GRANT MAKERS IN HEALTH

COMING OF AGE

Findings from the 1998 Survey of Foundations Created by Health Care Conversions

FEBRUARY 1999

Preface

Grantmakers In Health (GIH) has been tracking the emergence and activities of health care conversion foundations for the past several years. *Coming of Age: Findings from the 1998 Survey of Foundations Created by Health Care Conversions* is the latest in its series of reports on these new entrants into the field of philanthropy. The report focuses on the creation, governance, operations, and grantmaking of these foundations. It is designed to provide information not only for foundation board members and staff, but also for policymakers and others who are interested in this newest form of health philanthropy.

This report represents a team effort at GIH. Malcolm Williams, program associate, was the lead researcher and project manager. He and Deborah Brody, director of the Support Center for New Health Foundations, are responsible for much of the writing and analysis. Lauren LeRoy, president and CEO, and Anne Schwartz, director of policy programs, were involved in every phase of the project. Deborah Kramer, manager of information systems, and Mary Backley, chief operating officer, were key to the design and production of the report. Dustun Ashton, administrative assistant, and Sushma Pakalapati, intern, provided assistance by compiling data for several of the tables and figures.

Many experts on philanthropy helped GIH in developing the survey instrument and in understanding issues surrounding health care conversions. Special thanks go to Willine Carr, Daniel Fox, Bradford Gray, Judith Kroll, Loren Renz, and Cinthia Schuman. In addition, this report would not have been possible without the guidance and insights that the many staff and trustees of the health care conversion foundations provided.

Coming of Age is a building block for the work of GIH and its Support Center for New Health Foundations in tracking and assisting health care conversion foundations. It also strengthens GIH's ability to serve health grantmakers by adding to the field's understanding of the activities of these foundations.

Table of Contents

List of Tables

List of Figures

Background and Overview

The health care delivery system has experienced tremendous change in the past two decades. One of these changes is the unprecedented number of nonprofit organizations converting to for-profit status. A major outgrowth of these conversions has been the creation of new philanthropic foundations. Known for simplicity as *health care conversion foundations*, these organizations are endowed with the charitable assets generated by conversions and concentrate their funding on health-related activities in their communities.[1]

More than 100 of these new foundations, worth more than $13 billion collectively, have come on the scene in the last 15 years. If they were to disburse 5 percent of their endowments in a given year, they would have the potential to make annual grants of nearly $700 million. Their grantmaking could comprise as much as one-third of the estimated $2 billion that foundations give in health annually.

Because health care conversion foundations give almost exclusively in health-related programs in a defined geographic area, they are often the largest source of nongovernmental health funding in a community or state. Their emergence in many communities has occurred while the federal government is shifting resources and decisionmaking authority to the states. The convergence of these two developments creates the potential for these foundations to become natural leaders in helping their communities adapt to the changing policy and service environment.

Health Care Conversions

The term *conversion* refers to the sale of (or other transfer of assets from) an existing nonprofit health care organization to another corporation. In the health field, conversions can apply to hospitals, health plans, or health systems. They can be accomplished through a sale, merger, joint venture, or corporate restructuring. For struggling nonprofits, converting can offer a way to preserve their historical mission, gain access to capital, and enhance their competitive position. For thriving nonprofits, converting can allow their boards to secure the maximum assets for the community in the face of increasing uncertainty and competition in the health care market. Conversion options such as mergers and joint ventures may offer nonprofit organizations a way to remain viable and stay competitive while retaining partial ownership in the health care organization.

Health Care Conversion Foundations

Once a charitable organization is dissolved, state laws dictate that its remaining assets must be transferred to another nonprofit organization that will carry out the original purpose of the charitable trust as closely as possible. Creating a new foundation or utilizing an existing one are common ways to accomplish this goal.

Conversion foundations vary tremendously in their asset size, organizational structure, and mission depending upon factors such as the type of organization involved in the conversion and the regulatory requirements in a particular state. For example, foundations resulting from health plan conversions operate quite differently from

[1] *Health care conversion foundation* is not a legal term. The Internal Revenue Service classifies these foundations as private foundations or public charities in the same way that it classifies other philanthropic organizations.

those formed from hospital conversions. Different state regulatory agencies may become involved in structuring the conversion and the resulting foundation depending upon the type of converting organization. One basic reason for this is the difference in the products the converting organizations provide. Hospitals provide direct services, while health plans provide insurance coverage. State insurance authorities often have regulatory authority over health plan conversions, while state attorneys general usually regulate hospital conversions. Reflecting their origins, foundations created through health plan conversions generally fund on a statewide or regional basis and have a broad health mission. In contrast, state attorneys general may require foundations formed from hospital conversions to earmark some of their funds for local indigent care and other direct services to ensure the continuation of community services formerly provided under the aegis of the nonprofit hospital.

Most health care conversion foundations are incorporated as either private foundations or public charities. Public charities must raise a portion of their funds from outside sources. Sometimes hospital fundraising foundations that have existed for many years receive an influx of funds from the conversion of the hospital, which substantially alters their mission and structure. Both newly created and existing foundations that begin as public charities have been known to eventually change their status to private foundations, because it is difficult to fundraise in a community where they are often the largest health endowments (see Appendix 2 on the tax status of these foundations).

Coming of Age

Foundations with origins in health care conversions have been in existence for almost two decades. Those formed in the 1980s are reaching—or have reached—maturity in their organizational lifecycles. Many of these older foundations are now virtually indistinguishable from their counterparts that were formed in more traditional ways. Their boards and staffs are experienced in foundation operations, and their grantmaking reflects a carefully constructed focus and strategy. Accordingly, distinguishing these more mature organizations by their origins may no longer be a relevant or useful way to characterize them.

In addition, the foundations themselves may view the label *conversion foundation* differently as they evolve. This descriptor may be helpful in explaining their origins and in identifying a peer group of other foundations from which they can learn. Its drawback, however, is that the label itself retains a close association with the conversion and any of its residual controversy. It also suggests that these foundations are distinct from other health foundations, which may not be true.

The entry of so many new foundations into the ranks of health philanthropy has been accompanied by questions about their role and impact. It has generated great public interest in obtaining information about them. This report takes a fundamental step in providing information on some basic aspects of health care conversion foundations. In addition to presenting data on their structure and assets, it reports on survey responses that begin to shed light on some core questions—those of governance, grantmaking, and community involvement.

Board Structure and Independence

The effectiveness of the governing board is the single biggest determinant in how a foundation will perform. The trustees of a new health care conversion foundation are often inexperienced in philanthropy and face the daunting tasks of building a new organization and, at the same time, making grants. They must accomplish all of this while under considerable time pressure and in the public spotlight. Running the foundation requires skills in working with the community, developing an organizational mission and grantmaking focus, and over-

seeing the process of disbursing charitable funds. While some new boards are well-prepared for these challenges, others struggle for the first few years.

Often in the wake of a for-profit conversion, a key point of concern is whether the foundation board is operating independently from the for-profit converted organization. A clean break between the nonprofit and the for-profit organization is the clearest way for the foundation to avoid the reality or appearance of conflicts of interest. This is not always possible given the complex nature of the conversion transactions; however, boards can adopt and follow strong conflict-of-interest policies to help them avoid pitfalls.

Grantmaking

Conversion foundations' approaches to grantmaking encompass a range of techniques and strategies. The newest foundations usually begin by responding to proposals generated by nonprofit entities in their locale. As they hone their guidelines, they may elect to solicit proposals targeted to certain program areas or organizations that can help them meet one or more of their stated goals. Eventually, many experiment with *strategic initiatives*, which are a mechanism for supporting a targeted series of projects over several years. A foundation's ability to take advantage of these models depends upon how closely its grantmaking has been regulated. Conversion agreements sometimes restrict hospital conversion foundations to supporting traditional health and direct services to ensure that they are adhering as closely as possible to the hospital's original mission.

Community Involvement in Mission and Program Focus

Involving the community in determining the foundation's mission and program focus can help a new foundation to chart its course most effectively. Because of the community assets involved in health care conversions, there has been a growing expectation of community involvement with the resulting foundations. Some state regulators have required it. Effective ways of involving community stakeholders run the gamut from working directly with the public, consulting experts, or combining several strategies. Different strategies work in different communities depending upon the nature of the conversion and the characteristics of the stakeholders. If done with skill and sensitivity to the many competing concerns, community participation can help a foundation repair damaged relations in the aftermath of a difficult conversion, and it can heighten the foundation's credibility in the long run.

Conclusions

Health philanthropy is unique when it comes to the influx of new ideas, strategies, and funds associated with the entry of so many new foundations focused in a single area in such a short amount of time. Because of the controversy surrounding the for-profit conversions that spawned them, these new foundations as a group have been more in the spotlight than their peers and subject to greater scrutiny by the public and state regulators. That controversy has also raised issues about community involvement, effective communications, and accountability. The appearance of health care conversion foundations has heightened consideration of these issues throughout health philanthropy and may represent a key contribution of these newer foundations to the field.

As these foundations continue to expand and enrich health philanthropy, they will become an integral and perhaps indistinguishable part of the sector. How they define their roles and structure their operations over time will determine whether they remain distinct from other types of foundations. With time, more information will

be available to help assess their impact on health care and health philanthropy. Toward this end, GIH will continue to gather information, collaborate with, and track the activities of these foundations.

Survey Methodology

Grantmakers In Health began formally collecting data on the formation, structure, and behavior of health care conversion foundations in 1996. In 1998, it made several changes to its survey methods. First, a written questionnaire was developed to replace a more open-ended telephone survey in an effort to provide structure for the foundations' responses. This was done to create a more uniform set of baseline data to track the foundations' activities over time. This year, GIH also moved beyond collecting basic information about the foundations and expanded questions related to foundation grantmaking, board structure and independence, and community involvement in the development of the foundation.

