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| JOSEPH G. COLACITTI, THE CITY OF ELIZABETH, a Municipal Corporation, PLAINSBORO TOWNSHIP, a Municipal Corporation, PETE CANTU, NEIL J. LEWIS, ED YATES, NURAN NABI, CITY OF VINELAND, a Municipal Corporation, and LIVINGSTON TOWNSHIP, a Municipal Corporation,<br>Plaintiffs,<br><br>-v.-<br><br>PHILLIP D. MURPHY, in his official capacity as Governor of New Jersey, and the STATE OF NEW JERSEY,<br><br>Defendants. | : | SUPERIOR COURT OF NEW JERSEY<br>LAW DIVISION, MERCER COUNTY<br>DOCKET NO. MER-L-000738-21<br><br>Civil Action |

BRIEF ON BEHALF OF AMICI CURIAE NEW JERSEY CITIZEN ACTION, AMERICAN FEDERATION OF TEACHERS, NEW JERSEY and MARK AND KATHERINE SMITH

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## AMICI CURIAE STATEMENT OF INTEREST

*Amici curiae*, New Jersey Citizen Action ("NJCA") (and its Health Care Program Director, Maura Collinsgru), American Federation of Teachers, New Jersey ("AFTNJ") and its President, Donna Chiera) and Mark Smith and Katherine Smith submit this brief in support of the complaint of Plainsboro Township, City of Elizabeth and Livingston Township ("Municipal Plaintiffs") challenging the constitutionality of P.L. 2021, Chapter 17 (the "Bill") on several substantive grounds. *Amici* intend to focus this brief, however, on Section 3 of that Bill, which is codified as N.J.S.A. 54:4-3.6j.

N.J.S.A. 54:4-3.6j exempts not-for-profit hospitals from property taxation even if these hospitals and a host of third-parties, defined as "medical providers," actually operate on a for-profit basis and conduct for-profit businesses on hospital property, "provided the portion of the hospital or satellite emergency care facility [used by such providers] is used exclusively for hospital purposes." N.J.S.A. 54:4-3.6j(b). See also Plaintiffs' Statement of Undisputed Material Facts, ¶5. This legislative amendment constitutes a stark departure from New Jersey's nonprofit property tax exemption law that, as a constitutional matter, focuses on use rather than formal status of the property owner. In addition, the amendment impermissibly divorces "hospital" purposes from its common law charitable

meaning. As will be discussed in this brief, a medical provider operating on a for-profit basis cannot, as a matter of logic, "exclusively" serve hospital purposes. This is the case because "hospital" purposes must be delivered on a not-for-profit basis to be deemed charitable, and when providing medical services directly to the hospital, for-profit providers are also pursuing their own private gain.

NJCA is a New Jersey non-profit corporation, registered under Section 501(c)(4) of the Internal Revenue Code, with business addresses in the City of Newark, Essex County; Highland Park, Middlesex County; and Cherry Hill, Camden County. NJCA has 15,000 individual members, as well as 100 affiliated partner groups with vast networks of members across New Jersey. For nearly 40 years, NJCA and its members have engaged in issue advocacy, education and outreach, as well as electoral campaigns. In addition, it has provided assistance to tens of thousands of New Jersey residents through its empowerment programs that offer financial coaching, housing counseling and discrimination monitoring, and health care enrollment, as well as free tax preparation through its 501(c)(3) sister organization, New Jersey Citizen Action Education Fund ("NJCAEF"). Collectively, the work of NJCA and NJCAEF serves to improve the lives of low- and moderate- income individuals and taxpayers and advance social, racial and economic justice for all New Jerseyans.

NJCA has championed and advocated for earned sick days, paid family leave, raising the minimum wage, tax fairness (equity), housing protections, consumer financial protections and health care issues. Of particular relevance to this case, NJCA has had an active role in expanding access to quality, affordable health care and reining in health care costs by holding providers and other health care entities accountable. From NJCA's perspective, permitting property tax deduction on properties used by for-profit health providers renders the nonprofit hospital a mere forum for for-profit activities and violates the hospital's obligation to bring value to the community in exchange for the tax-exemption. It constitutes an abuse of their nonprofit status and contract with the community to provide affordable care on a not-for-profit basis and other community public health benefits.

Pursuant to this legislation, for-profit health care providers using property owned by not-for-profit hospitals are given an advantage, which only contributes to the increasing commodification of healthcare and provides an incentive for not-for-profit hospitals to contract out entire departments to for-profit physicians, permit out-of-network and excessive billing by private physicians who have privileges at the hospital, and hire temporary nursing staff that are provided by for-profit labor brokers – trends that NJCA has long opposed due to their negative impact on consumers in terms of access, affordability and quality

of care. NJCA has generally and specifically opposed the conversion of health care from non-profit to for-profit entities through campaigns it has waged, in partnership with New Jersey Appleseed Public Interest Law Center, to preserve hospitals as charitable community assets. Those efforts have included opposing the takeover of NJ not-for-profit hospitals by HCA Healthcare (Salem Hospital), Merit Health Systems (Mountainside Hospital), Care Point Health (Bayonne, Christ, and Hoboken University Hospitals), MHC, LLC. (Hudson Regional, formerly Meadowlands Hospital),[1] Prime Health Care (St. Mary's, St. Michael's and St. Clare's—at Denville and Dover Hospitals), and Prospect Medical Properties (East Orange Hospital), and the restructuring of Horizon Blue Cross Blue Shield as a mutual insurance holding company.

NJCA also took an active role in opposing earlier versions of the Bill that were introduced and passed by the Legislature prior to the pandemic. It is represented in this brief by Maura Collinsgru, who is a taxpayer and owner of property in Palmyra, Burlington County, the county in which Virtual Health System is located, and is also the Health Care Program Director of NJCA. Ms. Collinsgru is the principal coordinator of the New Jersey for

[1]Andrew Kitchman & Lilo Stanton, *Meadowlands Hospital's Tangled Web of Questionable Business Practices*, NJ SPOTLIGHT (August 11, 2016) (Noting reduction in staff, questionable business practices and lower quality of care upon conversion to for-profit).

Health Care Coalition, consisting of numerous consumer groups, civil rights and immigration advocates and social service providers. Its mission is to improve access, affordability and quality of health services in NJ, which includes a focus on holding not-for-profit hospitals accountable to their charitable mission.

AFTNJ is a New Jersey non-profit membership corporation, with its official business address at 720 King George Road, Suite 300, Fords, NJ 08863, in Middlesex County. It represents over 30,000 PreK through grade 12 and higher education workers who live and work throughout New Jersey. AFTNJ workers know firsthand the importance of large profitable institutions, including hospitals, paying their fair share in property taxes. As residents, taxpayers, homeowners and public servants, the union fully understands that the quality of education provided to students in New Jersey is directly tied to the ability of local Boards of Education to fund the programs our students and educators need. As many districts throughout the State struggle to cope with outdated facilities, staff shortages, and the inability to offer wrap-around student and family services, it is disheartening to see health care facilities skirt their social responsibilities by failing to pay property taxes despite the increasing level of for-profit activity occurring on their campuses. Working New Jerseyans should not be responsible for shouldering the burden of funding public education while large profitable institutions, such as hospitals, use their

political power to secure legislation which sanctions their failure to contribute their fair share of local taxes.

AFTNJ participates in this brief to right this wrong and to ensure that hospitals properly operate their facilities on a not-for-profit basis and contribute to the public health of the communities in which they are located and from which they financially benefit. AFTNJ is represented by Donna Chiera who is a taxpayer and owner of property in Perth Amboy, Middlesex County, a municipality in which Hackensack-Meridian Raritan Bay Medical Center is located, and is also the President of AFTNJ.

MARK and KATHERINE SMITH are individual taxpayers and owners of real property on which they reside in South Brunswick Township in the County of Middlesex. As residents of a county in which are situated at least two hospitals—Robert Wood Johnson University Hospital and Penn Medicine Princeton Health—that are tax exempt, Mark and Katherine Smith's contribution to Middlesex County's tax collection increases in proportion to the exempt status of the hospitals that are freed by the Bill from the burden of contributing to the county tax base.

As a result, *Amici Curiae* have a shared interest with Plaintiffs in the subject-matter of the case, although a different perspective regarding the nature of the economic and social problems that the hospital property tax-exemption, as amended, generates for New Jersey residents and taxpayers.

**BACKGROUND**

The central legal question posed in this litigation is whether P.L. 2021, Chapter 17, sections 3 and 5 transform the not-for-profit hospital property tax exemption in such a way as to violate *N.J. Const.*, art. VIII, §1, ¶2 (the "Exemption Clause") and/or art. VIII, §1, ¶1 (the "Uniformity Clause"). This is not an applied constitutional challenge as was the case in Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) or Provena Covenant Medical Center v. Dept. of Revenue, 894 N.E.2d 452 (Ill. App. 2008), *aff'd*, 925 N.E.2d 1131 (Ill. 2010), but rather raises the question of whether the Legislature can expand the historical nonprofit hospital property tax exemption to permit for-profit activity on the property seeking exemption, without violating constitutional norms. (*Amici*, of course, assert that the answer is "no.")

The Court is also not being asked to decide the larger policy question of whether not-for-profit hospitals should receive such local property tax exemption, let alone be exempt for purposes of state and federal income tax. It is to this larger policy question, however, that almost all of the legal and social science literature written in the past 25 years has been addressed.

As hospitals have become more complex and economically significant, and play an integral role in the U.S. healthcare system, social scientists and legal scholars have focused

primarily on whether the value of the tax benefits received by not-for-profit hospitals is equal to or greater than the community benefits such hospitals provide to the communities in which they are physically located;[2] or how the for-profit/not-for-profit

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[2] *E.g.*, Michael Ollove, *Some Nonprofit Hospitals Are Not Earning Their Tax Breaks, Critics Say*, STATELINE, (Pew Research) (Feb. 7, 2020) (whether nonprofit hospitals provide enough services to earn their tax-exempt status); Sean Nicholson et al., *Measuring Community Benefits Provided by For-Profit and Non-Profit* new method of identifying activities that should qualify as community benefits and compares nonprofits' current level of community benefits with their benchmark and show that actual provision falls short); Michael Rozier, et al., *How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?* 21(3) AMA JOURNAL OF ETHICS 273 (March 2019) (noting that community benefits efforts tend to prioritize inpatient medical care over community-based health improvements, and recommending changes to federal IRS policies); Michah Rothbard & Nara Yoon, *Holding Hospitals Accountable? Evidence on the Effectiveness of Minimum Charity Care Provision Laws*, CENTER FOR POLICY RESEARCH, Working Paper No. 218, Maxwell School (September 2019) (analyzing Illinois' minimum charity care provision imposed on nonprofit hospitals and finding "no evidence that the MCCP law increased charity care on average"); Bradley Herring, et al., *Comparing Value of Nonprofit Hospitals Tax Exemption to Community Benefits*, 55 J. OF HEALTH CARE ORGANIZATION, PROVISION and FINANCING 1 (Feb. 2018) (using 2012 data from IRS, CMS and AHA Annual Survey, finding that incremental community benefits provided by nonprofits beyond that provided by for-profit hospitals exceeds the value of the tax exemptions received for only 62% of nonprofit hospitals); Barbara Yasmin Lodge, *Not-for-Profit Tax Exempt Hospitals: is it Time to Start Paying Taxes?*, 44(S) *J. OF HEALTH CARE FINANCE*, (Winter 2018) (noting that despite the expectation that there is an "apparent quid quo pro" between forgone taxes and community benefits, "gains for the not-for-profit hospitals outweigh the charity care provided"); Eric J. Santos, *Property Tax Exemptions for Hospitals: A Blunt Instrument Where a Scalpel is Needed*, 8 *COLUMBIA J. OF TAX LAW* 113 (2017) (recommending replacement of "all-or-nothing" exemption with a more flexible system of tax credits); U.S. Congressional Budget Office, *Nonprofit Hospitals and Provision of Community Benefits*, (Dec. 2006) (nonpartisan analysis examining several

corporate form impacts types of services provided, the quality of services, overall costs and mortality rates.[3]

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measures of community benefits provided by hospitals and comparing nonprofit hospitals with for-profit hospitals that do not receive tax exemptions); David Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16(3) AM. J. OF L. & MED., 327(1990)(noting that nonprofit hospitals have entered into competition with tax-paying businesses, and increasingly behave like competitive actors, rendering tax exemption inappropriate; calling for more focused goals and incentives to provide nonprofit hospitals incentive to "do the right thing").

