Hospital Financial Transparency

Department of Health Recommendation on Hospital Financial Transparency

State of New Jersey Department of Health

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Summary of the Legislation

Legislation on Hospital Financial Reporting Requirements

On January 17, 2014, Governor Christie signed P.L. 2013, c.195, legislation to require the Commissioner of Health to undertake a review of State hospital financial reporting requirements and report any findings and recommendations to the Governor. In particular, the law called on the Commissioner of Health to examine the impact of, and make recommendations on the following areas: Internal Revenue Service filings, Securities and Exchange Commission filings and audited financial statements of all entities receiving Health Subsidy Funds payments to the State.

Background Information

Summary of Current Regulatory Approach

Currently, certain hospital financial reports are required by various statutory or regulatory authorities. The content of the reporting and the public availability of the reports varies by law, regulation and/or legal opinion as well as whether it is subject to disclosure to the public as a result of a request made pursuant to New Jersey's Open Public Records Act (OPRA). N.J.S.A. 47:1A-1 *et seq*. The following is a description of the data sets currently collected from hospitals.

Hospital Reporting Requirements and Data Sets

General, Early Warning System (EWS), New Jersey Health Care Facility Financing Authority (NJHCFFA) Apollo Reporting

Pursuant to the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 *et seq*. (the Planning Act), the Department of Health (the Department), "in order to provide for the protection and promotion of the health of the inhabitants of the State . . . [has] 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. . . , shall be subject to the provisions of this act." N.J.S.A. 26:2H-1. The Planning Act declared it "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." *Id.* The Planning Act led to the promulgation of regulations at N.J.A.C. 8:31B-1.1 *et seq*. for the reporting of hospital utilization and financial information. The Planning Act and the regulations have been interpreted to mean that the Department can take regulatory action to assure State residents have continued access to appropriate, high quality and affordable health care services. In 2008, as a result of numerous hospital closures (some sudden), bankruptcies and other hospital financial distress, the Planning Act was amended to create an early warning system (EWS) to provide the Department with a method to predict when a hospital might be in financial distress and tools to prevent the sudden or irreplaceable disruption of access to necessary health care services. N.J.S.A. 26:2H-5(d), -5.1a and -5.1b as

amended by P.L. 2008, c.58. The following information is currently provided to the Department as a result of the regulations and the 2008 amendments to the Planning Act:

- Audited Annual Financial Statements (available to the public);
- Quarterly Utilization Data - Form B-2 (available to the public);
- Quarterly Apollo Financial Information (not publicly available); and
- EWS - Monthly Days Cash on Hand, Days Accounts Payable, Days Accounts Receivable, Operating Margin and Average Daily Census (not publicly available).

The reports mentioned above are some of the tools that the Department uses for ascertaining if hospitals are experiencing financial distress. The reporting is a mix of prior year annual and current monthly unaudited reporting. The Department reviews hospital unaudited financial information, using this data as a mechanism to identify and communicate with hospitals about their financial condition.

Charity Care

Acute care hospitals in the State of New Jersey (State) are required by state law to provide all necessary care to patients regardless of ability to pay. Charity Care is free or reduced charge care that is provided to patients who receive their inpatient and outpatient services at acute care hospitals throughout the State. To offset the costs to hospitals of uncompensated care delivered to low-income uninsured patients, the State provides subsidies through the New Jersey Hospital Care Payment Assistance Program (Charity Care Program). The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under P.L. 1997, c.263.

Department Charity Care Audits

Charity care subsidies to hospitals are based on the charity care formula; however, the subsidy is not intended to be reimbursement for individual claims. Hospitals submit charity care claims to the State calculated at the Medicaid rate. The Department audits these submitted charity care claims on a quarterly basis. The total value of a year's audited charity claims is referred to as Documented Charity Care (DCC). The DCC is one of the factors used in the charity care subsidy formula to calculate charity care subsidies. Hospital-specific DCC summary information is available to the public. The most recent report on documented charity care is available on the following website at:

http://nj.gov/health/charitycare/documents/cc_reportdoc2012.pdf.