In late 1998, GIH developed and mailed questionnaires to 121 organizations identified as conversion foundations.[2] The list of organizations came from several sources. All of the foundations represented in GIH's report on conversion foundations, *Health Care Conversion Foundations: 1997 Status Report*, were included. Other conversion foundations were identified from lists shared by regional associations of grantmakers, the Council on Foundations, The Foundation Center, and various consumer advocacy organizations. Finally, GIH staff reviewed articles in the trade press and other periodicals that reported on health conversions.

By the end of the year, GIH collected responses from 97 of the 119 conversion foundations (a response rate of 82 percent). Of the 22 foundations that failed to respond, 4 were too early in their development to be able to respond adequately to the survey. Data on assets, year of formation, location, and tax status were drawn from GIH's earlier survey conducted in 1997 for an additional 12 conversion foundations that did not participate in 1998. Findings related to some survey questions thus reflect data from as many as 109 foundations.

[2]The Sisters of Charity Foundations of Canton, Cleveland, and South Carolina operate as three individual foundations, although they were created out of the same conversion and report information as one foundation. The three foundations share a mission and, to some degree, a program focus based on the Sisters of St. Augustine Order. By counting these three foundations as one, the total number of possible conversion foundations drops to 119.

Results

The tables and figures presented in this report describe the various dimensions of the development and behavior of conversion foundations as measured in the 1998 GIH survey. The data are presented in four major sections:

- ***Foundation Structure:*** basic information regarding the year of conversion, assets, type of organization that was converted, location, tax status, board size, and staff size.[3]
- ***Board Structure and Independence:*** data on the independence of the foundation from the purchasing organization and the converted for-profit health care organization. The survey asked a variety of questions that highlight several components of independence including whether the foundation reserves seats on its board for board members of the for-profit purchasing organization, whether the foundation has board members sitting concurrently on the board of the for-profit converted organization, if conflict-of-interest policies exist for board members, and what type of conversion had taken place.
- ***Community Involvement:*** data on the extent to which foundations have included the community in the development of their mission and grantmaking programs.
- ***Grantmaking:*** data regarding the funding priorities of conversion foundations as well as the grantmaking strategies they develop to target their funding.

Foundation Structure

A profile of health care conversion foundations, both individually and collectively, begins with a description of their core attributes. These include date of foundation formation, assets, type of organization converted, location, tax status, board size, and staff size.

Date of Foundation Formation. The first conversion foundation was formed in 1973 (Table 1). Only three new foundations were created in the decade that followed. In 1984, however, 11 were created, kicking off the first of two waves of conversion foundation development. The first wave ended in 1987 after adding 24 new foundations to health philanthropy. The second wave of conversion activity began around 1994, when 13 new foundations were created, and peaked in 1996 with the emergence of 21 foundations. By the beginning of 1999, this second period of activity had resulted in 73 additional foundations. It is too early to tell whether the lower number of new foundations established between 1997 and 1999 indicates an end to this most recent period of heightened activity. A combination of increased public and state regulatory scrutiny discouraging or slowing some conversions, some newly forming foundations possibly being overlooked in the GIH survey, and the inability of some new foundations to respond to the survey may, in part, explain the lower number of foundations reported in the late 1990s.[4]

[3] In the tables reporting assets, several notes appear regarding the year for which assets were reported. Foundations were asked to report their assets as of June 30, 1998. In some cases, however, they were only able to report assets for an earlier year or assets that were expected once the conversion was completed.

[4] Four foundations were identified that were too early in their formation to provide data for the survey.

Table 1. *Health Care Conversion Foundations by Year of Conversion and Asset Size (millions of dollars), 1973 Through 1999*

YEAR OF CONVERSION	NUMBER	TOTAL ASSET SIZE (6/30/98)	MEAN ASSET SIZE (6/30/98)
1973	1	$36.1	$36.1
1981	1	2.3	2.3
1983	2	30.7	15.4
1984 [a]	11	421.3	38.3
1985	8	1,226.9	153.4
1986	3	125.0	41.7
1987	2	87.7	43.9
1988	1	18.9	18.9
1990 [b]	1	127.1	127.1
1991	1	102.3	102.3
1992	3	1,189.1	396.4
1993	2	62.1	31.1
1994 [c]	13	1,088.4	83.7
1995 [b]	20	2,145.4	107.3
1996	21	5,185.3	246.9
1997 [d]	12	960.9	80.1
1998 [e]	6	389.4	64.9
1999 [c]	1	80.0	80.0
Total	109	13,278.8	121.8

[a] *Data include 1 foundation that reported assets as of December 31, 1996.*

[b] *Data include 1 foundation that reported assets as of December 31, 1997.*

[c] *Data include 1 foundation that reported expected assets as of December 31, 1998.*

[d] *Data include 1 foundation that reported assets as of December 31, 1997, and 1 foundation that reported assets as of December 31, 1996.*

[e] *Data include 1 foundation that used year of foundation formation rather than year of conversion.*

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Assets of Conversion Foundations. Data were collected on the assets of 109 conversion foundations. The total combined assets for these foundations equal more than $13 billion (Table 1); The assets of conversion foundations range from less than $1 million to more than $2 billion, but most are moderate in size (Table 2). The mean asset size for all conversion foundations is $121.8 million (Table 1); about 57 percent fall into the asset range of $11 to 100 million (Table 2).

Table 2. *Conversion Foundations by Asset Size (millions of dollars), June 30, 1998*

ASSET SIZE	NUMBER	PERCENT
$0-10	16	14.7
$11-100 [a]	62	56.9
$101-500 [b]	28	25.7
Greater than $500	3	2.8

N=109

[a] *Data include 2 foundations that reported expected assets as of December 31, 1998, 2 that reported assets as of December 31, 1997, and 1 that reported assets as of December 31, 1996.*

[b] *Data include 1 foundation that reported assets as of December 31, 1997.*

Note: Percentages may not add up to 100 due to rounding.
Source: Grantmakers in Health, Survey of Health Care Conversion Foundations, *1998.*

The average size of conversion foundations grew considerably between the two periods of greatest activity. The mean asset size for foundations created in the mid-1980s was about $78 million, while the mean asset size of the foundations created in the mid-1990s was almost $135 million. A number of factors contributed to the increase in average asset size, including the rise in the number of health plan conversions (which have larger average assets than hospital conversions, see Table 3). Perhaps more importantly, however, is the fact that communities became more aware of the significance of achieving the highest value possible for their nonprofit health organizations during the conversion process.

Although three-quarters of all conversion foundations were created as the result of hospital conversions; these foundations are generally smaller in asset size than those created through health system or health plan conversions (Table 3). The average asset size of a hospital conversion foundation is about $76 million. The average asset size of a health system conversion foundation is about $126 million. On average, when a health plan converts, it creates a foundation with greater assets than those for hospital and health system conversions. The average assets of all foundations formed from health plan conversions are more than $520 million; the total assets for all health plan conversion foundations account for 45.9 percent of the total assets of all conversion foundations.

Table 3. *Assets of New Health Foundations (millions of dollars) by Type of Organization Converted, June 30, 1998*

CONVERTED ORGANIZATION	NUMBER	TOTAL ASSETS	MEAN ASSET SIZE	ASSET RANGE
Hospital [a]	72	$5,492.1	$76.3	$2-466.1
Health Plan [b]	11	5,759.4	523.6	28.2-2,000
Health System	10	1,263.9	126.4	50-231.8
Other [c]	3	43.8	14.6	0.9-40.5
Total	96	12,559.2	130.8	0.9-2,000

[a] *Data include 1 foundation that reported expected assets as of December 31, 1998, 1 that reported assets as of December 31, 1996, and 3 that reported assets as of December 31, 1997.*

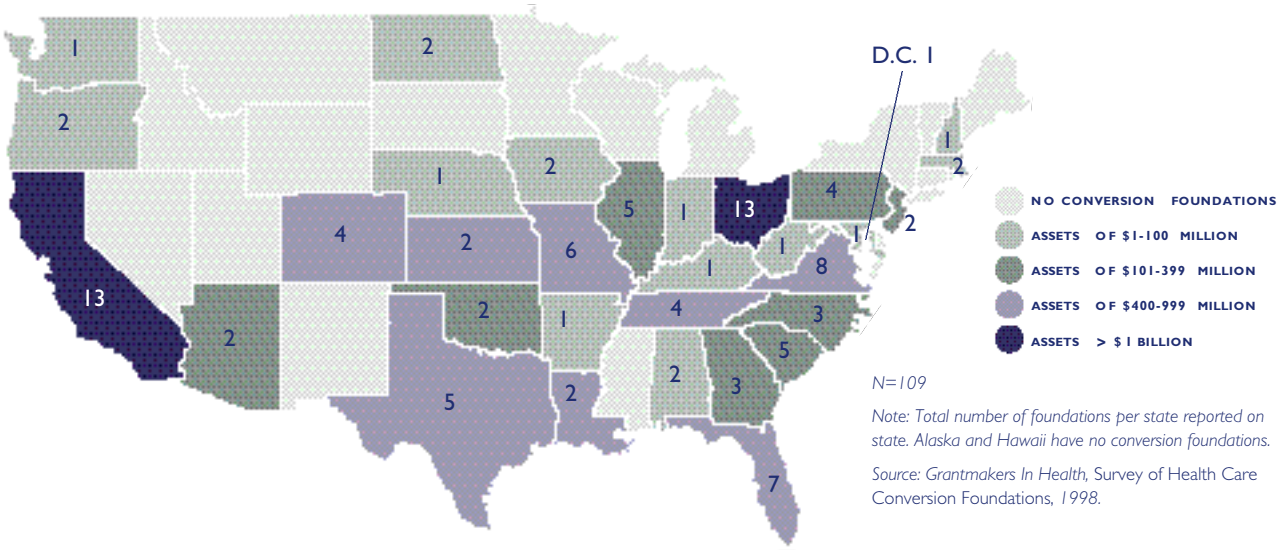
[b] *Data include 1 foundation that reported expected assets as of December 31, 1998.*

[c] *Data include 1 blood bank, 1 nursing home, and 1 rehabilitation center.*

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Geographic Distribution of Conversion Foundations. Conversion foundations operate in 32 states and the District of Columbia (Figure 1). More than half of these foundations, however, are located in just eight states: California, Florida, Illinois, Missouri, Ohio, South Carolina, Texas, and Virginia. The two states with the greatest number of conversion foundations are California and Ohio, with 13 new foundations each. Total combined foundation assets in California ($5 billion) are nearly five times that of Ohio ($1.1 billion), perhaps reflecting the large number of health plan conversions in California. Virginia has the third greatest number of conversion foundations with eight. Colorado has only four conversion foundations but ranks third in total assets, with $800 million.