[3] *E.g.*, Dave Muoio, *Southern and for-profit hospitals more frequently deliver unnecessary tests and* procedures; analysis, FIERCE HEALTHCARE, (May 2021)(finding overuse of unnecessary healthcare services most common among for-profit hospitals, nonteaching hospitals and those located in the southern U.S.); Patrick P.T. Jeurissen, et al., *For-Profit Hospitals Have Thrived Because of Generous Public Reimbursement Schemes, Not Greater Efficiency: A Multi-Country Case Study,"* 51(1) INT'L J. OF HEALTH SERVICES, 67 (2021)(studying historical development of for-profit hospital sector across four nations, including the U.S., and finding that "subsidies by public health care payors is an important factor in the rise of for-profit hospitals"; more important than physician's financial interests and political shifts); Ruth McCambridge, *Study Finds More COVID Deaths in For-Profit Nursing Homes than Nonprofit Ones*, NONPROFIT QUARTERLY (August 18, 2020)(discussing investigation by Mathematica Policy Research into nursing home deaths related to COVID-19, finding that there were about 60 percent more cases and deaths per licensed bed in for-profit facilities than in nonprofit ones); Ryan G. Chiu, et al., *Association of for-profit hospital ownership status with intracranial hemorrhage outcomes and cost of care*, 139 *J.* NEUROSURG. 1939 (Dec. 2020)(mortality rates were found higher in for-profit hospitals than nonprofits and length of stays were greater as were total hospital charges); Theresa Morris, et al., *Hospital Ownership status and Cesarians in United States; effect of for-profit hospitals,"* 44 BIRTH 325 (2017)(finding that women who give birth in a for-profit hospital are more likely to have cesarians than women who give birth in not-for-profit); Emmanuel Akintoye, et al., *Effects of Hospital Ownership on Outcomes of Heart Failure Hospitalization*, 120 AM. J. OF CARDIOLOGY 831 (2017)(noting significant difference in mortality rates of women, not men, between nonprofit and for-profit hospitals, with outcomes at for-

Most, if not all, of the literature grouped in the Value of Community Benefit vs. Value of Tax Exemption category, *infra* n. 2, has been framed by IRS standards imposed on nonprofit hospitals incorporated as 501(c)(3) corporations organized for "charitable, educational and/or scientific" purposes, and the studies each aggregate the value of various federal, state and local tax exemptions that nonprofit hospitals receive. See CBO Report, 2006

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profit hospitals generally better; and finding that total charges billed was highest in for-profit hospitals and lowest in in government hospitals); Amy J. H. Kind, MD, et al., *For-Profit Hospital Status and Rehospitalizations at Different Hospitals, An Analysis of Medicare Data*, 153 ANN.INTERN. MED. 718 (2010)(concluding that rehospitalizations at different hospital are common among Medicare patients, are more likely among those initially hospitalized at a for-profit hospital, and are related to increased overall payments without improved mortality); Jill Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-profit and Government Hospitals*, 24(3) Health Affairs 790 (May/June 2005)(For-profits are most likely to offer relatively profitable medical services, government hospitals are most likely to offer relatively unprofitable services, and nonprofits fall in the middle); Gabriel Picone, et al., *Are for-profit hospital conversions harmful to patients and to Medicare*, 33(3) RAND J. OF ECONOMICS 507(Autumn 2002)(finding that 1-2 years after conversion to for-profit status, mortality of patients, which is difficult for outsiders to monitor, increases while hospital profitability rises markedly and staffing decreases); Mark Duggan, *Hospital Market structure and behavior of not-for-profit hospitals*, 33(3) RAND J. OF ECONOMICS 433 (Autumn 2002)(findings indicate that not-for-profit hospitals mimic the behavior of private for-profit providers when they actively compete with them); Elaine M. Silverman, MD, et al., *Association Between For-Profit Hospital Ownership and Increased Medicare Spending*, 341(6) N. ENGLAND J. of MED. 420 (1999)(adjusted total per capita Medicare spending in the 208 areas where all hospitals remained under for-profit ownership during 1989, 1992 and 1995 was greater than in the 2860 areas where all hospitals remained under not-for-profit ownership).

at 3. None of the studies segregate the value of the state property tax exemption in any given state and compare it to the value of community benefits provided to the communities served by the hospital.

In addition, federal standards have evolved. Because hospitals in the late 1800s-early 1900s were purely charitable, in the everyday understanding of the term, when the federal government first excluded them from a 2% tax on corporate income in 1894, and later from the federal income tax in 1913,[4] their tax exemption was not questioned. However, as they started charging fees for their services and became more like other commercial service entities, their de facto exemption became less certain.

The Internal Revenue Service ("IRS") responded to this uncertainty by re-focusing its hospital exemptions on true non-profit or charitable work: first, by adopting the "charity care" standard in 1956,[5] and then establishing the "community benefit" standard in 1969, in response to the enactment of Medicare and Medicaid in 1965. This standard broadened community benefits beyond the provision of charity care to include the "promotion of

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[4] Paul Arnsberger et al., *A History of the Tax-Exempt Sector: An SOI Perspective,* IRS STATISTICS OF INCOME BULLETIN 105 (Winter 2008)

[5] IRS Revenue Ruling 56-185, 1956-1 CB 202, stated that, in order for a hospital to retain its tax-exempt status, it must provide care "to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."

health," so long as it was "deemed beneficial to the community as a whole." IRS, Revenue Ruling 69-545, 1969-2 CB 117. It reflects an understanding of the term that is consistent with the common law notion of "charitable health care" purposes. See Harvard Community Health Plan, Inc. v. Bd. of Assessors of Cambridge, 427 N.E. 2d 1159, 1163 (Mass. 1981)(where court, citing A. Scott, Trusts, §§368, 372; and G.T. Bogert, Trust & Trustees §374 (rev. 2d ed. 1977)), noted that "the promotion of health, whether through the provision of health care [meaning services delivered on a not-for-profit basis] or through medical education and research, is today generally seen as a charitable purpose"). More recently, the Affordable Care Act of 2010 specified that nonprofit hospitals must conduct a community health needs assessment and develop an implementation strategy to address identified needs every three years. (Rozier et al., March 2019).

Though New Jersey does not predicate its property tax exemption for hospitals on maintaining federal tax exemption under IRS 501(c)(3), nor does it tie such exemption to providing community benefits,[6] let alone mandate the provision of a minimum

[6] As of 2013, at least 25 states utilized some form of community benefit standard to determine property tax exemption: CA, DE, FL, IL, IN, ME, MD, MA, MS, MT, NV, NH, NM, NY, OH, PA, RI, SC, TX, UT, VA, WA, WV. See Martha H. Somerville, et al., *Hospital Community Benefits After the ACA: The State Law Landscape*, THE HILLTOP INSTITUTE (March 2013) (discussing that states have considered community benefits to mean contributions to improving

value of community benefits, there is little doubt that the federal requirements have influenced the policies and conduct of most of the not-for-profit hospitals operating in the State.[7]

The other body of literature that *Amici* have grouped together as Formal Corporate Status Impact on Costs and Health Outcomes, *infra* n.3, includes research and studies in which physicians and analysts have tried to determine the impact of the for-profit vs. not-for-profit corporate form on hospital procedures, employment, quantity and quality of care, and, more theoretically, on whether either corporate form is more "efficient." However, none of these studies goes beyond the formal status of non-for-profit hospitals, as entities that are typically governed by volunteer directors or trustees, with no shareholders. That is, even if one were able to conclude, for example, that not-for-profit hospitals charge lower costs for certain procedures than for-profit hospitals, one would not be able know whether that conclusion was driven by not-for-

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health care access and community health status as well as the fairness of their business practices).

[7] *Amici* assert that the Legislature would be permitted to utilize some form of community benefit standard for purposes of determining eligibility for the property tax exemption without offending the Exemptions Clause (as it was similarly able to define "hospital" to include other entities that provide health-related "caring" services to populations originally contemplated by the charitable property tax exemption). *Amici,* however, do not believe that the Legislature has the authority to either repeal the not-for-profit hospital property tax exemption in its entirety nor eliminate the prohibition against for-profit use.

profit hospitals that delivered care through their employees or contracted physicians or those that employed for-profit subsidiaries or contracted out whole departments to for-profit physician companies. *See* Issac Arnsdorf, *How Rich Investors, Not Doctors, Profit from Marketing Up ER Bills*, PROPUBLICA (June 12, 2020). *Amici* are not aware of any studies that, in effect, "pierce the corporate veil" when determining the impact of corporate status on a host of hospital policies and practices. *Cf.* (Jeruissen et al., 2021)(noting that physicians in Germany and England are mainly paid salaries; whereas in the United States, until recently, they were self-employed).

What is important for the Court's legal analysis (perhaps, especially for the court's consideration of the Uniformity Clause), is New Jersey's regulatory environment for acute care facilities. There are several requirements imposed on all hospitals in New Jersey concerning charity care, financial disclosure, and costs for the uninsured that are absent in many other states; and, which may minimize the differences between the two types of hospitals as a matter of fact rather than theory. They are:

1) N.J.S.A. 26:2H-8.64 (Penalty assessed against hospital for denial of admission or treatment based on ability to pay)(enacted in 1993 by L. 1992, c. 160 §14);

2) N.J.S.A. 26:2H-12.52 (Any hospital licensed by the Dept. of Health and Senior Services ("DHSS") cannot charge a

patient who is within 500 % of the FPL more than 115% above the Medicare reimbursement rate for a particular service);

3) N.J.A.C. 10:52-11.14 (Any hospital may not bill for services or initiate collection procedures against persons determined to be eligible for charity care. Persons determined to be eligible for reduced charge charity care may not be billed or subjected to collections procedures for the portion of the bill that is reduced charge charity care);

4) N.J.S.A. 26:2H-51(b)(Any hospital licensed by DHSS must report unaudited financial information, including information on joint ventures, investments etc. to DHSS on a monthly and quarterly basis);

5) N.J.A.C. 10:52-11.5(a) (Any hospital must provide patients with written notice of the availability of charity care, Medicaid, or NJ Family Care at either the time of service or no later than at the time the hospital issues the first bill to the patient, and all hospitals are required to post signs informing the public of the state's financial assistance program);and

6) The Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32. This Act provides enhanced protections for consumers (who are covered by New Jersey regulated insurance plans) for certain out-of-network bills, and imposes transparency and various disclosure requirements regarding costs on all health care providers, including hospitals. Effective January 1, 2022, the federal No Surprises Act will extend similar, and more rigorous protections to New Jersey residents covered by ERISA-regulated insurance plans. Together, both acts seek to shield patients from otherwise unanticipated high costs of care delivered by medical providers that are not within the patient's health plan network. Pursuant to both acts, advocates anticipate that all hospitals will work to ensure that the physicians that work within their four walls will participate in the same networks as the hospital itself. Until now, hospitals claimed they had no ability to impose such requirements on non-employee physicians working in the hospital.

Another real-life fact, perhaps because of the regulations mentioned above, is the relatively weak penetration of the for-

profit hospital industry in New Jersey. Unlike states such as "Texas, Florida and Nevada that have the highest percentage of for-profit hospitals, at just over 50%," (Karen Kahn, *How do Nonprofit and For-Profit Hospitals Differ? It's Complicated,* NONPROFIT QUARTERLY, (Sept. 2019), New Jersey's for-profits number around 16% of total acute care facilities. As of 1969, there were only three for-profit hospitals in New Jersey (plus 100 not-for-profit hospitals, and 40 governmental institutions).[8] Today, there are 69 acute care hospitals, 11 of which are for-profits, and one of which is governmental. *See* List on DHSS website at https://healthapps.state.nj.us/facilities/acFacilityList.aspx.

Several of the current for-profit hospitals in New Jersey emerged from conversions of financially strapped hospitals (starting in 2002), where for-profit investors purchased the hospitals out of bankruptcy proceedings at very low cost. The first nonprofit to convert to for-profit status, after many years during which there were no for-profit acute care hospitals operating in New Jersey, Salem Memorial Hospital, reverted to not-for-profit status in 2019 -- seventeen years after it had been

[8] Testimony of Jack Owen, New Jersey Hospital Association, Commission to Study the Laws of New Jersey Exempting Real Property Held By Religious, Educational, Charitable, and Philanthropic Organizations and Cemeteries From Taxation at 10. (Jan. 22, 1969) (Attached in Appendix).

sold to HCA, a nationwide for-profit hospital chain, in 2002.[9] And, just last month, Care Point Health announced that all three of its investor-owned hospitals in Hudson County will revert to not-for-profit status; but only after millions of dollars in profits were privatized since Bayonne Hospital converted in 2008, Hoboken University Hospital in 2011, and Christ Hospital in 2012. Joshua Rosario, *No sale! Care Point Health Founder Says Hospitals are Being Converted to Nonprofit*, JERSEY JOURNAL (Oct. 5, 2011).

This is the New Jersey environment, where three or four large nonprofit hospital systems (i.e., Atlantic Health System, RWJB Health System, Hackensack Meridian Health System, and Virtua Health Network) function together with a few smaller systems (e.g., Kennedy Jefferson Health System, Inspira Health Network, Prime Health Care and St. Joseph's Health Network) and several independent hospitals, only a handful of which are for-profit.

Under these circumstances, *Amici* see value in treating not-for-profit hospitals differently than for-profit hospitals for purposes of the property tax exemption, but only if the hospital is actually delivering its medical and public health services on a not-for-profit basis. Amici believe that not-for-profit hospitals have and still perform socially beneficial services that are worthy of subsidy through the tax system. However, once such

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[9] CN Letter from Commissioner Elnahal to William T. Colgen, dated Jan. 15, 2019. (Attached in Appendix).

entities mimic their for-profit counterparts and implement their charitable hospital mission by leasing whole departments to unaffiliated for-profit companies, infusing their corporate structure with for-profit subsidiaries, and/or contracting with independent physicians or incorporated physician groups (that are not subject to the billing practices and insurance network policies of the hospital), property tax exemption for the property used by such persons or entities should not be permitted as a matter of law and policy. Such activities are no longer the "charitable hospital" purposes for which the Constitution permits exemption.

