APPENDIX

Public Financial Disclosure Requirements for Hospitals

Organized by Type of Corporation

Information	Not-For-Profit	Publicly Traded For-Profit	Privately Held For-Profit
Sources of Public Support	YES (Via 990 & Medicare Cost Reports)	YES (Via SEC Filing & Medicare Cost Reports)	YES (Via Medicare Cost Reports)
Program Service Revenue	YES (Via 990)	YES (Via SEC Filings)	NO
Program Service Expenses	YES (Via 990)	YES (Via SEC Filings)	NO
Profit/Loss	YES (Via 990 & Medicare Cost Reports)	YES (Via SEC Filing & Medicare Cost Reports)	YES (Via Medicare Cost Reports)
Breakdown of Functional Expenses	YES (Via 990) (Also sent to DoH)	YES (Via SEC Filing) (Also sent to DoH)	NOT PUBLIC (Submitted to DoH in annual audited financials)
Statement of Program Service Accomplishments	YES (Via 990)	NO	NO
Balance Sheets	YES (Via 990 & Medicare Cost Reports)	YES (Via SEC Filing & Medicare Cost Reports)	YES (Via Medicare Cost Reports)
List of Key Individuals	YES (Via 990 & DOR Reports)	YES (Via SEC Filing & DOR Reports)	YES (Via DOR Reports)
Compensation of Key Individuals	YES (Via 990)	YES	NO
List of Subsidiaries	YES (Via 990 & DOR Reports)	YES (Via SEC Filing & DOR Reports)	YES (Via DOR Reports)
Compensation of Highest Paid Employees	YES (Via 990)	NO	NO
Compensation of Highest Paid Contractors	YES (Via 990)	NO	NO
Community Needs Assessment	YES (Via 990)	NO	NO
Value of Community Service	YES (Via 990)	NO	NO

Testimony before the joint hearing of the Senate Health, Human Services and Senior Citizens' Committee and the Senate Legislative Oversight Committee

Testimony submitted by Travis Stein
SEIU United Healthcare Workers – West
May 20, 2013

Thank you for this opportunity to speak to you today on behalf SEIU's hospital workers union in California, United Healthcare Workers – West, here in solidarity with SEIU's Committee of Interns and Residents. Both our unions strongly support effective laws to protect charitable assets and to ensure that community hospitals remain assets in service of their communities.

Our experience both in California and New Jersey suggests that very careful scrutiny of hospital conversions is critical to protecting high quality care and responsible corporate behavior. One California company, Prime Healthcare, inspired the out-of-network business model of HoldCo here in New Jersey, and now seeks to acquire at least four New Jersey hospitals of its own. Prime Healthcare's business typically leads to excessive healthcare costs, as was vividly demonstrated in a pair of recent New York Times articles. The stories, based on 2011 Medicare data, brought national focus on inflated hospital prices – and spoke directly to how the out-of-network model HoldCo adopted from Prime Healthcare has led to extremely high prices for out of network emergency room patients, including at Bayonne Medical Center in Hudson County.

Even beyond Prime and HoldCo's Emergency Room business model, Prime Healthcare provides an especially poignant example of why scrutiny of hospital acquisitions by regulators is so important. Non-profit officials eager to unload unprofitable facilities have reason *not* to scrutinize well-funded buyers, and may look for fig leaves to cover even the most conspicuously offensive behavior. In Prime's case the fig leaves are dubious "quality awards" issued by hospital ratings companies that rely on hospitals' Medicare bills. The awards cannot be trusted if medical diagnoses on a hospital's Medicare bills are inflated, because analysts use the same diagnoses to figure out whether patients are likely to survive. Prime's quality scores are inflated because the company tells Medicare that an impossibly high number of patients are extremely sick. Many of these diagnoses are questionable, which is why Prime faces a federal investigation for alleged Medicare fraud.

Although non-profits seeking to sell their hospitals to a well-funded purchaser have proven all-too-willing to turn a blind eye, it is not hard for regulators to judge whether the problems at Prime are real. For example, at one of Prime Healthcare's hospitals, 32% of seniors were diagnosed with severe forms of malnutrition, including 1 in 5 who were billed for Kwashiorkor, an extremely rare form of severe malnutrition typically found among starving children in impoverished, famine-struck regions.

Of course, over 1,000 patients in Redding California did not *really* have Kwashiorkor – so patient outcomes were better than would be expected for such severely ill patients. After all, if you are not really so sick, you are much less likely to die. But such outlier rates of serious conditions don't just lead to exaggerated quality scores – they also mean higher costs to the healthcare system as a whole, and a strain the trust between hospitals and patients.

While the impossibly high rates of serious conditions at Prime's hospitals – conditions like severe malnutrition, acute heart failure,

SEIU-UHW
United Healthcare Workers West

autonomic nerve disorder, septicemia and encephalopathy – have led to award-winning journalism and to state and federal investigations, non-profits eager to sell to companies like Prime are incentivized to overlook the warnings and point to the fig leaf. Because of these incentives, and given just how important our community hospitals are to us in our most vulnerable days, we strongly commend you for your continuing work towards improved scrutiny of hospital conversions by regulators who serve no interest beyond that of our communities.

Thank you.

For additional information, please contact:

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SEIU-UHW
United Healthcare Workers West

Testimony of Ann Twomey, President, HPAE

Senate Health and Regulatory Oversight Committees

May 20, 2013

Good afternoon. My name is Ann Twomey and I am President of the 12,000 member Health Professionals and Allied Employees. Thank you, Chairmen Vitale and Gordon and Committee members for the opportunity to discuss the rapid and aggressive incursion of for-profit companies into New Jersey's health care market in recent years; the impact on our communities and our not-for-profit hospitals and healthcare facilities; and the gaps in laws, regulations and oversight that should provide standards and safeguards for our communities' healthcare needs and access. HPAE members, nurses and health professionals working in NJ hospitals and health care facilities, are front-line witnesses to the impact of for-profit conversions on their patients, their communities and on health care working conditions.

In 1997 there were no for-profit companies operating hospitals in New Jersey. Now there are eight: Bergen Regional Medical Center (1998); Memorial Hospital of Salem County (2000); Mountainside Hospital (2004/2010); Bayonne Medical Center (2008); Meadowlands Hospital Medical Center(2010); Hoboken University Medical Center (2011); Christ Hospital (2011) and the about-to-be-re-opened Pascack Valley/HUMC/Legacy. In addition, there are 3 hospital purchases by for profit entities that are pending – St. Michael's, St. Mary's and St. Clare's, and others rumored.

These hospital conversions from not-for-profit to for-profit are at a tipping point – threatening to undermine access to care and affordability of care for our communities. The companies buying up our hospitals are notorious for aggressive 'billing and coding'; business models that rely on out-of-network care, increasing health care costs for consumers and insurers and encouraging inappropriate admissions through the Emergency Room; downsizing of staff and service cutbacks; and in some cases, a focus on specific 'niche' services can shift costs and 'less profitable' services onto existing not-for-profit community hospitals.

Generally, nurses and health professionals working at a financially fragile hospital learn of an impending sale when everyone else does, after months of rumors and anxiety, when hospital leadership announces that the sale to a for-profit buyer is the only option that will avoid closure. The new owners are able to purchase the hospital for 'pennies on the dollar'. In several instances, the buyers have sold the real estate on which the hospital sits to another group of investors in opaque sale-leaseback deals, reaping significant profits that are not necessarily invested in the facility.

The Board of Trustees of a hospital has the fiduciary duty to search for an appropriate buyer, solicit and review bids, select a buyer, and negotiate the sale. Community members, hospital employees and elected officials often wonder how and why Trustees selected a particular company. What we have learned, after reviewing board minutes that are submitted to the Office of the Attorney General (OAG) as part of the OAG's review of the sale under the Community Health Asset Protection Act (CHAPA), is that executive leadership all too often share little information with Board members who make pro-forma decisions with an appalling lack of due diligence. Scant attention is paid to the track record of the

applicants and their 'character and competence' as defined in state regulation. Little or no scrutiny is given to their commitment to preserving needed services and retaining staff, to meeting community healthcare needs and to respecting the rights of the existing workforce.

For example, at both Christ and Meadowlands hospitals we were concerned that companies were selected to run the hospitals without any public bidding process with standards for an acceptable bid. Nor did it appear that a not-for-profit option was searched for first. In the deals involving Bergen Regional Medical Center, Meadowlands Hospital and Bayonne Medical Center, the chosen companies had a number of significant violations on their track record, either in NJ or in other states, or had no experience running an acute care hospital. In other examples, there was a large disparity between promises made to staff and commitments included in the legal documents provided to NJ agencies.

Hospital staff feels compelled to support any company and any deal, or face their hospital's closure, with a loss of their jobs and of access to needed services. Under that pressure, workers with union contracts attempt to reach a new collective bargaining agreement with the buyer. When workers or community residents raise questions and ask for transparency, they are warned that they will be the cause of the hospital's demise.

At Christ Hospital, for example, hospital executives used flyers and 'town hall' meetings to blame the nursing union for raising questions about Prime Healthcare -- a company which later withdrew its bid after careful scrutiny by the community and OAG.

Working closely with community leaders and elected officials, our union members articulated a vision for the hospital they were trying to save, and we have advocated with both the NJ Department of Health and the OAG to place conditions on the sale that would:

- Protect and maintain current services & community access to care;
- Limit the out of network model and cost-shifting to consumers and other healthcare providers;
- Provide safe staffing;
- Protect the collective bargaining rights of the workforce, and their right to safe working conditions, job security and healthcare coverage;
- Hold these for-profit companies to the same requirements for accountability, service provision, and financial transparency as non-profit hospitals;
- Create community oversight and enforcement mechanisms that ensure continued access to safe, effective and needed healthcare services.

The Department of Health (DOH) and the OAG have adhered to the requirements to share relevant documents, hold public hearings, and listen to the community and worker concerns raised during the public scrutiny of these hospital conversions. What has been frustrating is the limited effectiveness of

many of the conditions placed on these conversions and the agencies' apparent inability or unwillingness to consistently and stringently enforce the standards and conditions set.

And that is why we are here today. I know that you will hear from others with recommendations for changes in our CHAPA law and CN regulations and I have listed ours at the end of my testimony. I will focus my comments on the problems that persist due to these gaps in law and the failures of oversight:

- **High costs, driven in part by out-of-network models**: The federal government's release of hospital charges data earlier this month put an unflattering spotlight on NJ, as headlines proclaimed "Jersey's hospitals are among the highest priced in the nation, ranking second only to California's" and Meadowlands Hospital and Bayonne Medical Center, were singled out for consistently charging prices that were among the highest in the state. http://www.northjersey.com/news/NJ_among_priciest_for_hospital_care.html?page=all Source: Centers for Medicare & Medicaid. Normally, insurers and patients pay only a fraction of these charges, but when Meadowlands and Bayonne converted to for-profit hospitals, both went 'out-of-network' for most insurers, leaving those insurers and patients liable for the full charged amount. In fact, gross revenues per patient day increased dramatically to levels far above surrounding hospitals after Bayonne converted to for-profit, and Meadowlands appears to be on a similar trajectory. The out-of-network model limits access for local residents, encourages admissions through the Emergency Room and results in skyrocketing costs.

- **Cuts in services**: Memorial Hospital of Salem County, owned by Community Health Services (CHS), a national for-profit hospital chain, asked the DOH to allow it to discontinue maternity services in 2010. This request was made despite conditions placed on CHS by the DOH and the OAG during the 2002 conversion of the hospital that required maintenance of these services. CHS ultimately withdrew the request in response to community and nursing protests. At Bayonne, bed capacity in some services has been reduced, and recent newspaper reports cite clinic closures at Bergen Regional Medical Center. In the first year of ownership, the Meadowlands Hospital owners focused primarily on providing highly profitable, hospital-based pain management services that dominated operating room time at the expense of other surgical services.

- **Lack of financial transparency**: The public, regulators, and elected officials are unable to "follow the money", even though the DOH requires financial reports as part of the conditions of purchase in all hospital sales. For example, the DOH has twice fined Meadowlands hospital $6,000 for failure to file its 2011 audited financial statement, which was due nearly one year ago. (DOH letters to CEO Lynn McVey December 21, 2012 and March 26, 2013). Meadowlands Hospital must file its 2012 Audited Financial Statement by June 30, 2013; it has yet to file the AFS for 2011.

- **Staffing cuts:** Even though CN Conditions usually require the new owners to 'hire substantially all employees", there have been profound staffing cuts at Meadowlands Hospital, Bergen Regional Medical Center and Bayonne Medical Center. According to our own analysis, there

were 450 full-time nurses, technicians and ancillary staff at Meadowlands Hospital before the conversion – and only 300 in 2013.

- **Attacks on Nurses' and Healthcare Workers' Rights:** Even though the DOH asks (and the bankruptcy court requires) that potential buyers negotiate with unions representing the existing staff, the new owners all too often violate the terms of the contract once the sale is completed. Basic rights to safe working conditions, the ability to speak up for patient care without fear of retaliation, health insurance coverage and job security all have been violated at Meadowlands Hospital. While we are challenging these violations through the National Labor Relations Board, these tactics threaten the retention of qualified staff and have a chilling effect on those willing to speak up for patient care and their profession.

- **Hidden Real Estate Deals:** At Bayonne, Hoboken and Meadowlands, hospital owners have sold the property out from under the hospital in sale-leaseback arrangements with 'real estate investment trusts' or other private investors. Beyond the sale price, the terms of these arrangements are totally opaque to government agencies and the public and are entirely unregulated. The owners of Bayonne Medical Center sold the hospital real estate to Medical Properties Trust Inc (MPT) for $58M in 2011[1], less than three years after they paid $100,000 in cash and assumed approximately $32M in liabilities to purchase the hospital, a nearly $26M gain. In Secaucus, MHA LLC sold the property where Meadowlands Hospital Medical Center is located to MHR Investments LP, a Montreal-based entity, in December 2012 for $18M.[2]

- **Self-dealing:** The for-profit operators of Bergen Regional, Bayonne and Meadowlands have arranged business relationships between the hospitals and related parties. Bergen Regional has entered into agreements with related companies worth an estimated $25.5 million in 2011 alone to provide services such as information technology, health insurance for hospital employees and management consulting. While not-for-profit hospitals are required to detail the transactions and have strict rules related to self-dealing and transparency, "following-the-money" is much more difficult in for-profit hospitals since disclosure is more limited.

- **No Protections for Public Institutions:** During the reorganization of UMDNJ and Rutgers, this legislature built in important protections for University Hospital's mission, staff and community services. These protections were crucial because CHAPA does not cover public hospitals such as Bergen Regional Medical Center and Runnells Hospital in Union County, although there are now some consultant reports recommending that Runnells be privatized, and the current lease at BRMC is up in 2017.

Despite the need for more oversight, the DOH is doing less in its ongoing oversight of hospitals:

1. *Since February 2011 the* ***DOH no longer conducts hospital license renewal survey inspections,*** *relying instead on accreditation inspections by the Joint Commission or DNV Healthcare, and Regulatory*

[1] Medical Properties Trust 2012 10-K available at http://phx.corporate-ir.net/phoenix.zhtml?c=185765&p=irol-sec
[2] Bargain and Sale Deed available at Hudson County Register's Office.

Compliance Statements (RCS) signed by the hospital CEO attesting to their adherence to NJ laws and regulations. Joint Commission inspections take place only once every three years; DNV inspections occur annually. ***Unlike the DOH's inspection reports which were publicly available through OPRA, the Joint Commission/DNV reports are considered "proprietary" and are not available to the public.*** *Although the accreditation reports are not routinely submitted to the DOH, regulations give DOH the authority to request a copy of the accreditation inspection report. We do not know if the DOH has ever exercised this right.*

2. *The* ***Regulatory Compliance Statements are the only assurance that hospitals are complying with those NJ hospital licensing laws*** *and regulations that have no equivalent requirement in the accreditation inspections. DOH regulations state that the DOH "shall not renew a license if the Department does not receive a facility's RCS". Nevertheless, DOH twice renewed Meadowlands Hospital's license without obtaining their Regulatory Compliance Statement. The first time, the Hospital filed its 2011 RCS in July 2011, four months after the DOH renewed the hospital's license, and the same month that the DOH cited the hospital for serious violations of state and federal licensing standards. The hospital filed its second RCS in December 2012, nine months after the DOH issued the hospital its 2012 license renewal.*

3. ***DOH no longer puts complaint inspection reports online, and it takes months to receive a copy of the outcome of a complaint.***

4. ***Fines and Penalties****: As of May 2, 2013, Meadowlands Hospital still has not submitted its 2011 Audited Financial Statement (AFS) to the NJDOH, which was due June 30, 2012. This is a requirement of both NJ hospital licensing regulations and a Condition of the Meadowlands Hospital Certificate of Need. This would be the first audited financial statement for the hospital since the conversion from not-for-profit to for-profit ownership by MHA LLC in December 2010. After repeated promises by the owners to submit their 2011 AFS went* ***unfulfilled, the DOH finally fined the hospital $6,000 ($1,000 per month) for violating its CN on December 21, 2012. When the violation continued, the DOH fined MHA LLC another $6,000 ($2000 per month) on March 26, 2013. NJ healthcare facilities licensing regulations at 8:43E-3.4(a)(12) require the DOH to levy a fine of $1000 per day for violating a CN Condition.***

5. Hospital Monitoring Law*: Early Warning System and Interventions, S1796/A2608, enacted in 2008, created an "Early Warning System" to alert the DOH to hospitals that are in financial distress or at risk of being in financial distress and gives the DOH the authority to appoint a monitor with wide-ranging powers when financial distress triggers are reached. The law requires the DOH to develop regulations that would specify the financial triggers for the "financial distress" designation and the potential interventions the DOH could implement, based on the recommendations in the report of the Commission on Rationalizing Health Care Resources ("Reinhardt Report"). This law is especially important because it gives the NJ Healthcare Facilities Financing Authority (HCFFA) and the DOH clear authority to intervene with hospitals even if they do not have bond debt through the state. Unfortunately, the implementing regulations have never been promulgated. Hospitals do submit a monthly "dashboard" of five financial indicators (not subject to OPRA) to the NJHCFFA. As far as we know, the DOH has not exercised its intervention authority beyond sending DOH/HCFFA staff to attend board and/or finance committee*

meetings of some financially distressed hospitals (eg Meadowlands; Christ Hospital-prior to sale to Hudson Holdco).

You might notice that Meadowlands Hospital figures prominently in most of my examples of failed oversight and limited enforcement. Nevertheless, despite numerous and repeated citations for significant patient safety, licensing, and CN violations, including for failure to file audited financial reports, the DOH has fined Meadowlands Hospital only three times for a total of a mere $15,000.

Beginning in June 2011, HPAE has repeatedly written to and met with DOH officials requesting the appointment of a monitor or a temporary manager to review and oversee patient safety and financial integrity at Meadowlands Hospital. Elected officials, including Senators Vitale and Weinberg; healthcare advocates, including NJ Appleseed Public Interest Law Center and NJ Citizen Action, and individual community members have joined us in making this request. To the best of our knowledge, the DOH has never formally responded to any of these calls for help.

For example, I wrote to Commissioner O'Dowd earlier this month after I filed an OPRA request for and received copies of several documents submitted by the Meadowlands Hospital owners to the DOH as required in the Conditions to their Certificate of Need. Some of the submissions were long overdue, some presented confusing data, others were not timely or not relevant or both. In my letter to the Commissioner, I pointed out that the Meadowlands Hospital owners had failed to provide the required data documenting that they are providing outpatient and preventive services to medically indigent patients; they had failed to provide reports from their Community Advisory Group; they had failed to provide an assessment of their outreach to the community, and they provided "utilization statistics" that are difficult to reconcile with Cost Reports and other data they have submitted to the DOH.

And now, as we meet here today, the NJ Department of Health and Office of the Attorney General are considering the sale of two not-for-profit hospitals to Prime Healthcare of California. More than 30 organizations and elected officials have written to the DOH and OAG asking that the process be suspended due to a U.S. Department of Justice investigation into Prime Healthcare over allegations of fraudulent billing practices and a U.S. Department of Health and Human Services' Office for Civil Rights investigation over alleged violations of patient privacy laws.

We once thought that if we set strong enough standards and protections, we could maintain quality, services and safe staffing and working conditions. But, we now know that we need to strengthen our laws and strengthen our oversight.

Along with NJ Citizen Action, NJ Appleseed Public Interest Law Center, I support a series of recommendations to strengthen the existing CHAPA law and enforcement mechanisms by the DOH, which are listed in my testimony here:

- **Codify the common law's mandate that a charitable corporation remain a charitable corporation rather than changing its mission**, including converting to a for-profit entity, unless it is impossible to remain a nonprofit health facility;

- **Make clear that the CHAPA process applies even after a bankruptcy court approves the sale of the license and facility in that process;**

- **Strengthen the CN track-record requirement to disallow transfer of hospital licenses to owners under current federal/state investigation, with a pattern of state violations** – in NJ or other states where owners have held licenses, regardless of the type of facility at which the violations occurred, or who employ business practices that are incompatible with state health policy.

- **Conduct a health impact study/analysis of the sale to determine its likely impact on the quality, affordability and access to care and require DOH undertake such analysis as set forth in CHAPA, rather than relying solely on its CN process.**

- **Expand the CHAPA law to cover public hospitals and hospital closings; and, in the event of closure codify a preference that the facility remain a healthcare facility.**

- **Require full disclosure and OAG and DOH review of all sale-leaseback plans and contracts, whether prior to, during or post-license transfer, and to permit the Attorney General to condition any sale to a for-profit entity on a claw-back if the facility is sold for more money than purchased (less capital improvements).**

- **Require purchasers to make a 10-year commitment to maintain the hospital as an acute care hospital that is directed to providing the medical and public health services that are actually needed by the community the hospital serves, and to collaborate with other area hospitals and state officials to ensure coordination of care on a regional basis, especially for government insured patients.**

- **Require purchasers at the time of sale to maintain staff at current levels, and thereafter, at appropriate levels to assure patient safety; to abide by workplace safety requirements; to honor any collective bargaining agreements; and to uphold workplace rights.**

- **Require purchasers to maintain existing insurance contracts** and continue to negotiate insurance contracts to assure coverage for local residents; and amend state laws so as to eliminate any incentives for hospital providers to employ an out-of network business model.

- **Require financial and governance transparency of all hospitals regardless of corporate status;** that is, for-profit entities must provide quarterly unaudited financial statements, annual audited financial statements, current list of investors, transfers of funds to other related entities and lists of board members and business relationships among or with board members to the NJ Department of Health – which will be available for public review subject to OPRA. This requirement ensures parity with the reporting requirements of nonprofit hospitals.

- **Require all buyers to maintain outpatient care and charity care services necessary to serve local communities**, not just maintain the same services and charity care levels as the seller. The NJDOH should evaluate prior levels of these services over a reasonable window (5 years), since distressed hospitals often reduce or eliminate needed services prior to a for-profit conversion.

- **Establish best practices for Board governance and establish a Community Oversight Board** that may include physicians and other providers not employed by the hospital, local elected officials, and community service providers and other local organizations. The Board shall not be chaired by the hospital and it must be is independent of the purchasing hospital. This Board must approve any significant change of hospital services prior to requesting DOH permission to do so.

- **Amend CHAPA to *require* DOH to hire a monitor for each conversion** to oversee compliance with state laws and regulations generally, not just charity care, and require the monitor to attend Board meetings and meet with community leaders, the Community Oversight Board and employees or representatives of employees for at least three years following conversion.

- **Increase fines and enforcement actions for a continuing pattern of non-compliance with CN/CHAPA conditions,** and makes available for public review the result of complaint inspections on the NJDOH website and to complainants following the inspection and any NJDOH citation but prior to acceptance of the Plan of Correction.

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March 25, 2013

Governor Chris Christie
Office of the Governor
PO Box 001
Trenton, NJ 08625

HPAE

Dear Governor Christie:

I am writing to you as President of the 12,000 member Health Professionals and Allied Employees (HPAE), to urge you to investigate the concerns raised by Registered Nurses and healthcare workers providing patient care services at Meadowlands Hospital and Medical Center (MHMC), and to ask that you take the steps necessary to appoint a temporary manager at Meadowlands Hospital, owned and operated by MHA LLC.

Since taking over the hospital in December 2010, MHA LLC has repeatedly violated hospital licensing standards and other laws and regulations; the Certificate of Need (CN) conditions imposed by the DOH when the license was transferred; and standards of good governance and prudent financial management. We believe a temporary manager is essential to assure the hospital's financial viability, patient safety, the community's continued access to care and the safety and security of employee working conditions.

