GRANT MAKERS IN HEALTH

ASSETS FOR HEALTH

Findings from the 2001 Survey of New Health Foundations

MARCH 2002

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Preface

Foundations with origins in health care conversions have been in existence for almost three decades. Those formed in the 1970s and 1980s have become mature organizations. Many of them 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 carefully constructed strategies. These organizations are working to affect not only the health of the communities they serve but also the field of health philanthropy.

Grantmakers In Health (GIH) has been tracking the emergence and activities of foundations formed from transactions involving nonprofit health care organizations since 1996. Data collected from these surveys are used to regularly document the key elements of foundation structure, organization, independence, accountability, and grantmaking. A year ago, we reported that assets from these foundations exceeded $16 billion, and that they resulted from a variety of conversion arrangements, including sales, mergers, joint ventures, and corporate restructuring. In years past, we have also documented variation in their structures, their relationships to the organizations that gave rise to them, and the extent of community involvement in the development of their missions and grantmaking agendas.

Reporting on the activities of new health foundations is important for several reasons. As the bulk of conversion activity resulting in the formation of foundations has taken place since the mid-1990s, this is still a relatively new phenomenon. These transactions have important implications for how health care is delivered at the state and local level, and for the role of philanthropy in addressing health. These conversions also represent significant increases in philanthropic dollars dedicated to local health improvement projects. Finally, the foundations are often created in the wake of controversy surrounding the conversion. Their structure and growth as grantmaking organizations is increasingly being monitored by their communities.

These reports are intended to educate a variety of audiences on the contributions new health foundations are making toward improving health and health care in local communities. New foundations use the information as a tool to help them gauge their own development. The larger field of health philanthropy uses these reports to identify new foundations that might partner with them in their efforts to improve health and health care at the local level. These data may also serve as a guide for key stakeholders in communities including policymakers, regulators, and consumer advocates that monitor and work with these new foundations.

In addition to updating data on the creation and activities of the 129 foundations discussed in last year's report, this report includes data on several additional foundations created by conversions. In total, 166 foundations were surveyed for this report, representing an increase in the number of organizations identified over previous years. This increase is due to several factors. First, while some of these foundations were already known to us, they were too new to respond to an extensive set of questions on their structure, governance, and behavior. Second, increased attention to the issue of nonprofit conversions and, in turn, the foundations that are created, has made it easier for local communities to identify them. Recognizing the increased visibility these foundations receive at the local level, we made a concerted effort this year to work with regional associations of grantmakers (RAGs) and other local funders to identify these new foundations.

Special thanks are due to the foundations that participated in the survey and to the grantmakers and RAGs that assisted us in our efforts to identify them. Saba Brelvi, program associate, and Malcolm Williams, senior program associate, comanaged the research, analysis, and writing of the report. Mary Kate Brousseau, research assistant, was instrumental in collecting the data. The authors would also like to thank Kate Treanor and Julia Tillman for their comments on earlier drafts, and Anne Schwartz and Lauren LeRoy for their ongoing support, advice, and important contributions to the final product.

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Background and Overview

The attention being paid to foundations formed as the result of transactions involving nonprofit health care organizations continues to grow. There is a great deal of interest from many segments of society about these new foundations – their origins, intentions, activities, and relationships with the community. Stories and reports of new health foundations have moved out of the realm of philanthropy and policy and onto the pages of the popular press. Some within philanthropy argue that this focus is inappropriate – that these new health foundations, once established, should be subject to no more public attention than other philanthropic organizations. Others assert that because the assets used to create these foundations are public in nature, they actually require an additional layer of scrutiny beyond that of their more traditionally formed peers. Still others hold that these new health foundations are the result of significant changes in the health care system, and so are natural subjects for this kind of examination.

While some foundations created from conversions have been in existence for nearly three decades, the majority have been created in the past 10 years. Born out of transactions involving nonprofit hospitals, health plans, and health systems, their assets are usually directed towards improving the health of the local community. While many early conversions occurred without much involvement by regulators and consumer advocacy groups, more recent conversions have involved numerous stakeholders in what are often contentious processes over valuation of assets and directed use of conversion funds.

Regardless of the circumstances surrounding their creation, these new health foundations have the potential to significantly affect health and health care in their communities. Although the assets of many of these individual foundations are small relative to their older, more well-established counterparts, the fact that most of these organizations fund in a limited geographic area means that they are often the largest single source of assets dedicated to health projects in the community. Altogether, the $15.3 billion in assets that these new foundations currently hold represent almost $752 million in potential annual grantmaking geared toward improving health and health care in local communities.[1]

To date, Grantmakers In Health (GIH) has identified more than 160 foundations that are either new foundations created through these conversion agreements or existing ones which have received assets generated by conversions. As new foundations continue to emerge, new questions and areas of inquiry arise. The purpose of this report is to:

- provide clear, concise, and comprehensive background information on these health foundations;
- highlight and examine important issues regarding these organizations, including independence, board structure, and community responsiveness; and
- serve as a user-friendly resource on new health foundations for different constituents, including funders, policymakers, community advocates, and the media.

[1] This amount reflects a decrease in the total assets of new health foundations from 2000; while there may be several reasons for this change, poor stock market performance in 2001 is likely the most significant factor.

What Are Conversions?

The past three decades have witnessed unprecedented growth in the number of transactions involving nonprofit hospitals, health plans, and health systems. Often referred to as *conversions,* many of these transactions involve the transfer of assets from a nonprofit to for-profit and sometimes other nonprofit health care organizations through sales, mergers, joint ventures, or corporate restructuring. For struggling nonprofits, converting can offer a way to preserve their historical missions, gain access to capital, and enhance their competitive positions. For thriving nonprofits, converting can allow nonprofit boards to secure the maximum assets for their communities 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.

Some conversion transactions have led to the creation of new foundations endowed with assets generated by the conversion that are charged with funding health-related activities in their communities. These foundations are often referred to as health care conversion foundations. This is not a legal term, nor is it adequately descriptive. The Internal Revenue Service (IRS) classifies these entities as private foundations, social welfare organizations, or public charities (see Appendix 2). Some transactions between nonprofits and municipal health care organizations have also led to the creation of foundations. Creating a new health foundation or transferring assets to an existing one are common ways to maintain the level of public benefit presumed to have been provided by the nonprofit organization prior to conversion. Although the degree to which nonprofit providers serve the community (and whether their behavior differs from for-profit enterprises) has been much debated, the trend in law and regulation is to require that converted assets be used in a manner consistent with the original nonprofit's mission. This trend is supported by the *cy pres* doctrine, meaning "as close as possible"; the doctrine supports an application of the assets to a mission as close as possible to that of the original nonprofit.

Survey Methodology

For this report, GIH was able to identify and survey 166 foundations that have developed as a result of transactions involving nonprofit organizations. In past surveys, we have tried to reduce the burden foundations face in completing multiple surveys by sending out one-page, fax-back forms to those foundations that had previously responded to a longer questionnaire. In 2001, however, we added a number of new questions and modified others in an attempt to gain a greater understanding of new foundation development and asked all foundations in our sample to complete the full survey. This year's survey was designed to delve deeper into the questions of community involvement, independence, and accountability, in order to draw a clearer picture of the circumstances that surround the development and operations of these foundations.

Responses were collected via mail and fax from 107 of the 166 new health foundations identified. Five foundations were too early in their development to respond to an extensive set of questions regarding their devel-

opment. Data related to many questions from previous years' surveys were used for 32 foundations that did not respond to the 2001 survey. Data on assets, location, year of transaction, and type of nonprofit organization converted for nine additional foundations were drawn from other sources and are included in the summary table at the end of the report.

Results

This report updates information contained in previous publications and provides new data on various dimensions of the development and behavior of new health foundations. These data are presented in five major sections:

- ***Foundation Structure:*** basic information regarding the year of transaction, assets, type of organization involved in the transaction, type of transaction arrangement (i.e. sales, mergers, joint ventures, and corporate restructuring), geographic location, tax status, and staffing.
- ***Board Structure:*** data on average board size, composition, origins, and racial and ethnic diversity.
- ***Foundation Independence:*** data on the independence of the foundations' boards from the organizations involved in the transaction.
- ***Community Involvement:*** data reflecting the extent to which the foundations have included the community in their development and ongoing operations.
- ***Grantmaking Priorities:*** data regarding geographic grantmaking restrictions and major funding areas of the foundations.

The foundations surveyed this year include funders appearing in previous reports as well as others surveyed for the first time. Some of these first-time respondents are brand new, while others have been in existence for some time but have only recently come to our attention. Given these different types of respondents, care must be taken in drawing comparisons between results from earlier reports and this report. For example, the increase in the number of foundations identified does not correspond to an increase in newly formed foundations. While differences between data from earlier reports and this year's report can indicate changes, comparisons should only be drawn where appropriate.