Annual Public Meetings

P.L.2008, c.59, requires that general hospitals conduct an annual public meeting organized to provide the community served by the hospital with information about the operation of the hospital, and to provide an opportunity for members of the public to ask questions and raise issues of concern. The meetings are open to members of the public. The Planning Act requires, at a minimum, that the CEO of the hospital, the chairman of the hospital board, and at least 25 percent of the members of the hospital board to be present at the meeting and available to respond to questions from members of the public. The dates of these meetings are publicly reported on the Department website at:

http://web.doh.state.nj.us/apps2/healthfacilities/hospitalmeetings.aspx

Medicare/Medicaid Reporting Requirements

Medicare and Medicaid-certified institutional providers are required to submit an annual cost report to a Medicare Administrative Contractor (MAC) and to the Department. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare and Medicaid settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). This information is available to the public through a request to the State or to the federal government pursuant to the Freedom of Information Act (FOIA).

Annual Acute Care Hospital Cost Report

N.J.A.C. 8:31B-3.3(a) requires that general hospitals complete the annual acute care hospital cost report. The report includes various costs by cost center and revenue data for all payers for each acute care hospital. This information is available to the public.

Other Reporting Requirements

Other Public Sources of Hospital Information (not submitted to the Department) are as follows:

IRS Form 990 Reporting for Not-for-Profit Hospitals

In addition to audited annual financial statements, the Internal Revenue Service (IRS) requires not-for-profit hospitals to provide the following relevant information in their annual tax returns on IRS Form 990, which is publicly available from the IRS:

a. Identity and Compensation of Board Members, Officers, Key Employees, Highest Compensated Employees and Independent Contractors;

b. A Statement of Functional Expenses;

c. Information on All Related Legal Organizations and Affiliates and Related and Unrelated Partnerships;

d. Transactions with Related Organizations;

e. Transactions with Interested Persons, including Loans, Grants, and Business Transactions; and

f. Statement of Activities Outside the United States.

It should be noted that the IRS requires disclosure of this information to ensure not-for-profit hospitals are fulfilling the requirements that they are charitable organizations entitled to the federal tax-exemptions provided to them under the tax code.

SEC Disclosure Requirements

- SEC Disclosure Requirements for Stock Companies - In addition to audited annual financial statements, for-profit hospitals (publicly or privately traded) with more than $10 million in assets and more than 500 stockholders must provide the following relevant information by filing the Securities and Exchange Commission's (SEC) required annual disclosure report (10-K), three quarterly disclosure reports (10-Q) and certain material event reports (8-K), which are publicly available documents:

a. Executive Compensation;

b. Description of Business, including Subsidiaries, and Description of Properties;

c. Legal Proceedings and Risk Factors;

d. Certain Relationships and Related Transactions, and Director Independence;

e. Controls and Procedures;

f. Identity of Owners of Five Percent or More of Company;

g. Quarterly Unaudited Financial Statements; and

h. Material Events including: Bankruptcy, New or Departing Director, Major Acquisition or Sale, Loan Defaults, Issuance of Bonds or Debentures, Changes in Control, Changes in Executive Management and Officers, Changes in Governance Policies including Code of Ethics, Large Layoffs or Plant Shutdowns and SEC Investigations and Internal Reviews.

It should be noted that the SEC requires these disclosures to ensure that stockholders and potential stockholders have all the relevant information they need to make an informed decision to purchase or sell stock in the company. This information is available to the public on the SEC's EDGAR website, located at http://www.sec.gov.

- SEC Disclosure Requirements for Obligors on Municipal Bonds - In addition to audited annual financial statements, not-for-profit hospitals provide the following information annually when municipal bonds are publicly issued on their behalf, in accordance with SEC Rules 10b-5 and 15c2-12 which require the following:

a. Description of the Business;

b. Risk Factors;

c. Defaults;

d. Rating Changes;

e. Bankruptcies; and

f. Release or Sale of Property Securing Payment of the Bonds.

It should be noted that the SEC requires these disclosures to ensure that bondholders and potential bondholders have all the relevant information they need to make an informed decision to purchase or sell bonds issued on behalf of a hospital. This information is available to the public on the Municipal Securities Rulemaking Board's EMMA website, located at http://emma.msrb.org/Home.

Additionally, bonds issued by NJHCFFA typically require borrowers to provide quarterly unaudited financial statements as a covenant in the Loan Agreement or other lending document. About 80 percent of New Jersey hospitals have bonds outstanding through NJHCFFA.

Stakeholder Feedback

Through the past year, stakeholder feedback was collected by the Department via meetings with industry stakeholders, advocates and by monitoring legislative hearings and testimony on the hospital industry.