It is within this New Jersey-specific context that the court must assess the constitutionality of the Legislature's amendments.

**LEGAL ARGUMENT**

The Exemption Clause, art. VIII, §1, ¶2 states:

> Exemption from taxation may be granted only by general laws. Until otherwise provided by law all exemptions from taxation validly granted and now in existence shall be continued. Exemptions from taxation may be altered or repealed, except those exempting real and personal property used exclusively for religious, educational, charitable or cemetery purposes, as defined by law, and owned by any corporation or association organized and conducted exclusively for one or more of such purposes and not operating for profit.

A review of the briefs submitted in this matter indicates that the State views the 2021 amendment to N.J.S.A. 54:4-3.6 as a benign change, simply because the Legislature has altered the not-for profit hospital tax to reflect a growing reality, i.e., the

use by not-for-profit hospitals of for-profit subsidiaries, unaffiliated physicians and other interlocking corporate entities to conduct their business. The State seemingly asserts that permitting such hospitals to conduct their business through the retention of for-profit providers of medical services working exclusively for the hospital (i.e., for "hospital purposes") is authorized, because the hospital property tax exemption pre-dated the 1947 Constitution, and can be altered as the Legislature desires.

On the other hand, even if viewed as a specific charitable exemption (subject to constitutional protection from alteration or repeal), the State argues that all the Legislature did was authorize hospitals (which, as a formal matter, operate on a not-for-profit basis because they have no shareholders) to implement their "hospital" mission by employing for-profit professionals, subsidiaries or unaffiliated corporations who operate on hospital property. Such special treatment of not-for-profit organizations organized exclusively for hospital purposes, in contrast to other charitable purposes, the State argues, is rational and justified because hospitals are "anchor" institutions in several New Jersey municipalities, providing jobs, and community benefits to the public at large. Viewed either way -- as a longstanding exemption existing prior to the 1947 Constitution or as an exemption given

to a specific type of charitable organization, -- the State's arguments are not constitutionally viable.

We begin by addressing the historically more accurate view of the hospital property tax exemption as an exemption given to hospitals as a specific type of charitable organization.

## I. N.J.S.A. 54:4-3.6(j) UNCONSTITUTIONALLY EXPANDS THE CHARITABLE, HOSPITAL PROPERTY TAX EXEMPTION.

In New Jersey, hospitals were first granted exemption from property taxes as not-for-profit institutions organized for charitable purposes in 1851. In 1913, the Legislature acknowledged, consistent with common law principles of charitable trusts and corporations, that not-for-profit entities organized exclusively for "hospital" purposes were entitled to exemption as a specific type of charitable corporation. A 1985 revision to the property tax exemption law made clear that the exemption applies to

> . . . all buildings, actually used in the work of associations and corporations organized exclusively for hospital purposes, provided that *if any portion of a building used for hospital purposes is leased to profit-making organizations or otherwise used for purposes which are not themselves exempt from taxation, that portion shall be subject to taxation* and the remaining portion only shall be exempt.
> (N.J.S.A. 54:4-3.6)(2020)(emphasis added.)

This statute, like its predecessors, restricted property tax exemption to buildings and land in and upon which the charitable, hospital work was conducted, with a focus on the actual use of the

property, not the owner. Cooper Hospital v. City of Camden, 68 N.J.L. 691 (E & A 1903). Properties used by for-profit operators to support hospital purposes or other charitable purposes were not exempt; only property that was used for exempt purposes and used or occupied by individuals or entities that operated on a not-for-profit basis was entitled to exemption.

This common law and statutory prohibition against for-profit use that existed prior to New Jersey's 1947 Constitution and since is embedded in the language of the Exemption Clause. Though the exact language of the Clause permits the Legislature to define the scope of "religious, educational and charitable purposes," it does not permit the Legislature to alter or eliminate the requirement that the property be actually used on a not-for-profit basis. Such language also makes it clear that if hospitals are to be exempt it is because their activities fall under the constitutional rubric of "charitable", the umbrella classification for the exemption. As a result, the Legislature's attempt to exempt from taxation property used by "a profit-making medical provider for medical purposes related to the delivery of health care services directly to the hospital" must fail. N.J.S.A. 54:4-3.6(j)(b).

### A. Not-for-profit Hospitals in New Jersey Are Considered Charitable Corporations

The test of whether an enterprise or institution is charitable

is whether it exists to carry out purposes recognized in law as charitable or whether it is maintained for gain, profit or private advantage." 14 C.J.S. CHARITIES §3 (1990). A charitable purpose must be for the public use or benefit, and it must be for the benefit of the public at large or a portion thereof, or for the benefit of an indefinite number of persons." Id. In re Estate of Butler, 137 N.J. Eq. 48, 50 (Prerog. Ct. 1945), *aff'd*, 137 N.J. Eq. 457 (E & A 1946).[10]

It "is well settled that the promotion of health is a charitable purpose" where operated on a not-for-profit basis. Austin W. Scott & William F. Fratcher, THE LAW OF TRUSTS 130 (Aspen, 1987); see also RESTATEMENT (THIRD) OF TRUSTS §28(d) (2003) (same); Edith Fisch, CHARITIES AND CHARITABLE FOUNDATIONS 275 (Lond Publications 1974)("T]he promotion of health is a valid charitable purpose in all American jurisdictions.") In New Jersey, providing health care to a large portion of the public or community as a whole on a not-for-profit basis is a charitable purpose. In re Pfizer, 33 N.J. Super. 242, 262 (Ch. Div. 1954)(where hospital provided care for the indigent and for the "protection of the public health" gift found appropriate). And, since their

[10] See also BLACK'S LAW DICTIONARY 212 (5th ed. 1979)(A charitable corporation is a corporation organized for charitable purposes, i.e., for purposes as promoting mankind at large or the community. "Charitable purposes" have as their "common element the accomplishment of objectives which are beneficial to [the] community or area.")

establishment in the late 1800s, hospitals have been considered charitable corporations. Paterson v. Paterson General Hospital, 97 N.J. Super. 514, 518 (Ch. Div. 1967)(holding that a not-for-profit hospital is "not strictly speaking, a charitable trust. It is rather a charitable corporation, governed by the laws applicable to charitable corporations."); 15 *Am. Jur. 2d* CHARITIES §168 ("the word 'hospital' in its popular usage denotes a charitable institution; it is only where income may be used for the profit of the owners that a hospital corporation ceases to be a charity"). See also Community Health Care Assets Protection Act, P.L. 2000, c. 143 (charitable nature of not-for-profit hospitals requires a charitable trust settlement upon conversion of a not-for-profit hospital to a for-profit entity)[11]

What is key to understanding the common law concept of a charitable hospital is that a tax-exempt entity cannot be owned nor operated on a for-profit basis, with surplus income going either to shareholders or individuals conducting for-profit business through the hospital. *See, e.g.*, Phillipsburg Riverview Org., Inc. v. Town of Phillipsburg, 26 N.J. Tax 167 (2011), *aff'd*

[11] Prior to approving the sale of a not-for-profit hospital to a for-profit entity, the Attorney General is required to determine whether "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." N.J.S.A. 26:2H-7.11(b).

27 N.J. Tax 188 (App. Div. 2013)(holding that non-profit arts center was not entitled to tax exempt status where it gave space to private galleries and artists to engage in their own commercial activity). As in the case of any alleged exempt entity, the provision of health care on a for-profit basis or to generate private, individual gain is not considered a charitable purpose.

One does not have to close one's eyes to the transformation of medicine, health care and hospitals since the mid-1800s, so well documented by Judge Bianco in AHS Hospital Corp. v. Town of Morristown, 28 N.J. Tax 456 (Tax Court 2015) (hereinafter, "AHS Hospital Corp."), to insist that the property tax exemption available to New Jersey hospitals (if they meet certain criteria) is given to them because of their status as charitable institutions.[12]

**B. The History of N.J.S.A. 54:4-3.6 Indicates that Hospital Purposes Mean Charitable Hospital Purposes.**

[12] A not-for-profit hospital in New Jersey is also exempt from state sales and use tax as a corporation organized "exclusively for charitable purposes." N.J.S.A. 54:32B-9(b). Whereas it enjoys a limited form of charitable immunity as a not-for-profit entity organized exclusively for hospital purposes. N.J.S.A. 2A:53A-7 to -11. See Bieker v. Community House of Moorestown, 327, N.J. 467, n.1 (App. 2000)(where court explains that prior to a 1995 amendment, the Charitable Immunity Act formerly set forth a hospital's immunity in the same language as the immunity provided not-for-profit entities organized exclusively for religious, educational or charitable purposes), rev'd on other grounds, 169 N.J. 167 (2001). In both cases, not-for-profit hospitals are considered charitable corporations rendering "hospital" purposes used in either context to mean "charitable, hospital purposes."

The history of N.J.S.A. 54:4-3.6 indicates that the exemption granted to not-for-profit entities organized for "hospital purposes" was a specific form of charitable exemption and, after 1947, was always understood to follow the constitutional requirement that an exempt property be used for religious, educational or charitable purposes. As the Appellate Division stated in Presbyterian Home at Pennington, Inc. v. Borough of Pennington, 409 N.J. Super. 166 (App. Div. 2009),

> [T]he framers of the 1947 Constitution clearly understood hospital purposes to be part of the charitable, religious, and educational tradition encompassed within the brief language of the Exemptions Clause.
> (Id. at 187).

Although the Appellate Court in Presbyterian Home at Pennington went on to characterize hospital purposes as "distinguishable from charitable ones," a review of the statutory history of N.J.S.A. 54:4-3.6, first enacted in 1941, indicates that hospital purposes, like other purposes listed (e.g. educational, public library, prevention of cruelty to animals, moral and mental improvement of men, women and children, etc.) were, and still are, "distinct" types of religious, educational, benevolent and/or charitable purposes under common law; and that is why they were grouped together. N.J.S.A. 54:4-3.6 does not represent just any string of not-for-profit organizations whose property may be eligible for tax exemption; rather, the property

exempted in this statute is owned and actually used by entities organized for specific types of charitable, educational, benevolent or religious purposes.

According to the detailed history presented in AHS Hospital Corp., hospitals were able to satisfy the requirements under the first property tax exemption statute in New Jersey (enacted in 1851), as institutions "used exclusively for charitable purposes." Id. at 43. In 1903, the statute "continued to focus on the use and income of charitable institutions in granting tax exemption to: `[A]ll buildings used exclusively for purposes considered charitable under common law.'" Id. at 52.

By 1913, however, the statute changed and became more detailed than previous iterations. For the first time, it provided property tax exemption for "[a]ll buildings actually used for . . . corporations organized exclusively for . . . religious, charitable, benevolent or hospital purposes; or for one or more such purposes, *not conducted for profit*." Id. at 55 (emphasis added). Although the statute listed hospital purposes separate from charitable purposes, it also kept the exemption for "all buildings used exclusively for purposes considered charitable under common law." Ibid.

On its face, the statute thus seems redundant, since at the time, operating a hospital on a not-for-profit basis was considered a charitable purpose under common law. Nonetheless, perhaps the

Legislature maintained this phrase in an attempt to be comprehensive and capture any future changes in the common law.

The fact that the property tax exemption was specifically available for buildings actually used for "hospital purposes" apart from "charitable purposes" or "buildings used exclusively for purposes considered charitable under common law" does not deny the conclusion that not-for-profit hospitals were at that time, and still today, considered charitable corporations under common law. *See* City of Long Branch v. Monmouth Medical Center, 138 N.J. Super. 524, 526 (App. Div. 1976)(noting that hospital was incorporated originally in 1889 pursuant to "An act to provide for the incorporation of associations for the erection and maintenance of hospitals, infirmaries, orphanages, asylums and other charitable institutions" P.L.1887, c.103.) It simply means that the Legislature decided to itemize a specific type of charitable institution rather than rely solely on the general term "charitable" to exempt property actually used for hospital purposes. And, as we know, by 1941, N.J.S.A. 54:4-3.6 (which was in effect when the framers adopted the 1947 Constitution) specified a growing number of purposes, all of which were considered charitable, religious, benevolent or educational under common law.

Another aspect of the 1913 law, also appearing in the 1918 property tax exemption law,[13] the 1941 version thereof (i.e., N.J.S.A. 54:4-3.6), and its current iteration, is the notion that the property tax exemption for a building would not be defeated if

> the charitable, benevolent or religious work therein . . . is supported partly by fees and charges received from or on behalf of the beneficiaries using or occupying said building provided the building is wholly controlled and the entire income therefrom is used for said charitable, benevolent or religious purpose.
> Id. at 57.

The absence of "hospital purpose" distinct from charitable purpose in this qualification is telling. This is because if the property tax exemption provided to associations and corporations organized exclusively for hospital purposes was separate from and distinguishable from charitable purposes, this phrase, still included within N.J.S.A. 54:4-3.6, would certainly have been changed. But it has not been changed. And, *Amici* assert that it has not been changed because, under common law, the fact that a hospital, medical facility, or similar institution charges a fee

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[13] The 1918 statute dropped the phrase "buildings used exclusively for purposes considered charitable under common law," but restored the exclusivity requirement to "All buildings actually and exclusively used in the work of associations and corporations organized exclusively for the moral and mental improvement of men, women or children or for religious, charitable or hospital purposes." Id. at 55 (emphasis added). The Legislature, however, in 1985, again eliminated the requirement that property owned by a corporation organized exclusively for an exempt purpose be "exclusively" used for that purpose, permitting proportional tax exemption of property used for exempt and non-exempt purposes. P.L. 1985, c. 395.

for its services or for the use of its facilities does not prevent the institution from being charitable. RESTATEMENT (THIRD) OF TRUSTS §28, Comment a(1) (2003).