Nevertheless, the addition of more than 30 foundations to the list has helped to clear our understanding of the development and operations of these foundations, and some interesting trends seem to have emerged. First, it is important to note that the conversion phenomenon is continuing. Between 1999 and 2001 at least 18 foundations were created, including five foundations that did not respond to the 2001 survey. In addition, the number of health plan conversions is growing relative to the number of transactions involving other types of nonprofit health care organizations. We are also seeing an increased diversity in tax status choices and foundation structures of these new organizations. Finally, the addition of new questions on board structure, and the increase in the number of surveyed foundations together mean that we have a better understanding of the interdependence of foundations and organizations involved in the conversion. In general, new health

foundations retain their independence by shying away from maintaining formal relationships with these organizations.

Foundation Structure

Our profile of new health foundations begins with a description of the origins of these organizations, including data on the type of nonprofit organizations involved in the transactions and the type of transactions that resulted in foundations. It also reviews information specific to the creation of the foundations, including date of foundation formation, whether new foundations were created or assets were placed with existing charities, and the average length of time to move from foundation formation to making grants. Finally, and perhaps most importantly, a clearer picture of the structure of these new foundations comes from an analysis of their core attributes, including asset size, location, and tax status.

Date of Foundation Formation. Although the conversion phenomenon continues and new foundations are created each year, most new health foundations were established in the mid-1980s or mid- to late-1990s (Exhibit 1). In fact, the greatest rate of growth was in the five-year period between 1994 and 1999 when 70 percent of the foundations responding to this survey were formed. In 1995 alone, at least 24 new foundations were created.

Exhibit 1. *New Health Foundations by Year of Transaction and Current Assets (millions of dollars)*

YEAR OF CONVERSION	NUMBER	TOTAL ASSETS	MEDIAN ASSETS	MEAN ASSETS
1973	1	$30.7	$30.7	$30.7
1977	1	47.0	47.0	47.0
1981	1	2.3	2.3	2.3
1983	1	18.5	18.5	18.5
1984	12	504.6	27.5	42.0
1985	5	1,043.8	143.0	208.8
1986	4	147.7	20.3	36.9
1987	3	178.7	75.0	59.5
1988	1	18.7	18.7	18.7
1989	1	9.0	9.0	9.0
1990	2	180.8	90.4	90.4
1991	1	96.3	96.3	96.3
1992	3	1,064.7	79.3	354.9
1993	2	81.6	40.8	40.8
1994	11	994.6	81.0	90.4
1995	24	2,517.9	81.8	104.9
1996	21	5,521.2	65.0	262.9
1997	18	621.8	27.5	34.5
1998	12	1,267.2	56.2	105.6
1999	9	495.5	45.0	55.1
2000	4	288.7	79.0	72.2
2001	2	148.5	74.3	74.3
Total	139	$15,279.9	$45.0	$109.9

N=139
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Foundation Assets. In total, the assets from new health foundations exceed $15 billion (Exhibit 1). The smallest foundation has assets of $1.75 million, and the largest $3.5 billion, with a median of $45 million. The highest median is for foundations created from health systems ($105.5 million), followed by foundations created from health plans ($76.7 million). The median for foundations created from hospitals is $36.4 million (Exhibit 2). Although the median for foundations created from health systems is the highest, the three largest foundations are the result of health plan transactions. Transactions involving health plans have also garnered more interest recently as the number of Blue Cross plans converting increases. To date, six foundations have been created from converted Blue Cross plans. In addition, four other foundations too new to respond to the survey this year were created from transactions involving Blue Cross plans. Three recent Blue Cross transactions in Maryland, New York, and North Carolina may also result in the creation of new health foundations.

Geographic Distribution of Foundations. Thirty-three states and the District of Columbia have had health care conversions that resulted in the creation of foundations. While these new foundations are spread across the nation, more than 50 percent of the total assets of all health foundations are concentrated in just four states – California, Ohio, Colorado, and Florida (Exhibit 3, page 6). The states with the most foundations are California (21 foundations totaling $6.8 billion) and Ohio (16, totaling $1.1 billion). California has not only the most foundations, but also the three largest funders, which alone account for one-third of all new health foundation assets. Virginia and Pennsylvania each have eight foundations, but their statewide assets are lower than the seven in Florida ($632 million) or the five in Colorado ($1 billion).

Transaction Arrangement. In nonprofit to for-profit transactions, the conversion arrangement has important implications for foundation independence. Unlike sales, both mergers and joint ventures result in agreements that maintain relationships between the nonprofit organization and the for-profit partners, and sometimes the foundation. Most foundations (109), however, have developed as the result of a sale of a nonprofit hospital, health system, or health plan (Exhibit 4, page 6). Of the remaining foundations, 13 developed from joint ventures, 11 are from mergers, and six are from corporate restructurings. The number of foundations created from joint venture transactions is declining relative to the total number of foundations, due in part to IRS rulings on these types of transactions. In 1998, the IRS ruled that some of these partnerships left too much control of the nonprofit health care organization to the for-profit partner, leaving the tax status of

Exhibit 2. *Assets of New Health Foundations (millions of dollars) by Type of Organization, 2001*

TYPE OF ORGANIZATION	NUMBER	TOTAL ASSETS	MEDIAN ASSETS
Hospital	94	$6,668.7	$36.4
Health plan	22	6,453.1	76.7
Health system	14	1,845.4	105.5
Multiple organizations[a]	5	258.9	42.0
Other[b]	4	53.7	7.9
Total	139	$15,279.9	$45.0

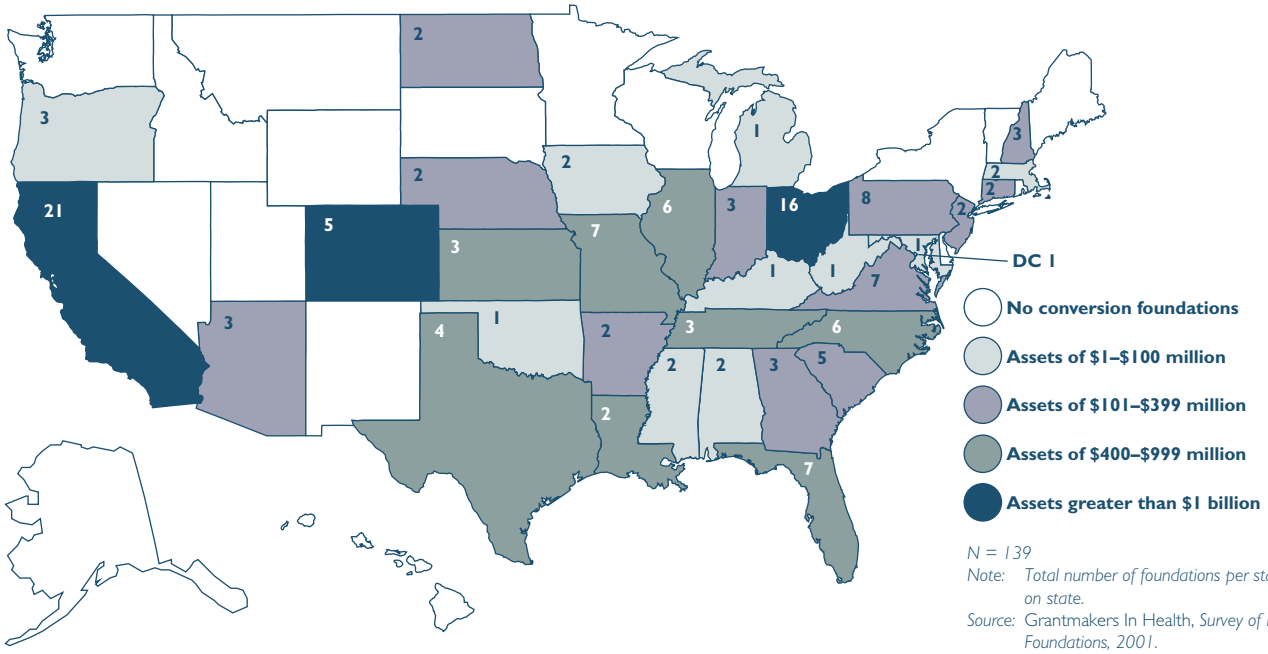
N = 139

[a]*Includes foundations created by transactions involving more than one type of nonprofit health care organization.*

[b]*Includes foundations created by transactions involving two nursing homes, one blood bank, and one rehabilitation hospital.*

Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 3. *States with New Health Foundations by Number and Total Assets, 2001*



N = 139
Note: *Total number of foundations per state reported on state.*
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 4. *New Health Foundations by Type of Transaction and Transaction Arrangement, 2001*

TYPE OF TRANSACTION	NUMBER	TRANSACTION ARRANGEMENT	PERCENT
Nonprofit to for-profit	101.0	All	100.0
	83.0	Sale/buyout/acquisition	82.2
	2.0	Merger	2.0
	11.0	Joint venture	10.9
	5.0	Corporate restructuring	5.0
Nonprofit to nonprofit[a]	33.0	All	100.0
	22.5	Sale/buyout/acquisition	68.2
	8.5	Merger	25.8
	1.0	Joint venture	3.0
	1.0	Corporate restructuring	3.0
Other[b]	4.0	All	100.0
	3.0	Sale/buyout/acquisition	75.0
	0.0	Merger	0.0
	1.0	Joint venture	25.0
	0.0	Corporate restructuring	0.0

N = 138
[a]*Data include one foundation that received assets from more than one transactoin – the sale of several hospitals, and the merger of one health center. A weighted average was created for this foundation's two types of conversion arrangements by assigning (0.5) for the sales and (0.5) for the merger.*
[b]*Data include two foundations formed from the conversion of municipal hospitals to nonprofit status, one foundation created from the partnership of both a nonprofit and a for-profit health care organization, and one from the sale of several hospitals to both nonprofit and for-profit organizations.*
Note: *Data do not include one foundation for which the transfer arrangement is not known.*
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

the health care organization and, in turn, the foundation in jeopardy. As a result, at least two joint ventures have been dissolved and one foundation (the Arlington Health Foundation) eliminated.