We make this request in light of our most recent discovery of at least $4.5M of outstanding federal tax liens against MHA LLC (attached) and after requests to the NJ Department of Health to appoint a temporary manager at MHMC, under N.J.A.C. 8:43E-3.1(a)(3). The attached letter of December 4, 2012 from NJ Appleseed Public Interest Law Center, on behalf of HPAE, to DOH Commissioner O'Dowd outlines the serious concerns we have raised and MHA's apparent continued refusal to follow DOH regulations and safeguards.

Why a Temporary Manager is Necessary at MHMC

Among the reasons cited in the attached letter for requesting that the DOH appoint a temporary manager include:

- Questionable Financial Practices and Fiscal Instability
- Termination of Experienced Staff
- Violations of the Certificate of Need Requirements Imposed on Hospital License Transfer
- Drastic Cuts in Employee Health Insurance – in Violation of CN Requirements

10x

Since this letter of December, 4,2012, developments listed below further add to the need for a temporary manager to be appointed to ensure compliance by MHA LLC with patient safety laws, licensure requirements and basic rights of the healthcare workforce.

Federal Tax Liens: We learned of two IRS federal tax liens against MHA LLC totaling at least $4.5M. The first lien, filed on August 20, 2012 is for $1,526,471. Of that, $17, 788 is for failure to file employer's annual federal unemployment tax for the tax period ending 12/31/2011 and the remaining $1,508,682 is for failure to file employer's quarterly withholding tax for the quarters ending 12/31/2011 and 3/31/2012. There is no record at the Hudson County Register's Office that the lien has been released as of our last inquiry of March 18. Additional interest and penalties likely are accruing.

The second lien, filed on March 5, 2013, is for $2,936,381, for failure to file employer's federal quarterly withholding tax for the quarters ending 6/30/2012 and 9/30/2012. Here again, additional interest and penalties likely are accruing. These outstanding and significant federal tax liens raise very serious concerns over the financial viability of our hospital.

Failure to File Audited Financial Statement: MHA LLC recently paid a $6,000 fine to the NJDOH for failure to file their 2011 audited financial statement (AFS) which was due June 30, 2012. Even after paying the fine, MHA LLC still has not submitted their 2011 AFS. This lack of transparency and flagrant disregard for CN requirements and licensing standards, coupled with the outstanding federal tax liens, demand immediate intervention to assure the continued safe operation of our hospital.

Sale-leaseback deal with company having questionable track record: MHA LLC entered into a 98 year-long sale-leaseback agreement with Rosdev Development Inc, a Montreal-based real estate company, for the land on which Meadowlands Hospital is located on December 24, 2012 for a sale price of $18M. (See attached Bargain and Sale Deed and Memorandum of Lease). Rosdev Development Inc is described in the Bargain and Sale Deed as the "predecessor-in-interest" of MHR Investments LP, which now owns the hospital's real property. Because there is no government scrutiny or oversight of these sale-leaseback transactions, we don't know the terms, conditions or covenants contained in the lease agreement.

We have uncovered however, some disturbing information about the track record of Rosdev Development and its affiliate, Rosdev Hospitality U.S. LLC, which is a General Partner of MHR Investments LP. In Canada, RosDev was engaged in a long-term dispute

with the Canadian government that spanned from 1996 until 2010 and included numerous multi-million dollar lawsuits.[1]

In New Jersey, in 2009, RosDev Hospitality, LLC, another name for the Crowne Plaza Secaucus, was criminally indicted in NJ's Superior Court for Unlawful Discharge of a Pollutant - Third Degree (Docket No. 09-09-00183-S) when an underground tunnel system was found in which raw sewage leaking from the Crowne Plaza Secaucus' pipes was being flushed into the Hackensack River.[2]

Insurance Product: The NJ Department of Banking and Insurance approved the application from Meadowlands Community Healthcare Trust to operate a Multiple Employer Welfare Arrangement (MEWA) in February 2013. This MEWA may be offering health insurance to the employees of MHMC. Given that solvency is a significant concern with respect to MEWAs, we cannot understand why this application was approved, in light of the federal tax liens against MHA LLC, their failure to file an AFS even after being fined by DOH, and their apparent failure to make payments to the third party administrator of the health plan currently offered to MHMC employees.

We urge your office to take immediate action to protect, our patients, the workforce and continued access to care for our community. Thank you for your consideration.

Sincerely,

Ann Twomey

Ann Twomey
President, HPAE

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[1] *Dispute with federal landlord spins 5 lawsuits*, Ottawa Citizen, December 23, 2006 http://www.canada.com/ottawacitizen/news/city/story.html?id=3092c3ee-202d-4b5b-934c-e0b77b02fce5&k=20699

[2] Michael Rispoli, *Crowne Plaza in Secaucus accused of dumping sewage into Hackensack River*, The Star-Ledger, September 02, 2009, http://www.nj.com/news/index.ssf/2009/09/crowne_plaza_in_secaucus_accus.html

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May 2, 2013

Commissioner Mary O'Dowd
NJ Department of Health
John Fitch Plaza
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Trenton, New Jersey 08625-0360

HPAE

Re: Meadowlands Hospital Medical Center

Dear Commissioner O'Dowd:

I am writing to you on behalf of the registered nurses and health professionals providing patient care at Meadowlands Hospital Medical Center (MHMC), members of HPAE Local 5147, to notify you of the hospital owners' continuing violation of Certificate of Need reporting requirements, and to point out some questionable items in documents recently submitted by MHMC to the DOH that we believe require further investigation by the Department.

In response to an OPRA request, I recently received several documents submitted to the DOH by Wolff Samson attorney A. Ross Pearlson on behalf of the MHMC owners on April 15, 2013. These submissions were made in response to an April 2, 2013 letter from John Calabria itemizing a number of reports, some long overdue, that the DOH required of MHMC as part of the CN conditions imposed at the time of license transfer. Although the cover letter appears to address each item the DOH requested, some of the documents submitted in satisfaction of the CN Conditions present confusing data; others are in fact either not timely or not relevant or both.

Specifically, I call your attention to Exhibit A to Mr. Pearlson's letter, apparently submitted in response to CN Condition 7, which requires MHMC to "provide on a regular and continuing basis, outpatient and preventive services, including clinical services for medically indigent patients, for those services provided on an inpatient basis". The data provided in Exhibit A indicates extreme fluctuations in the provision of outpatient and preventive services from quarter to quarter and a veritable explosion in the provision of some services from 2011 to 2012. Furthermore, there is no data indicating whether and to what extent these services have been provided to "medically indigent patients", as required by NJ law. We would ask that you follow-up with the owners of MHMC to verify the accuracy of this data.

I next refer you to Exhibit B to Mr. Pearlson's letter, apparently submitted in response to CN Conditions 12e and 12f. These conditions require MHMC to submit to the DOH semi-annual reports from the Community Advisory Group (CAG) on progress towards meeting CAG goals; and quarterly reports on progress toward implementing CN conditions. Mr. Calabria's letter explained that MHMC owed these reports for the last half of 2012 and the first quarter of 2013.

What MHMC submitted instead are:

- March, May, July, September, and December 2011 CAG minutes, all of which were submitted to the DOH months ago.

- January and February 2012 minutes, all of which were submitted to the DOH months ago.

In fact, only three of the many pages submitted cover the time period requested by the DOH. There is one report for Dec 2012 and one for the first quarter of 2013, neither of which address the issues the DOH calls for in Conditions 12e and 12f.

In addition, I wish to call your attention to Exhibit C of Mr. Pearlson's letter, apparently submitted in response to CN Condition 15. This Condition requires MHMC to send the DOH an annual self-evaluation of outreach to all residents of their service area, including the medically indigent. They were to send one for 2011 and one for 2012. Instead, they sent:

- "2012 Annual Self-Evaluation Community Outreach". Despite its title, this document does not appear to deal with Community Outreach, but instead appears to be a self-evaluation of board function.
- A set of slides or handout from a December 2012 "Town Hall" meeting that appears to consist primarily of photographs of MHMC employees and patients in various situations.

Finally, I ask you to consider Exhibit D of Mr. Pearlson's letter, entitled "Utilization Statistics", submitted in response to CN Condition 16, requiring MHMC to submit an annual payor mix report. The Hospital submitted a payor mix report for 2011several months ago. The 2012 report raises a number of questions:

- There seem to be inconsistencies between this report and the 2011 New Jersey Cost Report data submitted to the DOH last year. Clinic Visits (Net of Admissions) are reported to be zero for 2011 and 2012 in Exhibit D while that same figure was reported as 13,089 in the 2011 NJ Cost Report. In addition, Exhibit D reports 8,947 Same Day Surgery Patients in 2011while that figure was 18,577 in the 2011 NJ Cost Report. What accounts for these stark inconsistencies?
- The number of Newborn, neonatal ICU licensed bassinets dropped from 24 in 2011 to 4 in 2012. At the same time, however, the number of Newborn, neonatal ICU patient days jumped from 1,463 to 2,358. That would seem to indicate an average of nearly 6.5 newborn, neonatal ICU patients per day, with only four bassinets. How does the hospital account for this?
- The Payor Mix chart shows percentages for 2011 and 2012. It is difficult to reconcile the payor mix for 2011 in this report with the payor mix for 2011 submitted previously. Are these numbers consistent?

We urge the Department to investigate these questions. In light of these ongoing violations, we reiterate our longstanding request that your Office immediately take all measures available to you, including appointment of a temporary manager as provided at N.J.A.C. 8:43E-3.1, to address this and the many other violations of state and federal regulations committed by the owners of our hospital. Thank you for your attention.

Sincerely,

Ann Twomey

Ann Twomey, President

Cc: William Conroy
John Calabria
Mark Hopkins

New Jersey
Appleseed

December 4, 2012

Commissioner Mary O'Dowd
NJ Department of Health
John Fitch Plaza
P.O. Box 360
Trenton, New Jersey 08625-0360

Re: Meadowlands Hospital Medical Center

Dear Commissioner O'Dowd:

I am writing to you on behalf of the members of the Health Professionals and Allied Employees ("HPAE"), representing the nurses and health professionals who provide the patient care at Meadowlands Hospital, to request that the NJ Department of Health ("DOH") compel Meadowlands Hospital Medical Center ("MHMC") to comply with its license and the conditions that were imposed on that license at the time of purchase; and, in the case of continued defiance thereof to appoint a temporary manager, who would in fact bring management of the Hospital into compliance with those conditions.

As has been documented to you in previous correspondence over the past two years, the MHMC owners have repeatedly violated hospital licensing standards and other laws and regulations; the CN conditions imposed by the DOH when approving the license transfer from Liberty Health System to MHA LLC, ("MHA") and standards of good governance and prudent financial management. These violations are serious in nature and significant in extent. Patient safety, the community's access to care and the working conditions of hospital employees all demand immediate action by your office to get management to meet contractual and regulatory requirements, rather than the nominal gestures that have followed HPAE's requests to compel performance and which management has clearly ignored.

Since June 2011, HPAE has repeatedly asked the DOH to appoint a monitor at MHMC in order to ensure patient safety, compliance with licensure requirements and community accountability. HPAE has made these requests in letters to the Commissioner, in meetings with the Commissioner and DOH staff, and in testimony before the NJ Senate Health, Human Services and Senior Citizens Committee. HPAE has written to both the DOH and the Office of

New Jersey Appleseed
Public Interest Law Center of New Jersey
744 Broad Street, Suite 1600
Newark, New Jersey 07102

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Website: www.njappleseed.net

the Attorney General ("OAG") requesting an audit of financial practices at MHMC.[1] In addition, Senator Joseph Vitale, Senator Loretta Weinberg and NJ Appleseed Public Interest Law Center, the latter of which opposed the transfer of Meadowlands Hospital to the current owners based on those owners "bad" track record, also have called on the DOH to appoint a monitor at the Hospital. Despite documentation of problems and questionable practices and despite repeated requests for intervention, the DOH has not responded to any of these requests. Indeed, MHMC reported to its Community Advisory Board on October 30, 2011, that the DOH, after a four hour meeting with the Hospital in July, "determined that MHMC does not need any monitoring by the agency." HPAE was notified of such determination when reading a document it obtained from your office pursuant to an OPRA request. DOH's seeming determination "to do nothing" was never communicated to HPAE and we assert is not supported by the overwhelming evidence that something must be done to protect the public.

Why a Temporary Manager is Necessary at MHMC

N.J.A.C. 8:43E-3.1(a)(3) authorizes the DOH to appoint a temporary manager when a health care facility violates licensure regulations or other statutory requirements. In support of HPAE's request for a temporary manager, I am resubmitting and reiterating the information provided to your office in a letter from Ann Twomey, dated August 6, 2012. Management's apparent decision to ignore reporting requirements and remedy proven CN violations means that the appointment of a monitor that we previously had requested is no longer sufficient. A temporary manager–not a monitor who would simply report continuing violations to the Department without any authority to remedy such violations -- is needed to actually compel management to comply with CN regulations and conditions and to oversee an in-depth audit of financial practices at the Hospital. In addition to the concerns HPAE delineated in its August letter, I am now raising the following additional matters:

Questionable Financial Practices and Deteriorating Financial Condition of the Hospital.

According to materials submitted by MHMC to DAG Jay Ganzman in September and November 2012, and obtained by HPAE via OPRA, there is evidence of the following:

- $10,065,148.53 was distributed to investors in 2011. Note that MHMC's Draft 2011 audited financial statement reports distribution to investors of $8,371,520; no explanation is given for the discrepancy and MHMC still has not submitted a final audited financial statement for 2011.

- As of August 2012, the MHMC year-to-date loss from operations was $1.1M; the operating margin was (.2%). In 2011 the operating margin was greater than 10%.

- MHA acknowledges defaulting on the $5M loan from Liberty Health System. The loan required MHA to make certain additional pre-payments if the MHA monthly cash balance exceeded a trigger level. As of October and November 2011 the prepayment

[1] DAG Jay Ganzman has shared with us correspondence he has received from MHMC; however, such documents do not include audited financial statements.

trigger was reached but no prepayment was made. Liberty issued a Notice of Default on November 28, 2011, demanding $4.3M due and owing. On March 15, 2012 MHA paid the loan, using a $5M, 13% interest loan from two unidentified Trustees (as reported in their Draft 2011 AFS). This loan comes due December 31, 2012. MHA did not report this default to the OAG until September 25, 2012, in response to a September 7, 2012 letter from DAG Ganzman. In fact, in its quarterly reports to the OAG on March 8, 2012, June 8, 2012, and August 13, 2012, MHA characterizes the default as a "negotiated prepayment" of the $5M loan and requests an opportunity to discuss how this "prepayment" might impact its reporting requirements pursuant to the Final Order of the Chancery Court.

- Since June 30, 2012, MHA has fallen behind on its monthly payments on the $1,740,000 McKesson IT licenses.

- MHA has fallen behind on the $2,550,000 LRI Note. The June 2012 payment was made in July; the July payment was made in August. As of Sept 25, the August and September payments were still due.

- On Apr 19, 2012 the hospital wrote checks for $401,927.74 to Anastasia Burlyuk and $44,858.64 to Richard Lipsky, both of whom are MHA LLC principals and MHMC board members. The hospital made identical payments to Burlyuk and Lipsky on May 17, 2012 and again on July 16, 2012. Note that these payments were made just before MHA LLC fell behind on its monthly payments on the LRI Note and the McKesson IT licenses.

- It appears that MHMC may have used accounts receivable as collateral on a $5M revolving line of credit from Muneris Capital Group LLC in August 2011-- a transaction that ultimately did not come to fruition. MHMC never reported this transaction to the OAG.

These facts add to our concerns, raised in earlier correspondence with your office, that MHA is repaying principals and other investors ahead of other creditors, depleting the resources of the hospital, and jeopardizing the financial stability of the hospital. A temporary manager is needed to oversee an in-depth audit of the financial practices and financial condition of MHMC in order to prevent community harm.

Termination of Experienced Staff

One of the primary ways that the CN granted to MHA LLC protects continuity and quality of care was by requiring the new owners to "hire substantially all MHMC employees who are employed at the time of the sale". Since taking over the hospital in December 2010, MHA LLC has flouted the spirit, if not the letter of the CN by terminating registered nurses, pharmacy technicians, endoscopy technicians, respiratory therapists, obstetrics technicians, x-ray staff, transport staff, environmental services staff, dietary staff, and staff working in several other job titles. Between August 24 and November 27, 2011 alone, MHMC laid off 41 staff members. In many instances, the Hospital has replaced experienced employees with less experienced staff,

sometimes changing the job title and often replacing full time staff with part time and per diem staff with little or no training.

The hospital has also created a "nurse intern" program, hiring less experienced nurses for minimum wage and providing inadequate orientation and mentoring.

These changes have a significantly adverse impact on the continuity and quality of care offered at the Hospital. They must be reversed, and former, experienced staff must be rehired.

Violations of CN Requirements

HPAE has written to your office previously regarding MHMC's numerous violations of its CN Conditions, including Condition #7 (provision of outpatient and preventive services); Condition #10 (annual report of board roster, board policies, governance); Condition #11 (annual report of investments, debt, transfers of funds); Condition #12e and f (progress reports to Community Advisory Group and Hospital board); Condition #15 (annual community outreach report); and Condition #16 (annual payor mix report). Despite being cited by the Department for these violations, including a Directed Plan of Correction from the DOH, MHMC remains in violation of several of these conditions. In addition, other violations have come to our attention.

Reduction in Needed Services

The Hospital has violated CN Condition #6 which provides that MHA LLC "shall continue all clinical services and community health programs currently offered at MHMC by the previous ownership. Any changes in this commitment involving either a reduction or elimination of clinical services or community health programs...shall require prior written approval from the department", as well as a written analysis of the request by the Community Advisory Group. In mid-October, MHMC announced the "temporary" closing of its rehabilitation unit effective November 1. We believe that this announcement was made without notification to the DOH. The Department cannot ignore management's decision to cut services without securing the Department's prior written approval and without the proper analysis of why the unit is being closed and the consequences of such closing on patients and the community.

A temporary manager is needed to determine the circumstances under which this unit was closed, issue a report and make a recommendation to DOH whether to permit closure or require reopening of the unit.

Employee Health Insurance

The owners of MHMC also have violated CN Condition #17, requiring MHA LLC to "offer its employees who were affected by the transfer, health insurance coverage at substantially equivalent levels, terms and conditions to those that were offered to the employees prior to the transfer." In violation of this requirement, MHA LLC terminated the employees' Medco prescription coverage on August 1, 2012 and did not offer a comparable replacement until the first week of November. Specifically, MHA LLC did not inform employees of the termination of Medco coverage and how they could obtain prescription coverage until on or about September

some of these issues and for information necessary to draft an OPRA request that would not be overly broad and burdensome. Despite repeated promises that a response is forthcoming, as of November 29, 2012, the DOH has not provided HPAE with any of the requested information.

MHMC also recently began providing ambulance services to the town of Secaucus. Further evidencing what appears to be a pattern of disregard for the requirements of NJ laws and regulations, MHMC omitted information from their BLS/SCTU application to the NJ OEMS and advertised the impending opening of SCTU services on their website prior to OEMS approval of their SCTU application.

It appears that the DOH is unwilling to consider the track record of the MHA principals at their other facilities when dealing with them at MHMC. These violations at other health care facilities or concerning ambulatory services are not insignificant. They indicate management's disregard for the very regulations that are intended to protect patients. Patients' safety is at risk, and action must be taken to stop this behavior. A temporary manager is necessary to assure adherence to regulatory requirements at MHMC (if not these other related health services).

The Role of a Temporary Manager

A temporary manager, selected by the DOH and paid for by MHA LLC, should immediately be installed at MHMC and should remain in place until patient safety, the financial stability of the hospital, the community's access to care and the safety of employee working conditions can be assured and compliance with CN Conditions and licensing regulations has been achieved. The temporary manager should be tasked with the following responsibilities, including those that a fiscal monitor would have pursuant to N.J.S.A. 26:2H-5.

- Oversight of an in-depth audit of MHMC's financial position and financial practices to determine what is delaying the final 2011 audited financial statement; whether MHMC's financial practices follow the letter and intent of all applicable laws, regulations and best practices, and the causes of MHMC's apparent "financial distress";

- Development and implementation of measures to improve the Hospital's financial stability and assure compliance with laws, regulations and standard accounting and financial practices;

- Review of all current patient care protocols and procedures and implementation of all changes necessary to comply with applicable laws and regulations;

- Review of all aspects of compliance with CN requirements and assuring that all steps necessary to achieve compliance are taken;

- Review of all governance policies and practices and making all changes necessary to assure compliance with laws, regulations and best practices;

- Attendance and full voting power as well as veto power at board meetings, executive committee meetings, finance committee meetings and steering committee and/or turnaround committee meetings, which concern the fiscal health of the organization;

- Holding weekly meetings with the hospital's management and key members of the governing body to develop and oversee strategic plans;

- Determining whether and to what extent the Hospital's financial instability is affecting patient care, most notably with respect to availability of supplies, adequacy of staffing;

- Assessing the accuracy of the utilization, performance and quality of care claims that have been made to the Community Advisory Group, as outlined in reports of CAG meetings provided to the DOH;

- Determining whether any related party transactions violate a best-practice conflict of interest policy and develop, implement or revise a Hospital Conflict of Interest policy;

- Assuring that employees' legal rights are protected and that patient care, staffing, health and safety laws are being followed, and that opportunities are given for staff to address concerns and that 'whistleblowers' are not subject to retaliations;

- Inspecting the hospital to determine compliance with all prior Plans of Correction submitted to the Department and recommend remedies and penalties where appropriate;

- Report to the NJ DOH and NJ Senate Health, Human Services and Senior Citizens Committee on improvements or other recommendations for policy and practice changes at Meadowlands Hospital.

We believe that a temporary manager who will have the full authority to address HPAE's and the community's concerns with respect to patient care and fiscal abuse at the Hospital by ensuring compliance with hospital licensure and CN conditions is long overdue. The owners of MHMC are operating under their own set of rules—none of which ensure public health, welfare and safety. It is thus, DOH's responsibility to act to assure compliance, before the doors of the Hospital are closed unexpectedly. We look forward to your written response to this request.

Sincerely,

Renée Steinhagen

Renée Steinhagen
Executive Director

CC: Jay Ganzman, DAG
Ann Twomey, President, HPAE
JoAnn Dudsak, President, HPAE Local 5147
Senator Joseph Vitale
Senator Loretta Weinberg
Assemblyman Vincent Prieto

HPAE

Meadowlands Financial Highlights Oct 2012

Source: Aug 2012 Unaudited Financials Submitted to AG and obtained by us via OPRA request

- Current ratio (current assets/current liabilities) is .75 meaning their current liabilities are greater than the liquid assets they have to pay them.
- They have $260K of cash on hand; slightly better than the $71K at Dec 2011.
- Net assets=$9.8M down from nearly $11M on July 31, 2012 and $13.4M as of Dec 31, 2011
- YTD loss from operation was $1.1M; operating margin= (.2%). In 2011 the operating margin was 10+%.
- Non-operating gains = $1.7M. Because this is an unaudited statement there are no Notes or other explanation of what is included in these non-operating gains. By comparison, their Draft 2011 AFS shows only $26K of non-operating gains, all of it from interest income.

Source: Sept 25, 2012 letter from Wolff Samson to Jay Ganzman; obtained by us via OPRA

- Since June 30, 2012, MHA has fallen behind on monthly payments on the $1,740,000 McKesson IT licenses
- MHA has fallen behind on the $2,550,000 LRI Note. June payment was made in July; July was made in August. As of Sept 25, the Aug and Sept payments are still due.
- MHA acknowledges defaulting on the Liberty $5M loan. The loan required MHA to make certain additional pre-payments if the MHA monthly cash balance exceeded a trigger level. As of Oct and Nov 2011 the prepayment trigger was reached but no prepayment was made. Liberty issued a Notice of Default on Nov 28, 2011, demanding $4.3M due and owing. On March 15, 2012 MHA paid off the loan (using a $5M, 13% interest loan from two Trustees, as reported in their 2011 AFS. This loan comes due Dec 31, 2012)

Source: Payor Mix submitted by MHA to DOH on Aug 30, 2012 and obtained via OPRA.