Based on the above analysis of N.J.S.A. 54:4-3.6 and its predecessors, one can reasonably conclude that the hospital property tax exemption under New Jersey law has always been understood as a subset of the charitable exemption -- prior to the creation of the 1947 Constitution and after. And, it is this conclusion that explains why so many New Jersey not-for-profit hospitals are actually organized for charitable purposes under Title 15A, and not hospital purposes. E.g., Hunterdon Med. Ctr. v. Township of Readington, 195 N.J. 549 (2008) (where HMC, incorporated under Title 15A, owned and operated a general acute-care facility and related ancillary facilities and services, and was organized for charitable purposes).[14]

More important for purposes of this litigation, the conclusion that the hospital property tax exemption is a specific type of charitable property tax exemption places it squarely withing the third sentence of the Exemptions Clause that exempts "real and personal property used exclusively for religious, educational, charitable or cemetery purposes." Accordingly, any

[14] *Amici* acknowledge that eligibility for the federal income tax exemption as a 501(c)(3) organization is also driving New Jersey hospitals' decisions to incorporate for charitable, and not hospital, purposes.

changes to such exemptions are constrained by the Constitution's requirement that exempt property must be "owned by any corporation or association organized and conducted exclusively for one or more of such purposes and *not operating for profit*." art. VIII, §1, ¶2 (emphasis added).

### C. Actual Not-For-Profit Use of Hospital Property Is Required For Exemption of Property "Used Exclusively for Hospital Purposes."

In Bancroft Training School v. Haddonfield, 82 N.J.L. 192 (Sup. Ct. 1911), the Court found that the 1903 Tax Act showed a clear legislative purpose to exempt

> charities which are charitable in fact, although they may be partly supported by fees received from beneficiaries who are able to pay them, and to exclude from the privilege of exemption those enterprises which may be benevolent in spirit but what are concluded for private gain.

As noted by Judge Bianco in AHS Hospital Corp., the court in Bancroft aptly concluded that "[a] charity conducted for profit would be an anomaly both in law and ethics." AHS Hospital Corp. *supra*, 28 N.J. Tax at 54. That anomaly now exists. By adopting N.J.S.A. 54:4-3.6(j), the New Jersey Legislature has now authorized a charitable hospital to conduct its operation by retaining unaffiliated "profit-making" medical providers to use and occupy its buildings in order to deliver hospital services to the public, and still retain its property tax exemption.

N.J.S.A. 54:4-3.6(j) reads in relevant part:

> b. If any portion of a hospital or a satellite emergency care facility is leased to or otherwise used by a profit-making medical provider for medical purposes related to the delivery of health care services directly to the hospital, that portion shall be exempt from taxation, provided that the portion of the hospital or satellite emergency care facility is used exclusively for hospital purposes.

This amendment defies both the common law definition of a charitable hospital and logic. As noted above in Point IA, the property of an institution organized exclusively for "hospital purposes" is not exempt unless it provides such hospital services on a not-for-profit basis, something it cannot do by delivering those services through profit-making medical providers (in contrast to employees or independent contractors appropriately constrained by hospital policies and regulations, including billing practices). It also makes no sense linguistically to declare, as the Legislature has done in the Bill being challenged herein, that a for-profit provider conducts his business "exclusively for hospital purposes" when such purposes are required to be conducted on a not-for-profit basis, and the provider is by definition operating for his own personal gain. The statutory amendment, on its face, contradicts the constitutional requirement that the exempt property be operated as a charitable institution.

The sentiment against granting a property tax exemption for buildings used for private gain, whether owned by a corporation

organized exclusively for a charitable purpose, such as the establishment of a hospital (owned and operated by a not-for-profit entity), appeared in all versions of the property tax exemption statute enacted prior to the adoption of the Constitution in 1947; and, it continued to do so until 2021. The former statutes are able to inform one's understanding of what the framers of the Constitution meant when they included the words "must operate as nonprofit" in the Exemption Clause; and the latter statutes are able to support one's conclusion that post-1947 revisions to N.J.S.A. 54:4-3.6 have, until now, satisfied constitutional norms.

Early in the Twentieth Century, New Jersey courts started to make clear that property tax exemptions were restricted to buildings in, and lands upon which charitable work was conducted, with a focus on the actual use of the property, not the owner. *E.g.*, Cooper Hospital v. City of Camden, 68 N.J.L. 691, 707 (E & A 1903)(standing for the principle that "mere ownership of land by a charitable institution does not exempt the land, and that its exemption depends upon its actual devotion to the work of the charity" [citations omitted]). Subsequently, courts have advanced and applied this proposition by holding that property owned by a charitable organization, but used by for-profit operators to implement, support or further that organization's exempt purpose is also not exempt. *See, e.g.*, AHS Hospital Corp., *supra*, 28 N.J. Tax at 94-136 (finding physician contracts permitting revenue

sharing and other third-party agreements with medical service providers demonstrated a profit-making purpose inconsistent with N.J.S.A. 54:4-3.6); Hunterdon Med. Ctr. v. Township of Readington, 195 N.J. 549, 562 (2008)(*quoting* Paper Mill Playhouse v. Twp. of Millburn, 95. N.J. 503, 506 (1984) that ". . . operation and actual use of property must not be conducted for-profit" to be exempt). And more recently, since the Legislature's revision of N.J.S.A. 54:4-3.6 in 1985, P.L.1985, c.395, the courts have made clear that the elimination of the "exclusive use" requirement in the statute still does not permit a charitable or otherwise exempt organization to conduct for-profit activities in a "commingled fashion on its owned and occupied property." Int'l Schools Services, Inc. v. West Windsor Twp. 207 N.J. 3, 23 (2011)(noting that the statutory change "means that property of a nonprofit exempt-entitled entity can be used for non-exempt purposes so long as the two purposes can be separately stated and accounted for and so long as the non-exempt use is never subject to the property tax exemption").

This consistent statutory prohibition against for-profit use, which existed prior to New Jersey's 1947 Constitution and since, is embedded in the explicit language of the Exemption Clause itself (i.e., "owned by any corporation or association organized and conducted exclusively for one or more of such purposes *and not operating for profit.*"). Though the phrase, "defined by law"

permits the Legislature to define the scope of "religious, educational and charitable purposes,"[15] nothing in the wording of the Clause permits the Legislature to eliminate the longstanding requirement that the property to be exempt must be used on a not-for-profit basis.

As a result, the Legislature's attempt to exempt from taxation property used by "a profit-making medical provider for medical purposes related to the delivery of health care services directly to the hospital," N.J.S.A. 54:4-6(j)(b), violates the Exemption Clause. If permitted to stand, adherence to the amendment may even put the corporate status of many not-for-profit hospitals at risk. This is the case because New Jersey's property tax exemption law, as amended, now authorizes and promotes the use of unaffiliated medical providers, often themselves employed by for-profit equity companies (and the use of other profit-making entities), thus interjecting individual private gain directly into the hospital's operation in direct contradiction of the constitutional requirement that such exempt properties have a "charitable" purpose. In this way, the amendment to the property tax exemption law facilitates for-profit activity that also

[15] See e.g., P.L. 2001 c. 18, §1 amending the statute to define what types of facilities are to be considered as "hospital purposes."

violates Title 15A's prohibition against private inurement. N.J.S.A. 15A:2-1(d).[16]

## II. VIEWED SIMPLY AS A PROPERTY TAX EXEMPTION FOR NOT-FOR-PROFIT HOSPITALS THAT EXISTED PRIOR TO THE 1947 CONSTITUTION, THE STATUTE VIOLATES THE CONSTITUTIONAL UNIFORMITY MANDATE.

In order to defend the validity of the Bill, the State assiduously avoids acknowledging that, for purposes of determining whether N.J.S.A. 54:4-3.6(j) comports with the Exemption Clause, "hospital purposes" means "charitable hospital purposes." By doing so, it simply asserts that because the tax exemption given to real property used by not-for-profit organizations exclusively for hospital purposes pre-dated the 1947 Constitution, it falls within the ambit of the second sentence of the Exemption Clause. As such, it is not protected by the third sentence of the Clause and "may be altered or repealed" as the Legislature sees fit.

This interpretation of the Exemption Clause, however, creates a different constitutional problem. By eliminating the

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[16] *Amici* also note that there is nothing about the practice of modern medicine or the operation of the modern hospital that requires it to operate within a maze of corporate structures, "intertwined with both non-profit and for-profit subsidiaries and unaffiliated corporate entities," as described by the court in AHS Hospital Corp., *supra*, 28 N.J. Tax at 4. These complicated structures may be more a creation of corporate lawyers finding ways for the hospital to receive favorable tax treatment while still finding obscure ways to siphon off private gain for the executives, management and others involved in the actual operation of the hospital. There are alternative ways to deliver health care to the public that do not involve individual profiteering.

third prong of the Paper Mill Playhouse test, the Legislature has violated the Uniformity Clause by effectively granting all New Jersey not-for-profit hospitals exemption from the property tax based on the corporate status of the hospital owner, and not on the use of their property. In other words, a special class of exemption for a specific group of entities acting commercially, though incorporated as "not-for-profit", now exists in violation of the Uniformity Clause.

*N.J. Const.* art. VIII, §1, ¶1(a) contains the following mandate:

> Property shall be assessed for taxation under general laws and by uniform rules. All real property assessed and taxed locally or by the State for allotment and payment to taxing districts shall be assessed according to the same standard of value, except as otherwise permitted herein, and such real property shall be taxed at the general tax rate of the taxing district in which the property is situated, for the use of such taxing district.

This provision, known as the Uniformity Clause, was included in the 1947 Constitution in response to the preferential tax treatment of real property given to the railroad industry by statute and judicial decision. N.J. League of Municipalities v. Kimmelman, 105 N.J. 422, 431 (1987).

The first component of the clause -- that all property be taxed by general laws and uniform rules -- is almost identical to the analogous provision in the 1844 New Jersey Constitution, as amended in 1875, that stated:

> Property shall be assessed for taxes under general laws, and by uniform rules, according to its true value. 1844 *N.J. Const.*, art. IV, §7, ¶12

Under both constitutions, judicial decisions construing these provisions have found taxation or tax exemption to be valid "so long as there [is] compliance with the classification rule that all reasonably within the class are included, [and] that uniformity prevail throughout the whole class." N.J. League of Municipalities v. Kimmelman, *supra*, 105 N.J. at 429. In this way, "equality of treatment in sharing the duty to pay real estate taxes [in New Jersey] is a constitutional right." Township of West Milford v. Van Decker, 120 N.J. 354, (1990)(quoting Murnick v. Asbury Park, 95 N.J. 452, 458 (1984)).

Furthermore, courts have consistently held that the classification among similarly situated taxpayers must be of their property, according to its characteristics or the use to which it is put, and not according to their own personal status. *See, e.g.*, Teaneck Tp. v. Lutheran Bible Institute, 20 N.J. 86 (1955)(noting that "in matters of tax exemption the use to which the property is devoted is the essential consideration and not the character or status of the owner."); N.J. Turnpike Authority v. Washington Tp., 16 N.J. 38 (1954)(holding that tax exemption statutes, "if based on the personal status of the owner rather than on the use to which the property is put, run afoul of the" first component of the Uniformity Clause in the 1947 Constitution and its 1844

predecessor); Tippett v. McGrath, 70 N.J.L. 110 (Sup. Ct. 1903), aff'd, 71 N.J.L. 110 (E & A 1904)(holding that tax exemptions based on personal status of property owners and not upon any characteristic possessed by the property itself or upon the uses to which the property is put are void).

Given these principles, N.J.S.A. 54:4-3.6(j) violates the Uniformity Clause. There is little doubt that by eliminating the third prong of the Paper Mill Playhouse test, which requires that a not-for-profit corporation's "operation and use of its property . . . not be conducted for profit" in order to receive a tax exemption, the statute now bases the exemption solely upon the not-for-profit status of the hospital, not the use of its property. "Hospital purposes" no longer mean "charitable hospital purposes" or "hospital purposes delivered on a not-for-profit basis," but rather "hospital purposes delivered directly by profit-making medical providers." As such, there is no rational basis to exclude from tax exemption for-profit corporations that also use their property exclusively for "hospital purposes," and often operate in the same manner as some of the large not-for-profit health systems in the State, such as AHS Healthcare Systems.[17] No finding of fact

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[17] *See* Robert Pear, *Tax Exemptions of Nonprofit Hospitals Scrutinized*, N.Y. TIMES, Dec. 18, 1990, at A1, in which the author writes:

> Health-care economists and Federal officials say it is often hard to distinguish between tax-exempt nonprofit

was made in the Bill that the "not-for-profit" hospitals operate in any way materially different from the "for-profit" hospitals, or provide more extensive community services, rendering the grant of a tax exemption to the "not-for-profits" without Legislative findings adequate to support the distinction under the Uniformity Clause as well as general equal protection doctrine.