Figure 1. *States with Conversion Foundations by Number and Total Assets, 1998*



N=109

Note: Total number of foundations per state reported on state. Alaska and Hawaii have no conversion foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Tax Status. Once a conversion occurs, the foundation must apply to the Internal Revenue Services (IRS) for one of several tax status categories. The most common types of tax status chosen are private foundation and public charity, both classified as 501(c)(3) in the Internal Revenue Code (IRC) (Table 4). Public charities are further defined by the IRC as falling into one of three categories: 509(a)(1)—traditional organizations, 509(a)(2)—gross receipts organizations, or 509(a)(3)—supporting organizations. (See Appendix 2 for a description of tax status categories.) The final tax status category that a health care conversion foundation may choose is social welfare organization, identified by the IRC as 501(c)(4). Very few foundations, however, choose this option. The tax status of the organization carries with it certain regulatory requirements and operational expectations that have implications for the foundation's structure, including board size and staffing.

Among the 97 health conversion foundations responding to the 1998 survey, the most common tax status elected was that of public charity (53.6 percent); compared to the 43.3 percent of conversion foundations that are private foundations (Table 4). Private foundations, however, hold a disproportionate share of the total assets of conversion foundations. Additionally, the mean asset size of social welfare organizations and private foundations is considerably larger than that of public charities.

Table 4. *Conversion Foundation Assets (millions of dollars) by Tax Status, June 30, 1998*

TAX STATUS	NUMBER	TOTAL ASSET SIZE	MEAN ASSET SIZE	ASSET RANGE
Private Foundation [a]	42	$6,155.7	$146.6	$0.9-1,784
Social Welfare Organization 501(c)(4)	3	2,335.2	778.4	59.3-2,000
Public Charity [b]	52	4,088.2	78.6	2-345.6
509(a)(1)	25	1,982.1	79.3	2-345.6
509(a)(2)	6	548.6	91.4	27.2-198.1
509(a)(3)	21	1,566.8	74.6	4.7-231.8

N=97

[a] *Data include 2 foundations that reported assets as of December 31, 1997 and 1 that reported expected assets as of December 31, 1998.*

[b] *Data include 1 foundation that reported expected assets as of December 31, 1998, 1 that reported assets as of December 31, 1997, and 1 that reported assets as of December 31, 1996.*

Note: See Appendix 2 for a discussion of tax status.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Board Size and Composition. The boards of conversion foundations vary in both size and composition. Of the 94 foundations reporting on their boards, board size ranges from 5 to 60 members. The median board size among all conversion foundations was 12 members (Table 5). Private foundations had a median board size of 10 members compared to 15 among all public charities.

Table 5. *Median Foundation Board Size by Tax Status and Asset Size (millions of dollars), June 30, 1998*

TAX STATUS	NUMBER	ASSET SIZE	MEDIAN FOUNDATION BOARD SIZE
Private Foundation [a]	41	$0-500+	10
	5	0-10	14
	23	11-100	10
	11	101-500	14
	2	Greater than 50	15
Social Welfare Organization 501(c)(4)	3	0-500+	8
Public Charity [b]	50	0-500+	15
509(a)(1)	23	0-500+	15
	4	0-10	13
	13	11-100	11
	6	101-500	17
	0	Greater than 500	N/A
509(a)(2)	6	0-500+	14
509(a)(3)	21	0-500+	15
	3	0-10	10
	14	11-100	15
	4	101-500	13
	0	Greater than 500	N/A
All Foundations	94	0-500+	12

N=94

[a] *Data include 1 foundation that reported expected assets as of December 31, 1998, and 2 foundation that reported assets as of December 31, 1997.*

[b] *Data include 1 foundation that reported expected assets as of December 31, 1998, 1 that reported assets as of December 31, 1997, and 1 foundation that reported assets as of December 31, 1996.*

Note: Responses for foundation board size were missing for 3 foundations. N/A indicates that a median could not be calculated.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, 1998.

It might be expected that public charities would have larger boards than private foundations, because their boards are often chosen to reflect a cross-section of the community. Responses to the GIH survey suggest, however, that while board size does vary slightly among the different types of foundations, community representation does not. The foundations were asked to indicate the number of board members who were representatives of the community. Seventy-five percent of both public charities and private foundations reported that they had community representatives on the board, and the median number of community representatives on the board among public charities was 7, only slightly higher than the median of 6 among private foundations (Table 6).

Table 6. *Conversion Foundation Board Composition by Tax Status, 1998*

TAX STATUS	REPRESENTATIVES OF THE COMMUNITY		FORMER BOARD MEMBERS OF THE CONVERTED ORGANIZATION		PHYSICIANS		OTHER	
	Median No. of Board Members	*% of Foundations*	*Median No. of Board Members*	*% of Foundations*	*Median No. of Board Members*	*% of Foundations*	*Median No. of Board Members*	*% of Foundations*
Public Charities	7	75	6	61.5	3	57.7	2	30.8
Private Foundations	6	75	7	70.8	2	56.3	3	12.5

N=89

Note: Foundation board members could be classified under more than one category.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Staff Size. Like board size, staff size varies among the different foundations. Tax status appears to be one factor affecting staff size. Public charities require more staff than private foundations in order to run their non-grantmaking activities, such as fundraising and operating direct service programs. One public charity surveyed, for example, operates a number of wellness and adult day care centers in addition to grantmaking thus requiring it to employ a staff of roughly 20 people.

The 84 responding foundations had staff sizes ranging between 0 and 69 people, with the median staff size generally ranging from 1 to 9 (Table 7). Although most of the foundations have actual staff sizes of one, two, or four people, the median staff size of public charities was twice that of private foundations.

Table 7. *Median Staff Size of Conversion Foundations by Tax Status and Asset Size (millions of dollars), June 30, 1998*

TAX STATUS	ASSET SIZE	NUMBER	MEDIAN STAFF SIZE
Private Foundation [a]	$0-500+	372	2
	0-10	3	1
	11-100	21	2
	101-500	11	9
	Greater than 500	2	56
Social Welfare Organization 501(c)(4)	0-500+	3	11
Public Charity [b]	0-500+	44	4
509(a)(1)	0-10	4	2
	11-100c	12	4
	101-500	5	9
	Greater than 500	0	N/A
509(a)(2)	0-500+	6	4
509(a)(3)	0-10	2	2
	11-100	12	4
	101-500	3	4
	Greater than 500	0	N/A
All Foundations	All	84	4

N=84

[a] *Data include 1 foundation that reported expected assets as of December 31, 1998, and 2 foundation that reported assets as of December 31, 1997.*

[b] *Data include 1 foundation that reported expected assets as of December 31, 1998, 1 foundation that reported assets as of December 31, 1997, and 1 foundation that reported assets as of December 31, 1996.*

Note: Data do not include 11 foundations without staff. N/A indicates that a median could not be calculated. Responses on foundation staff size were missing for 2 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Staffing Solutions Among Conversion Foundations Without Permanent Staff. Ten of the surveyed foundations do not have staff. They typically rely on board members, consultants, staff from other organizations, or a combination of these to accomplish the foundation's work (Table 8). Although one might assume that those foundations without staff are newer, this is not always the case. Only four of the ten foundations without staff were formed during or after 1996, while some were created as early as 1981.

Table 8. *Staffing Solutions Among Conversion Foundations Without Permanent Staff, 1998*

STAFFING SOLUTION	NUMBER OF FOUNDATIONS
Board Members	1
Consultants	2
Staff From Other Organizations	5
Combination of Board Members and Consultant(s)	2

N=10

Note: Data do not include 3 foundations using a combination of permanent staff and some other staffing options. One foundation relies on consultants, another foundation uses staff from a community foundation, and a third uses staff from the local United Way. Data also do not include 1 foundation that reported having no staff, but did not explain further how the foundation operated.

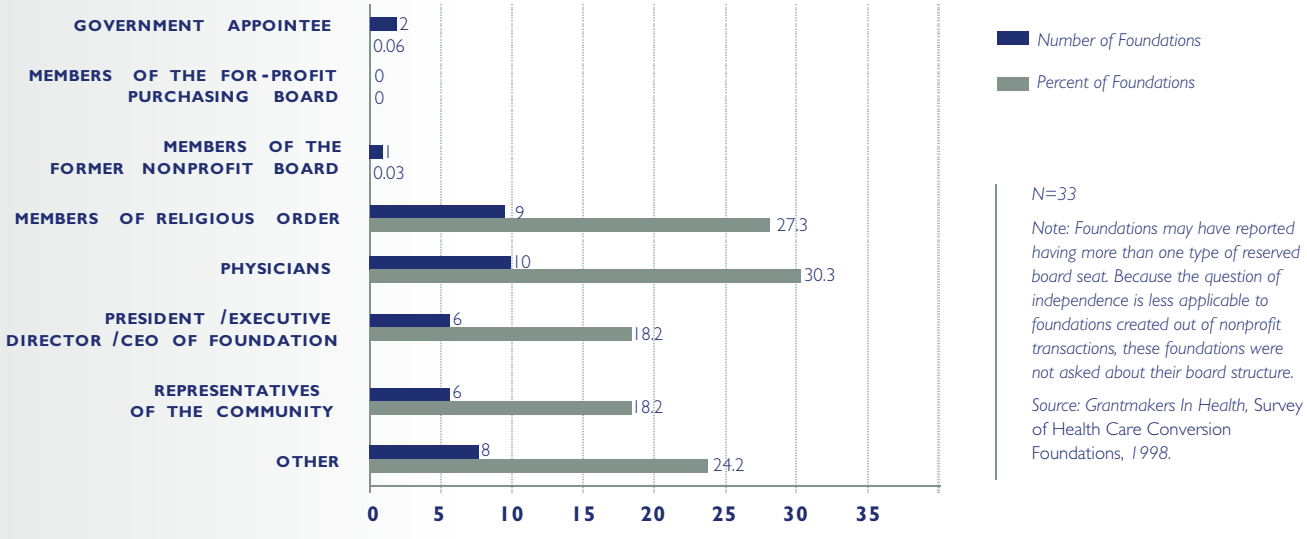
Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Board Structure and Independence

One way for conversion foundations to preserve the assets of the converted organization for the public's benefit is to remain independent from the financial interests of the purchasing organization and the converted for-profit organization. In an effort to gauge the autonomy of the health care conversion foundations, the survey asked questions that touched on several dimensions of independence. These included asking what type of foundation board seats were reserved, the number of foundation board members sitting concurrently on the board of the for-profit converted organization, the presence of conflict-of-interest policies, and the type of conversion transaction that took place (sale, merger, joint venture, or corporate restructuring). Data regarding these measures of board structure and independence generally suggest a high degree of independence among conversion foundations from both the for-profit purchaser and the former nonprofit health care organization.