- Covers 2011 and Jan-June 2012
- Medicaid HMO patients went from being 16% of patients in 2011 to being 21% of patients in 2012 and from 8.5% of total gross charges in 2011 to 17.4% of total charges in 2012.
- NoFault/liability patients went from being 16% of patients in 2011 to being 8% of patients in 2012 and from 26% of total gross charges in 2011 to being 12.6% of total gross charges in 2012.

Source: Check register sent to AG's office as attachment to Aug 13, 2012 submission by Wolff Samson on behalf of MHA, obtained from AG's office via OPRA

- Apr 19, 2012 check for $401,927.74 to Anastasia Burlyuk and for $44,858.64 to Richard Lipsky.
- May 17, 2012 same amounts again.
- It is possible that these are principal/interest payments to Burlyuk and Lipsky on the $5M loan that two unidentified board members made to the hospital in March 2012 so that the Hospital could pay off the %5M Liberty loan.
- These payments were made just before MHA began to fall behind on monthly payments on the LRI Note and the McKesson IT licenses.

- Voided checks: what are these? AG's office did not know and had not asked.

Source: 2011 and 2012 Summary Monthly Cash Forecasts and Untitled Spreadsheet of Investors and Distributions submitted as attachment to Sept 25, 2012 letter from Wolff Samson to AG's office on behalf of MHA and obtained from AG's office via OPRA

- In 2011, ~10M was distributed to owners/investors. Note: the 2011 draft AFS says $8.3M was distributed to investors. Why the discrepancy?
- Most of the investors have not been made whole on their investment. But one investor, the company owned by the Lipsky Family, Pogodin and Dunaev (ATRP) received distributions totaling $8.7 million on contributions of $4.6M.
- The first of seven disbursements was made in May, 2011 – it totaled $2.3 million. Disbursements continued more or less monthly in 2011 at between $1 and $2 million per month.
- Brach Eichler Attys Mark Manigan & Debra Lienhardt made $90,000 (had put up $650,000), Lobbyists Raj Mukherji and Mike Murphy made $45,454 (had put up $325,000)
- Another ~$2.2M is to be distributed to "owners" in 2012.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10906	A. BUILDING _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLANDS HOSPITAL MEDICAL CENTER	55 MEADOWLANDS PKWY SECAUCUS, NJ 07094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	8:43G INITIAL COMMENTS The facility is not in substantial compliance with N.J.A.C. Title 8 Chapter 43 G- Hospital Licensing Standards for this Complaint Investigation: C# NJ 58809.	D 000		
D3957	8:43G-18.2(a) NURSING CARE: POLICIES & PROCEDURES The hospital shall have written policies and procedures for the nursing care service that guide nursing practices in the hospital. These policies shall be reviewed at least once every three years, revised more frequently as needed, and implemented. These policies and procedures shall conform with the Nurse Practice Act, N.J.S.A. 45:11-23 and N.J.A.C. 13:37-1.4, 6.1, 6.2, 13.1 and 13.2. This REQUIREMENT is not met as evidenced by: Based on medical record review and review of facility policy and procedure, it was determined that the facility failed to implement all policies and procedures for patient care and physician notification. Findings include: Reference #1: Facility policy number: N111, Subject: Assessment of the Five Vital Signs, states "... Procedure/Process: ... 2. The nurse will notify the physician if the patient has a temperature above 100 [degrees] (oral or rectal). Reference #2: Facility policy number: N064, Subject: Pulse Oximeter Policy, states "Policy/Purpose: Pulse oximetry is a noninvasive	D3957		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

23x

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D3957	Continued From page 1 monitoring technique used to measure arterial oxygen saturation of functions hemoglobin. Use of pulse oximetry allows the nurse to detect clinical events associated with abnormalities in oxygen saturation. Early detection of these events facilitates interventions to prevent hypoxemic injury to patient. ... Process/Procedure: RN/LPN ... 6. SpO2 valves (sic) of 95% or greater are generally acceptable clinically. Saturation results should be integrated with other assessment data to determine overall clinical picture and appropriate interventions. ..." Reference #3: Facility policy number: N104, Subject: Change in Patient's Condition-Notification of Physician, states "Rationale/Purpose: The attending and or consulting physician, as well as the Clinical Manager or Administrative Manager shall be kept informed of a change in the patient's status at all times. Process/Process (sic): Administrative Supervisor/ Clinical Manager: 1. Shall notify the attending and/or consulting physician ... D. ... The following conditions are guidelines for the notification of the physicians. conditions are not limited to those listed. ... [2nd bullet] a change in the patient's respiratory status. [3rd bullet] A change in or deviation from the patient's heart rate and/or blood pressure. ..." 1. On 8/30/12, review of Medical Record #7 indicated that Patient #7 coded and expired on 8/22/12 at 9:20 AM. The following was observed in Medical Record #7: a. A nursing note on the 'Code Blue Data Sheet,' dated and timed 8/22/12 at 7:30 AM, that the patient's vital signs were: Blood Pressure= 132/72, Pulse=123, Temperature=101.	D3957		

24x

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D3957	Continued From page 2 b. A nursing note on the 'Code Blue Data Sheet,' dated and timed 8/22/12 at 8:00 AM, that "Rounds done by attending physician. Informed him regarding pt's (patient's) condition." The nurse did not document what information he/she informed the physician about regarding Patient #7's condition. c. There was no evidence of a physician assessment of Patient #7, documented in the Medical Record for 8/22/12 at 8:00 AM. 3. Further review of Medical Record #7 indicated, on the 'Cumulative Vitals/ Measurements Report,' dated and timed 8/22/12 08:00, that in addition to Patient #7's vitals signs above, (Blood Pressure= 132/72, Pulse=123, and Temperature=101), Patient #7's Pulse Oximetry=76%. a. There is no evidence in Medical Record #7 that the nurse re-assessed Patient #7's Pulse Oximetry for a reading that was not acceptable or 95% or greater as per the policy in reference #2. There was no evidence that the nurse called the physician immediately to keep him informed of a change in the patient's clinical status as per the policy in reference #3. 4. Without documentation of the information the nurse informed the physician about, or of a physician assessment, it could not be determined if the physician was kept informed of the patient's full set of vitals signs (blood pressure, pulse, temperature, and pulse oximetry).	D3957		
D4260	8:43G-19.2(a)(8) OBSTETRICS: POLICIES & PROCEDURES Policies and procedures of the obstetric service shall include at least:	D4260		

25x

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D4260	Continued From page 3 A visitors policy that includes who may visit the unit and at what times, security procedures for monitoring and controlling visitors, and infection control instructions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policy and procedure, it was determined that the facility failed to maintain security of the obstetrical area by monitoring and controlling visitors. Findings include: Reference #1: Facility policy 'Visitation, Trespassing, Solicitation, and Loitering" states "... Procedure: ... 2. All visitors, vendors and outpatients must register before entering the Hospital. a. All patient visitors are limited to the posted visiting hours for each particular unit. Visitors must stop at the Information/Security Desk to get a patient visitor pass before they are allowed to visit." Reference #2: Facility policy number: ADM047, Subject: Visiting Hours, states "Purpose/Rationale: The purpose of this policy is to provide flexibility and support to patients and families by providing open visiting hours. Policy/Procedure: 1. It is the policy of Meadowlands Hospital Medical Center to allow family members or significant others to visit patients at times convenient to patient and visitor. 2. No more than 2 visitors may remain at the patient's bed-side. The charge Nurse will enforce this procedure with the assistance of the Security	D4260		

26x

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10906	A. BUILDING _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLANDS HOSPITAL MEDICAL CENTER	55 MEADOWLANDS PKWY SECAUCUS, NJ 07094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D4260	Continued From page 4 Staff as needed." 1. On 8/29/12 at 12:00 PM the Labor and Delivery Unit (L&D) was toured in the presence of Staff #2 and Staff #14. Staff #16 was interviewed by the surveyor and stated that Security of the unit is terrible. Family is allowed in when they are not supposed to be. They should only allow 2 visitors in recovery, but sometimes the whole family comes in. The families do not listen to staff and Security does not help. Staff #16 added, that sometimes when assisting with a C-section procedure, she sees visitors walking in the hallway outside of the C-Section Room. 2. The double doors, by the elevator on the 4th floor, were observed with a posting that indicates 'Maternity Restricted Area'. Through the double doors, to the right, is the hallway of which L&D and the Post Partum Units are located. a. During the tour, the double doors were opened and a woman in a pink shirt was observed walking through the doors and down the hall to the Post Partum Unit's Nursing Station desk. She then walked behind the desk through the unlocked door that lead to the L&D Unit. b. The double doors,meant for visitor entry to the L&D unit, located to the right of the Post Partum Unit's Nursing Station, were also unlocked; because both the doors were unlocked; the entry into the C-section suite [entered through L&D and the nursery [through the C-section suite] were also unlocked. c. The double doors that are located between the Post Partum Unit and the old Pediatric Unit were also unlocked.	D4260		

27x

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10906	A. BUILDING _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLANDS HOSPITAL MEDICAL CENTER	55 MEADOWLANDS PKWY SECAUCUS, NJ 07094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D4260	Continued From page 5 3. Without monitoring and control of visitor access to the L&D and Post Partum units, the facility cannot ensure the "2 visitor at a time" standard is maintained as per policy, or that the units are secured for the safety of patients and staff.	D4260		
D4374	8:43G-19.11(a) OBSTETRICS: LABOR/DELIVERY STAFF TIME & AVAIL There shall be at least one registered professional nurse present whenever a patient is in a labor area. Nurse staffing assignments for patients in active labor shall be determined by patient acuity levels. This REQUIREMENT is not met as evidenced by: Based on review of the L&D Nurse Staffing, for a one week schedule, it was determined that the facility failed to meet their 'Master Staffing Plan Ratios' at all times. Findings include: Reference: Facility Policy Number: N047, Subject: Master Staffing Plan Ratios, indicates for the L&D Unit that the RN Staffing for all shifts will be a ratio of two patients to one nurse, unless the patient is in active labor. If the patient is in active labor, the ratio will be one patient to one nurse. 1. On 8/30/12 the nurse staffing for the L&D unit for the week of 8/12/12 through 8/18/12 was reviewed in the presence of Staff #2 and Staff #14. On Tuesday, 8/14/12 from 7 PM-11 PM, the unit was staffed with three nurses for the five patients. Two of the five patients were in active	D4374		

28x

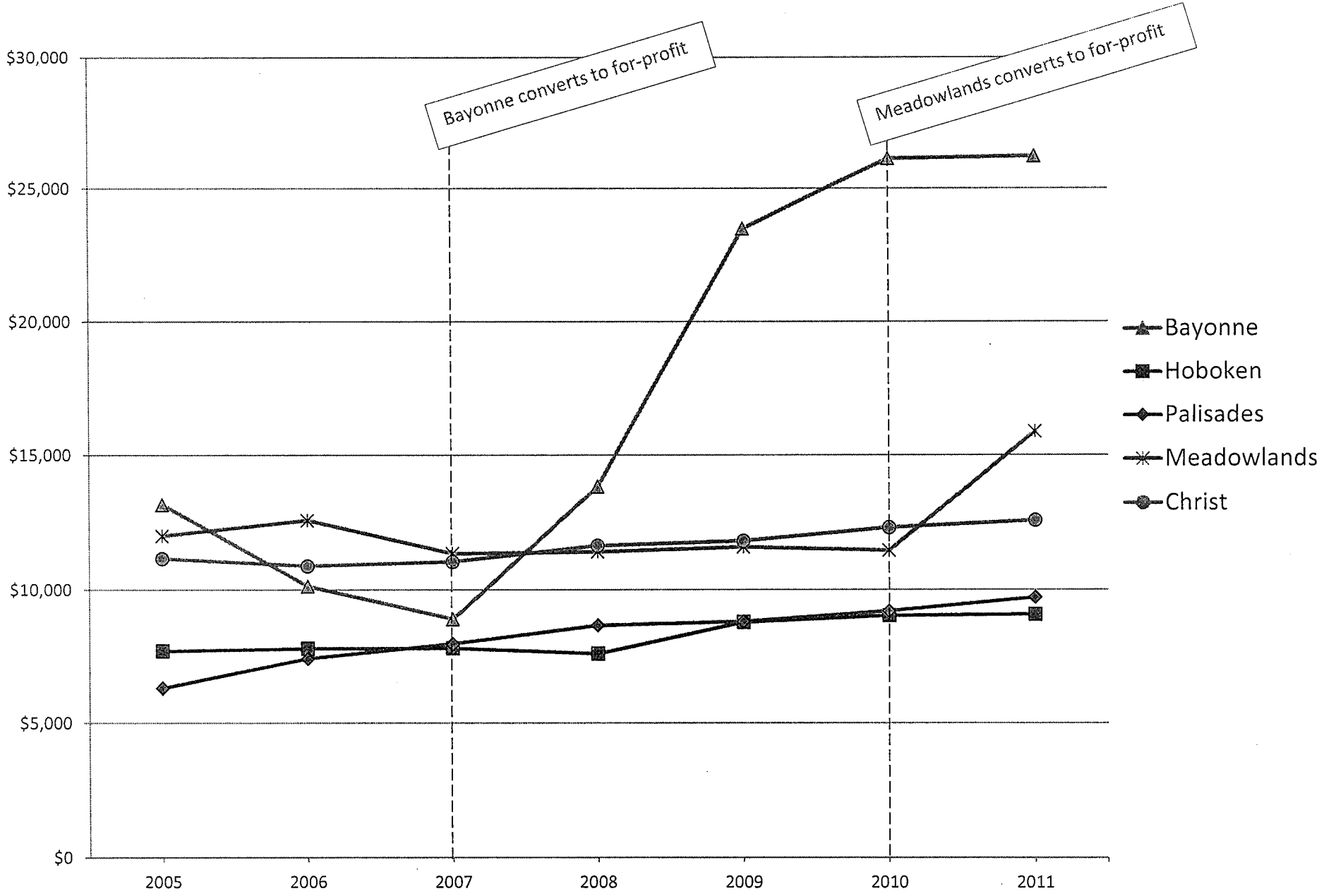
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10906	A. BUILDING _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLANDS HOSPITAL MEDICAL CENTER	55 MEADOWLANDS PKWY SECAUCUS, NJ 07094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D4374	Continued From page 6 labor, requiring a one nurse to one patient ratio, leaving the third nurse with a three patient assignment. A one nurse to three patient ratio is one patient more than the facility's Master Staffing Plan Ratio of one nurse to two patients. 2. Staff #2 confirmed the above.	D4374		

29x

Gross Revenues per Patient Day



Source: Calculated using Cost Report data from the New Jersey Department of Health

30x

Average Charges at NJ Hospitals, compared to US & NJ Averages

Source: Calculated using data from the Centers for Medicare & Medicaid Services (CMS)

3/x

HPAE

SEPTEMBER, 2012

SUMMARY

The accelerated introduction of for-profit hospitals in New Jersey over the past five years presents a challenge for patient care advocates, state legislators, government regulators, consumers and health professionals. The availability, quality and affordability of health care in our communities is threatened if and when these hospitals cut services and staff; conduct 'insider-dealings' with affiliates, investors and board members; cancel insurance contracts as a business strategy; violate patient care regulations, and undermine health care workers' rights.

Yet, as this paper will detail, state regulators have lagged behind in their willingness or ability to monitor and oversee the activities of for profit hospitals, and ultimately put a stop to violations of laws and regulations designed to safeguard patient care.

At Meadowlands Hospital, under the ownership of a privately-held for-profit group of investors (MHA) since December of 2010, citations and fines appear to be just a small cost of doing business for the owners. Even after state and federal agencies found serious violations of patient care and safety at the hospital, after reported investigations by insurance companies and government agencies, and after a publicized draft audit was reported to include numerous examples of financial failings, exorbitant profit-taking and insider-dealing among hospital board members, no effective penalties or remedies have been invoked.

The Record

AUGUST 1, 2012

Questions arise at for-profit hospital

First-year audit faults Meadowlands finances

By MARY JO LAYTON
STAFF WRITER

A year after a for-profit company took over Meadowlands Hospital Medical Center and vowed to shore up its finances, the hospital posted a 10 percent profit – more than four times the state average – and paid its investors

A recent story in *The Record* made Meadowlands Hospital an advertisement for the crucial and immediate need for transparency and accountability in for-profit health care, and for stricter regulations and oversight of the state's for-profit health care industry in (First-year audit finds fault in for-profit hospital's finances, 8/1/2012, available on HPAE's website at www.hpae.org/meadowlandsinfo).

Laws like the 'Community Healthcare Assets Protection Act' (CHAPA) and the Certificate of Need (CN) and hospital licensing regulations are designed to provide oversight, guidelines and monitoring for transfers of ownership from not-for-profit to for-profit hospitals, and, when necessary, to invoke sanctions or remedies against a hospital that is violating patient care standards or state or federal laws or regulations. In the case of Meadowlands Hospital, measures and remedies at the disposal of the NJ Department of Health (DOH) and the Office of Attorney General (OAG) include establishing initial conditions on the sale of Meadowlands Hospital to MHA; requiring monthly, quarterly and annual financial accountings; surprise inspections upon complaint; fines for licensing violations; intervention in the case of financial 'triggers'; curtailing admissions; and finally, establishment of a monitor at the hospital, or appointing a receiver or temporary manager.

To date, it appears that Meadowlands' owners have violated a number of CHAPA and CN conditions, yet sanctions have been few and far between, and many of the practices continue.

MHA owners, family members and the principals of its myriad related affiliated companies have spread their business and their political contributions far and wide as they've acquired other real estate, hospital ownerships, and ambulatory surgery centers. In 2011 and 2012 alone, individuals connected to MHA and

46X

its affiliates have donated more than $260,000 to elected officials and candidates, and have hired lobbying firms to oppose new laws that would further regulate their business practices.

This paper will describe the principal owners of MHA and their web of companies; their business practices; the history of violations of licensing laws and regulations; a snapshot of their finances and reporting irregularities for 2011; and apparent violations of the conditions set when they purchased Meadowlands Hospital. And we will chronicle the missed opportunities for state regulators to protect the public health and suggest steps the State of New Jersey can take to improve its oversight of for profit hospitals.

BACKGROUND/HISTORY

On January 8, 2010, HPAE, a health care union of 12,000 nurses and health professionals including 450 frontline staff working at Meadowlands Hospital in Secaucus, NJ, part of the not-for-profit Liberty Health System (LHS), learned of the impending sale of their hospital to private, for-profit investors calling themselves MHA LLC.

NJ law and regulations, when vigorously enforced, provide strong protections for preserving the quality and accessibility of health care when a community hospital is sold. Before the sale can be finalized, NJ's CHAPA and CN regulations[1] require the Attorney General and the DOH Commissioner to scrutinize extensive and detailed information from the buyer and the seller. Both the Commissioner and the Attorney General are given broad authority to impose conditions on the sale in order to protect the public health. The public has the right to review all the documents, voice their concerns at public hearings, and suggest conditions to be placed on the sale. Ultimately, the NJ Superior Court decides whether to approve the sale with the recommended conditions.

"In the midst of financial turmoil facing many hospitals, we have been notified that Liberty has entered into an agreement with a buyer for Meadowlands Hospital. As representatives of the 450 nurses and health care workers at Meadowlands Hospital we intend to assure that our community continues to receive the health care services they need and deserve, and that the contract rights of our members are protected during the pending sale of our community hospital by Liberty Health.

Our priority is and will remain protecting the health care of this community, and towards that end, we have already reached out to attorneys representing the potential buyers to make sure that the interests and rights of our patients and caregivers are protected."

HPAE

–Ann Twomey, President
January 8, 2010

NJ's Certificate of Need (CN) regulations require the NJ DOH to scrutinize the proposed transfer of a hospital's license before granting its approval, including looking at

- The financial viability of the hospital post-sale;
- The impact of the sale on the quality and accessibility of health care services in the community; and
- The buyer's 'character and competence', including their track record at other facilities.

In addition, the DOH Commissioner can require the buyer to demonstrate compliance with any conditions imposed.[2]

NJ's CHAPA requires the OAG, in conjunction with the DOH to determine if the sale is "in the public interest". To be "in the public interest", the sale must preserve the quality; availability and accessibility of health care in the affected communities and protect the value of the hospital's charitable assets. CHAPA authorizes the OAG to recommend conditions to be placed on the sale of the hospital.

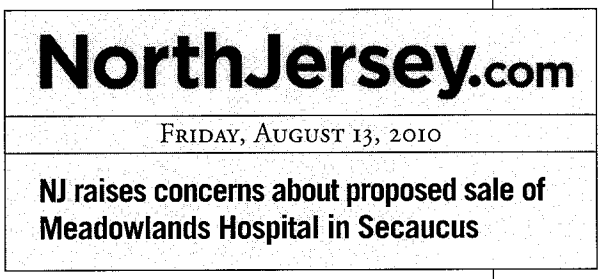
1 N.J.A.C.8:33-4.9 and 4.10
2 N.J.A.C.8:33-4.16

47x

When HPAE and other health care advocates reviewed the CHAPA and CN materials submitted to the DOH and the AG, serious questions emerged as to the character and competence of MHA's principals and its myriad of affiliated and related entities; MHA's business plan; and the financial and operating projections for the hospital after the sale to MHA. Among the concerns HPAE and others raised with the OAG and DOH were:

"Character and Competence" of the MHA Principals

MHA LLC has a complicated ownership structure. It is 100% owned by Complete Medical Project Management (CMPM) LLC, which is owned by ATRP LLC (80%) and passive investors (20%) in a complex web of ownership by various entities and individuals in varying percentages. Four individuals hold large interests in MHA: Pavel Pogodin, Anastasia Burlyuk, Richard Lipsky MD, and Tamara Dunaev. Dr. Lipsky and Ms. Dunaev are the sole managers of ATRP, CMPM and MHA. (www.hpae.org/meadowlandsinfo).


NorthJersey.com

FRIDAY, AUGUST 13, 2010

NJ raises concerns about proposed sale of Meadowlands Hospital in Secaucus

By the time of the CN and CHAPA review process, the DOH was very familiar with the track record of the MHA principals at other NJ facilities they owned and operated. Perhaps most striking was the Department's exercise of its rarely used authority to curtail admissions in response to conditions at the Lipsky-owned Xanadu Adult Medical Day Care Center in March 2010. Xanadu had failed to disclose that it had hired an Administrator and a Marketing Director with criminal records and as a result, the DOH had denied the facility the right to participate in Medicaid. Subsequent inspections of the facility found it was operating without a full-time administrator, a pharmacy consultant and a consultant dietician and was not conducting required assessments of its medically-vulnerable program participants (Go to the HPAE website at www.hpae.org/meadowlandsinfo to view a complete list of violations).

In addition, three ambulatory surgery centers owned and operated by the MHA principals were cited for numerous violations of state and federal regulations intended to protect patient safety and patients' rights, including:

- Failure to have a Director of Nursing and an Administrator on-site during operations;
- Failure to evaluate patients prior to discharge and to provide telephone follow-up consultation after surgery;
- Failure to properly sterilize, disinfect, decontaminate, and store surgical instruments and equipment;
- Failure to follow federal CDC Guidelines for hand hygiene;
- Failure to ensure there was a physician-signed order before medications were given;
- Failure to ensure that anesthesia equipment was safely maintained;
- Failure to notify patients of their rights before a surgical procedure is performed and to ensure patients' rights to privacy.

There were clear warnings based on violations at facilities owned by MHA principals that went unheeded when the DOH granted a license to MHA for Meadowlands Hospital (www.hpae.org/meadowlandsinfo).

Opiate Detoxification Institute

The DOH also knew of Dr. Lipsky's work as a practitioner of rapid and ultra-rapid anesthesia-assisted opiate detoxification. In what would prove to be foreshadowing of his business model at Meadowlands Hospital, these procedures have met with significant criticism from federal and state agencies and professional organizations[3], and are not covered by insurance. The National Institute on Drug Abuse, part of the National Institutes of Health (NIH), concluded in October 2006 that, "We now have several rigorous studies indicating that anesthesia-assisted detox – a costly and risky approach – offers no advantage over other methods".[4]

A few months later, the NJ Department of Human Services, Division of Addiction Services announced that, "An extensive literature search determined that UROD [ultra rapid opiate detox] and ROD [rapid opiate detox] procedures are controversial and may pose considerable risk to patients. Therefore, at the present time the Division does not sanction the use of such procedures."[5] Nevertheless, Dr. Lipsky continues to maintain state registration of his Opiate Detoxification Institute, Inc. since 2003.[6]

State tax liens

The DOH was also was aware that several MHA-related entities were delinquent in paying their ambulatory care assessment fees.[7]

Vogster Entertainment LLC

Tamara Dunaev, Pavel Pogodin and his wife Oksana Matyukhina, are the principals of Vogster Entertainment LLC,[8] a venture-funded video game development company and creator of CrimeCraft: Bleedout; CrimeCraft: Gang Wars, and Robocalypse: Mobile Mayhem. CrimeCraft was "Refused Classification" by the Australian Classification Board, which will not classify games that "depict, express or otherwise deal with... drug misuse or addiction... in such a way that they offend against the standards of morality, decency and propriety generally accepted by reasonable adults."[9] Recently-filed documents with the DOH reveal that Meadowlands Hospital paid nearly $1M to Vogster in 2011 for software development, computer hardware, and website maintenance and support.[10]

3 http://www.asam.org/1ROD-UROD%20-%20%20REV%20OF%20OADUSA%204-051.pdf

4 http://www.drugabuse.gov/NIDA_notes/NNvol21N1/Study.html, accessed on July 21, 2010.