The State's defense of the Bill seems to be no more than that New Jersey's not-for-profit hospitals are "anchor" institutions in their communities, and because they have no private investors or shareholders and do not issue dividends, they are deserving of tax exemption. Hiding behind the hospital's corporate status as a not-for-profit, however, is no defense at all. The Uniformity Clause prohibits giving a tax exemption based on the personal or corporate status of the property owner, rather than on the use of its property, and for that reason alone, N.J.S.A. 54:4-3.6(j) is void.

Furthermore, in New Jersey, where all hospitals regardless of corporate status are required by statute or regulation to provide charity care, limit charges to uninsured patients, refrain from balanced billing in some circumstances and submit to DHSS unaudited financial reports, among other things, there is no factual basis

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hospitals and investor-owned profit-seeking hospitals. In a fiercely competitive environment, many nonprofit institutions now engage in commercial activities, establish profit-seeking subsidiaries, form joint ventures with private physician groups and try to expand their share of the local health-care market.

for the unequal treatment; that is, unless and until New Jersey not-for-profit hospitals refrain from mimicking their for-profit counterparts and decide to operate their hospitals on a genuine not-for-profit basis they should, as a constitutional matter, be denied the property tax exemption otherwise reserved for charitable corporations.

## III. P.L. 2021, Chapter 17 CONSTITUES SPECIAL LEGISLATION PROHIBITED BY *N.J. Const.* art. IV, § 7, ¶ 9.

Special legislation is constitutionally barred because it favors a narrow class and excludes others that could equally benefit from the enactment; absent a rational distinction to support the exclusion, the Bill must fail. *See, e.g.*, Horizon Blue Cross Blue Shield of N.J. v. State, 425 N.J. Super. 1, 14 (App. Div. 2012)(the inquiry as to "special legislation" "must be whether any other entity should have been included . . ."). To determine whether there is a sufficient basis to justify special legislation, the court must determine if the favored group has distinct characteristics that justify creating a class unique to itself:

> A statute is not special legislation if the class established has characteristics sufficiently marked and important to make it a class by itself, it encompasses all of the subjects that reasonably belong within the classification, and it does not exclude any that naturally belong within the classification.

Horizon Blue Cross Blue Shield of N.J. v. State, *supra*, 425 N.J. Super. at 17.

To support a special enactment, the class receiving the benefit — hospitals organized as not-for-profit corporations engaging in commercial conduct — must have unique characteristics that would justify failing to extend the benefit to other not-for-profit entities that also have commercial attributes. If the State cannot demonstrate such distinct "characteristics" of the favored class, then the Bill will be deemed "special" legislation and will be unconstitutional.

Many not-for-profits share the hybrid commercial and non-profit characteristics of hospitals yet have not been given the benefit of property tax exemption as are hospitals under N.J.S.A. 54:4-3.6j. For example, not-for-profit counseling centers provide either discounted or free services but are not within the category of landowners favored with exempt status. Not-for-profit law firms, such as public interest organizations, generally do not receive tax exempt status though their business is subsidized with grants used to defray costs of litigation for the public benefit. Colleges and universities engage in hybrid commercial activity such as patent licensing, sponsored research or the lease of the campus for commercial medical services but are still subject to a loss of exemption on those properties used for such profit-making activities.

As the Municipalities in this case point out, houses of worship that lease space to for-profit entities or allow profit-

making activity on their grounds from caterers and the like are equally at risk of losing exempt status. Plaintiffs' Br. at 32. Art centers that give space to artists to sell commercial products have been deprived of tax-exempt status. *See, e.g.*, Phillipsburg Riverview Org., Inc. v. Town of Phillipsburg, *supra*, 26 N.J. Tax at 167 (depriving non-profit arts center of exempt status where it leased space to commercial artists and galleries). Only hospitals, however, are guaranteed by N.J.S.A. 54:4-3.6j the right to engage in such commercial activity without the loss of exempt status that any other not-for-profit would suffer. Clearly, the statute is a form of special legislation.

The New Jersey Supreme Court has established a three-part test to determine when a law violates the prohibition against special legislation. A court must examine: "(1) the purpose and subject matter of the statute; (2) whether any persons are excluded who should be included; and (3) whether the classification is reasonable, given the purpose of the statute." Jordan v. Horsemen's Benevolent & Protective Asso., 90 N.J. 422, 432-33 (1982) (citing Vreeland v. Byrne, 72 N.J. 292, 298-301 (1977)).

As to the first prong, N.J.S.A. 54:4-3.6j is plainly directed to benefitting the narrow and specific class of "not-for-profit" hospitals whose tax-exempt status was lost as a result of Judge Bianco's holding in AHS Hospital Corp., supra, 28 N.J. Tax at 456. Nowhere does the State dispute that the purpose and rationale for

the enactment was to specifically give a benefit to the not-for-profit hospitals who lost such benefit under Judge Bianco's holding. Being directed to protecting one narrow class of landowners who lost their exempt status in litigation, the "purpose and subject matter of the statute", Jordan, *supra*, 90 N.J. at 432-33, is undoubtedly to provide a "special" benefit.

As to the second prong, i.e., "whether any persons are excluded who should be included", it is clear from the discussion above that vast numbers of not-for-profit entities in New Jersey are imbued with a mix of charitable and commercial activities yet only "not-for-profit" hospitals are given a guarantee of exempt status. Plainly, the second prong of the Jordan test is satisfied.

As to the third prong, "whether the classification is reasonable", no evidence is proffered as to why non-profit hospitals are to be exempt from taxation simply because they exist in a not-for-profit corporate form where they engage in virtually the same activities as "for-profit" hospitals. Both "for-profit" and "not-for-profit" hospitals follow a near-identical business model, i.e., accepting and treating patients for payment directly and payment through patients' insurance companies, the licensing of space such as the emergency room to for-profit medical practices, the granting of privileges to physicians to bill patients at the hospital and both are obligated to provide the same public care and charitable regulations under New Jersey law.

Hence, there can be no material distinction between their business operations that justify giving one the exemption and not the other. Accordingly, it would appear that the Bill fails the third prong as it cannot rationally discriminate between the favored and the non-favored groups. *See, e.g.*, N.J. State Firemen's Mut. Benev. Ass'n v. N. Hudson Reg'l Fire & Rescue, 340 N.J. Super. 577, 587-590 (App. Div. 2001)(statute was declared illegal "special" legislation where it provided paid convention leave to members of certain fraternal groups but not to others who could equally benefit).

For the foregoing reasons, N.J.S.A. 54:4-3.6j violates the ban on special legislation and is unconstitutional.

## IV. THE BILL IS NOT REMEDIAL LEGISLATION AS IT DOES NOT SEEK TO REMEDIATE A SOCIAL OR SOCIETAL HARM OR "EVIL" OR PROTECT CONSUMERS OR OTHER VULNERABLE MEMBERS OF SOCIETY FROM ABUSIVE PRACTICES.

The Attorney General argues that the recent legislative changes are a mere "remedial" statute that should be given wide latitude and deference by the court. This argument ignores the longstanding rule that "remedial" legislation is designed to correct a social or societal "evil". *See, e.g.*, Masel v. Paramus Borough Council , 180 N.J. Super. 32, 40 (App. Div. 1981); Hirl v. Bank of Am., N.A. , 401 N.J. Super. 573, 584, (App. Div. 2008)(("'Remedial' statutes are liberally construed to suppress the evil and advance the remedy.")

A statute is remedial in nature where it is designed to provide protection for a class from a societal or business harm that could not otherwise be remedied. *See, e.g.*, Hirl v. Bank of Am., N.A., *supra*, 401 N.J. Super. at 584 (protection of consumers through legislation is always deemed remedial); Hargrove v. Sleepy's, LLC , 220 N.J. 289, 309 (2015)(noting that the Conscientious Employee Protection Act ("CEPA"), designed to protect a whistleblower employee from retaliation, is deemed remedial and entitled to liberal construction); Shelton v. Rest..com, Inc. , 214 N.J. 419, 443 (2013)(holding that the goal of protecting consumers under the Truth-in-Consumer Contract, Warranty and Notice Act ("TCCWNA") rendered the legislation "facially remedial").

Common to all of these decisions is the objective of eliminating a particular harm to a class of persons, the "evil" that the new statute seeks to remedy. Masel v. Paramus Borough Council, *supra*, 180 N.J. Super. at 40. It is because the statute corrects a prior pattern of abuse or injury that it is deemed remedial, not merely because it purports to effect a change in the law or to confer a benefit upon a narrow class, as with the hospital tax-exemption amendment at issue here.

N.J.S.A. 54:4-3.6j does not correct a prior societal or business harm but, instead, seeks to overrule Judge Bianco's holding in AHS Hospital Corp., *supra*, 28 N.J. Tax at 456, that

not-for-profit hospitals that engage in for-profit activities, or make their premises open to for-profit activities, are not within the scope of N.J.S.A. 54:4-3.6. A legislative effort to nullify a judicial interpretation is not a "remedial" enactment, but, in this case, is an effort to confer a benefit upon a narrow and discrete class, the "not-for-profit" hospitals that engage in commercial or for-profit activity.

The Bill cannot be deemed "remedial" for yet another reason: "remedial" statutes are to be liberally construed, Hirl v. Bank of Am., N.A., *supra*, 401 N.J. Super. at 584 ("The EFTPA is remedial legislation that should be construed liberally to effectuate its purpose to protect consumers"), whereas property tax exemption is a narrow grant that is always to be strictly construed. Int'l Sch. Servs., Inc. v. W. Windsor Tp., *supra*, 207 N.J. at 15, ("It is a fundamental legal tenet that a statute granting exemption from property taxation, such as *N.J.S.A.* 54:4-3.6, is subject to strict construction."), citing Princeton Univ. Press v. Borough of Princeton, 35 N.J. 209, 214, (1961); see also Hunterdon Med. Ctr. v. Twp. of Readington, supra, 195 N.J. at 569 (explaining that tax exemptions should be strictly construed against claimants to extent consistent with legislative intent).

As this analysis shows, N.J.S.A. 54:4-3.6j is not a "remedial"

statute and the State's argument to the contrary is without substantial support.[18]

**CONCLUSION**

For all the foregoing reasons, *Amici Curaie* assert that N.J.S.A. 54:4-3.6j is unconstitutional and should be declared void.

Respectfully submitted,

Dated: November 5, 2021

/s/RenéeSteinhagen
Renée Steinhagen, Esq.
NEW JERSEY APPLESEED

-and-

Dated: November 5, 2021

/s/Bruce Afran
Bruce Afran, Esq.

Attorneys for *Amici Curiae*

[18] The State's additional claim that the court in Presbyterian Home at Pennington, Inc. v. Borough of Pennington, *supra*, 409 N.J. Super. at 166 held that extension of exempt status to long-term care facilities was a "remedial" act is unsupported by the Appellate Division decision. Nowhere in Presbyterian Home is there any reference to the statute being "remedial" nor could there be in light of the clear doctrine that tax exemption acts must be narrowly and strictly construed, the very opposite of a liberal construed "remedial" act.

P U B L I C  H E A R I N G

New Jersey Legislature before
COMMISSION TO STUDY THE LAWS OF NEW JERSEY EXEMPTING REAL PROPERTY HELD BY RELIGIOUS, EDUCATIONAL, CHARITABLE, AND PHILANTHROPIC ORGANIZATIONS AND CEMETERIES FROM TAXATION, [created under Assembly Concurrent Resolution No. 42].



Held:
January 22, 1969
Assembly Chamber
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Chester Apy, Chairman
Senator Wayne Dumont, Jr.
Senator Alfred N. Beadleston
Senator Norman Tanzman
Assemblyman Webster B. Todd, Jr.
Russel T. Wilson
William H. McLean
Canon Stuart F. Gaust
Paxson Keats
Roy Cotton



* * * *

be more meaningful and fair, and New Jersey will be a better place for all of us to live.

And if any other members of the Commission wish to make any statements at this time, by way of general background or elucidation or add to what I have said, I invite them to do so.

I note, incidentally, that Senator Tanzman has joined us, seated over with Senator Beadleston. I welcome him. And on the other end, Assemblyman Todd - Good morning.

If not, I will ask the witnesses, as we call them, to come up to the desk here with the lowered microphone and if any of you have a prepared statement to submit it to us. If there are enough copies for the members of the Commission, we would like to distribute it; if not, if you will hand it to the Chairman, we will then have it available for those who are transcribing the hearing.

I would like to call first on Jack W. Owen, representing the New Jersey Hospital Association, to testify.

J A C K  W.  O W E N: Thank you, Mr. Chairman. I would like to read from a prepared statement which I think you have in front of you, dealing with the concepts of hospital exemption, and then answer any specific questions that you might have following this presentation.

My name is Jack W. Owen and I am the Executive Vice President and Director of the New Jersey Hospital Association. The New Jersey Hospital Association serves as a representative for the 140 hospitals in New Jersey. Of this number, 100 are voluntary, not for profit, hospitals who are tax exempt under the existing statutes and regulations.

I am pleased to have the opportunity to justify the exemption of voluntary, nonprofit hospitals from real property tax. In accordance with your charge, I shall approach this vital question both as a sound philosophical concept and as an economic fact of Twentieth Century life with far-reaching consequences.

When our legal structure began to take shape in feudal times, the Church constituted the sole existing organized charity, operating and maintaining institutions of learning, hospitals and asylums. While this system was highly decentralized and disjointed, it was deemed adequate for feudal society.