Placement of Assets. Distributing the assets of a conversion is one of the most important steps that a community takes regarding these transactions. Creating a vehicle that provides grants to improve health and health care is one way that regulators have interpreted their charge to use the assets in a manner that is consistent with the mission of the original nonprofit health care organization. In transactions that result in the creation of a foundation, regulators must also decide whether to create a brand new foundation or add the assets to an existing charitable organization. When the assets are deposited with an existing charity, there are usually two types of organizations that are recipients: the fundraising charity of the original nonprofit, or a local community foundation. When the former nonprofit's fundraising arm receives the assets, its mission is usually modified to meet the expectation that these assets be used to improve health in the local community. In cases where a local community foundation is asked to manage the assets from the conversion as a separate fund (which may occur when the assets generated from the transaction are too small to warrant the administrative expense of creating a new foundation), the mission of the foundation remains the same, but grants awarded from the fund are generally restricted to health projects. Of the 126 foundations that provided data regarding this issue, 80 were newly created. Forty-six foundations were existing charities that received assets from a conversion.

Tax Status. One of the first challenges faced by new foundations is selecting a tax status: private foundation, public charity, or social welfare organization. Because the tax status has implications for operations, grantmaking, and regulatory oversight, this can be an important decision as well. For foundations that were in existence prior to the receipt of conversion assets, the same tax status may be maintained. The most important difference among the various categories is that public charities, unlike other foundations, must also raise funds from the community. Private foundations face a number of restrictions regarding their grantmaking and lobbying; public charities face fewer of these requirements, and social welfare organizations have few such restrictions. (For a more in-depth discussion of tax status, see Appendix 2.)

Private foundations account for 45 percent of new foundations, but hold a disproportionate amount of new foundation assets (Exhibit 5). This is reflected in the higher median assets for private foundations ($56 million), compared to public charities, which represent 50 percent of all new foundations and have median assets of $41.7 million. Because most social welfare organizations have been created from health plans (which lead to larger health foundations), social welfare organizations have the highest median assets, at $97 million.

Exhibit 5. *Tax Status of New Health Foundations by Assets, 2001 (millions of dollars)*

TAX STATUS	NUMBER	TOTAL ASSETS	MEDIAN ASSETS
Private foundation	62	$9,481.4	$56.0
Social welfare organization 501(c)(4)	6	1,166.6	97.0
Public charity	69	4,555.7	41.7
509(a)(1)	33	1,751.9	27.0
509(a)(2)	3	167.8	34.8
509(a)(3)	33	2,636.0	58.0
Municipal conversion	2	76.2	38.1
Total	139	$15,279.9	$45.0

N = 139
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Time Elapsed Before Grantmaking. Another important marker of a new foundation's development is the length of time it takes to get up and running. Foundations are under pressure from a variety of sources to begin grantmaking. Once assets are received, foundations must make yearly reports on their activities to the IRS. Unlike public charities and social welfare organizations, private foundations are required to meet annual payout requirements and so face additional pressure to distribute assets quickly. Communities also are interested in having access to these assets as soon as possible. The length of time foundations have taken to distribute their first grants varies from 1 to 79 months. On average, however, foundations in this survey took 12 months after the conversion to make their first grants.

Staff Size. The number of staff members employed by foundations varies, depending on both tax status and asset size. Foundations with larger assets do more grantmaking and thus tend to use more staff to distribute the assets. Public charities require more staff than private foundations in order to run their non-grantmaking activities, such as fundraising and the operation of direct service programs. These direct service organizations can require a large number of employees – one public charity that responded to the survey employs 140 individuals in community clinics operated by the foundation (Exhibit 6). Finally, 10 foundations reported that they have no permanent staff. These foundations generally rely on board members, consultants, staff from other foundations, or a combination of these to conduct the work of the foundation.

Board Composition

An examination of board structure is important for several reasons. In addition to overall legal responsibility for the assets of the foundation, the board often provides direction to the foundation by developing its mission and vision. Boards also ensure that the work of the foundation reflects the mission and is responding to the

Exhibit 6. *Median Foundation Staff Size by Tax Status and Asset Size, 2001 (millions of dollars)*

TAX STATUS	NUMBER	ASSET SIZE (MILLIONS OF DOLLARS)	MEDIAN FOUNDATION STAFF SIZE
Private foundation	57	All	3.0
	7	0–10	1.0
	35	11–100	2.0
	15	>100	13.0
Social welfare organization 501(c)(4)	6	All	5.5
Public charity	64	All	4.0
509(a)(1)	30	All	4.0
	9	0–10	2.0
	16	11–100	4.0
	5	>100	6.0
509(a)(2)	3	All	3.0
509(a)(3)	31	All	5.0
	1	0–10	4.0
	21	11–100	4.0
	9	>100	6.0
All foundations	127	All	4.0

N = 127

Notes: *Data for 10 foundations without staff are not included. Data for two foundations resulting from the conversion of municipal hospitals are excluded; these endowments do not have a tax status.*

Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

health needs of the community. The structure of the board has important implications for its independence from other organizations involved in the transaction that created the foundation. This section explores several components of board composition and membership and provides important information on how new health foundation boards are selected. The following section discusses the relationship between board structure and foundation independence.

Board Size and Makeup. The boards of new health foundations vary in both size and composition. Board sizes for the responding foundations range from 5 to 52 members. The median board size among all new health foundations is 13 (Exhibit 7). New health foundations have board members who come from a variety of constituencies. Of 135 responding foundations, 93 had board members chosen from the community, 84 had board members who are former board members of the original nonprofit, and 11 had board members who are also government officials.

Racial and ethnic diversity at the board level is also an important consideration for new foundations. Because foundations often work in minority communities, a diverse board can help steer the work of the foundation so that it addresses the most pressing needs among racial and ethnic minorities. At the same time, having a diverse foundation board can help to build trust in the foundation's work in minority communities. Like their more traditionally formed peers, however, new foundations have boards that are fairly homogeneous. Of the foundations reporting on the racial and ethnic makeup of their boards, two-thirds have two or fewer minority board members (Exhibit 8, page 10).

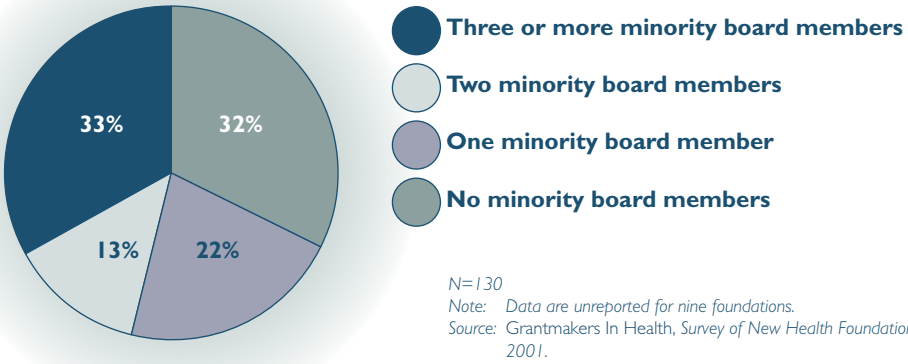
Board Membership. This year's survey included several questions regarding origins of the foundation board. Information on how the original board of the foundation was formed was collected from 101 organizations. The most common response (45 foundations) was that the foundation's board was comprised only of

Exhibit 7. *Median Foundation Board Size by Tax Status and Asset Size, 2001 (millions of dollars)*

TAX STATUS	NUMBER	ASSET SIZE (MILLIONS OF DOLLARS)	MEDIAN FOUNDATION BOARD SIZE
Private foundation	62	All	11.0
	8	0–10	15.0
	39	11–100	10.0
	15	>100	11.0
Social welfare organization 501(c)(4)	6	All	15.0
Public charity	69	All	15.0
509(a)(1)	33	All	14.0
	9	0–10	14.0
	18	11–100	13.0
	6	>100	19.0
509(a)(2)	3	All	10.0
509(a)(3)	33	All	15.0
	2	0–10	10.0
	22	11–100	15.5
	9	>100	15.0
All foundations	137	All	13.0

N = 137
Note: *Data for two foundations resulting from the conversion of municipal hospitals are excluded; these endowments do not have a tax status.*
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 8. *Racial and Ethnic Diversity of New Health Foundation Boards, 2001 (percentage of foundations)*



N=130
Note: Data are unreported for nine foundations.
Source: Grantmakers In Health, Survey of New Health Foundations, 2001.

members of the board of the original nonprofit health care organization. This is also reflected in the high number of foundations with board members who formerly served on the board of the original nonprofit. An assortment of other strategies were used among the remaining 56 responding foundations. These ranged from appointments by government officials or organizations involved in the conversion to the development of specialized committees to select new board members.