5 http://www.state.nj.us/humanservices/das/information/AB-ROD%20and%20UROD.pdf, accessed on July 21, 2010.

6 NJ State Business Gateway Service, Business Entity Status Report, Business ID Number 0100899249.

7 Response to DHSS Completeness Question 20, Apr. 14, 2010.

8 NJ State Business Gateway Service, Business Entity Status Report, Business ID Number 0400105250. Ms. Matyukhina is the wife of Mr. Pogodin.

9 http://www.kotaku.com.au/2009/11/drug-use-the-reason-for-crimecraft-banning/

10 Draft 2011 Audited Financial Statement of Meadowlands Hospital

Financing and Ownership

HPAE repeatedly raised concerns over the complex ownership structure and raised questions over the financing and financial projections for MHA, including the 43% guaranteed return on investment promised to the "preferred investors", amounting to nearly $2M annually.[11]

There was also widespread concern over the fact that MHA's ability to close the deal was contingent upon receiving a $5M Promissory Purchase Note from Liberty, covering one-third of the purchase price. Because of "concerns with the insubstantiality of MHA's financing and the risk that it would place on the repayment of the Promissory Purchase Note", the Attorney General's Office asked Navigant Consulting to review the initial financing arrangements. Based on the Navigant review and MHA's responses to the concerns that were raised, the Attorney General's Office required several changes in the financing arrangement so as not to "place the nonprofit seller's charitable assets at risk".[12]

These concerns appear to have been well-founded, as we learned upon reviewing the Draft 2011 Audited Financial Statement for Meadowlands Hospital (The Draft Audit is available on HPAE's website at www.hpae.org/meadowlandsinfo).

Warning Signs

From the outset, HPAE and others alerted the DOH to warning signs that MHA LLC was not committed to maintaining Meadowlands Hospital as the full service, acute care general hospital the community had been relying on for decades, but rather was looking for a new venue for their outpatient surgery services.

- MHA LLC's initial proposal to LHS, dated June 24, 2009 called for LHS, MHA LLC and Meadowlands Hospital to embark upon a real estate venture, coupled with Same Day Surgery and Rehab Practice Joint Ventures, and envisioned a hospital with "a reduced level of service lines. The idea would be to work-out with DOH an arrangement pursuant to which MH [Meadowlands Hospital] can direct to JCMC [Jersey City Medical Center] any and all services beyond the minimum services required of MH to maintain its acute care license". Liberty did not pursue that proposal.[13]
- In the same letter, MHA LLC Managing Partner Richard Lipsky MD wrote: "...would also be willing to discuss acquiring MH outright. In this regard, we are prepared to pay, at a minimum, $5,000,000. We also would be prepared to pay additional amounts based on the level of clinical streamlining that DHSS would permit us to undertake".
- Based on the information they had before them, the Liberty Board of Trustees during their deliberations expressed concern that Dr. Lipsky's intent was to turn Meadowlands Hospital into a specialty hospital focused on pain management and rehabilitation.[14]
- In a Dec 17, 2009 Status Report, the LHS Senior VP and General Counsel to the Board of Trustees clarified certain provisions of the Asset Purchase Agreement between Liberty and MHA LLC and stated:

"There is a provision that requires the buyer to apply for a license to operate Meadowlands as an acute care hospital. It is not a covenant that they will continue to operate Meadowlands as an acute care hospital for any specified period of time".[15]

11 Response to DHSS Completeness Questions, Apr. 14, 2010, Attachment F.

12 Office of the NJ Attorney General to Judge Oliveri, Nov. 10, 2010 (OAG CHAPA Recommendation) p.43-4.

13 Exhibit 18-1 of the CHAPA file.

14 OAG CHAPA Recommendation) p.10.

15 CHAPA Exhibit 7-493

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- Materials submitted in response to DOH "Completeness Questions", part of the CN review process, showed continued Obstetrics and Pediatrics admissions thru 2012, but at notably declining levels, while projecting increases in medical/surgical services, ER visits, and Same Day Surgery.[16]
- The Attorney General, in his submission to the Superior Court, noted that it was "striking" that, unlike in other prior hospital conversions, the Asset Purchase Agreement between MHA and Liberty omitted any contractual commitment from MHA to maintain the hospital as an acute care general hospital for a period of years; make capital improvements to the hospital; maintain current levels of staffing, clinical care and charity care; employ all current employees at current levels of compensation and seniority; and have a community advisory board.[17] Ultimately, the DOH, with the urging of HPAE and other advocates, required aspects of these provisions as Conditions to the license transfer.

There were warnings to regulators, before the license transfer, that the MHA business model was likely to focus on same day surgery, rather than a full-scale hospital. No one, however, fully anticipated the nature and extent of the pain management program that MHA would implement, or the way in which profits would soar, while the hospital was starved for cash.

After reviewing all the documents submitted to the DOH and the OAG, HPAE leaders and health advocates determined that the only chance of assuring quality care and continued service to the community would be if the DOH and the OAG imposed strong conditions on the sale and if HPAE could negotiate a contract with MHA that would retain safe staffing levels and other protections for continuity of staff and services.

On December 1, 2010 the NJ Superior Court approved the sale of Meadowlands Hospital to MHA LLC[18] incorporating the Conditions imposed by the DOH in the CN transferring the license to MHA[19] and the Conditions imposed by the OAG under CHAPA. By then, HPAE and MHA had reached a collective bargaining agreement covering nurses and health care workers.

16 Response to DHSS Completeness Questions April 14, 2010 Attachment C.

17 OAG CHAPA Recommendation, p.31.

18 Order for Final Judgment, Superior Court of NJ, Chancery Division: Hudson County Docket No. HUD-C-175-10.

19 http://www.state.nj.us/health/bc/documents/shpb10/shpb_cn_meadowlandshosp_medicalcenter.pdf

Summary of Conditions Placed on the Sale of Meadowlands Hospital to MHA by the NJ Department of Health and Senior Services:

- Maintain the hospital as a general hospital for at least seven years and maintain all clinical services and community health programs. Any change or reduction has to have the approval of the NJDHSS and an analysis by a 'Community Advisory Group';
- Provide services to all, regardless of ability to pay or payment source;
- Establish a Board of Directors responsible for maintaining quality of care, to include local community members and physicians who are not employees or owners;
- Adopt policies to prevent conflicts of interest among Board members, complying with best practices;
- Submit financial reports to the DHSS, including investments in the hospital, debts, liabilities and transfers of funds to their affiliates, subsidiaries, and owners;
- Develop a Community Advisory Group (CAG) for community input, to include local officials, community residents and labor union representatives;
- Report to DHSS and the CAG on quality measures and recommendations for improvement;
- Endeavor to maintain insurance and HMO coverage, and inform the DHSS and Department of Banking and Insurance of any changes to insurance contracts;
- Hire substantially all existing employees and offer equivalent health insurance coverage;
- Meet with the DHSS Commissioner at regular intervals to discuss the hospital's condition and compliance with the terms of the CN;
- Conduct an outreach self-evaluation.

HPAE

SEPTEMBER, 2012

WHO IS MHA?

MHA's structure is complicated. CMPM owns MHA LLC; ATRP LLC, WK Meadowlands and Investors own CMPM; Innovative Health Management and Tampa Associates own ATRP. Overall, the four principals at the center of this box own 74% of MHA (according to a CN application submitted to the DOH 5/2/2011). A diagram of MHA's full structure is available at www.hpae.org/meadowlandsinfo.

WK Meadowlands WK is the 'Preferred Equity Member' of MHA, it receives guaranteed payments of over $160,000/mo. Companies related to Julien Blumenthal and Saul Kuperwasser financed at least one other 'Lipsky operation'.

Innovative Health Management
Innovative Health Management is owned directly and indirectly by Dr. Lipsky, his relatives, Anastasia Buryluk and Nick Rentas. It is a Florida LLC.

Pavel Pogodin	**Anastasia Burlyuk**
Tamara Dunaev	**Richard Lipsky**

Individual Passive Investors
See list on page 11.

Tampa Associates, LLC
According to records from Florida Department of State, Tampa Associates is registered by Mark Manigan in Florida and managed by Ms. Dunaev and Mr. Pogodin. It is owned by TVsons and Danika, both Florida LLCs.

SELECTED COMPANIES WITH LINKS TO MHA OR ITS PRINCIPALS

1. Roseland Ambulatory Surgery Center (RASC)
RASC is an ASC managed by Lipsky as CEO. According to MHA's 2011 Draft Financial Statements, the Hospital bought over $500,000 worth of equipment and supplies from RASC. For more on RASC, www.hpae.org/meadowlandsinfo.

2. Bergen Ambulatory Surgery Center (BASC)
BASC is administrated by Ms. Dunaev and owned in part by Ms. Dunaev and the wife of Mr, Pogodin. According to MHA's 2011 Draft Financial Statements, the Hospital bought almost $250,000 worth of equipment from BASC. For more on BASC, www.hpae.org/meadowlandsinfo.

3. Essex Surgery Center
Note that Essex has been sold and renamed. Essex was a former Surgery Center owned by ELR Realty but managed by Dr. Lipsky. For more on Essex, www.hpae.org/meadowlandsinfo.

4. Orphan Drug Professional Services
According to the Centers for Medicare & Medicaid Services, Orphan Drug Professional Services is a Pharmacy that shares an address and a CFO with Columbus LTACH. Mikhail Lipsky lists himself as a Principal of the company on LinkedIn. It was registered in NJ by MHA stakeholder Debra Lienhardt.

5. Columbus MedRealty, LLC
One of several 'MedRealty' companies owned in part by Dr. Lipsky. Columbus counts among its holdings the property that houses Columbus LTACH (per the 2011 Financial Statements of St. Michael's Medical Center) and a stake in Columbus LTACH itself (per documents submitted to the DOH).

6. ELR Realty
ELR is one of several real estate companies controlled by Dr. Lipsky's family. ELR is owned by Dr. Lipsky's ex-wife and his daughters. It holds a stake in several companies linked to Dr. Lipsky and owns property in NY & NJ.

7. Compassionate Care Centers of America Foundation, Inc.
CCCAF was the focus of several articles in the Star-Ledger in 2011. According to the articles, CCCAF was one of 6 medicinal marijuana clinics 'approved' by the DOH. Ms. Burlyuk is the foundation's Vice-President and the hospital's foundation is listed as a beneficiary. One article claimed the paper's inquiries caused an "influential player" and uncle of "scam artist" Solomon Dwek to be removed from the organization.

8. Vogster Entertainment, LLC
According to a 2009 lawsuit filed by Vogster in New York, the company is a "developer and publisher of video and computer games and other interactive products that was formed in 2005." The Hospital paid Vogster nearly $1 million in 2011 for software development, computer hardware and website development.

9. Columbus LTACH
According to documents submitted to the DOH, Columbus is owned in large part by Dr. Lipsky. MHA has a small indirect stake in the LTACH through Saint James – Columbus MedRealty. It is located in the facility which formerly housed Columbus Hospital.

10. Essex Pain Management Group
The Group's CEO is Dr. Lipsky. Its website (no longer active) advertised pain management services at multiple locations in NJ.

11. Xanadu Adult Daycare
Xanadu was founded by MER Associates, a company owned by Mikhail Lipsky. For more on Xanadu, www.hpae.org/meadowlandsinfo.

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INDIVIDUAL PASSIVE INVESTORS (PER CHART ON P.10)

- Charles Nicola, D.C.
- Anastasia Burlyuk
- Dalia Levinsky
- Yury Treskunov
- Ronald Rosenfeld
- WS II LLC
  - Mark Manigan
  - Debra Liendhardt
- TV Sons, LLC
- John Ingallinera
- Margarita Rudnick
- Joseph Lorber
- GL Health Management
  - German Katsnelson
  - Leo Yudkin
- Victor Mora
- Alexander Slipets
- Marina Lozovsky
- Grigory Rasin M.D. and Yelizaverta Rasin
- Richard Lipsky M.D.
- Shaya Ackerman LLC
  - Shaya Ackerman
  - Aliza Ackerman
- Ambulatory Surgical Consultants
  - Charles Conzentino
- Meadowlands Hospital Holdings, LLC
  - Raj Mukherji
  - William Michael Murphy
- Global Venture Holdings LLC
  - Pavel Kapelnikov
  - Global Consultants, LLC
    - Dmitry Suprunov
    - Anna Suprunov

Main Sources of Information for the Chart (p.10)

1. Brittain, Amy. N.J. medical marijuana center official booted over ties to con man Solomon Dwek. The Star Ledger: September 18, 2011. Accessible at http://www.nj.com/news/index.ssf/2011/09/nj_marijuana_center_official_b.html.

2. New Jersey Division of Revenue, Business Status Reports and Business Filings

3. Florida Division of Corporations Annual Reports and other corporate filings

4. Certificate of Need applications and related documents and correspondence with the DOH

5. Court records related to appropriate cases, including:

   - United States District Court, Eastern District of New York: Vogster Entertainment, LLC v. Gary Mostovoy, Mikhail Vaysman and John Does 1-5.
   - Superior Court Of New Jersey, Appellate Division, Docket No. A-0979-11t4: Felix Mangual v. Lazar Berezinsky.
   - Superior Court Of New Jersey, Appellate Division, Docket No. A-0433-09t1: Selective Insurance Company of America, et. al. v. Hudson East Pain Management Osteopathic Medicine and Physical Therapy, Essex Surgery Center L.L.C., Essex Pain Management, Tower West Chiropractic, Giordano Chiropractic, and Advanced Neurological Orthopedic Associates, Defendants-Appellants, and Sente and Ferraro Chiropractic.

THE BUSINESS MODEL IN ACTION

Upon taking over Meadowlands Hospital, MHA immediately implemented a business plan based on pain management same-day surgery procedures, and experimental autism treatments and brain injury programs.

Comparing NJ Cost Report data submitted by Meadowlands Hospital to the DOH from before and after the change of ownership (2010 vs. 2011) shows stark changes in Meadowlands operations. Here are some of the highlights taken directly from NJ Cost Report forms:[20]

- Registered Nursing Services, Licensed Practical Nursing and Nursing Attendants (in employee-hours) fell by 28%, 53% and 32% respectively [NJ Form C6]. This number is consistent with reports of cuts in bedside nursing care.
- Same Day Surgery Visits rose from 1,868 to 18,577 (almost 900% increase) [Form B6]
- Gross Revenues from Same Day Surgeries rose by 881% from $41 million to $404 million [Form E]
- Same Day Surgeries contribution to the 'bottom line' grew from 10% to 44% of Total Gross Revenues (as a result, inpatient services fell from 74% of Total Gross Revenues to 45% despite a rise in Inpatient gross revenue of 31%) [also Form E]

Almost as soon as MHA took ownership, pain management procedures for auto accident victims took center stage at the hospital, pre-empting other procedures in the operating rooms.

Meadowlands Hospital reportedly charged $67,715, while another hospital charged $4,458, a more typical price, for a steroid injection in the lower back.[23]

News reports and a NJ Senate Health Committee hearing revealed that State and insurance company officials were investigating MHA's pain management program practices.[21] Investigators reportedly were looking at whether MHA was taking advantage of a loophole in the law, which limits what same-day surgery centers may charge, but does not regulate what hospitals may charge for most outpatient care.[22] For example, state regulations limit same-day surgery centers' charges for administering steroid injections to an accident victim's lower back to $3,800. Meadowlands Hospital reportedly charged $67,715, while another hospital charged $4,458, a more typical price, for a steroid injection in the lower back.[23]

Around the same time, the NJ Department of Banking and Insurance (DOBI) issued regulations tightening payment limits for 2000 procedures, including those most commonly performed at Meadowlands Hospital, and the rule became known as the 'Meadowlands Rule'. Despite support from insurance industry trade groups[24], DOBI later withdrew most of the regulation.

20 Cost Report data was obtained through a NJ Open Records request

21 President of Meadowlands Hospital Medical Center defends billing practices before N.J. Senate committee http://www.nj.com/news/index.ssf/2011/09/president_of_meadowlands_hospi.html

22 N.J. looks to close fee loophole utilized by Meadowlands Hospital Medical Center, Sept 19, 2011 http://www.nj.com/news/index.ssf/2011/09/nj_looks_to_close_fee_loophole.html

23 Ibid.

24 Ibid.

Meadowlands Hospital's owners also came under scrutiny for plans to implement programs to treat autism, coma and traumatic brain injury using hyperbaric oxygen therapy. Resonant of Dr. Lipsky's anesthesia-assisted opiate detoxification program, these hyberbaric treatments are not covered by insurance and their effectiveness has not been medically established.

After legislators and reporters raised questions about the treatments, Meadowlands withdrew its application to DOH to use hyperbaric therapy to treat autism and terminated Philip DeFina, the Vice President for rehabilitation at Meadowlands and the scientific adviser for its Rehabilitation Institute and Neuroscience Center.[25]

nj.com

TUESDAY, JANUARY 10, 2012

Meadowlands hospital neuroscientist fired over controversial autism treatment

Quality of Care and Violations: Nurses as Whistleblowers

The conditions in the hospital compelled a 35-year nursing veteran and president of the HPAE local union at Meadowlands Hospital, JoAnne Dudsak, to 'blow the whistle' to authorities. JoAnne attended a meeting with the DOH Assistant Commissioner and staff to report on the conditions at the hospital on June 23, 2011. Within the week, JoAnne was summarily fired. Only after a firestorm of protest from advocates, legislators and elected officials was JoAnne re-hired. Concerned that "access to care and patient safety are seriously threatened" and that "close and frequent scrutiny of operations is essential", and citing violations of the letter and intent of several CN Conditions the Department had placed on Meadowlands Hospital, HPAE followed up the initial meeting and wrote to then-Acting DHSS Commissioner William Conroy on June 29, 2011 requesting the appointment of a health care monitor at Meadowlands Hospital (Available in full at www.hpae.org/meadowlandsinfo).

Following reports from nurses and staff, the DOH inspected the hospital and confirmed the reports, citing the hospital for serious patient safety violations.[26]

Summary of DHSS Inspection and Deficiencies at MHMC, July 2011

July 29, 2011: Survey took place July 6, 2011.

1. **Sterilization:**
   - Failure to follow facility policy; manufacturer's guidelines and standards of the Association for the Advancement of Medical Instrumentation (AAMI);
   - Failure to store sterile supplies so as to maintain sterility;
   - Operating rooms were not clean; failure to follow policy and procedure re: cleaning between surgical cases.
2. **Operating room policies** – Pre-Admission testing: failure to perform pre-admission testing for same day pain management cases.
3. **Operating room policies** – Informed consent: failure to obtain completed written informed consent prior to anesthesia administration for same day pain management cases.

25 Meadowlands hospital neuroscientist fired over controversial autism treatment, Jan 10, 2012 http://www.nj.com/news/index.ssf/2012/01/meadowlands_hospital_neuroscie.html

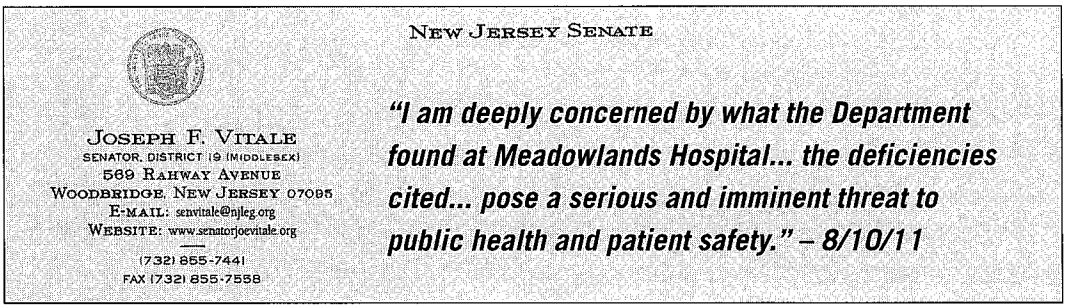
26 Meadowlands Hospital Medical Center skipped tests, did not ensure enough nurses were on duty, report says Aug 10, 2011. http://www.nj.com/news/index.ssf/2011/08/meadowland_hospital_medical_ce.html

56x

4. **Operating room policies** – Updated history & physical: failure to obtain an updated history and physical for same day pain management patients.
5. **Outpatient and Preventive Services** – Failure to provide outpatient pediatric services. DOH regulations require a hospital to provide outpatient and preventive clinic services for all inpatient services.
6. **Central supply/Sterilization:**
   - Failure to follow AAMI standards relating to sterilization of re-usable medical devices;
   - Failure to follow AAMI procedures when transferring items sterilized in the OR;
   - Failure to monitor and store sterilized materials so as to ensure sterility.
7. **Infection Control:**
   - Failure to include the Director of Surgical Services on the Infection Control committee as required by DOH regulations;
   - Failure to implement handwashing policies, as recommended by the US Centers for Disease Control and Prevention.
8. **Nurse Staffing:**
   - Failure to have an acuity system or other patient data base with objective data for determining proper staffing, as required by DOH regulations;
   - Failure to post staffing levels as required by DOH regulations.

HPAE reiterated a request that DOH install a monitor at Meadowlands Hospital, after reviewing the deficiencies cited by the Department in its July 2011 inspection, in an August 1, 2011 letter to Acting Commissioner Conroy. Concerned over what appeared to be a "threatening and hostile work environment for staff and an unsafe and hostile medical environment for patients", NJ Appleseed Public Interest Law Center also wrote to the Department in support of HPAE's request for a monitor on August 2, 2011. (Both letters are available at www.hpae.org/meadowlandsinfo)

Citing a "serious and imminent threat to public health and patient safety", Senator Joseph Vitale wrote to Acting DOH Commissioner Conroy on August 10, 2011 requesting that the Department appoint a health care monitor at Meadowlands Hospital, to be paid for by the Hospital. www.hpae.org/meadowlandsinfo



In September 2011, the NJ Senate Health Committee held a hearing to examine the rise of for-profit hospitals in NJ, their impact on quality of care and patient safety, and the financial secrecy under which these hospitals, including Meadowlands, operate. JoAnne Dudsak was among those testifying and she reiterated the call for a monitor.

STATEMENT OF JOANNE DUDSAK, RN

September 19, 2011

Senate Health Committee Hearing on For-Profit Hospitals

"My name is JoAnne Dudsak and I want to thank you for the chance to speak with you today about my experiences working at Meadowlands Hospital under for-profit ownership. I have worked at Meadowlands for more than 35 years.

As you have already heard, my hospital is front and center in the debate over for-profit ownership of our community hospitals, and how that affects patient care, services, and accountability – and from my point of view, my crucial right and obligation as a Registered Nurse to stand up for my patients and my profession.

As soon as I began advocating for my patients and my colleagues at Meadowlands, I was targeted for discipline, and in fact, dismissed. Very shortly after I participated in a meeting at the NJ Department of Health and Senior Services, raising concerns over what I believed were violations in meeting state standards for protocols, policies and practices affecting patient care, I was fired.

Because of the outrage expressed by my co-workers, my union, elected officials here today, and the DHSS, I was re-hired. Of course, my union rights were paramount in my quick return to work, rights that not every RN or health care professional has.

The investigation and inspection report of the NJ Department of Health and Senior Services is the confirmation that when we transfer our community hospitals to for-profit ownership, we must provide on-site monitoring on a consistent and regular basis. If we had done that at Meadowlands, we might have prevented the deficiencies, which included failure to perform pre-admission testing and informed consent; and failure to follow policies for sterilization, infection control and nurse staffing.

We still need a monitor at Meadowlands, as we continue to see what we believe are violations of patient safety laws and regulations – and an overall decline in staffing and services in favor of a pain-management practices that provides large profits for the owners. We need a monitor as well, to make sure that our staff can report these issues directly and quickly, without fear of retaliation."

