



# HEALTH CARE SECURITY ORDINANCE (HCSO) - MANDATORY ANNUAL REPORTING FOR 2009

RETURN TO: SAN FRANCISCO OFFICE OF LABOR STANDARDS ENFORCEMENT  
P.O. BOX 7378  
San Francisco, CA 94120-7378

FOR ASSISTANCE: Refer to the enclosed worksheet, visit  
<http://www.sfgov.org/olse/hcso>, or call (415) 554-7892

Business Certificate Number

Business Name and Address

## DELINQUENT AFTER April 30, 2010

Covered Employers must complete all of the questions below. Failure to do so shall constitute a violation of § 14.3(b) of Chapter 14 of the SF Admin. Code. Violators shall be subject to penalties and other corrective action.

<input type="radio"/>	FILL THIS CIRCLE IN COMPLETELY IF YOU ARE A NONPROFIT ORGANIZATION	<input checked="" type="radio"/>	FILL THIS CIRCLE IN COMPLETELY IF YOU ARE FILING THIS FORM ON BEHALF OF SEVERAL ENTITIES IN THE SAME CONTROL GROUP.	<input type="radio"/>
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For each quarter, enter the following information:		1st Quarter: January to March 2009	2nd Quarter: April to June 2009	3rd Quarter: July to September 2009	4th Quarter: October to December 2009
A	<b>How many employees did your business employ, company-wide?</b> <i>Count ALL employees, including those outside of SF. NOTE: Employers with 19 or fewer employees are NOT covered by the HCSO and should NOT complete or file this form.</i>	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+
B1	<b>How many employees meet the definition of a covered employee under the SF HCSO?</b> <i>Include all employees who were employed at least 90 days and worked at least 8 hours per week in San Francisco during the quarter.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B2	<b>Of the employees listed in B1, how many employees signed HCSO Voluntary Waivers or met another HCSO Exemption Category?</b> <i>See worksheet for list of exemptions.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B3	<b>Subtract B2 from B1, and Enter that Number Here:</b> <i>B3 is the number of employees for whom your business must make health care expenditures (HCEs).</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**IMPORTANT: The remaining questions refer only to those employees counted in line B3; they are your employees who are entitled to HCEs.**

C	<b>For how many hours were the employees in B3 paid?</b> <i>Hours paid includes both hours worked and paid time off, such as vacation and sick leave hours, but NOT exceeding 172 hours/month or 516 hours/quarter per employee.</i>	1st Quarter <input type="text"/>	2nd Quarter <input type="text"/>	3rd Quarter <input type="text"/>	4th Quarter <input type="text"/>
D	<b>How much did your business spend to provide health care benefits for the employees in B3?</b> <i>Please enter whole dollars only; do NOT include cents or commas. This number is the TOTAL cost of providing the benefits listed below, for your employees in B3.</i>	1st Quarter <input type="text"/>	2nd Quarter <input type="text"/>	3rd Quarter <input type="text"/>	4th Quarter <input type="text"/>
E	<b>What type of health care benefits did your business provide to the employees in B3?: Complete ONLY the sections that apply to your business. Also, count each employee only once per quarter; if your business made more than one type of health care expenditure for an employee, count that employee in the category where your business spent the most money to provide health care benefits for that employee.</b>				
E1	<b>Of the employees listed in B3, how many employees did your business enroll in group health insurance coverage?</b> <i>Include employees enrolled in union and/or self-insured group health plans</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E2	<b>Of the employees listed in B3, how many employees did your business enroll in a health/medical reimbursement or spending account funded by the employer and administered by a third party vendor?</b> <i>Do NOT count employee-funded FSAs!</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
complete only if E2 applies	<b>E2(a):</b> <i>If your business funded accounts described in E2, enter the total ANNUAL dollar amount funded by the employer, not including employee contributions (in whole dollars; do NOT include cents or commas). This is the amount you made available, not the amount actually reimbursed to employees, which should be entered in E2(b) below.</i>			\$	<input type="text"/>
complete only if E2 applies	<b>E2(b):</b> <i>If your business funded accounts described in E2, enter the dollar amount employees were ACTUALLY reimbursed for the 2009 plan year (in whole dollars; do NOT include cents or commas).</i>			\$	<input type="text"/>
E3	<b>Of the employees listed in B3, for how many employees did your business provide direct reimbursements or make direct payments for health care expenses?</b> <i>Include only funds administered internally, by/within your business.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
complete only if E3 applies	<b>E3(a):</b> <i>If E3 applies to your business, enter the ANNUAL maximum dollar amount (the cap or ceiling) that you made available or could have spent on direct reimbursements or payments (in whole dollars; do not include cents or commas).</i>			\$	<input type="text"/>
complete only if E3 applies	<b>E3(b):</b> <i>If E3 applies to your business, enter the dollar amount ACTUALLY spent on direct reimbursements or payments for the 2009 plan year (in whole dollars; do not include cents or commas).</i>			\$	<input type="text"/>
E4	<b>Of the employees listed in B3, for how many employees did your business make payment for the City Option</b> (which includes both Healthy San Francisco and the City's Medical Reimbursement Account)?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

By submitting this report the above-named employer certifies the following: (1) that the information on this reporting form is correct; (2) that all compensable hours paid to the employees who performed work in the geographic boundaries of the City and County of San Francisco during the period covered by this report are reported herein; (3) that this report, whether or not signed in the space provided below, is being submitted by the employer or duly authorized representative of the employer. Under the laws of the State of California, I declare under penalty of perjury that I have read the foregoing and that it is true, correct, and complete to the best of my knowledge and belief.

2875

SIGN HERE \_\_\_\_\_

DATE \_\_\_\_\_, 2010

PRINT NAME \_\_\_\_\_

TELEPHONE/EMAIL \_\_\_\_\_