There were also 109 foundations that reported on their process for adding new board members. A majority (85 foundations) use nominating committees of the board to recruit new board members. The other foundations used strategies ranging from a committee of outside community advisors to appointments by public officials. Several of the foundations created as supporting organizations relied on the supported organization to approve new board members. The Sisters of Mercy of North Carolina Foundation, for example, forwards its recommendation regarding board appointments to the leadership of the supported organization (Sisters of Mercy of North Carolina) for approval.

Finally, there were 104 foundations that reported on the term lengths of board members. A small number of these reported that their board members held lifetime terms. Of the others, term lengths varied from one year to six years; the median term length for foundation board members was three years.

Foundation Independence

An important issue faced by foundation boards – and one that receives a great deal of outside attention – is the extent to which they are independent from the organizations involved in the conversion. Because of the diversity of new health foundations, there is not a single standard for how independent these foundations should be, nor is there a single litmus test for how well foundations are performing in remaining independent. Rather, foundations' tendencies towards independence are based upon the nature of the transactions, the missions of the organizations involved, and the policies and procedures in place to address potential conflicts of interest.

Foundation independence is a high-profile issue because it highlights the possibility that ongoing relationships between the foundation and the other organizations involved in the transactions – both for-profit and nonprofit – can compromise the foundation's ability to provide public benefits or fulfill the mission of the original nonprofit organization. This is true even when the transaction involves two nonprofit organizations. While these types of transactions are unlikely to raise public benefit concerns, questions may still remain about the compatibility of the foundation mission with that of the original nonprofit.

Achieving independence from the financial interests of the organizations involved in the transaction is one way for new health foundations to ensure that the foundation serves the public's benefit. Many foundations choose to have a complete and total separation from all the organizations involved in the transaction that resulted in the creation of the foundation. These foundations do not share board members with the original nonprofit health care organization or the purchasing organization, nor do they maintain financial relationships with any organization involved in the transaction. For others, however, this is not practical; joint ventures, for example, require continued relationships among the foundation, the original nonprofit, and the for-profit venture partner.

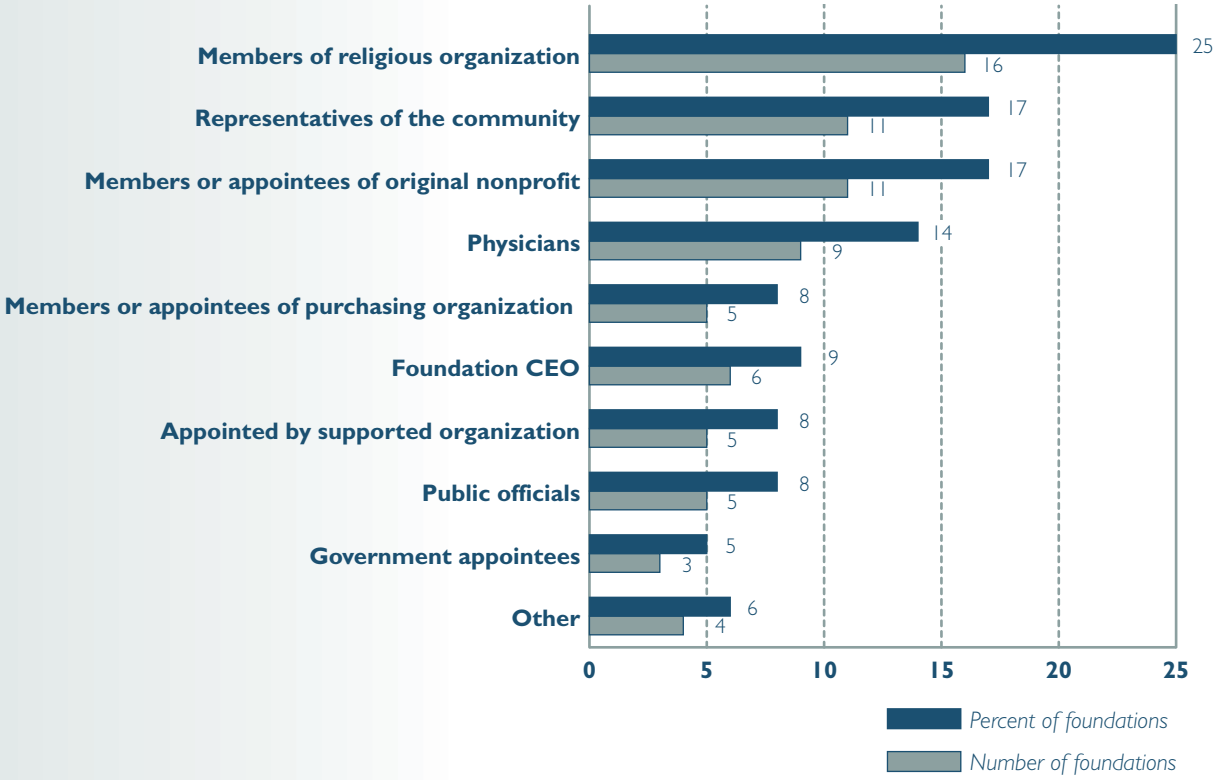
The survey contained questions on several areas related to foundation independence: the reservation of seats on a foundation board for individuals affiliated with organizations involved in the conversion; the practice of permitting board members to sit on both the foundation board and the boards of organizations involved in the conversion; and the existence of policies addressing conflicts of interest. In practice, however, foundation independence is determined not only by the existence of policies and procedures to increase and ensure autonomy, but also by the behavior of the foundation board and staff.

Reserved Board Seats. There were 131 foundations that reported on whether the foundation reserved board seats (Exhibit 9, page 12). Of the 64 foundations reporting reserved board seats, 25 percent reserved seats for members of the religious order that had previously owned or been affiliated with the original nonprofit organization, 17 percent reserved seats for representatives of the community, and 14 percent reserved seats for physicians. In some cases, foundations created from organizations without a religious affiliation also reserved seats for board, staff, or other appointees of organizations involved in the conversion. Approximately 17 percent of the foundations reserved seats for appointees associated with the original nonprofit, and 11 percent reserved seats for appointees affiliated with the purchasing organization.

Concurrent Board Seats. Whether or not board seats are reserved, the presence of trustees from the original nonprofit on the new foundation board can also affect the organization's independence. Of the 130 respondents to survey questions regarding concurrent board seats, 50 indicated that some of their board members also sat on the board of the original nonprofit (Exhibit 10, page 12). Twenty percent of these 50 are joint ventures and mergers, cases in which sharing of board members might be part of the partnership arrangement. There were also 18 foundations that shared board members with the purchasing organization (Exhibit 11, page 13). Of these, four were created from joint ventures and mergers.