Reserved Foundation Board Seats. One measure of foundation independence is whether the foundation reserves seats for board members of the for-profit purchasing organization. Specifically, a potential conflict-of-interest develops, and a measure of independence is lost, when the foundation shares board members with the purchasing organization. There were 33 foundations created out of nonprofit to for-profit transactions that reported having reserved seats on the board, with about 30 percent reserving seats for physicians, 18.2 percent reserving seats for representatives of the community, and less than 1 percent reserving seats for members of the former nonprofit health care organization's board (Figure 2). In addition, many foundations reported reserving seats for members of the religious order that had previously owned or managed the former nonprofit health care organization or the president, executive director, or chief executive officer of the foundation. No foundations, however, reported that they had reserved board seats for members of the purchasing organization's board.[5]

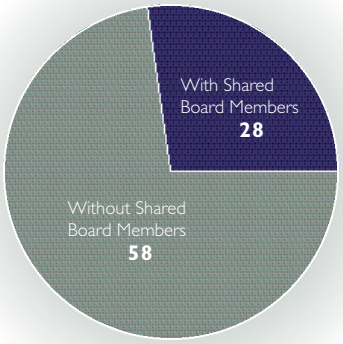
Figure 2. *Reserved Board Seats of Conversion Foundations by Type of Seat Reserved, 1998 (number and percentage)*



[5]The question of independence is less applicable to foundations created out of nonprofit to nonprofit transactions. Therefore, these foundations were not asked about their board structure.

Concurrent Board Seats. A dimension of board composition that can affect the independence of conversion foundations from the for-profit converted organization is the number of foundation board members sitting concurrently on the board of the converted organization, whether or not their seats were reserved. Results from the GIH survey show that this seldom occurs. Of the 97 respondents, 28 reported having board members sitting concurrently on the boards of both organizations (Figure 3). However, 9 of these 28 foundations were created out of joint ventures (Figure 4).[6] It would be expected that these organizations would share board members as a component of the partnership. Only 11 foundations created as the result of a sale of a nonprofit health organization shared board members with the converted organization.

Figure 3. *New Health Foundations Sharing Board Members with Converted Organization, 1998 (number)*



N=86

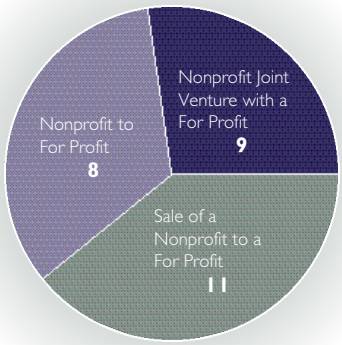
Note: Responses on whether board members sit concurrently on the board of the converted organization were missing for 11 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Figure 4. *New Health Foundations with Shared Board Members by Type of Conversion Arrangement, 1998 (number)*

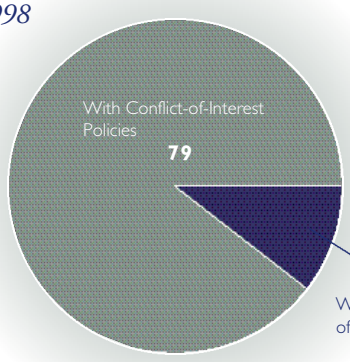
N=28

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*



Conflict-of-Interest Policies. Another measure of board independence is the existence of a written conflict-of-interest policy. Having a conflict-of-interest policy increases the independence of foundations by establishing rules of conduct for board members with respect to potential conflicts. Conflicts of interest for foundation trustees most often arise when a trustee sits on the board of a grantee or potential grantee organization. A conflict-of-interest policy usually requires board and staff to disclose all outside affiliations and recuse themselves from voting on grants to these entities. Of the 89 foundations responding to this question, 79 have a written conflict-of-interest policy (Figure 5). Importantly, all 11 foundations that were created as the result of a sale and share board members with the converted organization have written conflict-of-interest policies (see Figure 4).

Figure 5. *Conversion Foundations with Conflict-of-Interest Policies, 1998 (number)*



N=89

Note: Responses on the presence of a conflict-of-interest policy were missing for 8 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

[6]One additional foundation was created out of a merger between two nonprofit organizations.

Type of Organization Converted. The final component of independence that was measured was the type of conversion that took place. Unlike sales, mergers and joint ventures result in agreements that maintain a relationship between the nonprofit organization and the purchasing or for-profit converted organizations. Mergers link the nonprofit to the purchasing organization and joint ventures link the nonprofit to the for-profit converted organization. Therefore, the more joint ventures and mergers there are, the less independence there will likely be among conversion foundations. Most conversion foundations, however, have developed as the result of a sale of a nonprofit hospital, health system, or health plan (Table 9). This is true regardless of the ownership status of the purchasing organization. Although joint ventures were the second most popular conversion arrangement among nonprofit to for-profit transactions, there were actually very few transactions of this type.[7]

Table 9. *New Health Foundations by Type of Conversion and Conversion Arrangement, 1998*

TYPE OF CONVERSION	NUMBER	CONVERSION ARRANGEMENT	PERCENT
Nonprofit to For Profit [a]	70.0	Total	100.0
	54.5	Sale/Buyout/ Acquisition	77.9
	1.5	Merger	2.1
	10.0	Joint Venture	14.3
	4.0	Corporate Restructuring	5.7
Nonprofit to Nonprofit	25.0	Total	100.0
	18.0	Sale/Buyout/ Acquisition	72.0
	5.0	Merger	20.0
	2.0	Joint Venture	8.0
	0.0	Corporate Restructuring	0.0

N=95

[a] *Data include 1 foundation that received assets from more than one transaction: the sale of several hospitals, and the merger of 1 health center. A weighted average was created for this foundation's 2 types of conversion arrangements by assigning (.5) for the sales and (.5) for the merger.*

Note: Responses on the conversion arrangement were missing for 2 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Community Involvement

It is often expected (and sometimes required) that conversion foundations will involve the public in the development of their structure, purpose, governance, and system of accountability as a way to mediate the potential negative effects of the conversion. Public involvement can help ensure that the use of charitable assets continues to be sensitive and accountable to the health care needs and concerns of the community. This year's survey measured three dimensions of community involvement: direct involvement in the development of both the mission and program focus, and the use of geographic grantmaking restrictions.

Development of the Foundation's Mission. One dimension of community involvement is the level of participation in the development of the foundation's mission. The mission drives the foundation's work. Each grant proposal that the foundation reviews is evaluated in terms of its responsiveness to the mission. Foundations often use more than one approach to integrating the community's needs and interests in developing the mission. Nearly half of the foundations reported that the community was involved in the initial devel-

[7] Corporate restructuring occurs without a third party purchaser and generally does not relate to the question of independence for conversion foundations.

opment of the mission through community forums, consultations with academics, consultations with public health officials, focus groups, formal community needs assessments, public hearings, or some combination of these (Table 10). Some foundations relied on the expertise of health professionals to gauge the needs of the community. More than half of the foundations relied on consultations with public health officials as the only source of community involvement in the development of the mission. Other foundations relied on professionals from the community. About 16 percent of the foundations with any type of public involvement relied on the board of the foundation to represent the needs of the community, and about 13 percent set up special advisory committees made up of community experts. Others used a direct measurement approach. Forty percent of the respondents reported using a formal needs assessment to better understand the community.

Development of the Foundation's Program Focus. Community participation in the development of the program focus provides another measure of community involvement. The foundation's program focus describes the specific areas of health that will be funded in order to satisfy the mission of the foundation. Slightly fewer foundations relied on community input in developing their program focus as compared to development of the mission (Table 10). In a manner similar to the development of their missions, foundations relied on a number of strategies to involve the community in developing their program focus and often pursued more than one method. Most foundations looked to experts who could convey the viewpoints of the community. Sixty percent relied on consultations with academics, and 55 percent consulted public health officials. Others took a more direct approach. Almost 38 percent of the foundations that sought community input when developing the program focus conducted community forums or focus groups. Additionally, more than 40 percent of the responding foundations used formal needs assessments in determining their program focus.