During the Fourteenth Century, however, with the advent of the commercial system supplanting the economically self-sufficient manor, the rural peasant became the poverty-stricken inhabitant of the city. Contemporaneously, the Reformation curtailed Church participation in organized charity and the subsequent outgrowth of secular charities was woefully inadequate to meet the needs of a changing society.

During the reign of Elizabeth I, the first Poor Laws were passed, marking entry of the Crown into organized charity. Subsequently, the Statute of Charitable Uses authorized the Chancellor to oversee charitable funds and uses. This marked the first active participation by society through government in organized charity which, along with a common concern for charitable uses and purposes, has continued to this day.

Thus the concept of organized charity as we know it today, and more specifically the care of the sick and needy, has existed as an integral part of society for nearly a thousand years.

While the growth of the voluntary community hospital system has been phenomenal, the beginnings were as humble as they were highly motivated. One hundred years ago there were virtually no institutions in New Jersey providing care for the sick and injured. Throughout the State, groups of concerned and responsible citizens established the voluntary hospital, designed for and dedicated to the care of the sick and injured without regard for race, creed,

color, or ability to pay. This concept, conceived by public spirited citizens at the community level, has grown to a system of more than 100 voluntary, nonprofit hospitals. Today these hospitals perform a community service for all people, regardless of their ability to pay.

Both our Federal and State Governments have since the earliest times favored, fostered, and encouraged the classic charitable uses and purposes to which I have referred. The justification for this was not only the highly motivated and necessary character of the services rendered but also that organized charity benefits society as a whole.

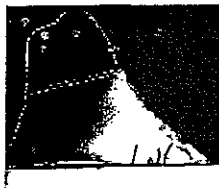
A classic legal definition of "charity" is a gift to be applied consistently with existing laws for the benefit of an indefinite number of persons, either by bringing their hearts under the influence of education and religion, by relieving their bodies from disease, suffering, or constraint, by assisting them to establish themselves for life, or by erecting and maintaining public buildings or works, or otherwise lessening the burdens of government. The reason for hospital exemptions is that care of the sick and needy is essential to public welfare and this need cannot be fully met by reliance solely on private hospitals operating from a profit motivation. The fact that some patients pay more than actual cost is immaterial if this income is used for care of the sick and disabled since this is a logical extension of the charitable purpose. Tax exemption for charitable hospitals encourages and facilitates their performance of a government duty which would otherwise have to be performed by the State.

While our New Jersey Courts have followed the general principle that the burden of taxation should fall equally upon all, they have long recognized the need for certain exemptions deriving from favored legislation. The well established theory for this "concession" is that it is due as quid pro quo for the performance of a service essentially public and which the State is thereby relieved pro tanto from the necessity of performing, that is works of charity and education freely and charitably bestowed. Under New Jersey Law, exemption or freedom from the burden of enforced contribution to expenses and maintenance of government must of necessity clearly serve a public purpose contemplated by the Statute.

Historically, our communities have relied upon hospitals to meet their obligation to care for the sick and needy. This is still the case. The voluntary, nonprofit hospital in New Jersey has assumed a burden of local government in that it has never received full reimbursement for care of patients who are the responsibility of the community. As recently as November 1968 this Association retained the services of Arthur Andersen & Co, a firm of public accountants to determine the losses which our voluntary hospitals suffered because of the insufficient funding by local governmental units. This amounted to $12,508,000 in 1967 for identifiable indigents. While it is true the recently approved Medicaid Act will appropriate some of these funds, the legislature did not approve a bill which would provide for care of all known indigents and those who are medically indigent. The cost of such a program for hospital care alone has been estimated by a committee of this legislature to be $24,700,000. This category, numbering in the thousands, has been and will continue to be the responsibility of our hospitals. In 1961 the State Board of Control adopted regulations requiring all hospitals to provide accident and emergency services at all times and to accept, when medically indicated, patients seeking such services without regard for their ability to pay.

Hospitals perform an additional service which is often overlooked. Traditionally they have offered education and training to the youth of the community. This is not on-the-job training but an education leading towards professional recognition and licensure throughout the United States. Indeed, hospitals are an integral part of the community service concept. Like the fire and police, they function for the benefit of the community.

We feel strongly that the widespread practice of exempting educational, philanthropic and religious organizations from taxation is more than justified from a philosophical, legal and historical viewpoint. If tax exemptions were repealed, the services and benefactions offered by hospitals will be correspondingly reduced. If government were to assume these responsibilities, what net gain would there be to the community? It would be to put money in one pocket and take it from another!



No tax can be raised except for a public purpose or use. Since we now have voluntary hospitals, should the State duplicate these established institutions or assist and further their work with public funds? The answer to this question seems to be obvious. Since we already have direct government subsidies on an increasing scale, why is it necessary or prudent to eliminate the indirect subsidy of real property tax exemption? We ask: To what higher use could this tax money be diverted?

In conclusion I would like to quote Mr. John Gardner, former secretary of Health, Education and Welfare, and one of the leading figures in the field of health and medical care.

> "Since our beginnings as a Nation, both the Federal Government and State Legislatures, have acted to preserve and encourage private initiative in good works. We have always believed that this was worth doing, and tax exemption has been the chief instrument for accomplishing it. Such exemption is not a negative act and certainly not a piece of legislative negligence. It is a positive measure designed to insure that in scientific, educational, religious, and charitable activities there will be multiple sources of initiative and creative diversity. Modern thinking about the value of pluralism in preserving freedom has only served to strengthen our convictions on this point."

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ASSEMBLYMAN APY: Thank you, Mr. Owen.

You indicate that your Association represents 140 of which approximately a hundred are voluntary. The other 40 hospitals then, that you represent, are profit-making institutions.

MR. OWEN: No. Governmental institutions.

ASSEMBLYMAN APY: They are governmental.

MR. OWEN: Yes. We have about three hospitals for profit, in the State.

ASSEMBLYMAN APY: And those three pay taxes?

MR. OWEN: Yes.

ASSEMBLYMAN APY: Now, do you have available any indication of the value of the various hospitals in the State of New Jersey, the private, non-profit hospitals?

MR. OWEN: I could not give you the total amount of value. It's extremely difficult. Each local government unit has different evaluations. But we have looked at what the possibility of the cost of this might be and there have been some very extensive studies done in New York City, and it appears to be about 5 percent of hospital costs. In other words, about 5 percent of the cost per day would be in real estate taxes.

ASSEMBLYMAN APY: All right. I asked the question then unclearly. Do you know what the capital value is of your hospitals? In other words, how many million dollars worth of hospitals are there in the State?

MR. OWEN: I couldn't answer that right now. I could tell you. I could get the --

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*Governor*

SHEILA Y. OLIVER
*Lt. Governor*

SHEREEF M. ELNAHAL, MD, MBA
*Commissioner*

January 15, 2019

**VIA ELECTRONIC AND FIRST-CLASS MAIL**

William J. Colgan, Chairman
Salem County Hospital Corporation
2 Broad Street, Suite 400
Bloomfield, NJ 07003
bcolgan@cha-properties.com

Re: The Memorial Hospital of Salem County
CN # FR 18-0503-17-01
Transfer of Ownership
Acquisition Cost: $3,000,000
Expiration Date: January 15, 2024

Dear Mr. Colgan:

I am approving the certificate of need (CN) application submitted on May 1, 2018, pursuant to N.J.A.C. 8:33-3.1, for the transfer of The Memorial Hospital of Salem's (Salem Hospital) ownership from Salem Hospital Corporation, a subsidiary of CHS/Community Health Systems, Inc. to Salem County Hospital Corp. (SCHC), a not-for-profit corporation d/b/a Salem Medical Center. SCHC will operate Salem Hospital as a not-for-profit general hospital. A transfer of ownership of an entire general hospital is subject to the full CN review process, in accordance with N.J.A.C. 8:33-3.3(a)(1). The Department evaluated this application according to the standards set forth in statute (N.J.S.A. 26:2H-1 et seq.) and by administrative rule (N.J.A.C. 8:33). I am satisfied that the application submitted by SCHC is consistent with those requirements. The application is being approved at the acquisition cost noted above.

This CN approval is for the transfer of ownership of Salem Hospital, the transfer of an approved CN for 26 open adult psychiatric beds (psychiatric beds) to the proposed new licensee of Salem Hospital, and the CN for 30 long-term care (LTC) beds at Salem Hospital, a general acute care hospital located at 310 Woodstown Road in Salem, NJ.

The current license composition includes: 114 Medical-Surgical Beds and 12 Adult ICU/CCU Beds. Salem Hospital's service complement will continue to include Acute Hemodialysis, one Computerized Tomography (CT), one Cystoscopy Room, one Mobile Lithotripter, five Mixed OR, one Magnetic Resonance Imaging (MRI) on site, one mobile Positron Emission Tomography (PET), and one Sleep Center. SCHC is committed to continuing the designation as Primary Stroke Center.

In a previous CN, Prime applied for a transfer of ownership of Salem Hospital. The Department approved Prime's CN to purchase Salem Hospital in a letter dated May 2017. However, subsequent to the Department's approval letter, Prime terminated the asset purchase agreement and the transfer of ownership was not completed. In the current CN, the applicant states, CHS has solicited and participated in numerous discussions with prospective buyers and/or health systems to provide continuity of services at the Salem Hospital location. After significant consideration of its alternatives, CHS has determined that a transfer of its assets to SCHC will strengthen Salem Hospital and will allow SCHC to be in a position to provide continuity of health care services to meet the needs of the residents of Salem County. The applicant has also documented that it and the current owner, CHS, believe that the transfer of ownership of Salem Hospital is the only alternative to closure of Salem Hospital. The applicant's assertion is supported by the review of Salem Hospital's Adequacy of Financial Resources performed by the New Jersey Health Care Facilities Finance Authority as part of the CN review process. The review indicates that Salem Hospital has: 1. Incurred significant operating losses; 2. An accumulated net asset deficiency; and 3. Declining occupancy. The review further states that factors raise doubt about the Hospital's financial ability to continue operating as a hospital and that significant operations improvement will be required to remove this uncertainty.

Upon completion of the Salem Hospital transfer of ownership transaction, the prospective licensee, SCHC, states it will reduce medical-surgical beds from 114 to 75, maintain 12 adult ICU/CCU beds, implement the psychiatric beds no later than November 17, 2019 as identified in the November 17, 2017 CN approval letter (CN FR #17-0509-17-01) and accept the conditions of this approval letter, and apply to the Department to license the LTC beds. SCHC also states it will maintain a Board of Directors and utilize the services of Salem Hospital Management, LLC which will assist SCHC with the long-term development of services and day-to-day operations of Salem Hospital.

The CN approval letter for psychiatric beds, referenced above, determined that there was an essential need for psychiatric beds in Salem Hospital's service area. Therefore, I find that it is not only appropriate but necessary to transfer the unimplemented CN to the proposed owner to ensure that the need for these beds is met. I also find that the addition of these psychiatric beds will strengthen Salem Hospital.

This CN also includes 30 LTC beds for post-acute services which will provide continuity of services at the current location. The LTC beds will enable SCHC to provide care to patients in need of higher acuity services during their post-acute recovery period and will be available to Medicaid and Medicare patients. The anticipated length of stay in the 30-bed unit is expected to be less than 20 days and will enhance the availability of continued observation and care by the patients' physicians. I have determined that the addition of 30 LTC beds will have a minimal impact on the health care system as a whole and will contribute to the financial viability of Salem Hospital, as indicated by the revenue projections submitted by the applicant as part of their application. The applicant stated at the State Health Planning Board (SHPB) meeting that if this approval does not contain the transfer of ownership, the psychiatric beds and the LTC beds, then the continued operation of Salem Hospital would be in question, and the closure of the hospital would have a greater negative impact on the area's healthcare system as a whole than the addition of the 30 LTC beds would.

For the reasons that follow, I am approving, with conditions, the application submitted for the transfer of ownership of Salem Hospital to SCHC as well as the 30 LTC beds, and the transfer of the CN for psychiatric beds. My decision to approve this CN application is consistent with the recommendation of the SHPB from the Board's December 6, 2018 meeting. Three of the four voting members present recommended approval of the CN application at the meeting. In reaching this decision, I have considered the CN application, responses to completeness questions, the public hearing transcript, written comments and exhibits, Department staff recommendations, and the SHPB recommendations. The referenced materials are incorporated herein and made a part of this final decision.

**Public Hearing:**

As part of the review process, the SHPB is required to hold at least one public hearing in the service area of the health care facility within 30 days of the application being declared complete by the Department. A public hearing was held on Thursday, November 8, 2018 from 6:00 pm to 7:15 pm at Salem High School in Salem, NJ. Approximately 75 individuals were in attendance, with eleven speakers, including representatives of CHA, Salem Wellness Foundation, Salem County College and the Health Professionals and Allied Employees (HPAE).

All speakers were in favor of the transfer, most noting that without new ownership it was likely Salem Hospital would close. One speaker who represented existing nursing homes in the area did object to Salem Hospital being granted approval for the 30 LTC beds proposed in the application as he contended these were "not needed." The head of the HPAE was in favor of the transfer but expressed some concern that new ownership might not negotiate with the union. One physician was concerned that the new owners only agreed to keep Salem Hospital open for 5 years and expressed concern that another entity would own the land on which Salem Hospital was located.

