

**Statement of Organization
Recipient Committee**

Type or print in ink

Statement Type Initial
Not yet qualified or

_____/_____/_____
Date qualified as committee

Amendment
List I.D. number:

1289607
08/17/2006
Date qualified as committee
(if applicable)

Termination - See Part 5
List I.D. number:

_____/_____/_____
Date of Termination

Date Stamp RECEIVED 2006 NOV -3 AM 9:37 OFFICE OF THE CITY CLERK CITY OF NEWPORT BEACH	STATEMENT OF ORGANIZATION CALIFORNIA FORM 410
	For Official Use Only

1. Committee Information

NAME OF COMMITTEE
Residents for Yes on V, Major Funding by Hoag Hospital, a Community Healthcare Provider

STREET ADDRESS (NO PO BOX)
1821 Mariners Drive

CITY STATE ZIP CODE AREA CODE/PHONE
Newport Beach, CA 92660 949-858-7448

MAILING ADDRESS (IF DIFFERENT)
Post Office Box 11926
Newport Beach, CA 92658,

OPTIONAL: FAX / E-MAIL ADDRESS
949-858-6807

COUNTY OF DOMICILE Orange	COUNTY WHERE COMMITTEE IS ACTIVE IF DIFFERENT THAN COUNTY OF DOMICILE
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2. Treasurer and Other Principal Officers

NAME OF TREASURER
Betty Presley

STREET ADDRESS
30151 Tomas

CITY STATE ZIP CODE AREA CODE/PHONE
Rancho Sta Margarita, CA 92688 949-858-7448

NAME OF ASSISTANT TREASURER, IF ANY

STREET ADDRESS

CITY STATE ZIP CODE AREA CODE/PHONE

NAME AND POSITION OF OTHER PRINCIPAL OFFICER(S), IF APPLICABLE

MAILING ADDRESS

CITY STATE ZIP CODE AREA CODE/PHONE

3. Verification

I have used all reasonable diligence in preparing this statement and to the best of my knowledge the information contained herein is true and complete. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 11/1/06
DATE

Executed on _____
DATE

Executed on _____
DATE

Executed on _____
DATE

By Betty Presley
SIGNATURE OF TREASURER OR ASSISTANT TREASURER

By _____
SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

By _____
SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

By _____
SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

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COMMITTEE NAME

Residents for Yes on V, Major Funding by Hoag Hospital, a Community Healthcare Provider

I.D. NUMBER

1289607

4. Type of Committee Complete the applicable sections.

Controlled Committee

- List the name of each controlling officeholder, candidate, or state measure proponent. If candidate or officeholder controlled, also list the elective office sought or held, and district number, if any, and the year of the election.
- List the political party with which each officeholder or candidate is affiliated or check "non-partisan."
- If this committee acts jointly with another controlled committee, list the name and identification number of the other controlled committee.

NAME OF CANDIDATE/OFFICEHOLDER/STATE MEASURE PROPONENT	ELECTIVE OFFICE SOUGHT OR HELD (INCLUDE DISTRICT NUMBER IF APPLICABLE)	YEAR OF ELECTION	PARTY
			<input type="checkbox"/> Non-Partisan
			<input type="checkbox"/> Non-Partisan

- List the financial institution where the campaign bank account is located (controlled "candidate election" committees only)

NAME OF FINANCIAL INSTITUTION	AREA CODE/PHONE	BANK ACCOUNT NUMBER

ADDRESS	CITY	STATE	ZIP CODE

Primarily Formed Committee

Primarily formed to support or oppose specific candidates or measures in a single election. List below:

CANDIDATE(S) NAME OR MEASURE(S) FULL TITLE (INCLUDE BALLOT NO. OR LETTER)	CANDIDATE(S) OFFICE SOUGHT OR HELD OR MEASURE(S) JURISDICTION (INCLUDE DISTRICT NO., CITY OR COUNTY, AS APPLICABLE)	CHECK ONE	
		SUPPORT	OPPOSE
General Plan Update V	Newport Beach	X	
		SUPPORT	OPPOSE

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I.D. NUMBER
1289607

4. Type of Committee (Continued)

General Purpose Committee

Not formed to support or oppose specific candidates or measures in a single election. Check only one box:

CITY Committee COUNTY Committee STATE Committee

PROVIDE BRIEF DESCRIPTION OF ACTIVITY

Sponsored Committee

List additional sponsors on an attachment.

NAME OF SPONSOR

INDUSTRY GROUP OR AFFILIATION OF SPONSOR

STREET ADDRESS

NO. AND STREET

CITY

STATE

ZIP CODE

Small Contributor Committee

____/____/____
Date qualified

Check box and provide the date this committee qualified as a small contributor committee. If the committee qualified as a small contributor committee on January 1, 2001, enter 1/1/01.

5. Termination Requirements

By signing the verification, the treasurer, assistant treasurer and/or candidate, officeholder, or proponent certify that all of the following conditions have been met:

- This committee has ceased to receive contributions and make expenditures;
 - This committee does not anticipate receiving contributions or making expenditures in the future;
 - This committee has eliminated or has no intention or ability to discharge all debts, loans received, and other obligations;
 - This committee has no surplus funds; and
 - This committee has filed all campaign statements required by the Political Reform Act disclosing all reportable transactions.
- There are restrictions on the disposition of surplus campaign funds held by elected officers who are leaving office and by defeated candidates. Refer to Government Code Section 89519.
- Additional filing obligations will be incurred if, after terminating, the committee receives or spends any funds, or receives the forgiveness of a loan, repayments of loans made to others, or any other receipts.