Table 10. *Conversion Foundations Involving the Community in the Development of the Mission and Program Focus by Type of Community Involvement, 1998*

TYPE OF COMMUNITY INVOLVEMENT	MISSION		PROGRAM FOCUS	
	Number	*Percent*	*Number*	*Percent*
Community Forums	17	37.8	15	37.5
Consultations with Academics	17	37.8	24	60.0
Consultations with Public Health Officials	24	53.3	22	55.0
Focus Groups	15	33.3	15	37.5
Formal Community Needs Assessment	18	40.0	17	42.5
Public Hearings	8	17.8	9	22.5
Through the Board [a]	7	15.6	2	0.1
Advisory Committee and Local Experts	6	13.3	9	22.5
Other	8	17.8	8	20.0
Total	45	100.0	40	100.0

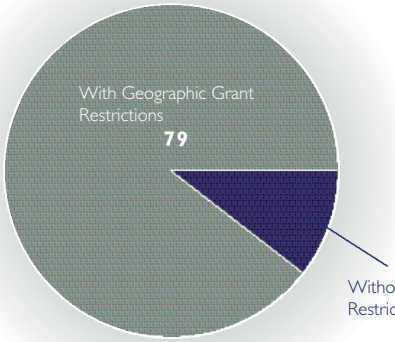
[a] *Data include such responses as community representation on the board or the development of a committee within the board.*

Note: Foundations may have responded with more than one category of community involvement.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Geographic Grantmaking Restrictions. A third and final dimension of community involvement measured by the survey was the number of health care conversion foundations with geographic grant restrictions. Geographic restrictions narrow the focus of the foundations' grantmaking and facilitate their understanding of community needs and interests. In addition, foundations developed as the result of a hospital conversion are preserving the former nonprofit organization's mission to provide services locally by restricting grants to the local community. The 1998 survey asked respondents to report on their grant restrictions. Of the 90 responding foundations, 79 indicated that they had geographic grant restrictions (Figure 6). Of those, only one foundation made grants nationally, while almost all of the rest focused on providing grants to the local community or region. In the case of foundations created from larger transactions (generally health plans), the grants were often restricted to the state rather than the community level.

Figure 6. *Conversion Foundations with Geographic Grant Restrictions, 1998 (number)*



N=90

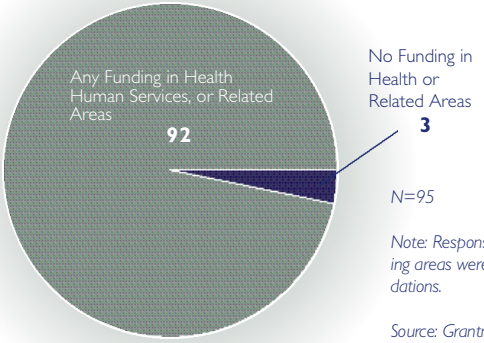
Note: Responses on geographic grant restrictions were missing for 7 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Grantmaking

The 1998 survey also gathered data on foundation grantmaking. First, foundations were asked to report on the proportion of grants they made during the previous year in the areas of arts, culture, and humanities; economic or community development; education; employment; the environment or wildlife; health; and human services. Nearly all of the responding foundations (96.8 percent) reported that some or all of their grant funding was in health, human services, or other health-related areas, such as aging (Figure 7). In addition, over 65 percent of new health foundations reported that at least half of their grant funding was made exclusively in health (Figure 8).[8]

Figure 7. *Conversion Foundations Funding in Health, Human Services, and Other Related Areas, 1998 (number)*

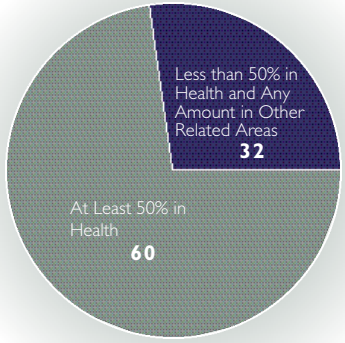


N=95

Note: Responses for primary funding areas were missing for 2 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Figure 8. *Conversion Foundations Funding in Health by Level of Funding, 1998 (number)*



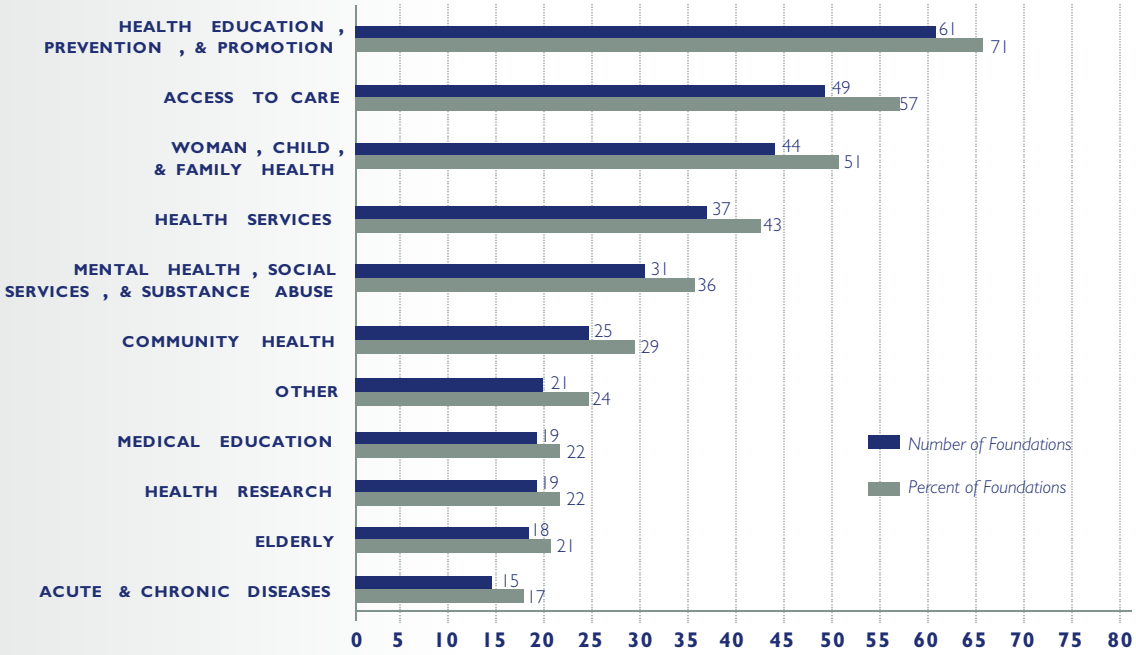
N=92

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

[8]Five foundations did not report making grants in health, human services, or some other related funding area. Two did not respond to the question and three foundations reported making the majority of their grants in other areas.

The foundations were also asked to report on their specific areas of health grantmaking. Most of the foundations reported funding in health education, disease prevention, and health promotion (Figure 9). At least half of the foundations also reported funding in access to care and in programs targeted towards women, children, and families. Additionally, 43 percent of foundations reported funding in health services.

Figure 9. *Conversion Foundation Health Grantmaking Areas, 1998 (number and percentage of foundations)*



N=86

Note: Foundations may have reported more than one health grantmaking area.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Strategic Initiatives. Grantmaking takes place within the framework defined by the mission of the foundation and the specific program areas that flow from it. Foundations can fund proposals that are either unsolicited or obtained through responses to a foundation request for proposals. When foundations proactively solicit proposals, they can be for projects that are either narrowly or broadly defined. One such broader strategy is to develop strategic initiatives such as tobacco awareness, teen pregnancy prevention, or violence prevention campaigns. Many foundations (48.6 percent) reported that they were funding strategic initiatives (Table 11). Almost 11 percent funded at least half of their grants in strategic initiatives, and nearly another 11 percent funded all of their grantmaking in strategic initiatives. The average amount of all funding going to strategic initiatives by foundations that fund in this way was slightly more than 50 percent.

Table 11. *Conversion Foundation Grantmaking by Funding Method, 1998*

METHOD OF FUNDING	NUMBER OF FOUNDATIONS	PERCENT OF FUNDING	PERCENT OF FOUNDATIONS
Strategic Initiatives	8	100	10.5
	8	50 or Greater	10.5
	21	Less than 50	27.6
	39	None	51.3
	76	0-100	100.0
Foundation-Initiated Proposals	12	100	17.6
	17	50 or Greater	25.0
	13	Less than 50	19.1
	26	None	38.2
	68	0-100	100.0
Grantee-Initiated Proposals	24	100	35.3
	18	50 or Greater	26.5
	13	Less than 50	19.1
	13	None	19.1
	68	0-100	100.0
Other	1	100	1.5
	0	50 or Greater	0.0
	1	Less than 50	1.5
	66	None	97.1
	68	0-100	100.0

Note: Percentages may not add up to 100 due to rounding. Responses on the funding method, strategic initiative, were missing for 21 foundations. Responses on the funding methods, foundation-initiated proposals or grantee-initiated proposals, were missing for 29 foundations.

Source: Grantmakers In Health, Survey of Health Care Conversion Foundations, *1998.*

Foundation-Initiated Proposals vs. Grantee-Initiated Proposals. Foundations may issue a request for proposals defining the specific types of projects for which they are seeking proposals. Alternatively they may simply offer general guidelines on their funding priorities and evaluate the unsolicited proposals that are submitted. More foundations (35.3 percent) fund only grantee-initiated proposals than fund only foundation-initiated proposals (17.6 percent) (Table 11). Others fund a combination of the two. About 6 percent of the responding foundations fund evenly between foundation-initiated and grantee-initiated proposals. Twenty-five percent fund mostly foundation-initiated proposals, and 26.5 percent fund mostly grantee-initiated proposals.

