and Medicare shortfalls, although these shall not be calculated or reported as community benefits.

(e) The governing board of a private nonprofit hospital or nonprofit multispecialty clinic shall adopt the community benefits plan. A private nonprofit hospital or nonprofit multispecialty clinic shall make its draft community benefits plan available to the public, in hard copy and on its Internet Web site, no later than 30 days prior to its adoption by the governing board of the private nonprofit hospital or nonprofit multispecialty clinic.

(f) After April 1, ~~2015~~ *2016*, a private nonprofit hospital or nonprofit multispecialty clinic shall, every two years, revise and submit its community benefits plan to the office, no later than 120 days after the end of the hospital's or clinic's fiscal year.

(g) A person or entity may file comments on a private nonprofit hospital's or nonprofit multispecialty clinic's community benefits plan with the office.

(h) A private nonprofit hospital or nonprofit multispecialty clinic, under the common control of a single corporation or another entity, may file a consolidated plan if the plan addresses services in all of the categories listed in paragraph (2) of subdivision (c) to be provided by each hospital or clinic under common control of the corporation or entity.

Article 3. Duties of the Office of Statewide Health Planning and Development

127487. (a) (1) The office shall develop and adopt regulations to prescribe a standardized format for community benefits plans pursuant to this chapter.

(2) The office shall develop a standardized methodology for estimating the economic value of community benefits.

(3) In developing standards of reporting on community benefits, the office shall, to the maximum extent possible, conform to

Internal Revenue Service reporting standards for those data elements reported to the Internal Revenue Service, but shall also include those data elements required under this chapter or other state law, including charity care, as defined in Section 127400.

(4) A private nonprofit hospital or nonprofit multispecialty clinic shall annually file with the office its IRS Form 990, or its successor form, and the office shall post the form on its Internet Web site.

(b) The office shall provide technical assistance to help private nonprofit hospitals and nonprofit multispecialty clinics comply with this chapter.

(c) The office shall make public a community health needs assessment and community benefits plan and any comments received regarding those assessments and plans. The office shall make these documents available on its Internet Web site.

(d) ~~The~~ *For each year that a community benefits plan is submitted pursuant to subdivision (f) of Section 127477, the* office shall annually calculate and make public the total value of community benefits provided by *each* private nonprofit ~~hospitals~~ *hospital* and nonprofit multispecialty ~~clinics~~ *clinic* that ~~report~~ *reports* pursuant to this chapter.

127488. The office may assess a civil penalty against any private nonprofit hospital or nonprofit multispecialty clinic that fails to comply with this article in the same manner as specified in Section 128770.

SEC. 5. Section 129050 of the Health and Safety Code is amended to read:

129050. A loan shall be eligible for insurance under this chapter if all of the following conditions are met:

(a) The loan shall be secured by a first mortgage, first deed of trust, or other first priority lien on a fee interest of the borrower or by a leasehold interest of the borrower having a term of at least 20 years, including options to renew for that duration, longer than the term of the insured loan. The security for the loan shall be subject only to those conditions, covenants and restrictions, easements, taxes, and assessments of record approved by the office, and other liens securing debt insured under this chapter. The office may require additional agreements in security of the loan.

(b) The borrower obtains an American Land Title Association title insurance policy with the office designated as beneficiary, with liability equal to the amount of the loan insured under this

chapter, and with additional endorsements that the office may reasonably require.

(c) The proceeds of the loan shall be used exclusively for the construction, improvement, or expansion of the health facility, as approved by the office under Section 129020. However, loans insured pursuant to this chapter may include loans to refinance another prior loan, whether or not state insured and without regard to the date of the prior loan, if the office determines that the amount refinanced does not exceed 90 percent of the original total construction costs and is otherwise eligible for insurance under this chapter. The office may not insure a loan for a health facility that the office determines is not needed pursuant to subdivision (k).

(d) The loan shall have a maturity date not exceeding 30 years from the date of the beginning of amortization of the loan, except as authorized by subdivision (e), or 75 percent of the office's estimate of the economic life of the health facility, whichever is the lesser.

(e) The loan shall contain complete amortization provisions requiring periodic payments by the borrower not in excess of its reasonable ability to pay as determined by the office. The office shall permit a reasonable period of time during which the first payment to amortization may be waived on agreement by the lender and borrower. The office may, however, waive the amortization requirements of this subdivision and of subdivision (g) of this section when a term loan would be in the borrower's best interest.

(f) The loan shall bear interest on the amount of the principal obligation outstanding at any time at a rate, as negotiated by the borrower and lender, as the office finds necessary to meet the loan money market. As used in this chapter, "interest" does not include premium charges for insurance and service charges if any. Where a loan is evidenced by a bond issue of a political subdivision, the interest thereon may be at any rate the bonds may legally bear.

(g) The loan shall provide for the application of the borrower's periodic payments to amortization of the principal of the loan.

(h) The loan shall contain those terms and provisions with respect to insurance, repairs, alterations, payment of taxes and assessments, foreclosure proceedings, anticipation of maturity, additional and secondary liens, and other matters the office may in its discretion prescribe.

(i) The loan shall have a principal obligation not in excess of an amount equal to 90 percent of the total construction cost.

(j) The borrower shall offer reasonable assurance that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

(k) The office has determined that the facility is needed by the community to provide the specified services. In making this determination, the office shall do all of the following:

(1) Require the applicant to describe the community needs the facility will meet and provide data and information to substantiate the stated needs.

(2) Require the applicant, if appropriate, to demonstrate participation in the community needs assessment required by Section 127476.

(3) Survey appropriate local officials and organizations to measure perceived needs and verify the applicant's needs assessment.

(4) Use any additional available data relating to existing facilities in the community and their capacity.

(5) Contact other state and federal departments that provide funding for the programs proposed by the applicant to obtain those departments' perspectives regarding the need for the facility. Additionally, the office shall evaluate the potential effect of proposed health care reimbursement changes on the facility's financial feasibility.

(6) Consider the facility's consistency with the Cal-Mortgage state plan.

(*l*) In the case of acquisitions, a project loan shall be guaranteed only for transactions not in excess of the fair market value of the acquisition.

Fair market value shall be determined, for purposes of this subdivision, pursuant to the following procedure, that shall be utilized during the office's review of a loan guarantee application:

(1) Completion of a property appraisal by an appraisal firm qualified to make appraisals, as determined by the office, before closing a loan on the project.

(2) Evaluation of the appraisal in conjunction with the book value of the acquisition by the office. When acquisitions involve additional construction, the office shall evaluate the proposed construction to determine that the costs are reasonable for the type

of construction proposed. In those cases where this procedure reveals that the cost of acquisition exceeds the current value of a facility, including improvements, then the acquisition cost shall be deemed in excess of fair market value.

(m) Notwithstanding subdivision (i), any loan in the amount of ten million dollars ($10,000,000) or less may be insured up to 95 percent of the total construction cost.

In determining financial feasibility of projects of counties pursuant to this section, the office shall take into consideration any assistance for the project to be provided under Section 14085.5 of the Welfare and Institutions Code or from other sources. It is the intent of the Legislature that the office endeavor to assist counties in whatever ways are possible to arrange loans that will meet the requirements for insurance prescribed by this section.

(n) The project's level of financial risk meets the criteria in Section 129051.

O