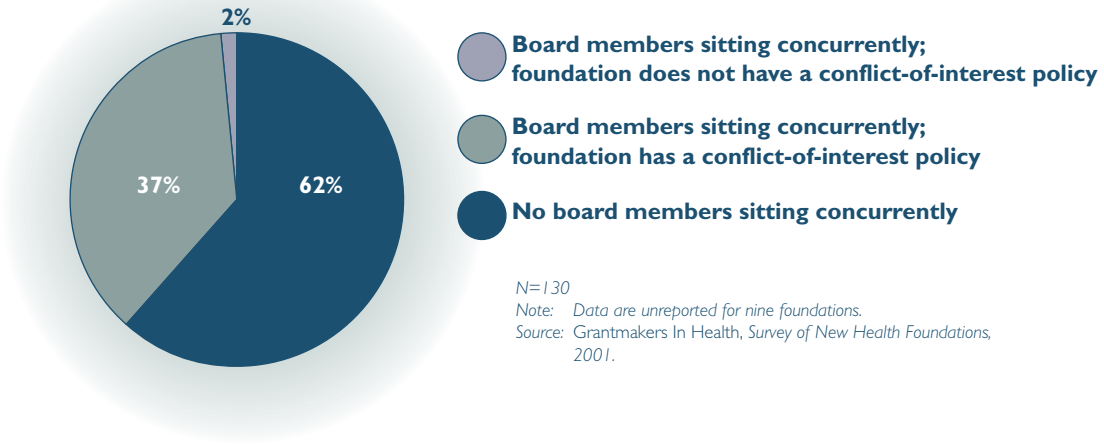
Conflict-of-Interest Policies. The development and use of conflict-of-interest policies are important ways for foundations to minimize both apparent and actual conflicts of interest among board and staff. These policies, created to address the situations faced by board members affiliated with other organizations, establish rules of conduct regarding these relationships. Most often, conflict-of-interest policies are used to address instances in which a foundation trustee is associated with a potential grantee. In order to limit this bias, these

Exhibit 9. *Reserved Board Seats of New Health Foundations by Type of Seat Reserved, 2001 (number and percentage of foundations)*



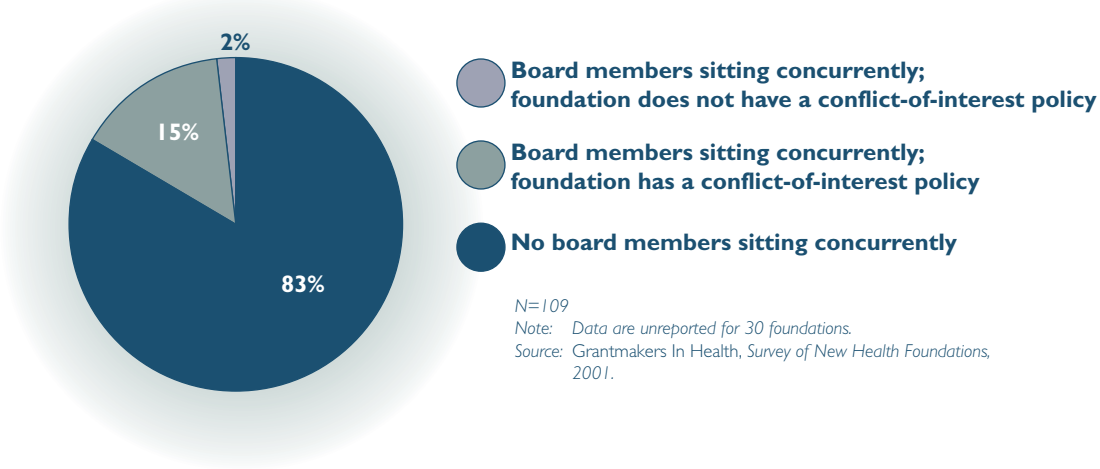
N=64
Notes: *Sixty-seven foundations reported no reserved board seats. Foundations may have reported more than one type of reserved board seat. Data are unreported for eight foundations. Total percentages are for foundations that reserve board seats only.*
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 10. *New Health Foundations with Board Members Sitting Concurrently on Board of Original Nonprofit Organization, 2001 (percentage of foundations)*



N=130
Note: *Data are unreported for nine foundations.*
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 11. *New Health Foundations with Board Members Sitting Concurrently on Board of Purchasing Organization, 2001 (percentage of foundations)*



N=109
Note: Data are unreported for 30 foundations.
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

policies usually require that board members disclose their outside affiliations and, in some cases, refrain from participating in foundation decisions regarding these potential grantees. Of the 136 foundations responding to this question, 124 (91 percent) had conflict-of-interest policies. Of the 58 foundations resulting from sales that shared board members with organizations involved in the transaction, only three did not have conflict-of-interest policies.

Community Involvement

All new health foundations have their origins in the communities they serve. For this reason, community involvement in the development and operations of these foundations is often a high-profile issue for them. It is usually expected (and often required) that the new foundations take into account the voices and opinions of their constituencies in some way. Community involvement is important for a number of reasons. Some argue that, by virtue of the benefit received by the original nonprofit health care organization from its tax-exempt status, the community has a stake in how the assets are used. Practically, community involvement can ensure that foundations are responsive to the most pressing health needs of the community.

For the purposes of this survey, community involvement encompassed a number of different activities and strategies. Survey respondents were asked which of the following they employed, and for what purpose:

- community advisory groups,
- focus groups,
- public hearings,
- consultations with local public health officials, and
- consultations with local academics.

An obvious starting point in the examination of community involvement and responsiveness is the definition of community. New health foundations have various definitions of communities; sometimes these definitions

are outlined during the conversion process, while other times they are realized only once the foundation is established. From a grantmaking perspective, there are several different kinds of communities, including those groups and populations whose needs are served by the foundation, people who live in the catchment area of the foundation, and other individuals and colleagues working in the nonprofit or health sector in the foundation's geographic area.

Many foundations understand the importance of involving the community in order to ensure that programs are responsive to community needs. Given that communities are not always in agreement about their most pressing challenges, foundations use a number of different approaches to learn more about community needs, assets, and preferences. Some of these involve the community directly – convening focus groups, holding public hearings, and developing community advisory groups. These strategies can be challenging to implement because they require identifying and bringing together community voices and representatives that may not necessarily work within an existing infrastructure. Many foundations and community advocates assert that while additional infrastructure may be needed to include these voices, foundations cannot effectively serve the needs of the community without their input. Other ways of collecting information on community needs exist as well. Consulting with individuals who are also formally working on community health issues, including public health officials and local academics, can provide insight into community needs, for example. As these individuals are easily identifiable, this type of information gathering presents less of a challenge for foundations.

Community Involvement Strategies. Overall, we found that the majority of foundations surveyed – 81 funders – employed at least one community involvement strategy (Exhibit 12). Of this number, 93 percent (75 foundations) used at least two strategies. Three-fourths of funders that involved communities used at least three strategies, two-thirds employed four or more, and 53 percent – 43 foundations – used at least five strategies to involve the community in their work.

The two strategies used most often by foundations to bring in community voices and learn about community priorities were consultations with local public health officials followed by focus groups. The third most frequently used strategy was to consult with academics – 52 funders used this technique to learn more about community needs to further the foundation's work. Community advisory committees, which are likely to be

Exhibit 12. *New Health Foundation Strategies for Community Involvement, by Reason for Use, 2001*

	DEVELOPMENT OF BOARD	DEVELOPMENT OF MISSION	DEVELOPMENT OF PROGRAM FOCUS	DEVELOPMENT OF POLICIES AND PROCEDURES	HIRING OF STAFF	ONGOING WORK OF FOUNDATION
Community advisory groups	13	15	27	12	4	30
Focus groups	2	18	50	6	0	32
Public hearings	1	12	13	0	0	10
Consultation with local public health officials	5	20	50	7	2	43
Consultation with local academics	5	14	38	8	3	39

N = 81

Notes: *58 foundations that did not indicate any community involvement are not included in this exhibit. Foundations may have responded with more than one strategy of community involvement, or more than one reason for use of each strategy.*

Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

more long term and require more commitment, were used by 40 foundations. Of these, only 18 percent – seven foundations – were required through their conversion arrangement to convene and utilize community advisory groups.

Levels of community involvement vary by type of foundation work. Board development, for example, involved only limited community engagement from foundations responding to the survey. For those foundations in which communities were actively engaged in board selection, recruitment, and development, this occurred most often through community advisory committees. In fact, of those that indicated that they used an identified strategy for board recruitment (focus groups, hearings, consultations, or community advisory committees), more than half indicated that they convened community advisory committees. Only a handful of foundations consulted with academics and public health officials in their communities as board members were identified, recruited, and trained.

Various community involvement strategies are also used to help develop the missions of foundations. The mission of a foundation is the basic guiding framework for its grantmaking. Consulting with local public health officials is the most preferred strategy for learning about community needs in the development of foundation missions, followed by consulting with academics and convening focus groups. Sometimes, however, foundation missions are determined during the conversion process itself. In these cases, negotiators in the conversion process – attorneys general, insurance commissioners, and representatives from the organizations involved in the conversion – may seek community input.

Foundations rely on community involvement and engagement frequently in determining the program areas on which the organization should focus. These program areas represent the foundation's priorities, outlining what steps the foundation will take in addressing the needs it has identified and what particular health issues or populations it will serve. Unlike mission statements, foundation program areas change over time, incorporating lessons learned by foundations in their work and reflecting changing community needs. Fifty foundations indicated that they conducted focus groups to help identify program areas, and fifty foundations (not necessarily the same group) consulted with local public health officials in deciding what program areas to fund. Consultations with local academics was another often utilized strategy in determining program focus, as was relying on community advisory committees.