At no time has the Department formally responded to any of these requests for a health care monitor at Meadowlands Hospital.

Violations Continue at Meadowlands Hospital Medical Center

The DOH conducted another inspection of Meadowlands Hospital on behalf of the federal government in November 2011. That inspection uncovered numerous deficiencies including:

1. Failure to follow state regulations and facility policy for administration of Oxytocin during obstetrical deliveries: Oxytocin was administered without prior examination and evaluation of the patients by a physician.
2. Failure to ensure that dialysis services that are provided under contract follow both facility and contractor policies and procedures, including documentation of patient assessment prior to beginning a dialysis treatment: Pre-dialysis safety checks were not documented prior to starting patient treatment;

Pre-treatment pain assessment was not documented prior to starting dialysis treatment; cleaning of the dialysis station between patients did not follow protocol.

3. Failure to ensure that medications were administered in accordance with physician's orders.
4. Failure to ensure that medications were stored in locked storage areas.
5. Failure to ensure that expired or unusable medications were not available for patient use.
6. Failure to properly maintain the intravenous medication preparation room in the pharmacy in order to assure the safety and well-being of patients.
7. Failure to properly store and monitor sterilized materials in the OR.
8. Failure to properly clean OR equipment between surgical cases.
9. Failure to properly dispose of personal protective equipment after use.
10. Failure to provide appropriate discharge planning evaluations: for a homeless patient and an 86-yr old patient living alone.
11. Failure to ensure that respiratory therapy treatments are performed in accordance with physician's orders: patient did not receive prescribed inhalation therapy.

The DOH also conducted an on-site Rehabilitation Unit Prospective Payment System Survey for the exclusion of 30 beds. In order to be excluded from the prospective payment system (PPS), a rehabilitation unit must meet certain requirements. Meadowlands failed to meet the following requirements:

1. Failure to maintain medical records for the rehab unit that are separate from the hospital records.
2. Rehab Unit Medical Director's credentials do not meet State licensing requirements; Unit does not have two full time physiatrists as required by State law.
3. The Rehabilitation Unit's Social Worker did not meet the education requirements, and did not comply with the job specific competencies of his/her job title, or facility policy, as State law requires, including failure to review patient admissions within specified time periods.
4. Failure to conduct Interdisciplinary Care Conferences as required by regulation and facility policy.

Another inspection, completed on Oct 31, 2011, identified several Life Safety Code Standard violations.

THE FINANCES: MONEY FOR PROFITS, NOT PATIENTS

Because of the $5M mortgage loan Liberty made to MHA to help finance the hospital purchase, the Superior Court's Order approving the sale of the formerly not-for-profit Meadowlands Hospital to the for-profit MHA requires MHA to submit quarterly reports to the Attorney General's Office for two years and prohibits certain uses of Hospital funds. The intent of this provision of the Court Order is to assure that there would be sufficient working capital available to the Hospital for the first two years of its operations and to prevent MHA from depleting the Hospital's operating cash by making payments to affiliates, accelerating payment on its debt or making payments to

Our review of documents MHA has filed with the State lead us to believe that they have violated the intent of the Order with respect to these prohibited uses.

The Record

AUGUST 1, 2012

Hospital: Audit raises concerns about Meadowlands finances

its investors. Our review of documents MHA has filed with the State lead us to believe that they have violated the intent of the Order with respect to these prohibited uses.

State regulations require all hospitals to annually submit their Audited Financial Statement (AFS) to the DOH by June 30th for the prior fiscal year. HPAE filed an Open Public Records Act request for the Meadowlands Hospital 2011 AFS with the NJ Health Care Facilities Financing Authority. In response we received Meadowlands Hospital's Draft 2011 AFS; as of the date of publication of this White Paper, the Hospital has yet to submit their Final AFS.

According to a report in *The Record,* a review of this Draft AFS reveals substantial profits as well as hefty distributions to investors and insider dealings among owners and investors. *The Record* also reported that the Draft AFS reveals the Meadowlands Hospital had severe cash and liquidity problems at the close of 2011 and that MHA defaulted on the $5M loan from Liberty in March 2012 (Liberty and MHA are now debating this issue in court along with other financial issues related to the sale of the Hospital in 2010). Specifically, as of December 31, 2011:

- Meadowlands Hospital had net income of $9M and an enviable operating margin of 10% in 2011, one of the highest in the State;
- MHA made $8.4M of distributions to investors.

Nevertheless:

- MHA had only $72,000 of cash, representing less than one day's worth of operating expenses. The state median was 62 days;
- MHA had a Cash Overdraft of $1M;
- MHA had failed to make payments on a bank loan which it assumed when it bought some equipment from one of its surgery centers;
- An unidentified Hospital board member opened up four bank accounts and set up a petty cash fund on behalf of the Hospital using her/his personal funds;
- Two unidentified Hospital board members loaned MHA $5M in March 2012 at an interest rate of 13% when MHA defaulted on its $5M loan from Liberty at only 1.53% interest;
- MHA purchased over $600,000 of equipment and supplies from another surgery center owned by two of the Hospital's Trustees.

Mary Jo Layton documented many of these concerns in a front-page article appearing in *The Record* on August 1, 2012 (The full text is available www.hpae.org/meadowlandsinfo).

MHA appears to have brought patients into the middle of a 'dispute' with Aetna over reimbursement for services despite its $9M net income in 2011 and a requirement that MHA "make a reasonable attempt to

60X

continue the current commercial insurance contracts of MHMC that are in effect for at least 1 year after licensure."[27] A recent article on the front page of *The Record* described the 'dispute':

The Record

WEDNESDAY, AUGUST 15, 2012

Aetna patients in a bind

Insurer tells Meadowlands Hospital clients not to pay bills

By LINDY WASHBURN
STAFF WRITER

Meadowlands Hospital Medical Center

Aetna's advice to the recipients: Don't pay.

The dispute shines a light on the complicated terrain that underlies relationships

for at least a year.

As a result, Aetna says, its contract with the hospital was in force in 2011 – when the bills were incurred – and so the hospi-

Contact information

Aetna customers who receive bills from Meadowlands Hospital

"Meadowlands Hospital Medical Center has billed hundreds of patients in the last few weeks for care they thought was covered by their Aetna insurance policies. The bills – some for thousands of dollars – demand payment within five days.

Aetna's advice to the recipients: Don't pay"
(Aetna Patients in a bind: Insurer tells Meadowlands Hospital clients not to pay bills, 8/15/2012, see www.hpae.org/meadowlandsinfo).

Earlier this year, MHA sued Aetna in federal court, alleging that Aetna paid for care at Meadowlands Hospital at 'in-network' rates negotiated with the former owners instead of paying the full bill, as submitted by MHA.

INFLUENCING THE PROCESS: POLITICAL CONTRIBUTIONS AND LOBBYING

MHA, its principals, investors and affiliated companies accompanied their business plans and expansions with political contributions to elected officials, from Mayors to NJ State Legislators, to political parties and PACs. An analysis of campaign contributions data from the New Jersey Election Law Enforcement Commission (NJ ELEC) and the Federal Elections Commission (FEC) shows over $260,000 in campaign contributions to candidates and committees since December, 2010, when MHA bought the hospital.[28] Not included are thousands of dollars in contributions that were later adjusted or returned (In one case, Lipsky's contribution of over $10,000 was returned to him for reasons the Auditor/Star-Ledger could not discern, http://blog.nj.com/njv_auditor/2011/10/poll_finds_nj_voters_may_not_h.html).

Contributions from Dr. Lipsky, MHA principals, family members and affiliated individuals went to both political parties and candidates from both parties. Top contributions included the Democratic Assembly Committee ($25,000) and the Republican Senate ($25,000) and Assembly ($35,000) Committees; and Democrats John Wisniewski ($71,750) and Jason O'Donnell ($15,600) and Republicans Jon Bramnick ($15,600) and Jay Weber ($10,400). MHA principals also gave a total of $7,500 to Republican presidential candidate Mitt Romney.

On some occasions, contributions were given in quick succession from many sources. In one instance in early August, 2011, at least thirteen individuals contributed a combined $80,000 over three days. Contributors over the three-day period included Dr. Lipsky, Ms. Dunaev, Mr. Pogodin, other investors in MHA, Hospital Administrators/Management and others linked to Dr. Lipsky's wide array of operations. Eleven of these contributions, over $27,000, were given on one day to one recipient, John Wisniewski.

27 Order for Final Judgment, Superior Court of NJ, Chancery Division: Hudson County Docket No. HUD-C-175-10.

28 Estimates of campaign contributions are based on an analysis of contributions data from ELEC and the FEC. In most cases, the searchable online databases of ELEC and the FEC were used, available at http://www.elec.state.nj.us/publicinformation/searchdatabase.htm and http://www.fec.gov/ respectively. Note that the ELEC online contributions database is not comprehensive over all years; some contributions may be missing or unaccounted for. Other contributions were found as the result of a review of ELEC's campaign disclosure reports for individual candidates and committees.

A review of NJ ELEC Annual Lobbying Reports reveals that MHA and other companies directly associated with its principals paid another $272,000 to lobbying groups for representation.[29] These dollars were spent:

- Opposing S782, the New Jersey Hospital Disclosure and Public Resource Protection Act, a bill for transparency and accountability at for-profit hospitals (Governmental Affairs Agents Quarterly Reports, 1st Quarter, 2012);
- Opposing A229, a bill that "Requires practitioners to disclose business relationship with out-of-State facilities when making patient referrals to those facilities," presumably to prevent conflicts of interest (Governmental Affairs Agents Quarterly Reports, 1st Quarter, 2012);
- Opposing S1743/A2511, a bill designed to combat insurance fraud (Governmental Affairs Agents Quarterly Reports, 4th Quarter, 2011);
- Opposing S2372, a bill that "Clarifies out-of-network payment responsibilities under health benefits plans; requires certain coverage and procedure disclosures to consumers; revises procedures for changes to managed care plan contracts" (Governmental Affairs Agents Quarterly Reports, 4th Quarter, 2011).

In May, 2012 PolitickerNJ.com published two stories on MHA's use of political connections and contributions:

EXCERPT FROM POLITICKERNJ.COM

"Legislation would have exempted sponsor's law client from hospital fee caps"

Late last year, as state officials sought to close a loophole that allowed Meadowlands Hospital in Secaucus to charge exorbitant fees for outpatient medical procedures, a prominent state lawmaker with direct ties to the hospital's ownership sponsored legislation that would have exempted the medical center from a measure capping its charges.

Assemblyman and Democratic State Party Chairman John Wisniewski, an attorney who represented Meadowlands Hospital owner Richard Lipsky in a 2008 Bayonne land development deal, was among three sponsors of a bill that would have exempted hospitals from the state's efforts to rein in fees for outpatient medical procedures performed under personal injury protection insurance (PIP).

A second lawmaker with ties to Lipsky, Republican Minority Leader Jon Bramnick, was a co-sponsor of the bill, which went nowhere. Prior to last year, Bramnick leased space in a Scotch Plains office building he owns to Essex Pain Management, among several companies owned by Lipsky.

In the months before and after the introduction of the bill, Wisniewski collected at least $70,000 in campaign contributions from Meadowlands Hospital owners and employees, Lipsky among them, as well as more than a dozen others with ties to the ownership group. Bramnick received at least $13,000 in donations from Lipsky and others tied to the hospital or to the many businesses Lipsky owns.

(To read PolitickerNJ.com's coverage of this story, go to: www.hpae.org/meadowlandsinfo).

29 Impact NJ's Form L1-A shows receipts of $20,000 from MHA, LLC, $25,000 from MedRealty, LLC (incl. Columbus MedRealty LLC & Saint James MedRealty LLC) and $120,000 from Compassionate Care Centers of America Foundation, Inc. Public Strategies Impact's Form L1-A shows receipts of $59,500 from MHA LLC and $17,500 from Essex Pain Management. Princeton Public Affairs Group Inc's Form L1-A shows receipts of $30,234 from Meadowlands Hospital.

MHA Lobbyists and Shareholders Also Expand MHA's Political Influence

The principals of Impact NJ, Raj Murkuji and Michael Murphy, have close ties to the company. According to documents filed with the DOH, together Raj Murkuji and Michael Murphy own Meadowlands Hospital Holdings, LLC, a company registered to Impact NJ's offices in Jersey City and formed when Meadowlands Hospital was transferred into the hands of MHA and its complex network of shareholders.

Other shareholders include members of Brach Eichler's Health Law Practice Group, Mark Manigan and Debra Lienhardt. Mr. Manigan is on the firm's Executive Committee, a champion of the Ambulatory Surgical Center industry and a member of Governor Christie's transition team. Ms. Lienhardt is an Executive Board member of the New Jersey Academy of Ophthalmology and Board of Trustees member of HackensackUMC Mountainside in Montclair.

Dr. Lipsky's other assets in the state have equally complex ownership structures with political ties and connections with health care providers throughout the State.

THE FAILURES OF STATE OVERSIGHT

Throughout 2011 and 2012, HPAE informed the appropriate state agencies of apparent violations of patient safety laws, hospital licensure laws and regulations, and the conditions established by the CN and CHAPA process that allowed MHA to purchase our community hospital. Repeated requests for inspections, and ultimately, a monitor were made by HPAE and other health advocates, including NJ State Senator Joseph Vitale (www.hpae.org/meadowlandsinfo).

On July 23, 2012, Ann Twomey again wrote to the DOH Commissioner regarding MHA's apparent violations of reporting requirements contained in the CN that would enable the DOH and the public to monitor the hospital owners' compliance with the commitments they made in their CN application and with NJ hospital licensing laws and regulations. HPAE cited MHA's failure to provide documentation for:

- Outpatient and preventive services for medically indigent patients as provided on an-inpatient basis;
- A board roster, board policies, and demonstration of best practices, including a conflict of interest policy;
- Community Advisory Group reports;
- Payor mix reports;
- Investments, debts and liabilities and transfers of funds (www.hpae.org/meadowlandsinfo).

HPAE has received a copy of DOH citations related to MHA's failure to comply with CN requirements, and the MHA's proposed Plan of Correction.

August 6, 2012, HPAE President, Ann Twomey, wrote once again to the DOH "to formally request that you [DOH Commissioner O'Dowd] take immediate steps to utilize the remedies at your disposal to protect the safety of Meadowlands Hospital's patients, the community's access to care and the workplace rights of Hospital employees."

Making a Case for State Intervention

HPAE briefly set forth the DOH's options and a rationale for action:

NJ law and regulations for example, give the DOH Commissioner the authority to appoint a temporary manager or receiver when a health care facility violates licensure regulations or other statutory requirements (N.J.A.C. 8:43E-3.1) and to appoint a monitor when she determines that a hospital is in "financial distress or at risk of being in financial distress" CN.J.S.A. 26:2H-5). We believe these remedies are urgently needed and appropriate in view, of the following:

- The Hospital's 2011 Draft Audited Financial Statement indicates that the Hospital meets or exceeds "Financial Distress" Triggers;
- The owners fully repaid investors despite the Hospital's serious financial vulnerabilities;
- The owners apparently defaulted on a $5M loan from Liberty Healthcare;
- The owners have violated numerous CN requirements;
- The owners have allowed the Hospital to violate state and federal regulations protecting patient safety and patient rights;
- The owners and Board members appear to have engaged in self-dealing;
- The owners have failed to timely file the Hospital's 2011 Audited Financial Statement;
- Potential violations of provisions of the Final Order of the Superior Court authoring the sale of the Hospital to MHA intended to prevent depletion of the Hospital's assets.

HPAE also asked of Commissioner O'Dowd "that the Department [DOH], in conjunction with the NJ Office of the Attorney General (OAG), conduct an in-depth audit of the financial practices at Meadowlands Hospital, including scrutiny of the records Meadowlands Hospital has submitted to the OAG in fulfillment of the Superior Court Order approving the sale of the Hospital to the current owners under the Community Health Asset Protection Act (CHAPA)." A similar request was sent to Deputy Attorney General Jay Ganzman at the OAG (See www.hpae.org/meadowlandsinfo for the full request).

Since February 2010, when MHA notified NJ regulators of its plans to purchase Meadowlands Hospital, there have been numerous opportunities for state regulators to invoke penalties or remedies for violations of state laws and regulations:

- During the acquisition process, due to the extent and seriousness of the prior violations at facilities owned by the MHA principals, the DOH could have required a monitor and more transparency in financial and governance operations at the onset of MHA's ownership of Meadowlands Hospital;
- Following the state's initial inspection of the Hospital in July of 2011, HPAE, Appleseed Public Interest Law Center and State Senator Joseph Vitale all requested a monitor at Meadowlands. No monitor was installed;
- Following reports of excessive charges for pain management procedures, the NJ Department of Banking and Insurance could have proceeded with its proposed regulations to limit charges for hospital-based same-day surgical procedures;
- Following the November 2011 federal inspection of the Hospital the DOH could have imposed a monitor;

- Following repeated failures by MHA to submit quarterly and annual reports to the DOH and the Office of the AG, as required in the CHAPA/CN Conditions, and in light of MHA's failure to submit a timely Audited Financial Statement for 2011 and the "red flags" in the Draft AFS, the DOH and the OAG could have undertaken an in-depth investigation of finances and governance at Meadowlands Hospital.

Despite all the remedies available to it, to our knowledge the DOH has chosen to impose only a small fine of $3,000 on MHA, which was paid on October 13, 2011.

- And finally, Governor Christie missed an important opportunity to protect all of our communities from for-profit companies that violate state laws and take excessive profits at the expense of our health care when he vetoed S782, legislation that would have required all hospitals to report to the DOH on how they are spending public funds.

IN CONCLUSION: RECOMMENDATIONS TO RESTORE 'PATIENTS BEFORE PROFITS'

As nurses and health caregivers, we are troubled when we believe that our patients are receiving less than the best care because profits are coming first – equipment might not get fixed quickly enough, supplies might be short, staffing and services get cut-back, insurance contracts are cancelled. It is particularly troubling when we witness cost-cutting while owners and investors take substantial profits for themselves.

In NJ, the rise of for-profit companies has been largely driven by groups of investors and 'entrepreneurs' who have seen a profitable niche in buying up troubled hospitals in urban areas. A business model developed based on cancelling insurance contracts, cutting back on less profitable services, and reducing staff, all in the service of increasing profit margins.

MHA and its ownership of Meadowlands Hospital provide a stark example of opportunities missed to protect our communities, and to set a standard for all stewards of our health care by New Jersey regulators. Repeated violations of patient safety, worker rights and hospital licensure requirements have been met with little response from the DOH or Office of Attorney General.

Whether a hospital is for-profit or not-for-profit, it is responsible for assuring vital health services to its communities. Both not-for-profit and for-profit hospitals receive charity care funds – $675 million in 2013 – as well as Medicaid, Medicare and other public funding. Our communities depend on their local hospital, and the deterioration of care at a local hospital is as serious as a hospital closing.

Certificate of Need Statutes

26:2H-1. Declaration of public policy (CN Process)

1. It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health shall have the central responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services and health care facility cost containment programs, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as residential health care facilities, nursing or maternity homes or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

26:2H-5.8 Review of application for certificate of need.

34. a. (Deleted by amendment, P.L.1998, c.43).

b. The State Health Planning Board shall review applications for certificates of need and make recommendations to the Commissioner of Health and Senior Services.

c. In the case of an application for a certificate of need to transfer ownership of an existing general acute care hospital or to close or eliminate a health care facility or service that is subject to review by the State Health Planning Board, the State Health Planning Board shall hold at least one public hearing in the service area of the health care facility or service; except that, in the event the Attorney General or the Department of Health and Senior Services is required by State law to hold a public hearing on the transfer of ownership of the hospital, the State Health Planning Board shall not be required to hold a public hearing on the application for a certificate of need to transfer ownership of the hospital. The public hearing shall be held no later than 30 days after an application is deemed complete by the Commissioner of Health and Senior Services. Public notice of the hearing shall be provided at least two weeks in advance of the date of the hearing.

Notwithstanding the provisions of this subsection to the contrary, in the event that the commissioner determines that a proposed closure or elimination of a health care facility or service should be considered on an expedited basis in order to preserve the quality of health care provided to the community, the commissioner may reduce the period of time required for public notice of the hearing.

26:2H-6.1 Findings, declarations relative to CN (eliminating for certain services)

1. The Legislature finds and declares that:

a. The regulatory structure for the State's health care delivery system put in place in the 1970's was an outgrowth of federal legislation predicated on the idea that the most satisfactory means of controlling health care costs was the allocation of health care resources by government through a highly centralized health planning mechanism;

b. For two decades, the State established strong controls over the health care delivery system by such means as the setting of hospital rates and through the certificate of need program, which allocated the provision of services among providers, regulated hospital expansion, and regulated the purchase of equipment and the use of medical technology;

c. The evolution of market-based means of controlling costs, most notably the growth of managed care, and the rapid development of new medical techniques and innovations in medical technology exposed the inefficiencies inherent in centralized health care planning, which was unable to respond quickly to the changing needs of the health care system;

d. In 1992, the Legislature began to dismantle the existing regulatory structure, responding to the needs of the health care system in New Jersey by eliminating hospital rate setting, leaving hospital charges to be established through negotiation between hospitals and those who paid for health care services and, by providing access to health insurance to all citizens of the State, without regard to health status or preexisting condition, contributed to the significant changes taking place in the underlying economics of the health care delivery system by helping to create a more competitive health care environment;

e. The certificate of need program is the last remaining vestige of the highly regulated environment, and its original purpose, which was to control costs by limiting the proliferation of health care services through State control of those services, has been undermined by the significant changes in the economics of the health care system that have taken place since its inception;

f. Decisions as to health care services, the acquisition of medical technology, and the expansion of facilities can best be made by the health care provider based on his own expertise in delivering health care services to the community he serves;

g. The appropriate role of the State with respect to services no longer subject to certificate of need is that of licensure of facilities and services, to ensure the quality of care;

h. For reasons of maintaining the quality of certain health care services, a limitation of the proliferation of such services may continue to be essential to protect the viability of the services as well as the providers now rendering them, to protect the role of such institutions as urban hospitals, whose importance to the Statewide health care system is indisputable, and to guard against the closing of important facilities and the transfer of services from facilities in a manner which is harmful to the public interest; and

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i. Therefore, it is essential, in order to promote greater efficiency in the State's health care delivery system, to eliminate the certificate of need requirement for many services immediately, to eliminate the requirement for other services over a more extended period, and to create a commission to consider whether certain remaining health care services should continue to be subject to a certificate of need requirement in the interest of the well-being of the public and to ensure the maintenance of quality health care throughout the State.

26:2H-7 Certificate of need required for construction, expansion of health care facility.

7. No health care facility shall be constructed or expanded, and no new health care service shall be instituted after the effective date of P.L.1971, c.136 (C.26:2H-1 et seq.) except upon application for and receipt of a certificate of need as provided by P.L.1971, c.136 (C.26:2H-1 et seq.). No agency of the State or of any county or municipal government shall approve any grant of funds for, or issue any license to, a health care facility which is constructed or expanded, or which institutes a new health care service, in violation of the provisions of P.L.1971, c.136 (C.26:2H-1 et seq.).

Except as provided in section 19 of P.L.1992, c.160 (C.26:2H-7a) and section 16 of P.L.1998, c.43 (C.26:2H-7c), the provisions of this section shall apply to:

a. The initiation of any health care service as provided in section 2 of P.L.1971, c.136 (C.26:2H-2);

b. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health and Senior Services;

c. The purchase by any person of major moveable equipment whose total cost is over $2 million;

d. The expenditure by a licensed health care facility of over $2 million for construction of a new health care facility; and

e. The construction of a facility by any person, whose total project cost exceeds $2 million, if the facility-type is the subject of a health planning regulation adopted by the Department of Health and Senior Services.

The commissioner may periodically increase the monetary thresholds established in this section, by regulation, to reflect inflationary increases in the costs of health care equipment or construction.

For the purposes of this section, "health care service" shall include any service which is the subject of a health planning regulation adopted by the Department of Health and Senior Services, and "person" shall include a corporation, company, association, society, firm, partnership and joint stock company, as well as an individual.