APPENDIX I

A Profile of Health Care Conversion Foundations

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Alleghany Foundation *Covington, VA*	1995	$50,000,000	Hospital	Quality of life, nurses, school and dental services.
Alliance Healthcare Foundation *San Diego, CA*	1994	$110,000,000	Health Plan	Care for medically underserved, substance abuse, communicable diseases, violence, mental health, environmental and community health, public education.
Andalusia Health Services, Inc. *Andalusia, AL*	1981	$2,372,686	Hospital	Medical scholarships.
Archstone Foundation *Long Beach, CA*	1985	$109,744,478	Health Plan	Aging, end-of-life care, and care givers of elderly.
Arlington Health Foundation *Arlington, VA*	1996	$345,638,888	Hospital	Access to health services, substance abuse prevention and treatment, teen pregnancy, support for frail elders.
The Assisi Foundation of Memphis *Memphis, TN*	1994	$188,000,000	Hospital	Medical research, preventive and primary care, health promotion and education, support and enhancement of health and human services systems, healthy communities.
Austin-Bailey Health & Wellness Foundation *Canton, OH*	1996	$11,000,000	Hospital	Community clinics for indigent care, mental health, senior health, childhood blood screening for lead poisoning.
Baptist Community Ministries *New Orleans, LA*	1995	$210,000,000	Health System	Childhood immunization, nursing education, substance abuse, health education, public safety, chaplaincy training, church nursing.
Barberton Community Foundation *Barberton, OH*	1996	$96,185,407	Hospital	Health, education, human services, economic and community development.
Bedford Community Health Foundation, Inc. *Bedford, VA*	1984	$4,498,979	Hospital	Medical and health-related services, nursing education, preventive medicine, wellness, public health.
Bernardine Franciscan Sisters Foundation, Inc. *Newport News, VA*	1996	$10,550,142	Hospital	Disease prevention and general health improvements, care for the sick and injured.
Birmingham Foundation *Pittsburgh, PA*	1996	$21,754,239	Hospital	Health-related needs of children, teens, the elderly and the working poor; health prevention, health outreach and access programs, education, employment.
Mary Black Foundation, Inc. *Spartanburg, SC*	1996	$79,531,000	Hospital	Primary health care, disease prevention, wellness promotion, housing, literacy, safety, healthy families, healthy communities, teenage pregnancy, substance abuse, nutrition.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
The Blowitz-Ridgeway Foundation *Northfield, IL*	1984	$26,000,000	Hospital	Mental health, health care, social services, research.
Brentwood Foundation *Maple Heights, OH*	1994	$20,000,000	Hospital	Medical education, research, patient care, and public education in the area of osteopathic medicine.
The Byerly Foundation *Hartsville, SC*	1995	$28,401,257	Hospital	Education, human services, economic and community development.
The California Endowment *Woodland Hills, CA*	1996	$1,784,000,000	Health Plan	Medically under- and uninsured, public health, community health, strengthening health care.
California HealthCareFoundation *Oakland, CA*	1996	$2,000,000,000	Health Plan	Access to health care, under- and uninsured, public health, community health.
The California Wellness Foundation *Woodland Hills, CA*	1992	$1,088,726,245	Health Plan	Violence prevention, population health, work and health, community health, teenage pregnancy prevention.
Cape Fear Memorial Foundation *Wilmington, NC*	1996	$53,200,000	Hospital	Elderly, physical and mental disability, under- and uninsured, domestic violence, substance abuse, socially transmitted diseases, maternal and infant health, chronic diseases.
Christy-Houston Foundation *Murfreesboro, TN*	1986	$88,020,864	Hospital	Health care, education, charitable activities, nursing homes, and nursing education.
Colorado Springs Osteopathic Foundation *Colorado Springs, CO*	1984	$18,148,958	Hospital	Operates indigent care clinic and geriatric clinic.
The Colorado Trust *Denver, CO*	1985	$354,069,789	Hospital	Community-based planning and problem solving, disease prevention, and health promotion.
Columbus Medical Association Foundation *Columbus, OH*	1992	$72,000,000	Health Plan	Health care delivery, education, innovative health care projects, research.
Community Health Corporation *Riverside, CA*	1997	$41,303,042	Hospital	Children and families.
Community Memorial Foundation *Hinsdale, IL*	1995	$72,600,000	Hospital	Youth, older adults, strengthening family, creating community cohesiveness, access to health care.
Consumer Health Foundation *Washington, DC*	1994	$28,183,285	Health Plan	Public health, improving access to care.
Dakota Medical Foundation *Fargo, ND*	1994	$94,800,755	Hospital	Community health, clinical research, community and patient education, medical education.
Daughters of Charity Healthcare Foundation of St. Louis *St. Louis, MO*	1995	$27,700,000	Hospital	Primary and preventive medicine, access to primary care, spiritual health care, health and wellness education.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Daughters of Charity West Central Region Foundation *Clayton, MO*	1996	$230,000,000	Hospital	Health and wellness education, primary and preventive medical service, spiritual health care, social science, employment.
Deaconess Community Foundation *Cleveland, OH*	1994	$45,000,000	Hospital	Aging, mental health, child immunization, housing, education.
The Deaconess Foundation *St. Louis, MO*	1997	$72,000,000	Health System	Public health, children at risk.
Drs. Bruce and Lee Foundation *Florence, SC*	1995	$105,000,000	Hospital	Health; human services; education; arts; religion; civic affairs; historical, cultural and environmental preservation.
The Federation of Independent School Alumnae Foundation *Pittsburgh, PA*	1996	$40,499,691	Rehabilitation Center	Physical rehabilitation, women's issues, sensory disabilities, head injury prevention.
Foundation for Seacoast Health *Portsmouth, NH*	1985	$75,983,990	Hospital	Health promotion and disease prevention for children and youth, women, underinsured and indigent.
Georgia Osteopathic Institute *Tucker, GA*	1986	$5,000,000	Hospital	Statewide training program for third- and fourth-year medical students working in underserved areas.
Good Samaritan Foundation, Inc. *Lexington, KY*	1995	$24,000,000	Hospital	Access for low-income and underinsured, health education in underserved areas, training of health care professionals.
Grotta Foundation *South Orange, NJ*	1993	$885,000	Nursing Home	Aging, mental and physical health of elderly, family caregivers of the elderly.
Group Health Foundation *St. Louis, MO*	1985	$4,900,000	Health Plan	Grants to health care providers, health promotion and illness prevention, seed money for new projects.
Gulf Coast Medical Foundation *Wharton, TX*	1983	$18,000,000	Hospital	Primarily medical-related, such as local emergency medical services, primary care.
Health Foundation of Central Massachusetts *Worcester, MA*	1997	$50,000,000	Health Plan	Guidelines not available.
The Health Foundation of Greater Cincinnati *Cincinnati, OH*	1997	$275,838,358	Health Plan	Primary care to the poor, school-based children's health, substance abuse, severe mental illness.
The Health Foundation of Greater Indianapolis, Inc. *Indianapolis, IN*	1985	$38,537,064	Health Plan	Adolescent programs, HIV/AIDS, general community health.
Health Foundation of South Florida *Miami, FL*	1993	$61,171,996	Hospital	Indigent care, research, social services, nursing scholarships, homeless health care, school-based health clinics.
Health Future Foundation *Omaha, NE*	1984	$70,000,000	Hospital	Indigent care, research, health-related projects at Creighton University.
The Health Trust *Campbell, CA*	1996	$99,590,326	Health System	Children, frail elderly, vulnerable adults, medically indigent, health services research and education.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
The Healthcare Foundation of New Jersey *Roseland, NJ*	1996	$165,922,000	Hospital	Medical training for disadvantaged youth in Newark, clinical medical research; Jewish community.
Healthcare Georgia, Inc. *Atlanta, GA*	1999	$80,000,000	Health Plan	Guidelines not available.
HealthONE *Denver, CO*	1995	$173,309,000	Health System	Community health and education, professional education, research.
Hill Crest Foundation *Bessemer, AL*	1984	$28,000,000	Hospital	Mental health, arts, education.
Hilton Head Island Foundation *Hilton Head Island, SC*	1994	$26,000,000	Hospital	Arts and culture, community development, education, environment, health, human services.
Howard County Community Health Foundation *Columbia, MD*	1998	$50,000,000	Hospital	Guidelines not available.
Irvine Health Foundation *Irvine, CA*	1985	$27,000,000	Hospital	Health services, research, education, prevention.
The Jackson Foundation *Dickson, TN*	1995	$80,000,000	Hospital	Education, arts, technology training.
Annabella R. Jenkins Foundation *Richmond, VA*	1994	$38,648,928	Hospital	Quality health care, strengthening families.
Jewish Foundation of Cincinnati *Cincinnati, OH*	1996	$80,000,000	Hospital	Capital improvement projects that enhance the functioning of the Jewish community, education.
Jewish Healthcare Foundation *Pittsburgh, PA*	1990	$127,120,322	Hospital	Aging, disease and disability prevention; building healthy neighborhoods and communities; women's health.
Kansas Health Foundation *Wichita, KS*	1985	$466,059,000	Hospital	Primary care education, rural health, health promotion and disease prevention, public health, children's health, health policy and research.
Lutheran Charities Foundation of St. Louis *St. Louis, MO*	1987	$76,000,000	Hospital	Physical and developmental disabilities, children, elderly, substance abuse, parish nursing, specific diseases, education, employment, and church outreach programs.
The M Health Foundation *San Francisco, CA*	1998	$25,000,000	Hospital	Health education and research.
Dr. John T. Macdonald Foundation, Inc. *Coral Gables, FL*	1992	$28,375,124	Hospital	Health education, prevention and early detection of diseases, children and the economically disadvantaged, medical rehabilitation, direct medical and dental, education.
The Memorial Foundation, Inc. *Goodlettsville, TN*	1994	$150,990,974	Hospital	Senior citizens, youth, children and teens; human services related to drug, alcohol and domestic violence; health and rehabilitation, education, mental health, vision and hearing, chronic long-term care.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Methodist Healthcare Ministries of South Texas, Inc. *San Antonio, TX*	1995	$64,000,000	Hospital	Operation of three clinics providing medical, dental, and support services; grants to four community health clinics to provide medical and dental services to uninsured or indigent clients.
MetroWest Health Foundation *Framingham, MA*	1996	$50,000,000	Health System	Poor, elderly, children.
Mid-Iowa Health Foundation *Des Moines, IA*	1984	$17,488,436	Hospital	Maternal and child health, teenage pregnancy prevention, substance abuse prevention.
The Mt. Sinai Health Care Foundation *Cleveland, OH*	1996	$88,000,000	Health System	Child development, elderly, organizational capacity-building, community programs, scholars program at Case Western Reserve University School of Medicine.
North Dade Medical Foundation, Inc. *North Miami, FL*	1997	$27,191,133	Hospital	Outpatient clinics.
Northwest Health Foundation *Portland, OR*	1997	$59,320,000	Health Plan	Health promotion and disease prevention; health protection especially for children; improving the delivery, accessibility, and quality of health care.
Northwest Osteopathic Medical Foundation *Portland, OR*	1984	$9,916,500	Hospital	Families and children, scholarships and loans to osteopathic medical students, training clinics for osteopathic residency programs.
Osteopathic Founders Foundation *Tulsa, OK*	1996	$4,702,318	Hospital	Early childhood education, medical scholarships.
Paso del Norte Health Foundation *El Paso, TX*	1995	$210,000,000	Hospital	Health education and disease prevention.
Phoenixville Community Health Foundation *Phoenixville, PA*	1996	$34,500,000	Hospital	Economic and community development, community health education and services.
Portsmouth General Hospital Foundation *Portsmouth, VA*	1988	$18,906,804	Hospital	Pregnancy prevention, health and the family, indigent care, substance abuse prevention.
Presbyterian Health Foundation *Oklahoma City, OK*	1985	$142,000,000	Hospital	Medical research, scholarships, clinical pastoral education, community health-related programs primarily through the University of Oklahoma.
Quad City Osteopathic Foundation *Davenport, IA*	1984	$6,007,869	Hospital	Grants, loans, and scholarships to advance quality and availability of osteopathic health care professionals.
Quantum Foundation Inc. *West Palm Beach, FL*	1995	$155,000,000	Hospital	Health and education, children's health, melanoma awareness, elderly support for independent living and pharmacy assistance, school nurses.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
QueensCare *Los Angeles, CA*	1998	$230,000,000	Hospital	Safety net and operation of outpatient clinics for the working poor, healthy communities, medical education and research in preventive medicine, wellness programs, primary care, health-related public policy, ethics, and law.
The Rapides Foundation *Alexandria, LA*	1994	$198,124,000	Hospital	Adolescent risk and pregnancy reduction, early childhood development, functional status of older adults, health care access, health and well-being, education, arts, and humanities.
John Randolph Foundation *Hopewell, VA*	1995	$32,000,000	Hospital	Teen pregnancy, violence prevention, mental health, substance abuse, access to care, prevention and health promotion, quality of life.
Michael Reese Health Trust *Chicago, IL*	1991	$102,352,509	Hospital	Health care, health education, health research, strengthening community-based efforts to provide health services to the vulnerable and underserved.
Rose Community Foundation *Denver, CO*	1995	$237,000,000	Hospital	Access to health and mental health services to low-income children and youth, facilitating the development of leadership capacity around healthcare issues in Denver, Jewish life.
Saint Ann Foundation *Cleveland, OH*	1973	$36,100,000	Hospital	Health issues for women, children and youth; religious communities' ministries.
Saint David's Health Care Foundation *Austin, TX*	1996	$118,000,000	Hospital	Access and prevention programs, behavioral health, parenting, life skills, violence, teen pregnancy, medical education, research.
Saint Joseph's Community Health Foundation *Minot, ND*	1998	$2,000,000	Hospital	Improvement, availability, and provision of charitable health care.
St. Luke's Charitable Health Trust *Phoenix, AZ*	1995	$109,412,588	Health System	Health prevention programs for children, youth and families, access and delivery of health services to underserved, behavioral health.
Saint Luke's Foundation *Bellingham, WA*	1983	$87,000,000	Hospital	Health education and capital improvements.
Saint Luke's Foundation of Cleveland *Cleveland, OH*	1997	$80,000,000	Hospital	Enhance community involvement and ownership in promotion of healthy behaviors, increase and improve health care, educate health-care professionals serving the needs of inner-city residents.
San Angelo Health Foundation *San Angelo, TX*	1995	$66,441,505	Hospital	Education, health, humanities, human services.
San Luis Obispo Community Health Foundation *San Luis Obispo, CA*	1998	$2,400,000	Blood Bank	College faculty education, infant bereavement, nurses training, health assessment.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
SHARE Foundation *El Dorado, AR*	1996	$55,800,000	Hospital	Health education, humanities, and disease prevention.
Sierra Health Foundation *Sacramento, CA*	1984	$151,609,585	Health Plan	Children's health, managed care, various health-related projects.
J. Marion Sims Foundation *Lancaster, SC*	1994	$75,000,000	Hospital	Health, human services, economic and community development.
Sisters of Charity Foundations of Canton, Cleveland, and South Carolina *Cleveland, OH*	1995	$231,800,000	Health System	Rural health care access in South Carolina, health coverage for children, indigent and low-income care for ages 0-18, substance abuse, behavioral disorders.
Sisters of Mercy of North Carolina Foundation, Inc. *Charlotte, NC*	1995	$149,749,000	Health System	Disadvantaged populations, women's and children's services, primary care, obstetrical and prenatal care, dental services, and prescription assistance.
Sisters of St. Joseph Foundation *Parkersburg, WV*	1996	$21,339,392	Hospital	Health of the community, senior citizens, and families.
South Lake County Foundation *Clermont, FL*	1995	$10,000,000	Hospital	Youth and family services, health and wellness, arts and culture, education, community economic development.
Spalding Health Care Trust *Griffin, GA*	1984	$22,400,000	Hospital	Free health care clinics, emergency equipment for fire departments, capital projects, education.
Truman Heartland Community Foundation *Independence, MO*	1994	$6,957,471	Hospital	Nutrition, public health programs, dental, economic and community development, education, humanities.
Tucson Osteopathic Medical Foundation *Tucson, AZ*	1996	$12,541,260	Hospital	Osteopathic medical scholarships, public understanding of osteopathic medicine, community health and well-being.
Tuscora Park Health and Wellness Foundation *Barberton, OH*	1996	$4,021,169	Hospital	Primary care for underinsured and underserved, health education, safety.
Union Labor Health Foundation *Eureka, CA*	1997	$4,747,727	Hospital	Enhancing the physical, mental, and moral well-being of people within Humboldt County.
United Methodist Health Ministry Fund *Hutchinson, KS*	1984	$67,250,000	Hospital	Capacity-building clinics, dental health, health insurance purchasing cooperatives, children and youth, health ethics, health ministries in religious settings.
The Venice Foundation *Venice, FL*	1995	$109,000,000	Hospital	Health, human services, education, art and culture, civic affairs.
Washington Square Health Foundation *Chicago, IL*	1986	$32,000,000	Hospital	Direct health care services, medical equipment, medical and nursing scholarships, clinical research.
Wesley Long Community Health Foundation *Greensboro, NC*	1997	$51,500,000	Hospital	Community wellness and capacity building, health care access for underinsured populations.
Westlake Health Service Foundation *Melrose Park, IL*	1998	$80,000,000	Health System	Guidelines not available.