By and large, though, it is in their ongoing work that many foundations include community opinions and voices. Many foundations (28) have ongoing community advisory committees to assist them; these committees can serve as sounding boards for new ideas, barometers to measure growing community concerns and needs, or simply as experienced advisors. Other foundations (43) consult regularly with public health officials, and 39 have an ongoing dialogue with local academics.

Grantmaking

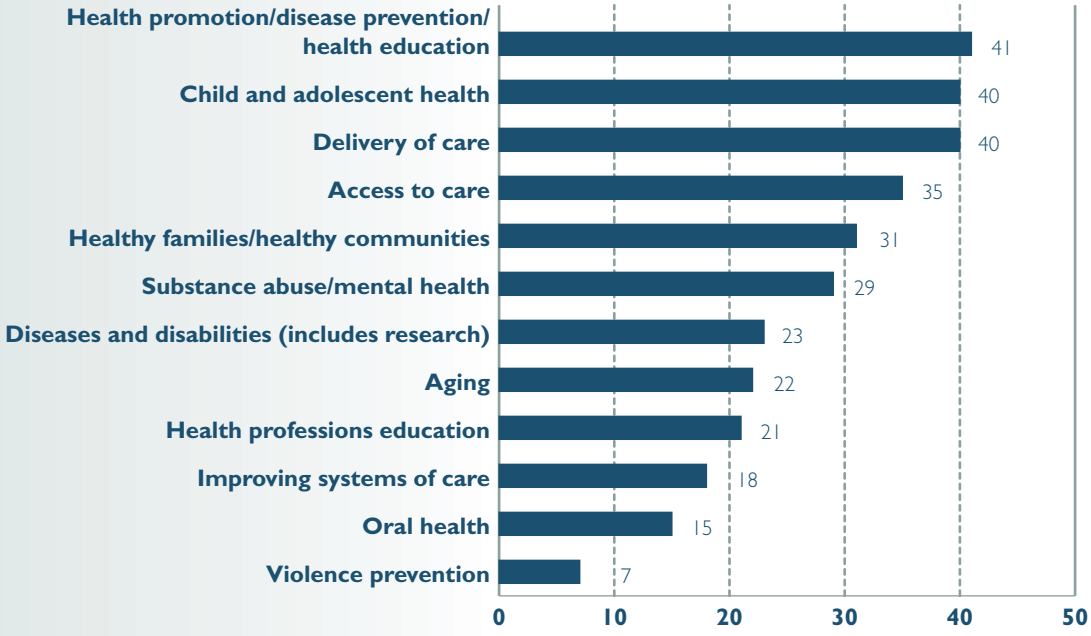
While foundations created from conversions differ a great deal from one to another, they do have some similarities in their approach to grantmaking. By and large, they fund within limited geographic areas. And although their priorities and program areas reflect diverse interests, almost all of these foundations make grants to address the health needs of their communities.

Geographic Grantmaking Restrictions. Most foundations created from conversions have geographic grantmaking restrictions that help to identify and define their communities. Some fund in several states, while others fund solely in their own state. Many others fund only in a limited number of counties or cities. In the 2001 survey, 121 of the 130 foundations that responded to inquiries on geographic grantmaking restrictions indicated that they did indeed have limited geographic areas within which they funded.

Health Grantmaking. Most foundations created from health care conversions focus their grantmaking in the health arena. Many (64 percent) fund exclusively in health; others spend the bulk of their grantmaking dollars in health but also fund other activities. Definitions of health vary a great deal from one foundation to another. Commonly funded areas of health and health care include delivery of services, child and adolescent health, and health education and prevention (Exhibit 13). Some foundations focus on specific populations – the elderly, minorities, or high-risk teens – while others concentrate on broader issues, including environmental health and access to care.

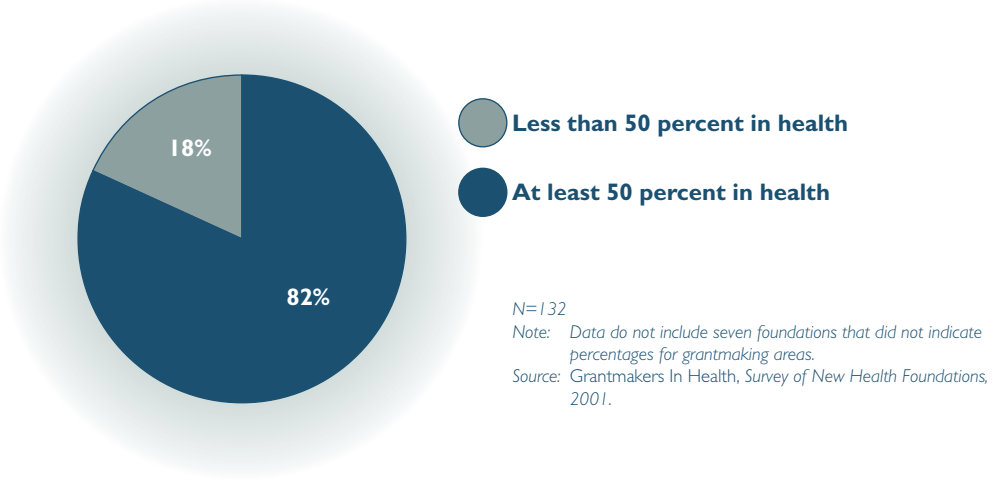
Some areas of health are beginning to attract more funders. A larger number of funders are supporting access to care and mental health and substance abuse in their communities. Other areas of health are being identified for the first time as priority areas for health foundations. Oral health and family violence are both emerging as areas in which foundations are becoming involved. Racial and ethnic disparities in health, the weakened public health system, and the uninsured are also among the timely issues that new health foundations have taken a leadership role in addressing.

Exhibit 13. *Selected Health Grantmaking Areas, 2001 (number of foundations)*



N=136
Notes: Foundations may have reported more than one health grantmaking area, and some grantmaking areas are included in more than one category. Data are unreported for three foundations.
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Exhibit 14. *New Health Foundation Funding in Health by Level of Funding, 2001 (percentage of foundations)*



N=132
Note: Data do not include seven foundations that did not indicate percentages for grantmaking areas.
Source: Grantmakers In Health, *Survey of New Health Foundations, 2001.*

Among foundations that fund outside health, the share of funding spent in these areas vary. As the chart indicates, only 18 percent of foundations indicate that they fund less than 50 percent in health, and only two foundations responded that they did not fund health at all (Exhibit 14). Even these numbers, though, are likely to underrepresent the actual amount of health funding provided by new health foundations. Areas outside the scope of health include family support, children and youth, arts, education, and Jewish identity. Funders working in these areas assert that due to the complex determinants of health, effective funding in some of these non-health related areas can influence the general health and well-being of communities.

Summary and Conclusions

New health foundations are at once maintaining a high profile and merging into the philanthropic mainstream. While this report focuses solely on a discrete group of foundations created from health care transactions, it is important to keep in mind that, in many cases, the source of their endowments may be the only factor these organizations have in common. In many ways, these foundations are like any other funder – they operate under the same federal and state guidelines for private foundations and public charities, they structure their organizations in the same manner, and they often seek similar ways to improve their work. As a result, they also reflect the diversity of the larger field of philanthropy, and have characteristics that make them each as unique as foundations in the larger philanthropic sector.

Over time, some foundations created from conversions have emerged as leaders in the field of health philanthropy. The lessons these foundations have learned – about start-up, grantmaking, and improving their work – have benefits both for their traditionally established peers and for brand new health foundations. This cohort of foundations has learned the importance of community involvement; brand new foundations can apply these lessons and seek community input earlier, and in more aspects of their work. They have also

developed expertise in evaluation, communications, and setting objectives and outcomes for their work, lessons from which even more established foundations can benefit. Overall, this growing cohort of well-respected foundations created from conversions is raising the bar for all of their grantmaking colleagues.

The origins of these new health foundations result in significant pressure from regulators and their communities to set high standards of effectiveness and be accountable for their actions. As new conversions continue to occur, there is greater attention paid to structuring the resulting foundation to address the most pressing needs of the community. Recognizing that important structural factors such as tax status and staffing affect the behavior of the foundation, many initial boards are spending more time thinking through these issues with an eye toward the ultimate goal of meeting community needs.

Another result of the increased prominence of these organizations is the growing response to new health foundations within the philanthropic sector. Organizations that serve foundations have changed and expanded their work to track, document, and address the needs of these new foundations. The Foundation Center, long a compiler of information about foundation funding, now includes discrete categories of funding conducted by foundations created from conversions. The Council on Foundations' annual salary and management reports specifically address the hiring and management practices of new health foundations. In addition to conducting surveys to track this emerging group of foundations, GIH's Support Center for Health Foundations provides technical assistance to these new funders on issues related to operations and governance. Organizations that rely on foundation funding have taken notice of new health foundations as well; grantees and community groups trying to raise funds look eagerly to the new health foundations in their neighborhoods.