A physician who initiates a health care service which is the subject of a health planning regulation or purchases major moveable equipment pursuant to subsection b. or c. of

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this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the equipment or health care service is such an essential, fundamental and integral component of the physician's practice specialty, that the physician would be unable to practice his specialty according to the acceptable medical standards of that specialty without the health care service or equipment; the physician bills at least 75% of his total amount of charges in the practice specialty which uses the health care service or equipment; and the health care service or equipment is not otherwise available and accessible to patients, pursuant to standards established by the commissioner, by regulation. The commissioner shall make a determination about whether to grant or deny the waiver, within 120 days from the date the request for the waiver is received by the commissioner and shall so notify the physician who requested the waiver. If the request is denied, the commissioner shall include in that notification the reason for the denial. If the request is denied, the initiation of a health care service or the purchase of major moveable equipment shall be subject to the certificate of need requirements pursuant to this section.

A health maintenance organization which furnishes at least basic comprehensive care health services on a prepaid basis to enrollees either through providers employed by the health maintenance organization or through a medical group or groups which contract directly with the health maintenance organization, which initiates a health care service, or constructs a health care facility pursuant to subsection a., b., d. or e. of this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the initiation of the health care service or the construction is in the best interests of State health planning; and the health maintenance organization is in compliance with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and complies with the provisions of subsection d. of section 3 of P.L.1973, c.337 (C.26:2J-3) regarding notification to the commissioner. The commissioner shall make a determination about whether to grant or deny the waiver within 45 days from the date the request for the waiver is received by the commissioner and shall so notify the health maintenance organization. If the request for a waiver is denied on the basis that the request would not be in the best interests of State health planning, the commissioner shall state in that notification the reason why the request would not be in the best interests of State health planning. If the request for a waiver is denied, the health maintenance organization's initiation of a health care service or construction project shall be subject to the certificate of need requirements pursuant to this section.

The requirement to obtain a certificate of need for major moveable equipment pursuant to subsection c. of this section shall not apply if a contract to purchase that equipment was entered into prior to July 1, 1991.

26:2H-8. Requirements for certificate of need

8. No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health care services in the region or Statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration (a) the availability of facilities or services which may serve as alternatives or substitutes, (b) the need for special equipment and services in the area, (c) the possible economies and improvement in services to be anticipated from the operation of joint central services, (d) the adequacy of financial resources and sources of present and future revenues, (e) the availability of sufficient manpower in the several professional disciplines, and (f) such other factors as may be established by regulation. The State Health Plan may also be considered in determining whether to approve a certificate of need application.

In the case of an application by a health care facility established or operated by any recognized religious body or denomination the needs of the members of such religious body or denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be a public need.

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"Community Health Care Assets Protection Act"
P.L.2000, c.143

26:2H-7.10 Short title.

1. This act shall be known and may be cited as the "Community Health Care Assets Protection Act."

26:2H-7.11 Additional requirements for nonprofit hospitals relative to acquisitions; exemptions; procedures.

2. In addition to the requirements of P.L.1971, c.136 (C.26:2H-1 et seq.) concerning certificate of need and licensure requirements, a nonprofit hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall satisfy the requirements of this act before applying to the Superior Court of New Jersey for approval prior to entering into a transaction that results in the acquisition of the hospital as defined in this act. The proposed acquisition shall be subject to the prior review of the Attorney General, in consultation with the Commissioner of Health, pursuant to the provisions of this section. The Attorney General shall review the application in furtherance of his common law responsibilities as protector, supervisor, and enforcer of charitable trusts and charitable corporations.

For the purposes of sections 2 and 3 of this act, "acquisition" means the purchase, lease, exchange, conversion, restructuring, merger, division, consolidation, transfer of control, or other disposition of a substantial amount of assets or operations, whether through a single transaction or series of transactions, with one or more persons or entities.

This act shall not apply to a nonprofit hospital if the proposed acquisition is in the usual and regular course of its activities and the Attorney General has given the nonprofit hospital a written waiver as to the proposed acquisition. As used in this section, a proposed acquisition is not in the usual and regular course of a nonprofit hospital's activities if it effects a fundamental corporate change that involves transfer of ownership or control of charitable assets or a change of the nonprofit hospital's mission or purpose.

a. (1) Within five working days of submitting an application pursuant to this section, the nonprofit hospital shall publish a notice of the proposed acquisition, in a form approved by the Attorney General, in a newspaper of general circulation in the service area of the hospital once per week for three weeks. The notice shall state the names of the parties to the agreement, describe the contents of the application to the Attorney General, and state the date by which a person may submit written comments about the application to the Attorney General.

(2) Within 30 days after receipt of an initial application, the Attorney General shall advise the applicant in writing whether the application is complete, and, if not, shall specify what additional information is required.

(3) The Attorney General shall, upon receipt of the information requested, notify the applicant in writing of the date of completion of the application.

b. Within 90 days of the date of completion of the application, the Attorney General, in consultation with the Commissioner of Health, shall review the application and support the proposed acquisition, with or without any specific modifications, or, if the Attorney General finds that it is not in the public interest, oppose the proposed acquisition. The Attorney General or commissioner may, for good cause, extend the time for review of an application submitted pursuant to this section.

The proposed acquisition shall not be considered to be in the public interest unless the Attorney General determines that appropriate steps have been taken to safeguard the value of the charitable assets of the hospital and to ensure that any proceeds from the proposed acquisition are irrevocably dedicated for appropriate charitable health care purposes; and the

Commissioner of Health determines that the proposed transaction is not likely to result in the deterioration of the quality, availability or accessibility of health care services in the affected communities.

c. In determining whether the acquisition meets the criteria of subsection b. of this section, the Attorney General shall consider:

(1) Whether the acquisition is permitted under the "New Jersey Nonprofit Corporation Act," Title 15A of the New Jersey Statutes, and other applicable State statutes governing nonprofit entities, trusts, or charities;

(2) Whether the nonprofit hospital exercised due diligence in deciding to effectuate the acquisition, selecting the other party to the acquisition and negotiating the terms and conditions of the acquisition;

(3) The procedures used by the nonprofit hospital in making its decision, including whether appropriate expert assistance was used;

(4) Whether conflict of interest was disclosed, including, but not limited to, conflicts of interest related to board members of, executives of and experts retained by the nonprofit hospital, purchaser, or other parties to the acquisition;

(5) Whether any management contract under the acquisition is for reasonable fair value;

(6) Whether the acquisition proceeds will be used for appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose or for the support and promotion of health care and whether the proceeds will be controlled as charitable funds independently of the purchaser or parties to the acquisition; and

(7) Any other criteria the Attorney General establishes by regulation to determine whether the proposed acquisition is in the public interest.

d. In determining whether an acquisition by any person or entity other than a corporation organized in this State for charitable purposes under Title 15A of the New Jersey Statutes meets the criteria of subsection b. of this section, the Attorney General shall consider, in addition to the criteria set forth in subsection c., the following criteria:

(1) Whether the nonprofit hospital will receive full and fair market value for its assets. The Attorney General may employ, at the nonprofit hospital's expense, reasonably necessary expert assistance in making this determination;

(2) Whether charitable funds are placed at unreasonable risk, if the acquisition is financed in part by the nonprofit hospital;

(3) Whether a right of first refusal has been retained to repurchase the assets by a successor nonprofit corporation or foundation if, following the acquisition, the hospital is subsequently sold to, acquired by or merged with another entity;

(4) Whether the nonprofit hospital established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes;

(5) Whether the nonprofit hospital considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes;

(6) Whether the nonprofit hospital exercised due care in assigning a value to the existing hospital and its charitable assets in proceeding to negotiate the proposed conversion;

(7) Whether officers, directors, board members, or senior management will receive future contracts in existing, new, or affiliated hospitals or foundations; and

(8) Any other criteria the Attorney General establishes by regulation to determine whether a proposed acquisition by any person or entity other than a corporation organized in

this State for charitable purposes under Title 15A of the New Jersey Statutes is in the public interest.

e. In the Attorney General's review of the proposed acquisition, the Attorney General may assess the entity proposing to acquire the nonprofit hospital for reasonable costs related to the review, as determined by the Attorney General to be necessary. Reasonable costs may include expert review of the acquisition and a process for educating the public about the acquisition and obtaining public input.

f. The Attorney General and the Commissioner of Health shall, during the course of the review pursuant to this section, hold at least one public hearing in which any person may file written comments and exhibits or appear and make a statement. The public hearing may, if the Attorney General and commissioner so agree, be conducted jointly. The commissioner may satisfy the requirements of this subsection by conducting a public hearing in conjunction with the certificate of need review process pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The Attorney General or the commissioner may subpoena additional information or witnesses, including, but not limited to, information about any transaction that is collateral to the proposed acquisition and any related documents, require and administer oaths, require sworn statements, take depositions and use related discovery procedures for purposes of the hearing and at any time prior to completing the review of the proposed acquisition.

The Attorney General shall make the information received pursuant to this section, and the Department of Health shall make any information in its records relating to the proposed acquisition, available for inspection at no cost to the public.

The public hearing shall be held no later than 60 days after the date that an application from a nonprofit hospital is deemed complete by the Attorney General. Public notice of the hearing shall be provided at least two weeks in advance of the date of the hearing.

g. In a proposed acquisition subject to review under subsection d. of this section, the Attorney General, after consultation with the principal parties to the transaction, shall make a determination as to the amount of assets which the nonprofit hospital shall set aside as a charitable obligation, based on the full and fair market value of the hospital at the time of the proposed acquisition as determined by the Attorney General.

h. Upon execution of a proposed acquisition subject to review under subsection d. of this section, the amount determined by the Attorney General to be set aside as a charitable obligation shall be placed in a nonprofit charitable trust or one or more existing or newly established tax-exempt charitable organizations operating pursuant to 26 U.S.C. s. 501(c)(3). The charitable mission and grant-making functions of any charitable entity that receives assets pursuant to subsection g. of this section shall be dedicated to serving the health care needs of the community historically served by the predecessor nonprofit hospital. Any charitable entity that receives assets pursuant to subsection g. of this section, the directors, officers, and trustees of any such charitable entity, and the assets of any such charitable entity, including any stock involved in the acquisition, shall be independent of any influence or control by the acquiring entity, its directors, officers, trustees, subsidiaries, or affiliates.

(1) The governance of the charitable trust that results from the acquisition or of any newly established charitable organization that is to receive charitable assets pursuant to subsection g. of this section shall be subject to review and approval by the Attorney General. The governance of any existing charitable organization that is to receive charitable assets pursuant to subsection g. of this section shall be subject to review by the Attorney General. The governance of the charitable trust or the charitable organization shall be broadly based,

and neither the trust or organization nor any officer, director, or senior manager of the trust or organization shall be affiliated with the acquiring entity and no officer, director, or senior manager of the trust or organization shall be a full-time employee of State government. No officer, director, or senior manager of the trust or organization shall have been a director, officer, agent, trustee, or employee of the nonprofit hospital during the three years immediately preceding the effective date of the acquisition, unless that person can demonstrate to the satisfaction of the Attorney General that the person's assumption of the position of officer, director, or senior manager of the trust or organization would not constitute a breach of fiduciary duty or other conflict of interest.

(2) The governing body of the charitable trust or organization shall establish or demonstrate that it has in place, as the case may be, a mechanism to avoid conflicts of interest and to prohibit grants that benefit the board of directors and management of the acquiring entity or its affiliates or subsidiaries.

(3) The governing body of the charitable trust or organization shall provide the Attorney General with an annual report which shall include an audited financial statement and a detailed description of its grant-making and other charitable activities related to its use of the charitable assets received pursuant to this act. The annual report shall be made available to the public at both the Attorney General's office and the office of the charitable trust or organization. Nothing contained in this act shall affect the obligations of an entity possessing endowment funds under P.L.1975, c.26 (C.15:18-15 et seq.).

i. (1) The entity acquiring the nonprofit hospital, if determined to be necessary by the Commissioner of Health, shall provide funds, in an amount determined by the Commissioner of Health, for the hiring by the Department of Health of an independent health care access monitor to monitor and report quarterly to the Department of Health on community health care access by the entity, including levels of uncompensated care for indigent persons provided by the entity. The funding shall be provided for three years after the date of the acquisition. The entity acquiring the hospital shall provide the monitor with appropriate access to the entity's records in order to enable the monitor to fulfill this function.

To prevent the duplication of any information already reported by the entity, the monitor shall, to the extent possible, utilize data already provided by the entity to the Department of Health.

No personal identifiers shall be attached to any of the records obtained by the monitor, and all such records shall be subject to the privacy and confidentiality provisions of medical records provided by law.

(2) Following the monitoring period, or in the event that no monitoring period is established, if the Commissioner of Health receives information indicating that the acquiring entity is not fulfilling its commitment to the affected service area pursuant to this act and determines that the information is true, the commissioner shall order the acquiring entity to comply with a corrective action plan. The commissioner shall retain oversight of the acquiring entity's obligations under the corrective action plan for as long as necessary to ensure compliance with this act.

j. The trustees and senior managers of the nonprofit hospital are prohibited from investing in the acquiring entity for a period of three years following the acquisition.

k. No director, officer, agent, trustee, or employee of the nonprofit hospital shall benefit directly or indirectly from the acquisition, including the receipt of any compensation directly related to the proposed acquisition.

l. Upon completion by the Attorney General of the review of the application required by this act, the nonprofit hospital shall apply to the Superior Court for approval of the proposed acquisition. In that proceeding, the Attorney General shall advise the court as to whether the Attorney General supports or opposes the proposed acquisition, with or without any specific modifications, and the basis for that position. Any person who filed a written comment or exhibit or appeared and made a statement in the public hearing held by the Attorney General pursuant to subsection f. of this section shall be considered a party to the proceeding, including consumers or community groups representing the citizens of the State.

m. Notwithstanding the provisions of subsections a. and f. of this section to the contrary, in the event that the Attorney General or the Commissioner of Health determines that a proposed acquisition should be considered on an expedited basis in order to preserve the quality of health care provided to the community, the Attorney General and the commissioner may combine the public notice about the acquisition with the notice for a public hearing as required in subsections a. and f., respectively, and may reduce the period of time required for notice, as necessary. In considering a proposed acquisition on an expedited basis, the Attorney General and commissioner may agree to reduce the period of time for review of a completed application to less than 90 days.

n. The Attorney General, in consultation with the Commissioner of Health, shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this act.

26:2H-7.12 Exemption.

3. A hospital owned and operated by a county is exempt from the provisions of this act.

26:2H-7.13 Applicability of act.

4. The provisions of this act shall apply to any proposed acquisition of a nonprofit hospital that is initiated after the effective date of this act.

26:2H-7.14 Construction of act.

5. Nothing in this act shall be construed to limit the existing authority of the Attorney General, the Commissioner of Health, or any other government official or entity or the court to review, approve or disapprove conditions related to an acquisition, transaction, or disposition under current law.

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May 20, 2013

Senate Health, Human Services and Senior Citizens Committee
Senate Legislative Oversight Committee

State House Annex
PO Box 068
Trenton, NJ 08625-0068

Testimony on non-profit hospital conversions in New Jersey

Chairman Vitale, Chairman Gordon, Honorable Members of the Committees:

The trend in conversions of nonprofit hospitals to for-profit entities is a complex and multifaceted issue with several points to be addressed. While we are largely agnostic as to the for-profit vs. non-profit question in health care, we do recognize that for-profit entities and non-profit entities have different motivations. Furthermore, we recognize that regardless of corporate structure, hospitals provide vital services to our communities, and that the conversion to for-profit structure is a relatively new phenomenon in New Jersey and that laws and regulations have yet to catch up. Therefore, at the nexus of the for-profit/non-profit debate is the need for accountability, transparency, and adequate review of conversions from non-profit to for-profit. For-profit health care is not a negative thing on its own – but every hospital must be held to similar standards of financial transparency, quality, and safety, and should provide a notable community benefit.

In order to assess a difference in for-profit hospitals and non-profit hospitals, it is necessary to assess the hospitals themselves. When assessing a hospital at the Quality Institute, we routinely ask the following questions: 1. Does the hospital deliver quality care, and is it cost-effective? 2. Is the hospital safe? 3. Is the hospital transparent, financially and otherwise? 4. Does the hospital benefit the community in which it operates?

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Quality of Care and Cost-Effectiveness: In a 2005 study in Health Affairs titled, "Making Profits And Providing Care: Comparing Nonprofit, For-Profit, And Government Hospitals," Jill Horwitz found that although the corporate structure of hospitals didn't entirely predict behavior, for-profit hospitals were much more likely to prioritize profitability over other considerations when making supply decisions. It makes sense – if one is "for-profit," one will invariably seek profits. And while we are not against profits, making them a priority is somewhat problematic given the misaligned incentives in our health care system. Take for example the Journal of the American Medical Association study published earlier this year, titled "Relationship Between Occurrence of Surgical Complications and Hospital Finances." That study found that Hospitals profited more from complications and inefficient care. If a for-profit hospital is motivated primarily by the profitability of a given service, and the financial incentives in our system reward inefficient care, then certainly we'll want to look closely at the conversion of non-profit hospitals to for-profit hospitals, to determine that quality outcomes are maintained, that vital services are protected, and that the care they are delivering is cost-effective. Publicly held data – like the Medicare hospital charge data that was released last week by CMS – can help us properly assess that quality and cost-effectiveness going forward.

Safety: Building off of quality data, it is important to assess hospitals based on their safety. The Leapfrog Hospital Survey and Hospital Safety Score help consumers and health care purchaser choose safer hospitals. When looking for trends between for-profit and non-profit hospitals and safety, it's hard to pin one down. For example, Bayonne, the for-profit hospital in hot water over their exorbitant charges, received an 'A' rating on this year's Hospital Safety Score, while University Hospital in Newark, a non-profit, received a 'C'. When it comes to safety, it seems that the culture and practices at individual hospitals trumps any sort of larger trends, but nonetheless in the case of hospital conversions and sales, safety should certainly be considered in the initial review and in ongoing regulation.

Transparency: Uwe Reinhardt, the famous professor of political economy and out-spoken health care expert, has expressed on multiple occasions that the only way healthcare can function in a free market is if its operations, prices, quality, and products are completely transparent to the public. Thus it is important that any hospital, non-profit or for-profit, is transparent with its prices, investments, and plans for the future. Otherwise consumers cannot make good decisions, the market becomes dysfunctional, and entities are able to develop business models that game the system. This is especially important to note with hospitals. As entities that are funded through Medicare, Medicaid, and Charity Care, they are stewards of public funds, and as such, should hold the same responsibility and accountability when it comes to financial management and transparency, regardless of corporate structure. There needs to be parity when it comes to reporting for all hospitals that receive public dollars. At the very least, we believe this sort of transparency should be required by the State in any sort of conversion process.

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Community Benefits: In addition to transparency, any hospital that receives public funds should provide community benefits, regardless of corporate structure. In New Jersey, we passed a law to ensure community benefits and community needs were taken into consideration in any hospital sale or conversion: the Community Health Care Assets Protection Act (CHAPA). The State has unfortunately been lax in regards to these requirements, and regulations have not yet been promulgated. Many of the hospitals in New Jersey that are converting to for-profit status are safety net hospitals – hospitals that are much needed by their communities and that are often the only health care for many. While we should be looking to address that disparity in a variety of ways, we should also ensure that when a hospital converts from non-profit to for-profit, that a rigorous review occurs and that it's affect upon the community is taken into strong consideration. We need our regulatory process to keep up with the changing health care delivery system in these communities.

The bottom line is that the business of health care is changing, but the needs of our patients and our communities remain the same. While many safety net hospitals are struggling under a shrinking payer mix and government cuts, for-profit companies are often a last resort for a failing hospital. In many cases, a for-profit takeover can protect vital jobs and services. In others, it can turn a needed community hospital into a profit machine that is no longer beholden to the people it serves. In either case, what doesn't change is that our patients need health care that is high quality, cost-effective and safe, and our communities need trustworthy and transparent institutions to deliver that care. Thus, we need our laws to keep up with the changing times. We need a regulatory framework in place and a rigorous review process that ensures all of these needs are met, regardless of corporate structure. Thus, we need to enforce CHAPA, promote transparency among all hospitals, and ensure quality and cost-effectiveness in any conversion and in all hospitals moving forward.

If you have any questions about the above testimony, please contact Jeff Brown, Chief of Staff at the NJ Health Care Quality Institute at 609-303-0373, or by email at jbrown@njhcqi.org

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Wardell Sanders
President

Sarah McLallen
Vice President

Testimony of the New Jersey Association of Health Plans for the Senate Legislative Oversight Committee and the Senate Health, Human Services and Senior Citizens Committee May 20, 2013

Chairmen Gordon and Vitale and Members of the Committees:

Thank you for the invitation to testify before this joint committee hearing to discuss the trend in conversions of nonprofit hospitals to for-profit entities, and whether oversight of such conversions by independent monitors is warranted.

The New Jersey Association of Health Plans ("NJAHP") is a non-profit association representing leading health care plans in the state which cover nearly seven million New Jersey residents. Our members include Aetna, AmeriGroup, AmeriHealth, CIGNA, Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare, and our membership includes three of the largest health plans partnering with the State to administer the State's NJ FamilyCare Program.

Two days ago the *New York Times* had a front page article noting that New Jersey is home to the hospital with the highest billing rates in the country: Bayonne Medical Center, a for-profit entity. The *New York Times* found that "the Bayonne Medical Center charged the highest amounts in the country for nearly one-quarter of the most common hospital treatments...." The article, as an example, noted that Bayonne Medical Center "charged on average of $120,040 to treat transient ischemia, a type of small stroke that has no lasting effect. That was 5.6 times the national average and 23.6 times what Medicare paid."

This article follows CMS's May 8, 2013 press release announcing that it had posted on its website information comparing hospital charges for services that may be provided during the 100 most common Medicare inpatient stays. In response to that CMS press release some have asserted that a hospital's charge master or "sticker price" doesn't matter. But it does matter to consumers and payers – and it matters a lot. Here's why:

1. Consumers without insurance, and not protected by N.J.S.A. 26:2H-12.52, which limits charges for certain uninsured patients, are asked to pay these exorbitant fees.
2. Consumers with insurance with out of network benefits may have substantial out of pocket exposure, which will be based on the billed amount. Inflated charges have a real impact on these consumers.
3. Many fee profiles used to determine the "reasonable and customary" amount or "allowed amounts", for benefits received out of network under an insurance contract are based on charged amounts, not paid amounts. (*e.g.*, PHCS fee profile and Fair Health). Inflating the charged amounts rewards entities by inflating what is considered "reasonable" in these databases. That's why payers generally don not favor charged-based fee profiles – it doesn't necessarily accurately reflect either the value of the services or what is reasonable.
4. Even for consumers generally without out-of-network benefits (*i.e*, a closed-panel HMO product), if a consumer comes in through an emergency room, New Jersey laws protect those patients by requiring a carrier to ensure that the consumer pays just what would be her in-network cost-sharing requirements -- but as a result hospitals can demand these high OON sticker prices from payers without respect to any contract terms about an "allowed amount" or "reasonable and customary" amount. Carriers in these circumstances are required to protect their members but have no leverage at that point in negotiated fees. A well-intended law has had the unintended consequence of fostering excessive charging practices. This affects what employers, unions, governments and other plan sponsors pay in premiums or claims, which is borne in part by employee/member premium contributions.

Some for profit-entities have set up business models in which they go out-of-network with most payers and then set charge masters unreasonably high. Some will also waive a consumer's cost sharing. New Jersey has become fertile ground for this model.[1] Some of this can be discerned from the attached chart using publicly reported data to show cost to charge ratios over time. While there has been a state-wide trend toward lower ratios, clearly Bayonne, Hoboken and Christ Hospitals, for-profit entities in Hudson County appear to be outliers.

As some of these hospitals have transitioned to for-profit entities, the CN approvals have set forth certain conditions for the approval. One condition, found in the Hoboken Medical Center approval required the hospital to bargain in "good faith" with payers. Some payers reported that they received a network termination on the date the transaction closed, without any negotiations let alone "good faith" negotiations, despite the conditions in the CN approval letter.

As a result of these experiences in watching hospitals move to for profit entities, we would recommend the following:

[1] Health plans do not care about a hospital's tax status. Rather, it has been this business model of certain for-profit facilities in New Jersey that have creating this disturbing problem.

1. Require the appointment of an independent monitor to oversee the transition and compliance with CN conditions.
2. Require, as part of every CN approval, that the new owner will not engage in practice of routine waiver of cost-sharing, which under Medicare and in many states is considered fraud.
3. Require, as part of every CN approval, that the new owner not increase the hospital's charge master for a period of three years from the date of the transition without a showing of good cause.
4. Expand CHAPA to include cases where a hospital is sold by a public entity to a for-profit entity. (CHAPA has been interpreted not to apply to such transfers – Hoboken Hospital.)
5. Expand CHAPA to require the Attorney General's intervention at an earlier state when a hospital sale is emerging out of bankruptcy and to not provide deference to the court's approval of a new buyer.
6. Require for-profit hospitals to submit the equivalent of the Internal Revenue Service Form 990 to the Department, and make such documents publicly available. S782, which was conditionally vetoed, includes this requirement.
7. Require any hospital with a high out-of-network utilization rate (*e.g.*, more than 50%) to adjust billed charges for emergency services and care provided prior to stabilization to some relationship to Medicare payments rates.