NAME AND LOCATION	YEAR OF CONVERSION	ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Williamsburg Community Health Foundation *Williamsburg, VA*	1996	$77,500,000	Hospital	Disease prevention, increasing primary health services for poor and uninsured children and families, improvement of health of elderly people, support of community health initiatives.
Winter Park Health Foundation *Winter Park, FL*	1994	$115,368,000	Hospital	Older adults, children and families, wellness and prevention.
Woodruff Foundation *Cleveland, OH*	1987	$11,662,260	Hospital	Mental health, mental illness, chemical dependency.

APPENDIX 2

Tax Status of Health Care Conversion Foundations

Foundations that receive assets from the conversion of a nonprofit health care organization can operate under several different tax status categories. Which type of tax status they choose will affect their operations, both directly and indirectly. Choice of tax status is revocable, and foundations do find reasons for changing their tax status after they have gained some experience in philanthropy. Below are definitions of the types of tax status health care conversion foundations may obtain from the Internal Revenue Service (IRS).

501(c)(3)

The section of the Internal Revenue Code (IRC) that entitles entities organized exclusively for charitable, educational, or scientific purposes to be exempt from most federal taxes. Many states honor the 501(c)(3) designation and confer similar exemptions for state and local taxes. Several different types of foundations fall under the 501(c)(3) tax category.

Private Foundation. A grantmaking foundation with an endowment from a single source such as an individual, family, or corporation. Private foundations generally do not engage in direct charitable activities but instead make grants to other nonprofit organizations. They do not raise funds from the public and must make grants each year equaling about 5 percent of their endowments. The funds available for the grants and administrative expenses generally come from their endowment income. Private foundations also pay a 1 or 2 percent excise tax to the federal government as determined by an IRS formula. Subsets of private foundations include independent foundations, in which the board is selected independently of the donor(s); family foundations, in which the donor or the donor's family controls the board; and corporate foundations, in which the donor corporation has selected the board.

Public Charity. A tax-exempt religious, educational, or social service organization that receives regular contributions from several sources such as individuals, corporations, private foundations, government, and sometimes fees for services. These organizations may operate programs and make grants.

Public charities are classified as 501(c)(3) organizations. Within the 501(c)(3) category, there are subdivisions for further classifying different types of public charities including:

- ***509(a)(1) traditional:*** A public charity that receives funds from public donations and/or government. It generally must meet an IRS public support test requiring that, over the most recent four-year period, its support from public sources equaled or exceeded one-third of its total support.
- ***509(a)(2) gross receipts:*** A public charity that must raise more than one-third of its total support from any combination of gifts, grants, contributions, or membership fees *and* gross receipts from admissions, merchandise sales, or services provided in relation to its tax-exempt function.
- ***509(a)(3) supporting organization:*** A nonprofit corporation with an established relationship to an existing public charity, often a community foundation or a religious order. Supporting organizations do not have to meet a public support test, and they generally receive grantmaking, investment, and administrative assistance from the nonprofit with which they are affiliated.

Community Foundation. These foundations are public charities but, because of their importance in many communities, are described separately here. They develop, receive, and administer endowment funds from private sources and manage them under community control for charitable purposes. Their grants are normally limited to charitable organizations within a specifically identified region or community. A board of directors representing the diversity of community interests oversees their charitable giving. They are classified under the IRC with the designation 509(a)(1), a subset of 501(c)(3).

501(c)(4)

A tax-exempt organization, known as a social welfare organization, that is allowed to lobby. These organizations include political or lobbying groups such as Common Cause or the American Association of Retired Persons. They are not obliged to spend any portion of their income or endowment on charitable activities and are not required to report the same detailed information as private foundations. A few health care conversion foundations have obtained this status if they resulted from the sale of a 501(c)(4) medical association or other type of organization that had the 501(c)(4) status.