On May 29, 2014, NJHCFFA moderated a conference of stakeholders on behalf of the Department to discuss appropriate financial reporting requirements for hospitals. Stakeholders included at least one representative from each of the following: five hospital trade organizations, three unions representing hospital employees, three community action groups, a publicly traded for-profit hospital, the trade association for health insurers and the trade association for nursing homes. Also attending were eight staff members from the Department and six staff members from NJHCFFA. A representative of Senator Loretta Weinberg attended as an observer. A full list of attendees is attached as Appendix A.

The meeting was held in furtherance of P.L.2013, c.195, signed January 17, 2014, which instructs the Commissioner to "undertake a review of New Jersey's hospital financial reporting requirements and . . . report any findings and recommendations directly to the Governor no later than six months from enactment." The law further instructs the Commissioner to "examine the impact of, and make recommendations on, the following areas for all entities receiving Health Care Subsidy Fund payments from the State: Internal Revenue Service filings, Securities and Exchange Commission filings, and audited financial statements."

Summary of Comments Received at 2014 Conference with Stakeholders

Generally, representatives of unions, community action groups and the health insurers' trade association advocated for additional financial information to be made publicly available. The primary reason cited for the additional financial information was that privately held for-profit hospitals were being opaque, thus raising concerns about their financial viability, potentially impacting cost of, access to, and quality of health care, and the stewardship of public funds. Those seeking additional financial reporting agreed that the following should also be required to be reported and made available to the public: (i) quarterly financial statements; (ii) compensation of board members, officers and highly compensated employees; (iii) compensation of the highest paid contractors; (iv) contracts with related parties; and (v) terms of sale-leaseback arrangements.

Some conference participants also wanted public reporting of: (i) a statement of functional expenses, breaking down expenses in the same manner that the IRS Form 990 requires expenses to be reported; (ii) names of owners and board members; (iii) emergency room utilization; and (iv) out-of-network services provided.

There was also a request that penalties be consistently applied to hospitals that do not timely comply with reporting requirements.

Representatives of unions and community action groups also wanted a requirement for procedures similar to the Certificate of Need review and/or the review pursuant to the Community Healthcare Assets Protection Act (CHAPA), for sale-leaseback arrangements. One stakeholder requested that CHAPA be imposed when a for-profit hospital is sold to another for-profit hospital.[1]

In opposition to additional financial reporting, three hospital associations, the publicly traded for-profit hospital and the trade group for nursing homes generally agreed that there were already several burdensome and costly reporting requirements and that existing reporting requirements provided the public and the Department with sufficient information. One hospital association, however, agreed that all hospitals should report similar information as is reported on the IRS Form 990. Another hospital association agreed that any penalties for failure to timely comply with reporting requirements should be consistently applied. One hospital association did not make any comments.

Rationale to Support Additional Reporting Requirements

Representatives of unions, community action groups and the health insurers' trade association all offered as one justification for requiring additional reporting that all hospitals should be viewed as community assets or quasi-public trusts, due to their importance to the community, their role

[1] The CHAPA process is administered by the Attorney General's office and therefore outside the jurisdiction of the Department. Furthermore, the public policy and legislative history behind CHAPA is to protect not-for-profit hospital assets for the community. This suggestion to conduct a CHAPA review of sales from one for-profit hospital to another is ultra vires and, therefore, is not addressed in the recommendations below.

in providing access to the State's health care system and the vital service they provide. Another justification offered to support this argument included that hospitals are, on average, more than 50 percent funded by public funds and accordingly should be more transparent, so that both the government and the public are able to monitor their stewardship of those public funds. The fact that hospitals enjoy the limited privilege of operating a hospital in the State as a result of the Certificate of Need and licensing processes was also agreed to be a reason hospitals should be more transparent. Lastly, the argument for more financial reporting was that there should be parity between the not-for-profit hospitals and publicly held for-profit hospitals on the one hand and the privately held for-profit hospitals on the other. Those who took this position contend that the playing field is otherwise not level because not-for-profit hospitals and publicly held for-profit hospitals have significant additional reporting requirements as a result of, respectively, the IRS Form 990 and SEC Forms 10-K, 10-Q and 8-K.

Other arguments included: (i) high prices resulting from out-of-network business models which result in barriers to health care access; (ii) other businesses on the health care spectrum are prohibited from charging excessive fees; (iii) patients might want to select their hospital based on a hospital's finances; (iv) hospital employees should know their employer's finances to get a sense of their job security; (v) more transparency would enable unions and insurers to know the current financial conditions of a hospital, particularly during contract negotiations; (vi) there is not a significant burden placed on hospitals by additional financial reporting; and (vii) transparency is generally good, preventing corruption and fraud.