Thank you again for the invitation to provide testimony on this important issue.

NJ Outpatient Cost to Charge Ratios (Medicaid)

County	Facility	2008	2009	2010	2011	2012	2013
Hudson	Bayonne Hospital Center	24.50%	16.30%	13.30%	12.60%	3.00%	3.00%
Hudson	Hoboken University Medical Center	27.20%	25.30%	25.30%	16.40%	7.40%	7.60%
Hudson	Christ Hospital	28.60%	28.60%	18.00%	17.50%	14.40%	4.40%
Hudson	Meadowlands Hospital Medical Center	11.40%	11.40%	11.40%	12.50%	11.70%	9.20%
Hudson	Palisades	42.90%	42.90%	28.10%	29.60%	26.10%	25.50%
Hudson	Jersey City Medical Center	42.00%	42.00%	33.10%	24.60%	22.10%	21.40%
Bergen	Hackensack University	38.80%	38.40%	31.30%	23.60%	22.70%	22.70%
Bergen	Holy Name	21.90%	21.90%	20.90%	18.80%	18.90%	16.90%
Monmouth	Jersey Shore Medical	46.80%	45.10%	42.90%	36.10%	29.30%	29.30%
Middlesex	JFK Medical	28.10%	27.50%	26.50%	21.60%	20.40%	20.40%
Essex	Mountainside	31.00%	26.60%	23.90%	19.30%	15.90%	15.10%
Mercer	Princeton	21.40%	20.60%	19.50%	25.70%	20.00%	20.00%
Essex	St Barnabas	25.90%	25.10%	25.10%	20.90%	21.60%	15.50%
Bergen	The Valley Hospital	33.00%	29.40%	27.70%	29.90%	29.30%	28.20%
Cumberland/Salem	South Jersey	16.80%	16.40%	15.70%	14.70%	11.20%	11.20%
Burlington/Camden	Virtua	33.30%	32.90%	24.90%	19.10%	18.40%	18.40%
	Holdco	26.80%	23.40%	18.90%	15.50%	8.30%	5.00%
	Hudson County Average	29.40%	27.70%	21.50%	18.90%	14.10%	11.90%
	Overall Average	29.60%	28.10%	24.20%	21.40%	18.30%	16.80%

Source: State of New Jersey Department of Human Services Division of Medical Assistance and Health Services (NJMMIS Website)

New Jersey
Appleseed

TESTIMONY OF NEW JERSEY APPLESEED PILC
WITH RESPECT TO CHAPA GOVERNING NONPROFIT HOSPITAL CONVERSIONS
BEFORE THE SENATE LEGISLATIVE OVERSIGHT COMMITTEE AND THE SENATE
HEALTH, HUMAN SEVICES AND SENIOR CITIZENS COMMITTEE
(MAY 20, 2013)

Chairman Gordon, Chairman Vitale and Members of the Committees:

Thank you for the invitation to testify before this joint committee hearing to discuss the trend in conversions of nonprofit hospitals to for-profit entities, and to suggest changes to the Community Health Assets Protection Act, ("CHAPA"), N.J.S.A. 26:2H-7.10 et seq., that would provide improved protection to the public as a result of such conversions. New Jersey Appleseed Public Interest Law Center, a nonpartisan, legal advocacy organization is a lead member of the New Jersey Healthcare Coalition, and a founding member of the relatively new Labor-Community-Business Coalition that has emerged to address the escalating entry of for-profit investors and corporations into New Jerseys hospital market. New Jersey Appleseed has participated in several hospital conversions prior to and after the enactment of CHAPA, and has spoken about this

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issue before the Senate Health Committee in September 2011. We submit this testimony in support of your current efforts to explore whether current regulatory procedures adequately protect the public.

Rather than provide a review of the many problems that conversions have generated for various stakeholders (as addressed by other witnesses), I would like to make several suggestions as to how to improve CHAPA, based on my observations over the past 13 years. I would welcome any questions you have with respect to any one of them.

First, as you know, CHAPA was enacted to codify certain aspects of the Attorney General's common law authority over nonprofit hospitals, derived from his common law authority as the protector and enforcer of charitable trusts. As the prime implementer of CHAPA, the Attorney General was directed by the Legislature to issue regulations so as to inform hospitals and the public generally as to how that office would implement the law. Those regulations have never been written, despite several requests by NJ Appleseed, which we have made to several administrations. As a result, the only guidance provided by the Attorney General has been that Office's decisions, which are prepared typically as, and constitute, recommendations to the Chancery Division of the Superior Court; each of which, to the best of my knowledge, has recommended approval of the proposed

acquisition of a nonprofit hospital either by another nonprofit or for-profit entity. The law should be amended to require the Attorney General to issue regulations within a certain time period.

Second, the law governs only one aspect of the Attorney General's common law authority: that is, his supervision of "licensed nonprofit hospitals." This means that CHAPA, as currently interpreted, does not reach public hospitals, closings of nonprofit hospitals if sale is not part of the closing plan, and nonprofit hospitals whose sale is determined in bankruptcy (though CHAPA does apply after the completion of the bankruptcy proceeding if the hospital remains licensed and is sold, rather than liquidated).

Public assets. The Attorney General has taken the position, that the acquisition of a public hospital is not covered by CHAPA (though the CN process applies if the hospital intends to continue to operate as a hospital). This is the case even if the hospital was once a nonprofit, as is the case of Hoboken University Medical Center - previously known as Saint Mary's Hospital, transferred to the Hoboken Municipal Hospital Authority by the Bon Secours system.

This means that a potential sale of Bergen Regional Medical Center (owned by the county, but whose license sits in the Bergen County Improvement Authority), University Hospital (owned

by UMDNJ, an independent state agency, currently subject to reorganization), and Roosevelt Hospital (owned by Middlesex County) would not be subject to the same scrutiny as the sale of a nonprofit hospital. As we have seen in the case of Hoboken University Medical Center, the Open Public Records Act and Open Meetings laws are not sufficient to achieve transparency of such sales, even if the Local Lands and Building Law would apply (which in the case of Hoboken it did not). Moreover, the investigation of a hospital board's RFP process, selection criteria, reasons for selecting one bidder over another simply do not occur by virtue of current oversight laws governing the sale of public hospitals.

Therefore, although the Attorney General does not have common law authority over public assets, NJ Appleseed strongly recommends that CHAPA be amended to reach publicly owned hospitals, whether they are owned by the State, county, municipality or an independent authority.

Closings. It became apparent during the sale of St. James and Columbus Hospitals that the Attorney General interpreted CHAPA to cover only licensed hospitals; that is, the Attorney General commenced CHAPA proceedings regarding the acquisition of both hospitals by Catholic Health East, but ended the CHAPA proceeding with respect to Columbus Hospital, when the Commissioner of Health permitted closure of the hospital prior

to approval of the sale by the Chancery Division. Similarly, CHAPA does not apply to any closing of a hospital when there is no concomitant sale, even though the Attorney General retains his common law authority over such nonprofit assets, including any foundation or endowment funds associated with the hospital.

What this means as a matter of public policy is twofold: the process by which a hospital board decides to close a hospital is not given the same public scrutiny as a decision to sell (often leading to conspiracy theories within communities affected by such closings), and the public is often not aware of and cannot participate in the Attorney General's oversight of such properties once the license has been relinquished. This in effect has decreased public participation in the fate of Orange Hospital, Muhlenberg Hospital and Irvington, where formerly licensed hospitals sit (with minimal, if any health care services being provided on site), and their respective futures do not entail public processes.

In addition, CHAPA did not apply to the reopening and partial sale of Pascack Valley Hospital to an out-of-state for-profit entity, Legacy (in a joint venture with Hackensack Hospital), because it simply was no longer licensed at the time of sale. After the closing of Orange Hospital, NJ Appleseed worked with Senator Codey and former Assemblyman Mims to amend

the statute to govern closings -- that effort should be restarted.

Bankruptcy. In addition, although bankruptcy court does not pre-empt state regulatory proceedings, it is clear that the Attorney General has played a minimal role in the fate of nonprofit hospitals that have filed for bankruptcy. Unlike other state Attorneys General, our Attorney General appears to take a passive role with respect to such hospitals, thus permitting the bankruptcy judge to determine who can acquire the hospital and on what terms, with the creditors playing the primary role in that decision. That is, the Attorney General has waited for the bankruptcy court to act, before undertaking his CHAPA review. This delay also precludes the public, and public health concerns, from having any standing in the bankruptcy court itself. Although the Commissioner of Health has conditioned sales that have emerged from the bankruptcy court (after the fact), such as requiring the purchasers of Barnert Hospital to provide certain reproductive services at the medical mall permitted by the judge, these concerns must occur prior to approval of the sale, not after.

Furthermore, NJ Appleseed wants to point to the practical inequities that flow from the sale of nonprofit hospitals to for-profit entities through the bankruptcy process. That is, for-profit investors are able to walk away with valuable

physical assets, free from the debts incurred by the Hospital due to historical operational deficiencies, with the ability to transfer those assets at significant private gain immediately or several years after acquisition. See Sale of Bayonne Hospital to a REIT for $58 million two years after it purchased the assets out of bankruptcy for $100,000 plus the assumption of $35-40 million in debt (including obligations accrued to employees). We therefore recommend addressing this issue explicitly in CHAPA.

Role of DOH. Although CHAPA codifies the Attorney General's supervision of charitable corporations, the law requires the Attorney General to consult with the Department of Health to determine whether the transaction is not likely to have an adverse impact on the health services in the affected community. Over the past several years, DOH commissioners have consistently taken the position that their review, pursuant to the CN process (specifically, the review pursuant to N.J.A.C. 8:3.3-4.9 and 4.10) satisfies their obligation under the CHAPA, N.J.S.A. 26:2H-7.11(b), which requires the Commissioner to find, prior to recommending approval under the Act, that the proposed sale "is not likely to result in the deterioration of the quality, availability or accessibility of health services in the affected communities." Whether this standard is equivalent to the criteria set forth in the CN regulations, it is clear that pursuant to the CN process, the Commissioner has an obligation

to "satisfy the legislative preference for a regulatory review that will serve as a check on undue harm to [New Jersey's] valuable, and vulnerable, urban hospitals." In re Application of Virtua-West Jersey Hospital Voorhees for a Certificate of Need, 194 N.J. 413, 436 (2008). In order to satisfy this obligation "to guard against severe or pervasive negative impacts on urban hospitals," id., the Commissioner must provide an analysis of the impact that a particular CN will have on the delivery of health care services in a region, and conversely, cannot just accept the proffers of an applicant. Id. at 435. This requirement has rarely, if ever, been satisfied.

Again, to the best of my knowledge, DOH has never hired a consultant to undertake such analysis nor has really undertaken such review when confronted with the acquisition of a nonprofit hospital -- something that the Attorney General of California does as a routine matter. Accordingly, CHAPA should be amended to permit DOH, like the AG, to hire a consultant, at the applicant's expense, to undertake a serious analysis of whether the proposed transaction will have an adverse impact on the affected community, and if so, to recommend conditions that would offset such impact.

Health Care Monitor. Furthermore, CHAPA currently authorizes the DOH to appoint a health care monitor for a period of three years, primarily to monitor whether the for-profit

hospital satisfies its charity care obligations. N.J.S.A. 26:2H-7.11(i)(1). A monitor was appointed in the case of the conversion of Salem Memorial Hospital, the first nonprofit to for-profit transaction analyzed under CHAPA. Former Commissioner of Health, Dr. Fred Jacobs, subsequently declined to appoint a monitor when Meritt investors purchased Mountainside Hospital, and instead imposed heightened reporting requirements to insure financial transparency, oversight of money in and out of the hospital, capital improvements and charity care obligations. It is unclear whether the DOH actually enforced such requirements. It is clear, however, that in the case of the conversions of Bayonne Hospital, Hoboken University Hospital, and Christ Hospital, the buyers - referred to in a recent CHAPA filing concerning the sale of St. Mary's Hospital(Passaic), as the Bayonne Threesome-- refused such reporting requirements and, inexplicably, DOH relented.

Moreover, the recent experience at Meadowlands Hospital, where DOH approved the transfer of a license to an investor/operator who had no hospital track record, and whose track record operating ambulatory care centers, was seriously compromised, indicates that the scope of a monitor must be broader than charity care. Accordingly, we recommend that CHAPA be amended to require the DOH to appoint a monitor, and be

expanded to include financial transparency and quality and safety within the jurisdiction of such monitor.

Continuity of Mission. As noted above CHAPA codifies the Attorney General's supervisory role over charitable corporations. It also codifies the Superior Court's supervisory role over *cy pres* proceedings; which, in turn, requires that the Court must first find that the maintenance of the charitable mission is "impossible or impracticable" before conversion of assets is permitted. CHAPA's adherence to the common law on this point - i.e., the trustee's duty of obedience to the mission, is embodied in N.J.S.A. 26:2H-7.11(d)(5), where the Attorney General must consider whether the nonprofit hospital considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes.

In the initial transactions under CHAPA, the applications filed with the Superior Court acknowledged this common law principle inherent in the doctrine of *cy pres*. Later pleadings, however, have omitted such allegations of impossibility and impracticability, and in the case of the sale of Christ Hospital, where there was a viable nonprofit option where the license remained in the hands of a nonprofit corporation, the Board of Trustees, the Attorney General and the Court acted as if it did not exist. For this reason, New Jersey Appleseed

believes that CHAPA must be amended to make this principle explicit:

Trustees must understand that the duty of obedience is essential to thier understanding on how to proceed when considering a significant change of control decision like that implicated by CHAPA. Otherwise, common misconceptions as to the nature and extent of a board of trustees' fiduciary duty to the charitable corporation reign. It is fundamentally misleading to tell the public that once a transaction is approved, the hospital will continue to function in much the same way as it has a nonprofit hospital for years to come and that the sale will continue the hospital's mission of providing essential health services to the neediest members of the community. In New Jersey, provision of charity care is a function of licensure, not corporate status; and, no matter what spin is attached, the provision of hospital services by a for-profit entity does not, as a legal matter, constitute a charitable purpose.

Preservation of Community Assets:Claw-back

Pursuant to N.J.S.A. 26:2H-7.11(b), the Attorney General must determine that "appropriate steps have been taken to safeguard the value of the charitable assets of the hospital and to ensure that any proceeds from the proposed acquisition are irrevocably dedicated for appropriate charitable health care

purposes." This has meant taking steps to ensure that the hospital is sold for fair market value, and that any proceeds received over debt are placed in a foundation serving similar purposes as the nonprofit hospital. As a preliminary matter, since the sale of Salem Memorial Hospital no new conversion foundation has been established, and only in the case of Mountainside Hospital has the hospital's former foundation continued in existence. Rather, over the years, we believe that this seminal requirement has been diluted primarily because the Attorney General and the courts have failed to restrict the future sale of any real estate (land and facility) held by the converting nonprofit hospital in such a way as to ensure that any increased value (above current assessments) redounds to the benefit of the community. This has especially been the case, where the hospital was purchased out of bankruptcy pursuant to an expedited sale process, and the purchasing entity turns around and sells the facility and/or the land to a Real Estate Investment Trust, known as a REIT.

In the past, the Attorney General has taken the position that CHAPA does not authorize him to recommend any conditions on a subsequent sale/leaseback transaction, even though CHAPA does apply to the sale of the assets of a nonprofit hospital through a "single transaction or <u>series of transactions.</u>" The Attorney General has taken this position even where the new buyer

explicitly stated its intent to sell the real property of the hospital to a REIT, where such a transaction was permitted in the Asset Purchase Agreement, and where the principals of the purchaser had already done so with respect to two previous hospital conversions in Hudson County.

Since it is often easy to imagine the sale of assets shortly after the approved conversion is complete which realizes a significant profit over the bankruptcy value of the hospital or the hospital under stress, New Jersey Appleseed recommends that in order to protect the full and fair market value of the charitable assets that have often accrued for decades, CHAPA must be amended to permit the Attorney General to recommend to the Superior Court that restrictions be imposed on the current sale that would result in any profits from the post-sale disposition of the hospital's real estate assets to be reclaimed for charitable purposes. It is our position that the proceeds of such sale should then be placed in a conversion foundation whose mission would be consistent with the hospital's charitable health care mission. In addition to supporting other non-profit health care institutions and activities serving affected community, the proceeds of such sale would enable the community to hold a right of first refusal in the event that the new owners seek to close the hospital as an acute care facility.

There is little doubt that since the first conversion of a nonprofit hospital in New Jersey under CHAPA, where the Board of Salem Memorial Hospital strictly followed both the letter and spirit of CHAPA, the Attorney General has consistently recommended approval of such conversions even if significant criteria set forth in CHAPA have not been satisfied. Often, he has done so simply by ignoring or diluting the full meaning of such criteria, and giving undue deference to the decisions of the Commissioner of Health. Accordingly, the law must be strengthened to ensure that its purpose is satisfied. There is little doubt that CHAPA was a very significant step forward. Without it, it is unlikely that the Attorney General would have undertaken the comprehensive investigation that it has in each of the covered transactions since the enactment of the law. Moreover, the public would not have had access to a significant amount of meaningful information, and would have not have had the influence that it has had given the public's standing in the Chancery Division. It is for these reasons, that NJ Appleseed strongly recommends strengthening and broadening the Act, and permitting the public to hold the government and hospitals accountable through the regulatory process in more situations that only the acquisition of licensed nonprofit hospitals.

NEW JERSEY CITIZENACTION

Phyllis Salowe-Kaye, Executive Director

TESTIMONY

Phyllis Salowe-Kaye
Executive Director
New Jersey Citizen Action

For Immediate Release
Monday, May 20, 2013

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Senate Health, Human Services and Senior Citizens Committee
Senate Legislative Oversight Committee

I have served as the Executive Director of New Jersey Citizen Action, the state's largest consumer watchdog coalition since 1986. NJCA is an organization with a membership of over 60,000 families statewide and over 120 organizational affiliates that has worked on Healthcare issues since it was established in 1983.

As one of the founders of the "Campaign to Protect Community Healthcare" a coalition of organizations and individuals representing New Jersey residents, health care advocates, community leaders, elected officials, healthcare and insurance providers, health care unions and policy experts working together to protect and advance access to quality and affordable health care for all New Jerseyans, I urge you to broaden the scope of the Community Healthcare Assets Protection Act (CHAPA).

In light of the recent rash of hospital sales to for profit companies, additional protections are needed as these sales threaten access to care of many residents, shift costs to consumer and other providers, weaken quality standards and diminish the standard of living for the healthcare workforce. We will be working together to:

1. Oppose health care business models that limit or reduce access through practices that eliminate insurance contracts, reduce services, quality, staffing or affordability of care to residents or that rely on cost-shifting to consumers, other health care facilities and taxpayers.

2. Improve and strengthen NJ standards for approval and enforcement of hospital and health care conversions under existing laws such as the Community Healthcare Assets Protection Act and the Certificate of Need licensing laws and regulations.

3. Require strong standards and enforcement of standards for access and quality of care; protections for employee rights and safe working conditions; financial transparency and accountability to our communities; and for track record of entities purchasing our community hospitals or healthcare facilities.

4. Promote policies that protect the community mission, financial sustainability and accountability of our state's non-profit and public hospitals, and that require periodic assessment of a community's need for health services with a goal to right-sizing those services in the context of regional healthcare planning.

Recently 35 organizations came together expressing concern over a for profit company's attempt to purchase 2 non- for profit hospitals in Newark and Passaic. The company has since made a bid to buy a third hospital in Denville. The for profit hospital, Prime Healthcare Services is the subject of two federal investigations which are probing its Medicare billing and alleged violations of patient confidentiality laws and our Coalition has asked the Department of health to stop the sales and permit the hospitals to be legally free to explore other alternatives. ADDITIONALLY WE RAISED CONCERNS THAT THE IMPACT OF ANY POTENTIAL FINANCIAL SETTLEMENT BETWEEN PRIME AND THE FEDRAL GOVERNMENT COULD RUN AFOUL of CHAPA which requires that charitable dollars not be placed at risk in a hospital conversion or sale.

This hearing will hopefully lead to the passage of a law that by broadening the scope of CHAPA will also apply to a proposed transaction that may result in t he the closure of a nonprofit hospital or the closure of a hospital owned or operated by a county or a municipal hospital authority.

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For Immediate Release
May 20, 2013

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Press Statements

Joint Hearing Senate Health, Human Services and Senior Citizens Committee and the Senate Legislative Oversight Committee

"New Jersey led the nation in protecting community health care and hospitals when it enacted CHAPA. Now Senators Gordon and Vitale are again leading the way by asking the questions that need to be asked about whether the law is living up to its promise. When we read in the papers that the costliest hospital in the nation is a for-profit in New Jersey and that another for-profit is on a spending spree, buying distressed hospitals left and right, we clearly need to update our patient and community protections for the 21st Century."
Tim Foley
Political Director, Committee of Interns and Residents/SEIU

"The NAACP, along with our allies, remains concerned about the availability of high-quality health care provided by reputable, honest and community-focused organizations. Such high-quality and affordable health care, provided by hospitals that are accessible and managed by culturally sensitive and honest personnel is a basic civil right."
James Harris
President, NJ State Conference NAACP

"As one of the founders of the Campaign to Protect Community Healthcare, a coalition of community, labor, industry and healthcare advocates, it is essential to broaden the scope of the Community Healthcare Assets Protection Act. In light of the recent rash of hospital sales to for-profit companies, additional protections are needed as these sales threaten access to care for residents, shift costs to consumers and other providers, weaken quality standards and diminish the standard of living for the healthcare workforce."
Phyllis Salowe-Kaye
Executive Director, New Jersey Citizen Action

"At the time of sale or merger, the State has the obligation to assess the impact of the transaction on the quality, affordability and access to health services in the affected community. In addition, it must determine whether the board of the hospital satisfied its fiduciary duties to the community when negotiating and consummating the deal. It appears from the State's failure to adequately do so since the initial enactment of the Community Healthcare Assets Protection Act, that we need to make that obligation more explicit so the public can have confidence that the regulators are protecting their interests."
Renee Steinhagan
Executive Director, NJ Appleseed Public Interest Law Center

"These hospital conversions from not-for-profit to for-profit are at a tipping point - threatening to undermine access to care and affordability of care for our communities. The companies buying up our hospitals are notorious for aggressive 'billing and coding' business models that rely on out-of-network care, increasing health care costs for consumers and insurers and encouraging inappropriate admissions through the Emergency Room; downsizing of staff and service cutbacks; and in some cases, a focus on specific 'niche' services can have the effect of shifting costs and 'less profitable' services onto existing not-for-profit community hospitals."
Anne Twomey
President, Health Professionals and Allied Employees of NJ

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Community-Labor-Industry-Healthcare
The Impact of For-Profit Hospital Chains on
NJ Community Health Services

PRINCIPLES OF CAMPAIGN TO PROTECT COMMUNITY HOSPITALS
Version 4-April 15, 2013

The undersigned organizations and individuals represent New Jersey residents , health care advocates, community leaders, elected officials, healthcare and insurance providers, health care unions and policy experts working together to protect and advance access to quality and affordable health care for all New Jerseyans.

We believe that the growing and aggressive expansion of certain health care business models in our communities threatens access to care for many residents, shifts costs to other consumers and providers, weakens quality standards and diminishes the standard of living for the healthcare workforce.

We therefore will work together to:

1. Oppose health care business models that limit or reduce access through practices that eliminate insurance contracts, reduce services, quality, staffing or affordability of care to residents or that rely on cost-shifting to consumers, other health care facilities and taxpayers.

2. Improve and strengthen NJ standards for approval and enforcement of hospital and health care conversions under existing laws such as the Community Healthcare Assets Protection Act and the Certificate of Need licensing laws and regulations.

3. Require strong standards and enforcement of standards for access and quality of care; protections for employee rights and safe working conditions; financial transparency and accountability to our communities; and for track record of entities purchasing our community hospitals or healthcare facilities.

4. Promote policies that protect the community mission, financial sustainability and accountability of our state's non-profit and public hospitals, and that require periodic assessment of a community's need for health services with a goal to right-sizing those services in the context of regional healthcare planning.