**State Health Planning Board (SHPB) Meeting:**

The SHPB meeting was held on Thursday, December 6, 2018 at the Public Health and Environmental Laboratories, located at 1040 River Road in Ewing. Prior to the SHPB meeting, the Department received correspondence from counsel from the Salem Health and Wellness Foundation (Foundation), relating to the transfer of the Foundation's assets to SCHC. At the beginning of the meeting, the Department responded to the aforementioned correspondence, and made a statement which removed a condition related to the Foundation funding from the recommendations. The Department acknowledged the commenter's statement that pursuant to N.J.S.A. 26:2H-7.11(h)(4) the mechanism for determining the disposition of the funds held by the Foundation is through an application to the Superior Court upon recommendation of the Attorney General's Office, not via a CN condition. Upon review, it was decided that it is not within the Department's purview to determine the disposition of these funds.

Nine individuals addressed the Board during the meeting. Eight speakers were in favor of the transfer with two speakers opposed only to the approval of the LTC beds. The representative for neighboring LTC facilities stated that the addition of the LTC beds would have a negative impact on long-term care facilities within the region. In response, a speaker representing the purchaser stated the LTC beds were essential to the financial viability of Salem Hospital. The representative further stated that the only alternative to the approval was the closure of the hospital. He further stated that closure of the hospital would have a larger negative impact on the long-term care facilities in the region. The Board discussed both points, and asked additional questions related to the impact of LTC beds on all parties. Upon motion for a vote, three of the four voting members approved the staff recommendations as presented.

**Analysis:**

N.J.S.A. 26:2H-8, as well as N.J.A.C. 8:33-4.9(a), provide for the issuance of a CN only where the action proposed in the application for such certificate is necessary to provide required health care in the areas to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health services in the region or statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations, I must take 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.

As to the specifics of this application, N.J.S.A. 26:2H-8(a) requires that I consider the availability of facilities or services which may serve as alternatives or substitutes. The applicant has documented that it and the current owner, CHS, believe that the transfer of ownership of Salem Hospital, along with the transfer of the CN for the psychiatric beds to the proposed owner, as well as the approval of the 30 LTC beds, is the only alternative to closure of Salem Hospital. The transfer of ownership and licensing of the psychiatric and LTC beds is the least disruptive alternative to maintaining the current level of care and services in the area. The addition of 30 LTC beds represent an addition of 5.3% of the capacity in the Salem County service area and will have a minimum impact on the health care system as a whole. The applicant's plan to bring the hospital into good financial health includes the addition of the 30 LTC beds and without the beds the hospital's financial forecast would not be sustainable thereby placing the continuing operation of the hospital in jeopardy. Thus, the minimal impact coupled with the need for this hospital to have these beds in order to maintain the operations of the hospital necessitates the granting of these LTC beds to Salem.

The approval of this application will preserve access to health care services for the Salem community; including the medically indigent and medically underserved populations. The Department has taken into consideration that only one other general hospital, Inspira Medical Center-Elmer (Inspira-Elmer), is located in Salem County. Inspira-Elmer is located 16 miles from Salem Hospital, and all other New Jersey hospitals in the area are located greater than 16 miles from Salem Hospital. I find that the proposal —as opposed to closure of Salem Hospital—will preserve appropriate access to health care services for the community, including the medically indigent and medically underserved population.

I also find that the requirement at N.J.S.A. 26:2H-8(b) to consider the need for special equipment and services in the area would be met in this case. SCHC has documented its intention to continue the same services that are currently licensed at the facility and maintain all equipment and services necessary to operate Salem Hospital, as well as implement the CN for the psychiatric beds and license the LTC beds. The applicant states that any future adjustments to services offered at Salem Hospital will be based on an assessment of the health care needs of the region, determined in conjunction with the Salem community, with the result being the expansion of identified gaps in services and elimination of duplicated services. SCHC intends to bring its health care experience to Salem Hospital to improve the quality and delivery of existing health services and program previously operated by CHS.

With respect to N.J.S.A. 26:2H-8(c) regarding the possible economies and improvement in services to be anticipated, SCHC will, in conjunction with community leaders and Salem Hospital medical staff, identify those specialties, if any, that are needed at Salem Hospital and will work with Salem Hospital's medical staff to identify and recruit specialists. SCHC further notes that it will bring operational efficiencies to Salem Hospital's Emergency Department (ED), which will increase access to care for the community and decrease time paramedics and EMTs are required to wait in the ED,

thus allowing for efficient patient care. SCHC also will implement a community outreach program designed to meet the primary care need of the community so that members of the community may receive primary care in the community rather than in the ED.

N.J.S.A. 26:2H-8(d) requires consideration of the adequacy of financial resources and sources of present and future revenues. A financial analysis of SCHC's application undertaken by the Department indicates that the applicant will have sufficient resources to implement and sustain the project, part of which being the addition of the 30 LTC beds and the psychiatric beds. The application notes that its method of financing the $3 million purchase of Salem Hospital will be from readily available funds. According to completeness responses, Salem Hospital may procure a grant from the Foundation to finance the purchase. In the event the grant from the Foundation is not procured, Salem Hospital Management, LLC, has a $3 million commitment from Community Healthcare Associates, LLC to fund the transaction. Based on the applicant's representation I find that continuation of the operating losses at Salem Hospital could put the future of Salem Hospital at risk and lead to Salem Hospital's closure. As such, I find that Salem Hospital's transfer to SCHC will afford it an opportunity to maintain current services and grow additional needed services.

With respect to N.J.S.A. 26:2H-8(e), regarding the availability of sufficient manpower in the several professional disciplines, I am satisfied that there will be sufficient personnel because SCHC has committed to retain substantially all Salem Hospital's current employees when the transfer of ownership is completed. In addition, SCHC has committed to actively recruit new physicians and encourage those physicians who previously utilized Salem Hospital to once again return to provide care. Part of SCHC's plan is to work in conjunction with community leaders and their own medical staff, as well as surrounding hospitals, to identify health care needs for more specialized services and recruit appropriate medical staff to fill any service gaps.

N.J.S.A. 26:2H-8(f) requires consideration of such other factors as may be established by administrative rule. Therefore, I have taken into consideration the applicable administrative rules governing the services subject to full review (i.e. N.J.A.C. 8:33-1.1 et seq.). SCHC is in compliance with the access requirements set forth in N.J.A.C. 8:33-1.1 et seq. and N.J.A.C. 8:33 Certificate of Need: Application and Review Process-4.10(a). Specifically, the applicant will continue to maintain its commitment to the community to preserve access to health care for the residents, including the medically indigent and medically underserved populations. SCHC states that it will provide care in accordance with N.J.S.A. 26:2H-18.64 and N.J.A.C. 8:43G-5.29(c) regarding the provision of health care services regardless of the patient's ability to pay or payment source.

Regarding the transfer of the 26 psychiatric beds to Salem Hospital, the November 17, 2017 CN approval letter (CN FR #17-0509-17-01) awarding these beds to Salem Hospital addressed the requirements of N.J.S.A. 26:2H-8(a)-(f) in regard to the psychiatric beds and that analysis is incorporated herein by reference.

N.J.A.C. 8:33-4.9(a) requires a demonstration by the applicant that this transfer of ownership shall not have an adverse impact on the population being served in regard to both access and quality of care. The applicant indicates that the transfer of ownership of Salem Hospital will preserve and enhance the financial viability of Salem Hospital and allow it to continue as a general acute care hospital providing the same level of health care services in the community. I find that denial of the CN transfer of ownership application would adversely affect the patients in the Salem community, who have historically received care and services at Salem Hospital, including the medically indigent and underinsured, because Salem Hospital is a major provider of emergency and urgent care for those populations. As discussed above, the transfer of ownership of Salem Hospital, along with the transfer of the psychiatric beds as well as the award of the 30 LTC beds appear to be the only manner in which Salem Hospital may remain in operation. This approval is the only manner in which the current level of care and services may be maintained in the area. This approval will preserve access to health care services for the Salem community, including the medically indigent and medically underserved populations. Therefore, in order to ensure that these services are maintained I have revised Condition 5 of the staff recommendations, to require SCHC to operate Salem Hospital as a general acute care hospital for a minimum of ten years, instead of the recommended five years. In addition, I have added Condition 32, which requires that for five years from the date of licensure SCHC shall submit quarterly reports to the Department detailing its efforts to sustain the financial viability of the acute care hospital.

I find that SCHC has provided an appropriate project description, information as to the financial impact of the transfer of ownership, including operating costs and revenues, services affected, equipment involved, source of funds, utilization statistics, and justification for the proposed project (N.J.A.C. 8:33-4.10(b)), assurance that all residents of the area, particularly the medically underserved, will have access to services (N.J.A.C. 8:33 Certificate of Need: Application and Review Process-4.10(a)), and assurance that it will meet appropriate licensing and construction standards (N.J.A.C. 8:43G -1.1 et seq. and N.J.A.C. 8:33-4.10(d)).

**Approval With Conditions:**

Based on the foregoing, I am approving the application for the transfer of ownership of Salem Hospital to SCHC with conditions. The decision to approve the transfer of ownership, the 30 LTC beds, and the transfer of the CN for 26 open adult psychiatric beds is based on my finding that the operation of Salem Hospital under the proposed new ownership would be beneficial to the population in its service area and will preserve access to health care services for the community, including the medically indigent and medically underserved population. In addition, this CN is also approved based on Salem Hospital's significant operating losses, accumulated net asset deficiency and declining occupancy. The alternative would be to close the hospital, which would have a significant negative impact on the local healthcare system as a whole.

This transfer of ownership, the transfer of psychiatric beds, and the approval of LTC beds will strengthen the financial viability of Salem Hospital and I believe that this approval will not have an adverse impact on the other existing hospital in Salem County, hospitals in the surrounding counties, or other healthcare providers. I concur with the seller, CHS, and the proposed buyer, SCHC, that the closure of Salem Hospital would disrupt and decrease access to healthcare services for the Salem Community. My decision to approve this application also factors in the Applicant's plan to stabilize and/or grow admissions at Salem Hospital and allow Salem Hospital to meet the health care needs of the community by: (1) negotiating with health insurers on new contracts that will lead to increased access to patients at Salem Hospital; (2) planning to recruit new physicians to Salem Hospital and encouraging physicians who previously utilized Salem Hospital to once again utilize Salem Hospital to meet the health care needs of their patients; (3) committing that, in conjunction with community leaders and Salem Hospital medical staff, SCHC will identify specialties, if any, that are needed at Salem Hospital and surrounding hospitals; (4) proposing to increase operational efficiencies in Salem Hospital's ED and increasing access to care for the community; and (5) committing to implement a community outreach program designed to meet the primary care need of the community so that they may receive primary care in the community as opposed to using Salem Hospital's ED to receive primary care services.

For the reasons set forth in this letter and noting the recommendations of the SHPB, I am approving the SCHC application for the transfer of ownership of The Memorial Hospital of Salem subject to the following conditions:

1. The applicant shall file a licensing application (CN-7) with the Certificate of Need and Licensing Program (CN&L) to execute the transfer of ownership of assets of Salem Hospital to SCHC, a separate licensing application (LCS-9) for the 30 LTC beds, and a licensing application (CN-7) to implement the psychiatric beds.

2. The applicant shall comply with all conditions related to the 26 psychiatric beds as stated in the CN approval letter dated November 17, 2017 (CN FR #17-0509-17-01).

3. Within 60 days of licensure, the applicant shall notify CN&L, in writing, of the individual who is responsible for the safekeeping and accessibility of all Salem Hospital's patients' medical records (both active and stored) in accordance with N.J.S.A. 8:26-8.5 et seq. and N.J.A.C. 8:43G-15.2 Hospital Licensing Standards.

4. As noted by the applicant, "SCHC has committed to retain substantially all Salem Hospital's current employees when the transfer of ownership is completed." Six months after licensure, SCHC shall document to the CN&L the number of full-time, part-time and per diem employees retained and provide the rationale for any workforce reductions.

5. In order to ensure the continuity and sustainability of care and services, SCHC shall operate Salem Hospital for at least a ten-year period as a general acute care hospital following the effective date of SCHC's licensure as the operator of the Hospital. This condition shall be imposed as a contractual condition of any subsequent sale or transfer, subject to appropriate regulatory or legal review, by the SCHC within the ten-year period.

6. As noted in the CN application, SCHC shall continue all clinical services currently offered at Salem Hospital and for Salem Hospital patients. Any changes in this commitment involving either a reduction, relocation out of Salem Hospital's current service area, or elimination of clinical services offered by Salem Hospital, shall require prior written approval from the Department and shall be subject to all applicable statutory and regulatory requirements.

7. SCHC shall continue compliance with N.J.A.C. 8:43G-5.21(a), which requires that "all hospitals...provide on a regular and continuing basis, out-patient and preventive services, including clinical services for medically indigent patients for those services provided on an in-patient basis." Documentation of compliance shall be submitted within 30 days of the issuance of the license and quarterly thereafter for a period of five years.

8. In accordance with N.J.S.A. 26:2H-18.64 and N.J.A.C. 8:43G-5.2(c), Salem Hospital shall not only comply with federal Emergency Medical Treatment and Labor Act (EMTALA) requirements, but also provide care for all patients who present themselves at Salem Hospital without regard to their ability to pay or payment source and shall provide unimpaired access to all services offered by Salem Hospital.