Rationale to Maintain Existing Reporting Requirements

Most hospital associations, the nursing home trade group and the publicly traded for-profit hospital generally agreed that there was already ample reporting in the industry and opposed additional financial reporting for cost and resource reasons.[2] It was also argued that the additional financial reporting requested: (i) is neither meant for, nor needed by the public due to its complexity and, in some cases, the information being incomplete or preliminary; (ii) is only appropriate to be disclosed to regulators such as the State or federal government and for the limited purpose of regulation (e.g. IRS Form 990 to ensure compliance with tax-exempt laws and regulation and SEC disclosure for investors); and (iii) may be proprietary, disclosure of which may put the hospital at a competitive or negotiating disadvantage. Also raised was the concern that requiring the reporting of additional financial information could discourage for-profit hospital entities from investing in New Jersey hospitals, possibly resulting in the closure of a hospital with the attendant loss of access to hospital care and jobs. In fact, there were several examples given where the only entities interested in purchasing hospitals were privately held for-profit entities. Without their interest several hospitals would have likely closed, thereby ending access and reducing jobs in those areas.

It was also pointed out that there may be a business advantage to limited disclosure in certain cases. A recent study was mentioned which concluded that privately held companies showed more agility, flexibility and innovation than publicly traded companies due in part to their ability to reserve proprietary information, make decisions more quickly, and have less pressure to show positive quarterly returns to investors.

[2] The Catholic Health Partnership did not disagree with requiring for-profits to provide similar information as the not-for-profits report on the IRS Form 990 and the Council on Teaching Hospitals expressed no opinion.

In countering the argument that public funding should require additional financial disclosures, it was noted that nearly all public funding is related to discrete services performed, such as that provided by Medicare, Medicaid and Charity Care. All hospitals are paid according to a formula, not based on the charges or costs of the particular hospital providing the services. This circumscribed type of public funding does not necessarily make all hospitals quasi-public trusts or community assets. It was also noted that these payments are, on average, below the costs of the services provided by the hospital.

With respect to sale-leasebacks it was argued that there is no real advantage to the public having access to the terms of sale-leaseback agreements and that the sale-leasebacks contain important business and financing plans that make them proprietary to the parties.

Recommendations

The following recommendations are made keeping in mind the careful balance between the unique and important nature of health care services, the significant amount of public funds hospitals receive and the need to prevent imposing too steep a burden on health care providers. These recommendations focus primarily on enhancing the Department's access to information in its role as a regulator protecting the public's interest and access to health care while also providing additional information to the public so that it can raise concerns if it believes the hospital is not being a good steward of public funds.

Audited Annual Financial Statements

Audited Annual Financial Statements should continue to be provided to the Department but within 180 days of the close of the hospital's fiscal year (rather than the current July 1st). If the

hospital is part of a multiple hospital system, the audited annual financial statements should include both the system's audited annual financial information and a breakdown for each New Jersey hospital owned or operated by the system. For each hospital, the annual financial information provided should include, at a minimum, the four financial statements, prepared in accordance with Generally Accepted Accounting Principles (GAAP), i.e. the Balance Sheet, the Statement of Operations or Income, the Statement of Changes in Net Assets and the Statement of Cash Flows. The hospital should publish, in a conspicuous place on its own website, the audited annual financial statements within the same time frame as it is required to file the information with the Department and have copies available for review by the public at the hospital's annual public meeting, which should be within 60 days of the publishing of its audited annual financial statements. If the audited annual financial statements are not provided to the Department within the allotted time, the Department should consistently levy an escalating fine or penalty for each day the financial statements are delayed, which fine or penalty may be waived for good cause shown upon application or may be appealed pursuant to administrative law. Publicly providing audited annual financial statements on the hospital website and at the annual public meeting should provide the public easy access to the most reliable information within and appropriate context for each hospital while not overly burdening the hospital, because audited annual financial statements are routinely prepared by hospitals and currently publicly available. Publishing of audited annual financial statements and the other limited financial information recommended herein should not be done on the Department's website so as not to add additional costs or burdens on the Department, as well as to avoid any claim resulting from information that is wrongly reported or not updated timely.