Over half of the foundations responding to the Grantmakers In Health 1998 survey of health care conversion foundations—mostly those formed in the 1990s—have the classification of public charity. Most of the rest are private foundations. It is likely that many of the public charities will eventually become private foundations because their large endowments make it difficult for them to raise the funds required by the IRS. The IRS allows these new organizations a few transition years before it determines their permanent tax status.

About 20 percent of the public charities surveyed are supporting organizations. They legally affiliate with an existing public charity, such as a community foundation, but operate largely like a private foundation. Most of the supporting organizations formed from health conversions are attached to religious orders and have resulted from the sale of a religious hospital. While the parent organization technically governs the supporting organization, the supporting organization operates independently. It usually has its own board of directors and has the added benefit of not having to meet the public support test or the pay-out requirement of a private foundation.

APPENDIX 3

Resource List

The Conversion Process

Bell J., H. Snyder, and C. Tien, *The Public Interest in Conversions of Nonprofit Health Charities* (New York, NY: Milbank Memorial Fund and Consumers Union, 1997). This report explores why and how health conversions are occurring and how the resulting assets are valued. It also contains a useful overview of nonprofit law and foundation tax status. It concludes with several case studies of conversions including most of the major Blue Cross/Blue Shield conversions and several Columbia/HCA purchases.

Lutz, Sandy and Preston E. Gee, *The For-Profit Healthcare Revolution: The Growing Impact of Investor-Owned Health Systems in America* (Burr Ridge, IL: Irwin Professional Publishing, 1995). This book chronicles the rise of investor-owned health systems. It pays special attention to Columbia/HCA and Humana, discussing how they became aggressive purchasers of nonprofit hospitals. It also places these activities into the historical context of health care in the United States.

Miller, Linda B., *When Your Community Hospital Goes Up for Sale* (Washington, DC: Volunteer Trustees Foundation for Research and Education, 1996). This booklet is written to help community advocates understand why a nonprofit hospital might be selling and what they can do to protect the community's interests. It contains advice on working with state government officials and the media. It includes a helpful glossary of terms used in the conversion process.

Pomeranz, John, *Communities & Health Care Conversions* (Washington, DC: Center for Policy Alternatives, 1997). This report provides a good legal overview of the health conversion phenomenon. It discusses issues facing policymakers as a result of the consolidation of the health care market and recommends actions they can take to ensure that communities secure the maximum assets from conversion sales.

Shactman, David and Stuart H. Altman, *The Conversion of Hospitals From Not-For-Profit to For-Profit Status* (Boston, MA: The Heller School, Brandeis University, Council on the Economic Impact of Health System Change, 1996). This paper provides an economic analysis of the differences in levels of community benefits provided by for-profit and not-for-profit hospitals. The authors conclude that for-profit hospitals generally have higher prices than their nonprofit counterparts and that competition is causing nonprofit hospitals to behave more like for profits. The authors also propose a legal and regulatory framework for hospital conversions.

"Special Issue: Hospital & Health Plan Conversions," *Health Affairs* 16(2), March/April, 1997. This is one of the most comprehensive resources on the public policy implications of health care conversions. It is a compendium of articles by different authors that together present a review of national public policy issues, state regulations, the differences between health plan and hospital conversions, and the financial aspects of health conversions, including assignment of a monetary value to the nonprofit entity and management of the assets resulting from the sale.

Health Care Conversion Foundations

Bader, Barry S., "The Conversion Foundations: A Pot of Gold or Pandora's Box for Communities?" *Health System Leader 3(8) 4-18, October, 1996.* This article provides a concise, critical look at the challenges and potential pitfalls inherent in the creation of health care conversion foundations. It also offers examples of some health care conversion foundations' grantmaking and raises questions about their accountability to the public.

Community Catalyst, "The New Health Philanthropy: Ensuring the Effective Use of Conversion Foundation Assets," *States of Health 8(6): 1-7,* November 1998. This article discusses how some health care conversion foundations are being open and accountable to the public and offers suggestions for other ways they can accomplish this.

Council of Michigan Foundations, *The Sale of Nonprofit Hospital Assets to For-Profit Corporations: Philanthropic Options for Community Decision Makers* (Grand Haven, MI: June 1996). This is a concise, easy-to read synopsis of the legal mechanisms for setting up a conversion foundation. It includes the pros and cons of electing to become a public charity, private foundation, or supporting organization to a community foundation. It also contains a useful list of questions for hospital decisionmakers.

Grantmakers In Health (D. Beatrice, W. Carr, and S. Isaacs), *Health Care Conversion Foundations: 1997 Status Report* (Washington, DC: October 1997). This report is based on the findings from Grantmakers In Health's 1997 survey of health care conversion foundations. It provides a brief overview of conversion foundations in the changing health care market; basic statistics on the foundations such as the year of formation, asset size, tax status, and grantmaking focus; a discussion of how health care conversion foundations may be affecting health philanthropy; and a reference table summarizing information on each conversion foundation.

Grantmakers In Health (Catherine E. McDermott), *The New "Conversion" Foundations: Preliminary Results of GIH Survey* (Washington, DC: April 1996). This is the text of a speech based on Grantmakers In Health's first survey of health care conversion foundations. It provides statistics on the number, asset size, and grantmaking focus of health care conversion foundations. It also identifies the major challenges health care conversion foundations are facing and emerging trends for this field.

Grantmakers In Health, *Some Tools-of-the-Trade in Grantmaking. Techniques and Lessons For Health Foundations—Highlights of Workshop Proceedings* (Washington, DC: February 1997). This report shares grantmaking strategies and offers advice on developing a grantmaking agenda. It includes insights on strategies foundations can undertake besides grantmaking, advice on conducting and using community needs assessments, and suggestions for evaluating foundation programs and grantee activities.

Grantmakers In Health, *Telling a Foundation's Story: Nuts & Bolts For New Health Foundations—Highlights of Workshop Proceedings* (Washington, DC: October 1997). This report addresses how health care conversion foundations can use communications strategies and tools to advance their grantmaking mission, community involvement, and public accountability. Suggested strategies include media relations, publications, and Web site management.

Legislation and Regulation

Bovjberg R., J. Marsteller, and L. Nichols, "Nonprofit Conversion: Theory, Evidence, and State Policy Options," *Health Services Research 33(5): 1495-1535,* December 1998. This is an economic analysis of the contributions of nonprofit hospitals and health plans to health care markets. The authors conclude that nonprofit hospitals provide more uncompensated care than for-profit hospitals; however, nonprofit hospitals seem to set norms for providing services that for-profit hospitals follow. The authors conclude by recommending various options to state policymakers for conversion oversight.

Bureau of National Affairs, *Special Report on Nonprofit Conversions: States Slow Pace in Adopting Merger Oversight Laws, Volume 6, No. 35* (Washington, DC: August 1, 1998). This is a summary of the legislative activity of the 16 states that have enacted statutes to oversee and regulate the purchase of nonprofit hospitals by for-profit companies. It includes a discussion of legislative trends regarding health conversions.

Nilles, Kathleen M., *The New IRS Joint Venture Ruling: No Way Out?* Client Memorandum, Gardner, Carton, Douglas (Washington, DC: April 1998). This memorandum discusses the Internal Revenue Service's (IRS) Revenue Ruling 98-15, which provides guidance on how a joint venture between a nonprofit, tax-exempt hospital and a for-profit entity should be structured in order for the nonprofit partner to retain its tax-exempt status. It includes an analysis of the IRS's two hypothetical joint venture scenarios and advises joint ventures to work proactively with the IRS on clarifying their arrangements.

Silas, Julie, *Creating Supporting Organizations: An Option for Conversion Foundations* (San Francisco, CA: Consumers Union, 1998). This document explains in clear and concise language the legal mechanism of a supporting organization and how it can be applied to health conversion assets.

Volunteer Trustees Foundation for Research and Education, *The Sale and Conversion of Not-For-Profit Hospitals: A State-By-State Analysis of New Legislation* (Washington, DC: 1998). This publication identifies and summarizes common elements of legislation governing health care conversions and provides guidelines for oversight by attorneys general. It offers a comparison of hospital conversion legislation across 14 states and a summary of each state's legislation.

Foundations and Philanthropy

Council on Foundations (John A. Edie), *First Steps in Starting a Foundation, Fourth Edition* (Washington, DC: 1997). This is the definitive legal guide to starting a foundation. Written in language that is easily understood by those who are not lawyers, it describes the various tax statuses available for philanthropic foundations including the different types of public charities and the private foundation option. It also includes sample bylaws and IRS forms.

Council on Foundations, *Foundation Management Series, Ninth Edition, Volumes I, II, and III* (Washington, DC: 1998). Based on a survey of 673 foundations, this is the most comprehensive source in the foundation field for comparative data on foundations' management, governance, and grantmaking. Volume I covers finances, portfolio composition, investment management, and administrative expenses. Volume II is devoted to governance, and Volume III focuses on staffing resources and program issues.

Council on Foundations, *Grantmakers Salary Report* (Washington, DC: 1998). Based on a survey of 667 foundations, this report contains salary information for 4,605 full-time employees. It includes a discussion of staffing issues, chief executive compensation, and salary administration. It also includes salary information for 37 foundation positions.

The Foundation Center, *Foundation Giving: Yearbook of Facts and Figures on Private, Corporate, and Community Foundations* (New York: 1998). This is a comprehensive statistical report on foundation assets, grants, and giving trends. It looks at trends in foundation growth, creation, and giving. It explores funding in areas such as health, human services, international programs, environment, and the arts.

The Foundation Center, *Health Policy Grantmaking* (New York: 1998). This report describes trends in foundation funding for health policy-related activities during the first half of the 1990s. The first chapter discusses why foundations support policy-related activities and strategies for effective grantmaking. The second chapter presents an analysis of foundation grantmaking in 1990 and 1995—based on a sample of larger U.S. foundations. It includes an examination of health policy's share of all giving for health, areas of growth in health policy funding, and emerging topics in the field.