The landscape of health and health grantmaking has been significantly changed by these new health funders. Because of both their origins and their geographic grantmaking restrictions, these foundations are often poised to play important roles in both raising an awareness of community health needs and responding to them. While the overall asset base of some of these foundations is small, in many communities, these relatively small foundations are among the largest funders. This makes each of them a potentially influential player in the community, depending on how they choose to structure their programming and define their community role. Many foundations have taken advantage of this role by focusing on pressing public health issues, simultaneously injecting needed resources while raising awareness of these concerns. Working alone or in concert with local organizations, other grantmakers, or government, these foundations bring newfound assets to the task of improving the nation's health.

APPENDIX I

A Profile of New Health Foundations

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Alleghany Foundation *Covington, VA*	1995	$51,094,345	Private Foundation	Hospital	Nurses in schools, arts/humanities, education, economic development, historic preservation, social and community services
Alliance Healthcare Foundation *San Diego, CA* www.alliancehf.org	1994	$100,000,000	Private Foundation	Health Plan	Restricted access to care, substance abuse prevention and treatment, communicable disease control, violence prevention, mental health, environmental and community health problems
Andalusia Health Services, Inc *Andalusia, AL*	1981	$2,315,653	Private Foundation	Hospital	Medical scholarships
Anthem Foundation of Connecticut *West Hartford, CT*	1999	$45,000,000	Public Charity[3]	Health Plan	Compliance, community empowerment, options to expand health care coverage to small employers
The Anthem Foundation of Ohio *Cincinnati, OH* www.greatercincinnatifdn.org	1995	$28,300,000	Public Charity[3]	Health Plan	Preventive oral health and prevention of family violence
Archstone Foundation *Long Beach, CA* www.archstone.org	1985	$143,001,109	Private Foundation	Health Plan	Aging issues
Asbury Foundation of Hattiesburg, Inc. *Hattiesburg, MS*	1997	$102,236,316	Private Foundation	Health System	General health
The Assisi Foundation of Memphis, Inc. *Memphis, TN* www.assisifoundation.org	1994	$201,000,000	Private Foundation	Hospital	Health, education, literacy, religion, community enhancement, other related activities
Austin-Bailey Health & Wellness Foundation *Canton, OH* www.foundationcenter.org/grantmaker/austinbailey	1996	$10,000,000	Private Foundation	Hospital	A broad range with no specific focus other than health and wellness
Baptist Community Ministries *New Orleans, LA* www.bcm.org	1995	$235,000,000	Private Foundation	Hospital	Children ages 0–5 years, behaviors, parenting, immunization
Barberton Community Foundation *Barberton, OH*	1996	$101,054,651	Public Charity[3]	Hospital	Health, education, human services, economic and community development
Bedford Community Health Foundation, Inc. *Bedford, VA* www.bchf.org	1984	$4,390,712	Public Charity[1]	Hospital	Emergency medical services, senior care, nursing scholarships, charity care

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Bernardine Franciscan Sisters Foundation *Newport News, VA* www.bfranfound.org	1996	$12,809,674	Public Charity[3]	Hospital	Care of the poor, Salvation Army, free clinics, drug and alcohol abusers
Berwick Health & Wellness Foundation *Berwick, PA* www.berwickfoundation.org	1999	$27,000,000	Public Charity[1]	Hospital	Dental health, mental health, women's health (related to domestic abuse), community health
BHHS Legacy Foundation *Phoenix, AZ*	2000	$104,000,000	Public Charity[3]	Health System	Children, families, and seniors
Birmingham Foundation *Pittsburgh, PA* www.birminghamfoundation.org	1996	$21,564,546	Private Foundation	Hospital	Senior wellness, children's wellness, health access, capacity building, mental health, substance abuse, violence prevention
Mary Black Foundation, Inc. *Spartanburg, SC* www.maryblackfoundation.org	1996	$76,687,853	Public Charity[1]	Hospital and Health System	Children, youth, and families; cardiovascular disease prevention; nutrition improvement; prevention of adolescent pregnancy; literacy
The Blowitz-Ridgeway Foundation *Northfield, IL*	1984*	$26,692,592	Private Foundation	Hospital	Health care, social services, medical research, early childhood development, education
The Brentwood Foundation *Medina, OH*	1994	$20,473,439	Private Foundation	Hospital	Medical education, research, community health
Drs. Bruce and Lee Foundation *Florence, SC*	1995	$141,890,000	Private Foundation	Hospital	Health, human services, youth education; cultural, historical, environmental preservation
Byerly Foundation *Hartsville, SC* www.byerlyfoundation.org	1995	$26,000,000	Public Charity[2]	Hospital	Education, economic development, quality of life
Calhoun County Community Foundation *Anniston, AL* www.cccfoundation.org	1997	$18,885,499	Public Charity[1]	Hospital	Substance abuse, child abuse/neglect intervention and prevention, mental health, elder health, environmental health, and indigent health care
The California Endowment *Woodland Hills, CA* www.calendow.org	1996	$3,500,000,000	Private Foundation	Health Plan	Workforce diversity, access, cultural competency, disparities in health
California HealthCare Foundation *Oakland, CA* www.chcf.org	1996	$779,000,000	Social Welfare Organization	Health Plan	Access to health care, California's uninsured, health policy, quality of care, e-health, health care delivery systems
The California Wellness Foundation *Woodland Hills, CA* www.tcwf.org	1992	$951,800,000	Private Foundation	Health Plan	Women's health, environmental health, mental health, work and health, healthy aging, violence prevention, diversity in health professions, teen pregnancy prevention
Cape Fear Memorial Foundation *Wilmington, NC*	1996	$65,000,000	Private Foundation	Hospital	Health sciences
Caring for Colorado Foundation *Denver, CO* www.caringforcolorado.org	1999	$140,000,000	Social Welfare Organization	Health Plan	Infrastructure, community-specific projects, informed health decisions

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Central Florida Healthcare Development Foundation *Leesburg, FL* www.cfhcdf.org	1997	$37,260,967	Public Charity[3]	Hospital and Health System	Access to care, education, direct service
Christy-Houston Foundation *Murfreesboro, TN*	1986	$93,915,877	Private Foundation	Hospital	Health care, education, charitable activities, nursing homes, nursing education
Colorado Springs Osteopathic Foundation *Colorado Springs, CO* www.csof.org	1984	$13,000,000	Public Charity[1]	Hospital	Operation of a family practice training program and clinic for the underserved
The Colorado Trust *Denver, CO* www.coltrust.org	1985	$376,980,495	Private Foundation	Hospital	Advancing delivery of quality health care
Columbus Medical Association Foundation *Columbus, OH* www.cmaf-ohio.org/cmaf	1992	$79,330,893	Public Charity[1]	Health Plan	Access to health care, health promotion, health education
CommunityCare Foundation, Inc. *Springdale, AR* www.ccfound.org	1998	$134,500,000	Public Charity[3]	Health System	Health, human services, education
Community Health Corporation *Riverside, CA* www.rchf.org	1997	$25,000,000	Public Charity[1]	Hospital	Underinsured families, uninsured, dental health
Community Health Endowment of Lincoln *Lincoln, NE* www.chelincoln.org	1997	$43,500,000	Other**	Hospital	Provision of prescription medications to those in need, case management for mental health and substance abuse, improving health status for those at highest risk for poorest outcomes, prevention of family violence, health technology
Community Health Foundation *Massillon, OH* www.chfoundation.org	1999	$6,700,000	Private Foundation	Hospital and Health System	Health and wellness in all areas including emotional, physical, and mental
Community Memorial Foundation *Hinsdale, IL* www.cmfdn.org	1995	$90,000,000	Private Foundation	Hospital	Youth, older adults, families, access to health and building organizational effectiveness
Moses Cone – Wesley Long Community Health Foundation *Greensboro, NC* www.mosescone.com	1997	$101,000,000	Public Charity[3]	Hospital	Access, wellness
Connecticut Health Foundation *Farmington, CT* www.cthealth.org	2001	$120,000,000	Social Welfare Organization	Health Plan	Oral health, children's mental health, reduction of racial and ethnic health disparities
Consumer Health Foundation *Washington, DC* www.consumerhealthfdn.org	1994	$33,961,668	Private Foundation	Health Plan	Improving access to health care (particularly for the most vulnerable members of a community), consumer education and empowerment, health systems reform, capacity building