New Jersey Appleseed | NEW JERSEY CITIZENACTION | CIR Committee of Interns and Residents SEIUHealthcare. | HPAE SETTING THE STANDARD for HEALTH CARE

New Jersey Appleseed

NEW JERSEY CITIZENACTION

Committee of Interns and Residents SEIUHealthcare.

HPAE SETTING THE STANDARD for HEALTH CARE HPAE/AFT/AFL-CIO

May 1, 2013

To: Mary M. O'Dowd, Commissioner, NJDOH

Re: Request for Suspension of Pending Applications to Transfer Licenses and Assets of St. Michael's Hospital in Newark and St. Mary's Hospital in Passaic to Prime Healthcare.

Cc: Mark E. Hopkins, Executive Director , NJHCFFA
Bill Conroy – Assistant Commissioner, NJDOH
John Calabria – Office of Licensing, NJDOH

On behalf of our organizations, we are writing to ask that the DOH suspend the current CN review of the pending applications to transfer the licenses and assets of St. Michael's Medical Center in Newark and St. Mary's Hospital in Passaic to Prime Healthcare Services and that each hospital be legally free to explore other alternatives. We make this request because of our deep concern over two current federal investigations into Prime Healthcare Services and our belief that the outcome of these investigations could have a profound impact on whether or not these transactions would pass muster under CN and CHAPA review.

We are asking that the DOH suspend the current CN process pending the outcome of these investigations, and that hospitals be legally free to explore other alternatives.

Prime Healthcare Services has acknowledged that it is the target of two federal investigations: a U.S. Justice Department probe of its Medicare billings and an inquiry into alleged violations of patient confidentiality laws. (www.californiawatch.org/dailyreport/prime-hospital-chain-acknowledges-it-faces-2-federal-investigations-18801) Yet, it is our understanding that these investigations were not disclosed in the documents submitted to the DOH, though they were revealed in a due diligence report that was prepared by Drinker, Biddle on behalf of St. Mary's Hospital and submitted to the Office of the Attorney General as part of the CHAPA submission.

Recently, the Rhode Island Office of Attorney General did suspend Prime's bid to purchase Landmark Medical Center due to deficiencies in Prime's application and inadequate responses to its Attorney General's questions, including inadequate submissions on conflicts of interest.

We strongly believe that suspension of the license transfer application is necessary to ensure the future of St. Mary's Hospital and St. Michael's Medical Center as vibrant health care facilities that are working to solve the problems of delivering health care to New Jersey's low income, urban communities. We cannot risk these facilities being drawn into or involved with allegations of Medicare fraud and serious patient confidentiality violations. Any potential financial settlement between Prime Healthcare and the federal government potentially could run afoul of the Community Healthcare Assets Protection Act (CHAPA) requirement that charitable assets not be placed at risk in a hospital conversion or sale (including the huge investment that the State anticipates making in these transactions, with respect to long-term debt reduction).

Without knowing the outcome of these investigations, we cannot be sure that Prime Healthcare could meet its commitments and obligation to invest in these hospitals and deliver services in the community in a manner that does not adversely impact the quality, affordability and accessibility of those services.

We would be pleased to meet and discuss these concerns with your offices.

Thank you for your consideration.

Steering Committee

Tim Foley - Committee of Interns and Residents/SEIU

Jeanne Otersen - Healthcare Professionals and Allied Employees

Phyllis Salowe -Kaye - New Jersey Citizen Action

Renee Steinhagen - New Jersey Appleseed

See Page 3 for additional sign-on's....

Community-Labor-Industry-Healthcare Coalition Sign-on's (in formation)

AFT Local 1904, Montclair State University Federation of Teachers

Diana Autin - Statewide Parent Advocacy Network

Paul Bellan-Boyer – Save Christ Hospital

Kevin Brown – 32BJ

Novi Carter - Peoples Organization for Progress

William Chapel - The Historic James Street Neighborhood Association

Donna M. Chiera – American Federation of Teachers NJ

The Honorable Mildred C. Crump - Council Member At Large - Newark, NJ

Lizette Delgado - Polanco - SEIU New Jersey State Conference

Paulette Eberle and Ethan Ellis - Next Step

Fran Ehret – IFPE Local 194

10-4 Evans - Grumman Ave Citizen Center

Elena Fernandez – Black Issues Convention

Mike Flynn - New Jersey Education Association

Charles N. Hall Jr. – RDSU Local 108/UFCW

Tim Haresign - Council of New Jersey State College Locals, AFT

James E. Harris - NJ State Conference NAACP

Alberto Hernandez – Communication Workers of America Local 1082

Community-Labor-Industry-Healthcare Coalition Sign-on's (in formation)

Bill Holland - New Jersey Working Families Alliance

Mitch Kahn - Bergen County Housing Coalition

Ken McNamara – Communications Workers of America Local 1037

Marcia Marley - BlueWave NJ

Daniel Santo Pietro - Latino Action Network

Trina Scordo - New Jersey Communities United

Matt Shapiro - New Jersey Tenants Organization

The Honorable Darrin Sharif - Council Member - Central Ward, Newark, NJ

Harold Simon – National Housing Institute

Milly Silva – SEIU NJ State Council & SEIU 1199 NJ

Anita Thomas - Main Street Alliance and AM Thomas Associates, LLC

The Honorable Cleopatra Tucker - Assemblywoman - State of NJ Legislative District 28

David Weiner – Communication Workers of America Local 1081

Statement

by

Mr. Arnie Kimmel,

Senior Vice President for Development, Prime Healthcare

Prime Healthcare is an innovative, successful and expanding health system that has been cited for its excellence in patient care delivery, particularly in the area of charity care.
Prime Healthcare Services and the non-profit Prime Healthcare Foundation employ more than 20,000 people and own and operate 23 acute care hospitals in California, Kansas, Nevada, Pennsylvania and Texas.

Truven Health Analytics (formerly Thomson Reuters), ranked Prime as one of the Top 15 Health Systems in its 2013 survey of more than 252 health systems nationwide. This was the third time in five years that Prime has been recognized. To achieve such a prestigious commendation by Truven Health, Prime Healthcare had to:

- Save more lives and cause fewer patient complications
- Follow industry-recommended standards of care more closely
- Make fewer patient safety errors
- Release patients half a day sooner
- Score better on overall patient satisfaction surveys
- Maintain sufficient working capital

This year, eight Prime Healthcare hospitals were among the "100 Top Hospitals" in the nation by Truven Health Analytics, based on quality of care and patient satisfaction. Prime Healthcare

hospitals have earned this recognition 21 times. Eight Prime Healthcare hospitals were recognized as "Top Performers on Key Quality Measures" by The Joint Commission in 2012, the leading accreditor of health care organizations in the nation.

Our motto is saving hospitals, saving jobs and saving lives. We endeavor to provide comprehensive, quality healthcare in a convenient, compassionate and cost effective manner. Prime Healthcare Services is consistently at the forefront of evolving national healthcare reform. Our organization provides an innovative and integrated healthcare delivery system. We remain ever cognizant of our patients' needs and desires for high quality affordable healthcare. We partner with the communities in which we serve in order to perfectly tailor our services and attract a larger patient base.

Prime Healthcare acquires hospitals that are either preparing for bankruptcy, in bankruptcy or are on the verge of closure before Prime came to their rescue. As a result, achieving financial stability to keep these hospitals operational is our first priority.

We invest significant capital to stabilize these hospitals. These investments give patients access to hi-tech facilities and state-of-the-art patient care equipment that not only enhance patient care, but improve overall quality scores.

Prime Healthcare is a large health system and through rigorous documentation and diligent patient tracking, the development of best practices is able to flourish. Specifically, Prime identifies successful practices at each hospital and then tries to replicate them across the

organization. In turn, the hospital is able to be run much more efficiently than when it was struggling to survive. Therefore, each of the hospitals is able to introduce new services, buy state-of-the-art equipment and strategically plan for a sustainable future. As a result, once-struggling facilities have now earned a number of quality awards from organizations including the Joint Commission and the American Heart Association.

Over the past few years, Prime Healthcare has sought to expand its expertise to financially struggling hospitals across the country, not just in California. Recently, Prime purchased hospitals in Texas and Kansas and others on the East Coast in Rhode Island and Pennsylvania. New Jersey is not alone. The larger our system, the more our best practices model improves and the better all of our hospitals will become.

New Jersey happens to have many hospitals for sale and now that we understand the New Jersey healthcare landscape, we see no reason not to create a robust system within New Jersey. Experts have found larger health systems control costs and have higher quality care.

Prime has also been the subject of due diligence and a competitive bid process by all three hospitals that we are attempting to purchase and clearly the leadership at St. Mary's, Saint Michael's and Saint Clare's is excited by our award-winning background.

Specifically, Prime has been supporting St. Mary's with working capital advances to strengthen the hospital's financial capacity until the deal is completed. Prime Healthcare will invest $44 million in St. Mary's Hospital and at least $25 million at Saint Michael's, on capital

improvements beyond routine replacements and additions. This injection of much needed capital will help stabilize the hospitals.

Prime's investments will give patients access to hi-tech facilities and state-of-the-art patient care equipment and medical personnel that will enhance patient care and reshape both St. Mary's and Saint Michael's into the best in New Jersey. St. Mary's, Saint Michael's and Saint Clare's, as part of the Prime Healthcare system, will reap the benefits of being part of a large, award-winning and innovative health system. Prime Healthcare will introduce best practices at both hospitals, and in turn improve the hospitals' quality scores. The stabilized financial situation, cutting-edge equipment, medical personnel and improved quality scores will all lead to an increase in the overall customer base.

Not all for-profits are the same and clearly Prime's track record is much better than some other for-profits and non-profits in the state and across the country.

As mentioned earlier, Prime Healthcare was recently ranked in the Top 15 by Truven Health Analytics for the third time in five years. Eight of Prime's hospitals also rank in the Top 100 based on quality of care and patient satisfaction.

Prime Healthcare has good relationships with insurance companies across our health system. In the past year and a half, Prime has signed hundreds of contracts with insurance companies at

many of our hospitals, including Blue Cross, Cigna and United Healthcare which also have a sizeable presence in the New Jersey market.

Recently Aetna, a major insurer in California, and 13 Prime hospitals announced an agreement on a new contract to cover hundreds of thousands of Californians. Prime is committed to maintain contracts with insurance companies. Prime hospitals want to contract with health insurance providers in order to allow for continuum of care for patients.

Prime Healthcare recognizes and contracts with unions. Prime Healthcare maintains contracts with the California Nurses Association including a new contract that has been praised by the California Nurses Association for offering an extraordinary safety benefit to its members for the first time in the nation. Prime Healthcare has struck a multi-year deal with JNESO at St. Mary's Hospital and is currently negotiating with JNESO at Saint Michael's.

Prime Healthcare has pledged to keep all three hospitals open as an acute care hospital for at least five years. Prime will continue to provide charity care services based on the existing charity care policies currently in place at all three hospitals. Prime will uphold the Ethical and Religious Directives for Catholic Health Care Services.

Prime has pledged to hire substantially all employees at all three New Jersey hospitals that it's in the process of purchasing. With Prime's support, these hospitals will remain open and thousands of jobs will be saved. As part of Prime's agreement with each hospital, a local governing board will be maintained to increase collaboration with patients, neighbors and community groups.

Thank you.

Hospital Alliance
of New Jersey

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Statement for Senate Health Committee Meeting

Monday, May 20, 2013
1 p.m., Committee Room 1, State House Annex

Hospital Alliance of NJ appreciates the opportunity to voice our thoughts regarding the oversight of a non-profit hospital conversion to for-profit status.

Our primary focus as an organization has always been ensuring access to care for the poor and uninsured in our state.

We all recognize that the hospital landscape in New Jersey is undergoing changes in the business structure of some of our hospitals.

However, notwithstanding the profit status of a hospital, New Jersey's regulatory requirement of treating all comers regardless of ability to pay still applies.

Hospital Alliance believes that the State already has regulatory oversight to ensure that all hospitals meet this requirement.

A level-playing field with respect to evaluating if this requirement is being met at all hospitals is what is required.

It is incumbent upon the State to ensure that NJ's poor and uninsured have access to quality healthcare regardless of the business structure of the hospital.

HackensackUMC
Mountainside

Testimony Submitted to the Joint Meeting of Senate Oversight and Health and Senior Services Committees
May 20, 2013

John Fromhold
Chief Executive Officer, HackensackUMC Mountainside

Thank you Chairman Vitale, Chairman Gordon and distinguished Committee members for this opportunity to provide comments. I applaud your desire to learn more about for-profit hospitals and not-for-profit/for-profit partnerships.

As the CEO of HackensackUMC Mountainside, it's my pleasure to represent our hospital and its joint venture owners, the LHP Hospital Group and the Hackensack University Health Network - and, I have compelling information to share with you.

First, I want to emphasize that for-profit is not a care model, it's a tax status. The shared mission of all *ethical* for-profit and not-for-profit hospitals is to promote wellness and healing within the communities we serve. Patient care decisions are always the purview of skilled physicians, who are free to choose where they will practice based upon the caliber of the facilities, their quality and safety track record, reputation, geographic location and other factors. Many physicians have multiple affiliations and simultaneously practice at both not-for-profit and for-profit hospitals.

In fact, the commonality of purpose and patient care practices among hospitals, as well as mutual respect for the role of physicians, accounts for the ability of not-for-profit and for-profit entities to successfully enter into partnerships. It also explains why national studies have shown that the vast majority of patients are unconcerned about the tax status of their local hospital.

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Although the presence of for-profit and not-for-profit/for-profit partnership hospitals is still relatively new in New Jersey, they've been an established, integral part of the health care systems of other states for many years. With respect to patient outcomes, quality and safety, there is no evidence of any differences among hospitals based upon tax status.

Furthermore, the lack of any disparity in the caliber of care will soon be more vividly underscored. Federal health care reform is creating a "pay for performance" environment that will place greater emphasis on quality and safety; gather and transparently share relevant data with the public; and realign Medicare reimbursement patterns to reward hospitals that achieve the best outcomes without regard for their tax status.

Yet another area where some have sought to find differences between not-for-profit and for-profit hospitals, is access to care and community benefits. And, once again, it's important **not** to make assumptions based solely upon tax status. In fact, independent assessments of charity care practices in other regions have found that for-profits sometimes devote *more* resources to charity care than their not-for-profit counterparts.

Furthermore, the willingness of for-profit companies to enter into partnerships with established not-for-profit facilities represents a willingness to uphold their commitment to serving community needs. In fact, at HackensackUMC Mountainside, our governance structure is designed to ensure that keeping abreast of medical breakthroughs and keeping in touch with community concerns are priorities.

Our Joint Venture Board, which has fiduciary oversight of the hospital, includes representatives from our medical team in addition to representatives for our two owners – and, we also maintain a local community hospital board whose role is to help ensure that our services and policies are in alignment with our constituents.

What's been happening at HackensackUMC Mountainside provides an excellent example of how the involvement of ethical, for-profit hospital companies can revitalize a hospital and I'm proud to have the opportunity to very briefly share some highlights with you.

Six years ago, Mountainside Hospital's performance was lackluster by every measure and many were ready to write its "death certificate." As a result of the involvement of two ethical private hospital management companies - Merit Health Systems, followed by current joint venture partnership owner, LHP Hospital Group - Mountainside has experienced a dramatic transformation.

Those for-profit entities have contributed an infusion of capital and strategic management direction which has been essential to the success of the hospital. In fact, as a result of their involvement, the hospital has:

- Built strong relationships with all key stakeholders including physicians, staff, civic leaders and the public
- Improved all key quality and safety benchmarks while simultaneously streamlining operating expenses and achieving financial stability
- Added or expanded more than a dozen services that address timely, unmet community needs
- Successfully negotiated in-network agreements with all major insurance providers and required affiliated physicians to establish compatible in-network agreements to minimize patient billing concerns
- Provided more than $18 million in charity care in a three-year period, 2008 - 2010.
- Paid more than $5 million in taxes including local property and county taxes, sales tax and state and federal taxes in the same period.
- Partnered with municipal health departments and other local organizations to offer free and low-cost health education and screening events

- Provided employment for more than 1,600 area residents and maintained union relationships
- Supported countless area businesses through the purchase of goods and services, *and*

Our revitalization, which began under the stewardship of one for-profit company, ultimately led to an opportunity to join a new network formed by the Hackensack University Medical Center, one of the nation's top 50 hospitals, and the LHP Hospital Group, one of the country's leading private hospital management companies.

As a result of this network affiliation, we're now well-positioned to realize the high level of clinical excellence, operating efficiency and community engagement that will be necessary to thrive in years to come.

This is a time of unprecedented challenge and change for all hospitals with many, unfortunately, caught in the stagnant, uncertain position that Mountainside was in a few years ago. At this juncture, the stakes are high for all hospitals and health care consumers.

State actions that inhibit the participation of ethical owners and potential investors with for-profit tax status or target them for excess layers of costly, time-consuming bureaucratic activities would make successful turnarounds like HackensackUMC Mountainside almost impossible to achieve and sustain.

I urge you to use your legislative authority to foster the development of a healthy, integrated hospital sector that includes both not-for-profit and for-profit entities, encourages them to work together as partners and fosters a culture that prompts all hospitals to "step up their game" and improve their quality, safety and efficiency.

I invite you to visit HackensackUMC Mountainside, at your convenience, to witness our revitalization and speak directly with some of our stakeholders.

NEW JERSEY HOSPITAL ASSOCIATION
NJHA

Testimony submitted to the joint meeting of Senate Legislative Oversight and Health, Human Services and Senior Services Committees
May 20, 2013

Randy Minniear
Senior Vice President, Government Relations and Policy, New Jersey Hospital Association

I appreciate the opportunity to offer comments on the current trend of the for-profit acute care hospital business model in New Jersey. NJHA membership includes acute care hospitals, specialty hospitals, rehab hospitals, nursing homes, home health agencies, adult and pediatric day health providers, PACE and hospice providers. It also includes for-profit and not-for-profit members.

It is true that the for-profit business model for the delivery of acute care hospital services is increasing in prevalence in New Jersey. For-profit acute care hospitals first appeared in the state in the late 1990's with Memorial Hospital in Salem and Bergen Regional Medical Center, although Bergen Regional is actually a county owned facility run by a for profit company. Since then, New Jersey has seen a gradual increase of for-profit hospitals in our state with the current number being 8, which includes HackensackUMC at Pascack Valley which is expected to open sometime later this year.

However, the presence of for-profit entities running acute care hospitals is not a new phenomenon on the national level. According to a data report from 2010 the American Hospital Association for-profit hospitals have grown at a faster pace over time than non-profits. Of the total 5,754 registered hospitals in our country, nearly 17 percent are for-profits. In 2002, that number was only around 10 percent, demonstrating a marked growth in the for-profit healthcare industry over the past decade. The for-profit trend has and will continue to make a presence in New Jersey especially with hospitals continuing to operate near the breakeven point, and others facing the need for capital to modernize their aging facilities and invest in medical technology.

It is worth noting, that New Jersey does have a history of for-profit healthcare delivery in our state, albeit, not at the acute care level. Of the 364 nursing homes in New Jersey, 251 of them are for-profit while the remaining are non-profit or government-owned. In 2010, the Center for Medicare and Medicaid Services issued its Nursing Home Data Compendium and New Jersey's for-profit nursing home rate was cited between 65-70 percent. The number of for-profit nursing homes is not surprising as New Jersey is right on track with the rest of the country. On a national scale, roughly two thirds of nursing homes are investor owned for-profit institutions. New Jersey's strong focus on licensing standards that emphasize quality and that require operational standards of practice that are meaningful, coupled with federal conditions of participation for these post acute care providers, have helped ensure that for-profit entities appropriately balance financial benchmarks with the expectations of superior quality and service delivery.

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As a trade association which represents 71 of the 72 acute care hospitals in this state, we also must embrace the evolving landscape of healthcare. In the wake of the 2010 passage of the Affordable Care Act, the changes confronting payment delivery, system alignment and quality measurement are significant. Accountable Care Organizations, value based purchasing, pay for performance, patient centered medical homes and other, new delivery models have become the norm for our healthcare system. As such, the increased presence of for-profit entities in our state's healthcare market is a "sign of the times" and a trend we expect will continue. However, NJHA does not distinguish its members based on their tax status. Rather, we hold that an organization's commitment to its mission, its communities and its patients – including the uninsured and underserved – is the standard by which it should be judged. In support of this perspective, NJHA adopted a set of guiding principles to reflect appropriate hospital business practices (copy attached). You will note that at the core of these principles is the paramount focus on the patient. Again this is a reflection of that fact that while hospitals must be able to function as businesses, they are, first and foremost, mission-driven organizations that provide a necessary social service.

Hospitals, whether operated for-profit or not, must adhere to regulations promulgated by the State Department of Health. Among some of the regulations required are acquiring a certificate of need which includes a thorough vetting process both by the Department of Health and the public, filing licensure inspection surveys, holding annual public meetings for the communities in which they serve, and maintaining their own internal quality assurance program to monitor the quality of care. In addition, the facilities are required to review and update policies and procedures to ensure the health and safety of their patients and to monitor and maintain compliance with state and federal statutes and regulations.

In the wake of the passage of the Affordable Care Act, New Jersey is expected to see a significant increase in the number of insured lives in this state as a result of Medicaid Expansion and the implementation of the Health Insurance Exchange. In order to ensure that these newly covered lives, as well as all patients in our state, have access to quality healthcare; it is vital that we ensure an adequate infrastructure is in place. In order to do this, we cannot discriminate amongst providers due to their tax status. There are instances in which for-profit entities have successfully salvaged financially failing hospitals on the brink of bankruptcy; thereby ensuring those communities continue to have access to vital healthcare services. Access and quality must be the guiding factors as we all engage in the evolving healthcare landscape.

I thank you for the opportunity to submit these comments to you and hope to continue to offer our resources to you as the discussion over for-profit healthcare delivery continues.

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NEW JERSEY HOSPITAL ASSOCIATION
NJHA

Guiding Principles
For Hospital Business Practices

Hospitals have a unique position in the marketplace. They are, first and foremost, mission-driven organizations that provide a necessary social service. But they also must function as prudent businesses, focused on maintaining appropriate revenues to support that essential mission.

The New Jersey Hospital Association, the state's oldest and largest hospital trade organization, does not distinguish between nonprofit and for-profit providers. Rather, we hold that an organization's commitment to its mission, its communities and its patients – including the uninsured and underserved – is the standard by which it should be judged.

With that premise as a foundation, the NJHA Board of Trustees has adopted the following guiding principles for appropriate hospital business practices.

Consumer-based Principles:

- All policies should be approached with a patient-first perspective, as evidenced by a hospital's mission;
- Patients should not be held liable, beyond contractual cost-sharing responsibilities, for receiving treatment at an in-network hospital; and
- Hospitals should make good-faith efforts to provide general notification to consumers that some providers may be out-of-network and to direct consumers to contact their insurance carrier.

Business Model-based Principles:

- Providers and payers should make good-faith efforts to enter into contracts, but providers must be able to competitively engage in the contract negotiation process and should not be forced into entering into contracts with inadequate terms;
- Any government intervention should not impede the provider and payer's right to contract;
- Providers should not induce consumers to go out-of-network as a business model;
- Any hospital that receives funds from the charity care subsidy pool should be required to honor both the spirit and intent of the State's charity care mandate in its entirety; and
- Providers should abide by responsible and compassionate billing practices.

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ADDITIONAL APPENDIX MATERIALS
SUBMITTED TO THE

SENATE HEALTH, HUMAN SERVICES, AND SENIOR CITIZENS COMMITTEE
AND
SENATE LEGISLATIVE OVERSIGHT COMMITTEE
for the
May 20, 2013 Meeting

Submitted by Ann Twomey, President, Health Professionals and Allied Employees:

Julie Creswell, Barry Meier, Jo Craven McGinty, "New Jersey Hospital Is the Costliest in the Nation," *New York Times*, May 16, 2013.

Dan Goldberg, "Alleged misdeeds haunt California chain poised to buy Newark, Passaic hospitals," *Star-Ledger* ©nj.com, March 10, 2013.

Bill Gallo Jr., "Fate of maternity ward at Memorial Hospital of Salem County to be discussed at community forum," *South Jersey Times* ©nj.com, August 15, 2009.

Linda Washburn, "Owners of for-profit North Jersey hospitals cash in on land beneath," *The Record*, NorthJersey.com, May 20, 2013.