Quarterly Unaudited Financial Statements

Quarterly Unaudited Financial Statements should be provided to the Department within 45 days of the end of each quarter, and should be made available to the public on each hospital's website within 60 days of the end of the quarter except when it conflicts with the SEC or other federal requirements. Each hospital may wish to include a suitable disclaimer on its website indicating that the quarterly financial statements have not been audited and may be subject to change. The quarterly unaudited financial statements should be prepared in accordance with GAAP and contain the same four financial statements included in the audited annual financial statements for each New Jersey hospital. The quarterly unaudited financial statements should be provided in addition to the quarterly financial information currently being provided to the Department. The Department, as the regulator of hospitals and of New Jersey's health care system has good reason to have quarterly unaudited financial statements and quarterly and monthly financial information in order to appropriately monitor the fiscal health of hospitals and ensure citizens have continued access to hospital care. The quarterly unaudited financial statements are important to further inform and clarify the quarterly financial information and monthly financial ratios currently being collected. The reporting of quarterly unaudited financial statements would not overly burden hospitals because the information is routinely prepared.

Compensation of Board Members, Officers and Highly Compensated Employees

Under the Planning Act, the Department's regulatory role is primarily focused on maintaining access to quality health care services where needed. Compensation of board members, officers and highly compensated employees does not provide the Department with information that is helpful for this purpose assuming the other financial information recommended herein is provided. The IRS requires this information of not-for-profit hospitals to assure that there is no prohibited private benefit which would render the organization taxable. The SEC requires this information of publicly traded companies so that investors and potential investors are informed so they can make investment decisions. Absent those IRS and SEC concerns, the public need for compensation information has not been clearly demonstrated and is outweighed by the privacy rights of the organization and its employees wherein its payment structure may provide it with more flexibility, incentive or agility to experiment with new and, possibly, improved methods or results.

Statement of Functional Expenses

A Statement of Functional Expenses is available to the public in the State's acute care hospital cost reports required pursuant to N.J.A.C. 8:31B-3, as well as the Medicare cost reports, which are available pursuant to a FOIA request. Requiring a separate filing of this information would place a redundant and unnecessary burden on hospitals.

Payments to the Highest Paid Independent Contractors

Similar to the compensation discussion above, payments to the highest paid independent contractors should not be required to be reported unless otherwise required by the IRS, SEC or

other governmental entity. This would add an undue additional burden to hospitals. Furthermore, this could also involve reporting of: union dues or benefits; payments resulting from Accountable Care Organization contracts or agreements; joint ventures with doctors; or payments to bio/pharmaceutical companies. Finally, any concerns the Department might have about independent contractors should be resolved by the provisions recommended below in "Contracts with Related Parties."

Contracts with Related Parties

Self-dealing and conflicts of interest can lead to losses that endanger the health care system, compromise access to hospital care, and bring into question the stewardship of public funds. In particular, transactions with related parties[3] may be entered into for fraudulent purposes rather than for legitimate business purposes. The Department should work with stakeholders to explore reporting by hospitals of contracts with related parties over a certain threshold dollar amount and public access to this information. The Department is in favor of standardizing disclosure of related-party transactions across for-profit and not-for-profit hospitals, to the extent permitted by law.

Names of Owners, Board Members and Officers – Board Accountability

Names of board members and officers are required to be submitted to the Department with any licensing application and upon request for annual renewal of license. Currently, N.J.A.C. 8:43G-5.1(b) requires that a hospital provide, with a license application or annual renewal, the names of each member of the hospital's governing body, the name of the chairperson of the governing

[3] Examples of related parties include a parent company and its subsidiaries; subsidiaries of a common parent; an enterprise and trusts for the benefit of employees, such as pension and profit-sharing trusts that are managed by or under the trusteeship of the enterprise's management; an enterprise and its principal owners, management, or members of their immediate families; and affiliates. Statement of Financial Accounting Standards (FAS) No. 57.

body and the name of the chief executive officer. Similar information is also required to be submitted annually by all domestic corporations and foreign corporations doing business in the State as for-profit corporations[4] and not-for-profit corporations[5]. The names of the owners of five percent (5%) or more of the corporation should also be reported to the Department as part of the annual license renewal process. Unless otherwise required by the IRS, SEC or some other governmental entity, owners names should be encouraged, but not required, to be made available to the public in order to prevent unreasonable reporting requirements on the hospitals. The public, as always, can seek redress against any hospital by filing a complaint with the Department rather than an individual owner. The Department should have access to this information as a regulator and should be able to communicate with the hospital decision-makers, including inquiries into finances and violations of conflicts of interest and self-dealing, discussed above. Given the rapidly changing health care environment, there is a greater expectation of board member accountability. A recent whitepaper by the American Hospital Association describes how hospital boards must evolve in order to be more accountable in a number of areas including transparency. The Department recommends that a working group review current regulations related to hospital boards and make recommendations to strengthen hospital; board accountability.