9. The value of indigent care provided by Salem Hospital shall be determined by the dollar value of documented charity care, calculated at the prevailing Medicaid rate, and shall not be limited to the amount of charity care provided historically by Salem Hospital.

10. Within 60 days of licensing, SCHC shall establish a Local Governing Board as described by the applicant in the application. The applicant states, "Subject to any additional regulatory requirements, SCHC will form a Local Governing Board consisting of no less than five and no more than eleven members that will provide recommendations and guidance to SCHC's corporate board as it relates to the operation of Salem Hospital and serve other important functions. At the present time, SCHC anticipates that no less than three community members and three medical staff members will serve on the Local Governing Board. In addition, Salem Hospital's Chief of Staff, Medical Director, Chief Executive Officer, and Chief Nursing Officer will also serve as ex-officio members and some, but not all, of them may also be appointed as regular/voting members. Although the Local Governing Board will be subject

to the authority of the corporate board, the Local Governing Board will play a primary role with respect to medical staff issues, strategic planning, and changes to service areas, and provide oversight as to the quality of care being provided at Salem Hospital."

11. Within 30 days of licensing, SCHC shall provide CN&L with an organizational chart of Salem Hospital and each service that shows lines of authority, responsibility, and communication between SCHC and Salem Hospital management and the Local Governing Board. SCHC, as licensee operating Salem Hospital, shall be responsible for compliance.

12. For the initial five years following licensure, SCHC shall submit annual reports to CN&L detailing:

    a. The investments it has made during the previous years at Salem Hospital. Such reports shall also include a detailed annual accounting of any long- or short-term debt or other liabilities incurred on Salem Hospital's behalf and reflect on the SCHC balance sheet.

    b. The transfer of funds from Salem Hospital to any subsidiary or affiliate. Such reports shall also detail the amount of funds transferred, in order to document that assets and profits reasonably necessary to accomplish the healthcare purposes remain with Salem Hospital. Transfer of funds shall include, but not be limited to, assessment for corporate services, transfers of cash and investment balances to centrally controlled accounts, management fees, capital assessments, and/or special one-time assessments for any purpose.

    c. All financial data and measures required pursuant to N.J.A.C. 8:31B and from the financial indicators monthly reporting; and

    d. A list of completed capital projects itemized to reflect both the project and its expenditure.

13. Within 15 business days of approval of this application, SCHC shall provide a report to CN&L detailing its plans for communications to Salem Hospital's staff, the community, including but not limited to elected officials, clinical practitioners, and EMS providers, concerning the approval of the transfer of the license and the availability of fully-integrated and comprehensive health services.

14. Prior to licensure, SCHC shall identify a single point of contact to report to CN&L concerning the status of all of the conditions referenced within the timeframes noted in the conditions.

15. In accordance with the provisions of N.J.S.A. 26:2H-18.59h, SCHC shall "offer to 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." This condition does not prohibit good faith contract negotiations in the future.

16. SCHC shall maintain compliance with the United States Department of Health and Human Services Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. Compliance shall be documented and filed with the Division with annual licensing renewal.

17. Within 12 months of licensure, and annually thereafter for five years, SCHC shall provide CN&L with a written report detailing:

    a. Its plan to reduce unnecessary and duplicative services and excess inpatient beds, if any;

    b. Its plan for addressing the need to expand or add ambulatory care services; and

    c. Capital improvement plans, including physical plant improvements, equipment upgrades, additions (including IT), and other capital projects.

18. SCHC shall convene periodic meetings with the Department and the Department of Banking and Insurance (DOBI) within the first year following the licensure of the hospital to SCHC to review and evaluate all issues arising in contract negotiations. Written documentation shall be provided to the Department on a monthly basis during that first year which shall include, but not be limited to, a description of the number and subject of telephone calls, correspondence and meetings with existing HMO and commercial insurance carriers, as well as follow-up telephone calls, correspondence and meetings. At a minimum, SCHC shall have monthly contact with the existing HMO and commercial insurers. If the existing HMO and commercial insurers fail to respond to requests for negotiations, then SCHC shall notify the Department and DOBI to request assistance.

19. After the transfer is implemented:

    a. SCHC shall use its commercially reasonable best efforts to negotiate in good faith for in-network HMO and commercial insurance contracts, with commercially reasonable rates based on the rates that HMOs and commercial insurance companies pay to similarly situated in-network hospitals in southern New Jersey region.

b. Within 10 days of licensure, SCHC shall post on the Salem Hospital's website the status of all insurance contracts related to patient care between Salem Hospital and insurance plans, including all insurance plans with which SCHC contracted at the time of submission of this CN application. SCHC shall also provide notices to patients concerning pricing and charges related to coverage during termination of plans.

c. Within the first year of licensure, SCHC shall notify the Department of the status of notices to terminate any HMO or commercial insurance contract that will expand out-of-network service coverage. SCHC shall meet with representatives from the Department and DOBI to discuss the intent to terminate such contract, willingness to enter into mediation, and shall document how it will provide notice to patients and providers, as well as the impact that such action is reasonably expected to have on access to health care.

d. During the first year from the date of licensure, SCHC shall report to the Department, for each six-month period, Salem Hospital's payer mix and the number and percent of total Salem Hospital admissions that came through the emergency department. For four years thereafter, SCHC shall report the aforesaid information to the Department on an annual basis.

20. SCHC shall comply with the requirements of N.J.A.C. 8:96, Hospital Financial Transparency;

21. SCHC shall comply with the requirements of N.J.S.A. 26:2SS-1 et seq., the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act," which shall include all Departmental Guidance and regulations promulgated pursuant to the Act;

22. SCHC shall invest in programs designed to improve public health, community health services, and health and wellness and, within 12 months of licensure, shall provide CN&L with a written sustainability plan detailing how it intends to ensure the financial viability of such programs.

23. Every 12 months for the next five years, starting on the date a license is issued to SCHC, SCHC shall report to CN&L the progress on the implementation and measured outcomes of the following initiatives noted in the application to improve the operational efficiency and quality of care at Salem Hospital, and shall present the most current report to the public at Salem Hospital's Annual Public Meeting:

a. Negotiations with health insurers on new contracts to increase better access for patients at Salem Hospital;

b. Efforts to fill service gaps to actively recruit new physicians and encourage those physicians who previously utilized Salem Hospital to once again return to provide care;

c. The plan to work in conjunction with community leaders and their own medical staff as well as surrounding hospitals to identify health care needs for more specialized services and recruit appropriate medical staff to fill any service gap;

d. Plans to increase the operational efficiencies of the ED by decreasing "wall time" (the time paramedics and EMTs are required to wait in the ED) to increase overall community access;

e. Plans to implement a community outreach program to provide more accessible primary care in an effort to change the community culture of using the ED as a primary care provider thereby allowing the ED to function as intended for the delivery of emergency care; and

f. Plans to expand outpatient services and reduce or eliminate duplicative services and excess inpatient beds.

24. Within 90 days of licensure, SCHC shall develop and participate in a Community Advisory Group (CAG) to provide ongoing community input to Salem Hospital's CEO and Salem Hospital's Local Governing Board on ways that SCHC can meet the needs of residents in its service area.

    a. SCHC shall determine the membership, structure, governance, rules, goals, timeframes, and the role of the CAG in accordance with the primary objectives set forth above, and within 60 days from the date of formation of the CAG; shall provide a written report setting forth that information to Salem Hospital's Local Governing Board, with a copy to CN&L and subject to the Department's approval.

    b. SCHC may petition the Department to disband the CAG not earlier than three years from the date of licensure and on a showing that all of the requirements in this condition have been satisfied for a least one year.

25. SCHC shall agree to take steps to ensure transparency, provide quality care to patients, and provide assurances to the Department of its continued financial viability. SCHC shall designate an Advisory Board, which shall be comprised of at least three individuals. Three individuals shall be selected by Salem Hospital and two individuals may be selected by the Commissioner of Health.

The Advisory Board shall hold its first meeting within six months of licensure and quarterly thereafter in order to:

a. review and assess SCHC compliance with the Capital Commitments;

b. evaluate SCHC compliance with the Charity Care policies;

c. evaluate SCHC compliance with the ethical and religious directives; and

d. evaluate SCHC compliance with maintenance with State and Federal laws, statutes, regulations, administrative rules, and directives and the impact on community health care access and quality, and all conditions in any approval letter, and report such findings to the Department. Department staff may attend meetings of the Advisory Board.

SCHC shall agree to release, discharge, and hold harmless members of the Advisory Board from any and all claims, liability demands, causes of action or suits that may be made by or on behalf of SCHC, direct and indirect subsidiary companies, companies under common control with any of the foregoing, affiliates and assigns, and all persons acting by, through, under or in concert with them that arise out of or are incidental to acts, omissions or reports issued in good faith by the Advisory Board, in accordance with the Condition. This release shall not apply to any loss, damage, liability or expense incurred as a result of any unlawful or malicious acts or omissions by any member of the Advisory Board.

The Advisory Board members shall be independent of any SCHC entity, having no current or previous familiar or personal relationship to any SCHC entity, its principals, board members and/or managers, or entities owned by an SCHC entity in whole or in part. A list of the membership shall be provided to the Department, and updated as necessary A member of the Advisory Board shall serve as ex-officio, non-voting member of the Local Governing Board.

The Advisory Board shall also monitor the following, and these findings shall be reported semi-annually, starting within one year of the licensure, in writing, to both the Salem Hospital's Local Governing Board and the Department:

- Levels of uncompensated care for the medically indigent;
- Emergency department admissions;
- Provision of clinic services;
- Compliance with standard practices related to coding of diagnoses;
- Rationale for termination of insurance contracts;

- Insurance participation and policies related to out-of-network charges;
- Compliance with Department licensing requirements related to staffing ratios and overtime, and Department of Labor and Workforce Development (DOLWD) Wage and Hour requirements; and
- Compliance with all other CN conditions within the required timeframes required by each condition.

SCHC shall provide information to the Advisory Board upon request, and in the form requested. The Advisory Board shall be active for a minimum period of at least two years and shall provide all reports, findings, projections, and operational or strategic plans to the Department and SCHC Local Governing board for assessment. In the event SCHC does not fulfill the commitments set forth in this Condition, the failure may be considered a licensing violation subject to maximum penalty and/or revocation.

26. SCHC shall comply with all state and federal requirements for LTC beds, including but not limited to physical plant compliance and the 2018 Edition of the Facility Guidelines Institute Guidelines and license and implement the beds within two years of this CN approval.

27. For five years after initial licensure, the Salem Hospital's Board Chairman, President/CEO and other senior Salem Hospital management shall have periodic conference calls with the Commissioner/Representative of Department of Health at regular intervals on a schedule to be determined by the Commissioner to discuss Salem Hospital's condition and compliance with the terms of this CN. SCHC will invite a Department of Health representative to the Board Meetings.

28. SCHC shall comply with requirements of the Department of Labor and Workforce Development's Division of Wage and Hour compliance that address conditions of employment and the method and manner of payment of wages.

29. The applicant shall comply with their statement from the application, "SCHC will implement a community outreach program designed to meet the primary care needs of the community so that members of the community may receive primary care in the community rather than the emergency department." Applicant further states, "SCHC will develop a community outreach program designed to provide preventive and primary care to the medically indigent in the communities surrounding Salem Hospital. At a minimum, this program will provide the medically indigent access to the services of a nurse practitioner and/or physician assistant to address their preventive and primary care needs on a regular basis."

30. The applicant shall comply with their statement from the application, "SCHC will comply with all Federal and State administrative requirements and rules related to reporting of quality measures and patient safety. SCHC will report such quality measures to the Department in timeframes set by applicable requirements. SCHC will provide summary reports on the quality and safety issues to the Community Advisory Board."

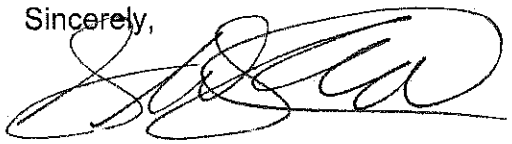
31. For a least five years, SCHC shall not enter into any contract or other service or purchasing arrangements, or provide any corporate allocation, or equivalent charge to affiliated organizations within SCHC except for contracts or arrangements to provide services or products that are reasonably necessary to accomplish the healthcare purposes of Salem Hospital and for compensation that is consistent with fair market value for the services actually rendered, or the projects actually provided.

32. For five years from the date of licensure, SCHC shall submit quarterly reports to the Department detailing its efforts to sustain the financial viability of the acute care hospital, including but not limited to strategic partnerships, affiliations or system opportunities to gain capabilities and efficiencies.

Failure to satisfy any of the aforementioned conditions of approval may result in sanctions, including license suspension, monetary penalties and other sanctions in accordance with N.J.S.A. 26:2H-1 et seq. and all other applicable requirements. Acceptance of these conditions will be presumed unless written objections are submitted to the Department within 30 days of receipt of this letter. Upon receipt of such objections, this approval will be deemed suspended and the project shall be re-examined in light of objections.

I look forward to working with the applicant and helping you to provide a high quality of care to the patients of Salem Hospital. If you have any questions concerning this certificate of need approval, please do not hesitate to contact Alison Gibson, Assistant Commissioner, at 609-292-5380.

Sincerely,



Shereef Elnahal, MD, MBA
Commissioner