[4] This information is reported to the Department of Treasury pursuant to N.J.S.A. 14A:4-5.
[5] This information is reported to the Department of State pursuant to N.J.S.A. 15A:4-5.

Hospital Charges

Making hospital charges public was discussed briefly. The fact that CMS, as of October 1, 2014, is requiring all hospitals to make available a list of the hospital's standard charges for items and services provided by the hospital on its website or otherwise make them reasonably available adequately addresses this issue.

Insurance Networks and Out-of-Network Services

Hospitals are not currently required to routinely publish or disclose insurance network coverage or Out-of-Network services. The Department believes that hospitals should inform their communities and patients about which insurance covers care and what are charges that patient may expect. As noted above, each hospital will be required to post a list of the hospital's charges. Each hospital should make information available to its patients concerning network coverage that is in a form that allows the patient to understand information and services and use them to make appropriate decisions about health. This should be done as part of existing licensing requirements at N.J.A.C. 8:43G-4.1, Patient rights. However, this could be an area of future Department guidance or rulemaking.

Sale-Leaseback Arrangements

Sale-Leaseback Arrangements should be reported to the Department by filing a form of notice before an agreement is entered into by a hospital. Hospitals should also report this transaction at their annual public meeting. In a sale-leaseback transaction, the ownership of the property and often the building is transferred to another entity such as a Healthcare Real Estate Investment Trust. There is a possibility that either the owner can evict the hospital operator tenant or the tenant can terminate its lease on little or no notice and without consequence, leaving the

surrounding community with less access to hospital care. Any sale-leaseback agreement shall be contingent upon the continuance of an established and functioning governing body responsible for institutional management and planning.

Financial Reporting of Other Entities

Most of the participants believed that any discussion of other entities was beyond the scope of the directive in the legislation. Some, however, believed that further discussion was warranted, particularly in health care organizations that receive public dollars directly from the government to pay for goods or services and/or as a result of having the privilege to operate under the issuance of a State license for such facilities. Broad public policy decisions on healthcare transparency should be considered for the all parts of the delivery system.

Effectively Making Hospital Data Publicly Available

The Department has recently made significant changes to its website to improve overall transparency. The Department does not recommend that all the financial data recommended for publication in this report be provided on the Department's website. However, the Department does recommend adding to its website links to the sources for financial data, such as EMMA, EDGAR, GuideStar and individual hospital websites, in addition to its link to file an OPRA request. The same webpage may also link to the Department's hospital quality reports as well as CMS's Hospital Compare and possibly other publicly available hospital quality reports. This would assist the public by allowing them to go to one central location to link to all the information on hospitals that is publicly available. Moreover, as recommended, hospitals should

post annual and quarterly financial statements on their own website in addition to notifying the public at their annual public meeting.

Appendix A

Hospital Transparency Meeting Attendees
May 29, 2014

Elizabeth (Betsy) Ryan, Esq., President & CEO - NJ Hospital Association
Randy Minniear, Sr. Vice President, Government Relations & Policy & Jessica Hritz

Suzanne Ianni, President & CEO - NJ Hospital Alliance

Rick Pitman, Executive Director - Fair Share Hospitals Collaborative

Sr. Patricia Codey, SC, Esq., President - Catholic HealthCare Partnership of NJ

Lenore Robison, Ph.D., Director, Program Management - Council of Teaching Hospitals (attending for Deborah Briggs, President & CEO)

John Indyk, Vice President - Health Care Association of NJ (HCANJ)
Tom Dorner, Director of Reimbursement

Marilyn Askin, NJ Chief Legislative Advocate - AARP

Ann Twomey, President - Health Professionals and Allied Employees (HPAE)
Jeanne Otersen, Harriet Rubenstein

Renee Steinhagen, Executive Director - NJ Appleseed PILC

Phyllis Salowe-Kaye, Executive Director - NJ Citizen Action
India R. Hayes Larrier

Douglas A. Placa, Executive Director - JNESO
Christina Zuk

Wardell Sanders, Esq., President - NJ Association of Health Plans

Susan M. Cleary, President - District 1199J, NUHHCE, AFSCME, AFL-CIO

Ryan Jensen, CEO - Memorial Hospital of Salem