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Dakota Medical Foundation Fargo, ND www.dakmedfn.org	1998	$102,000,000	Public Charity[1]	Hospital	Children's health, dental health, diabetes, drug/alcohol abuse, helath information/education, indigent care, mental health
Daughters of Charity Foundation *St. Louis, MO* www.daughtersofcharityfdn.org	1996*	$235,000,000	Public Charity[3]	Hospital	Health and wellness, primary and preventive health care
Daughters of Charity Healthcare Foundation of St. Louis *St. Louis, MO* www.daughtersofcharityfdn.org	1995	$1,800,000	Public Charity[3]	Hospital	Health and wellness, primary and preventive health care, healthy community initiatives
Deaconess Community Foundation *Cleveland, OH* www.fdncenter.org/grantmaker/deaconess	1994	$38,000,000	Public Charity[3]	Hospital	Intercity health projects, human services, education, seniors
Deaconess Foundation *St. Louis, MO* www.deaconess.org	1997	$70,000,000	Public Charity[3]	Health System	Children in urban core
Desert HealthCare Foundation *Palm Springs, CA* www.dhfonline.org	1997	$6,400,000	Public Charity[1]	Hospital	Enhancement of community health and wellness by providing innovative programs and services
Eden Township HealthCare District *Castro Valley, CA* www.ethd.org	1998	$32,663,000	Other**	Hospital	Health care access, cardiovascular disease, delivery of care to high-risk/special needs populations, substance abuse, collaboration with school districts to improve health
Endowment for Health, Inc. *Concord, NH* www.endowmentforhealth.org	1999	$87,000,000	Private Foundation	Health Plan	Oral health, access to health care
FISA Foundation *Pittsburgh, PA* www.fisafoundation.org	1996	$35,500,000	Private Foundation	Rehabilitation Hospital	Health and human service needs of women and girls, quality of life issues for adults and children with disabilities
Foundation for Seacoast Health *Portsmouth, NH* www.fsh.org	1984	$65,678,333	Private Foundation	Hospital	Access to mental and dental health care for low-income and uninsured people, dissemination of health promotion information, expansion of access to quality child care for low-income families
Four County Community Foundation *Almont, MI* www.4ccf.org	1987	$6,500,000	Public Charity[1]	Hospital	Healthy seniors, healthy youth, public safety, arts and culture
Franklin Benevolent Corporation *San Francisco, CA* www.frankben.org	1998	$38,387,000	Public Charity[1]	Hospital	Health education and research
Friends of Public Health *Portland, OR*	1997	$1,750,000	Public Charity[1]	Health Plan	Public health, graduate scholarships, public health workforce development, urgent needs in public health system

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Georgia Health Foundation *Atlanta, GA* www.gahealthfdn.org	1985	$10,500,000	Private Foundation	Health Plan	All areas of health – education, research, facilities
Georgia Osteopathic Institute *Tucker, GA* www.goi.org	1986	$6,000,000	Public Charity[1]	Hospital	Statewide training program for third- and fourth-year medical students working in underserved areas
Good Samaritan Foundation, Inc. *Lexington, KY* www.gsfky.org	1995	$24,142,360	Public Charity[1]	Hospital	Access for low-income and underinsured populations, health education in underserved areas, training of health care professionals
Greater St. Louis Health Foundation *St. Louis, MO*	1985	$5,400,000	Private Foundation	Health Plan	Health care providers, health promotion and illness prevention, seed money for new projects
Grotta Foundation *South Orange, NJ*	1993	$8,852,880	Private Foundation	Nursing Home	Alzheimer's disease
Gulf Coast Medical Foundation *Wharton, TX*	1983	$18,500,000	Private Foundation	Hospital	Medically related services, local emergency medical services, and primary care
The Health Foundation of Central Massachusetts, Inc. *Worcester, MA* www.hfcm.org	1995	$53,300,000	Social Welfare Organization	Health Plan	Oral health and mental health
The Health Foundation of Greater Cincinnati *Cincinnati, OH* www.healthfoundation.org	1997	$260,000,000	Social Welfare Organization	Health Plan	Strengthening primary care providers to the poor, school-based child health interventions, substance abuse, severe mental illness
The Health Foundation of Greater Indianapolis, Inc. *Indianapolis, IN* www.thfgi.org	1984	$35,500,000	Private Foundation	Health Plan	Adolescents, elders, AIDS
Health Foundation of South Florida *Miami, FL* www.hfsf.org	1993	$72,700,000	Public Charity[1]	Hospital	Indigent care, research, social services, nursing scholarships, homeless health care, and school-based health clinics
Health Future Foundation *Omaha, NE*	1984	$70,000,000	Public Charity[1]	Hospital	Indigent care, research, health-related projects at Creighton University
The Health Trust *San Jose, CA* www.healthtrust.org	1996	$107,000,000	Public Charity[2]	Health System	Access to health services
The HealthCare Foundation for Orange County *Santa Ana, CA* www.hfoc.org	1996	$17,500,000	Private Foundation	Hospital	Education, prevention, and treatment for low-income families
The Healthcare Foundation of New Jersey *Roseland, NJ* www.hfnj.org	1996	$151,000,000	Private Foundation	Hospital	Health care needs of the vulnerable population of Newark, New Jersey; medical education; clinical medical research; school-based health care; humanism in medicine; the vulnerable members of the Jewish community of northern New Jersey

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	CURRENT ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Healthcare Georgia, Inc. *Atlanta, GA*	1999	$80,000,000	Private Foundation	Health Plan	Guidelines not available
HealthONE Alliance *Denver, CO* www.health1.org/philanthropy	1995	$178,482,000	Public Charity[1]	Health System	Community health and professional education
Healthy New Hampshire Foundation *Concord, NH*	1997	$12,737,909	Private Foundation	Health Plan	Acquiring health insurance coverage, health promotion
Hill Crest Foundation, Inc. *Bessemer, AL*	1984	$28,000,000	Private Foundation	Hospital	Mental health, arts, education
Hilton Head Island Foundation, Inc. *Hilton Head, SC* www.hhif.org	1994	$24,900,000	Public Charity[1]	Hospital	Arts and culture, community development, education, environment, health, human services
The Horizon Foundation *Columbia, MD* www.thehorizonfoundation.org	1998	$74,000,000	Public Charity[1]	Hospital	Community health and wellness, substance abuse, elder health
Incarnate Word Foundation *St. Louis, MO* www.incarnatewordfund.com	1997	$32,000,000	Public Charity[3]	Hospital	Community health and wellness, women, children, economically poor
Institute for Healthcare Advancement *Whittier, CA* www.iha4health.org	1995	$35,000,000	Private Foundation	Health System	Community service activities
Irvine Health Foundation *Irvine, CA* www.ihf.org	1986	$27,000,000	Private Foundation	Hospital	Prevention, services, research, policy
The Jackson Foundation, Inc. *Dickson, TN* www.jacksonfoundation.org	1995	$80,000,000	Private Foundation	Hospital	Education, arts, technology training
Jenkins Foundation *Richmond, VA* www.tcfrichmond.org	1995	$41,690,000	Public Charity[3]	Hospital	Access to care for the medically underserved, substance abuse prevention, violence prevention, teen pregnancy prevention
The Jewish Foundation of Cincinnati *Cincinnati, OH*	1996	$96,283,000	Private Foundation	Hospital	Capital improvement projects
Jewish Healthcare Foundation *Pittsburgh, PA* www.jhf.org	1990	$132,000,000	Public Charity[1]	Hospital	Advancing health, financing and delivering health, integrating health
Kansas Health Foundation *Wichita, KS* www.kansashealth.org	1985	$412,000,000	Private Foundation	Hospital	Public health, children's health, leadership
Lancaster Osteopathic Health Foundation *Lancaster, PA*	1999	$11,800,000	Public Charity[1]	Hospital	Osteopathic profession and health of the children of Lancaster county
Lower Pearl River Valley Foundation *Picayune, MS*	1998	$14,012,000	Private Foundation	Hospital	General health

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Lutheran Charities Foundation of St. Louis *St. Louis, MO*	1987	$97,232,317	Public Charity[3]	Hospital	Physical and developmental disability, children, elderly, substance abuse, parish nursing, church service in community
Dr. John T. Macdonald Foundation, Inc. *Coral Gables, FL* www.jtmacdonaldfdn.org	1992	$33,543,612	Private Foundation	Hospital	School health clinics, genetic research
MacNeal Health Foundation *Berwyn, IL* www.macnealhf.org	2000	$86,000,000	Private Foundation	Hospital	Health education, health care for elderly and families, health research, literacy
The Memorial Foundation, Inc. *Goodlettsville, TN*	1994	$144,000,000	Public Charity[1]	Hospital	Youth and children, education, elder health, human services
Methodist Healthcare Ministries of South Texas, Inc. *San Antonio, TX* www.mhm.org	1995	$216,000,000	Public Charity[3]	Hospital	Primary health care and dental services
MetroWest Community Health Care Foundation *Framingham, MA* www.mchcf.org	1996	$44,000,000	Private Foundation	Health System	Children and youth, elderly, community health data collection, nursing and medical scholarships
Mid-Iowa Health Foundation *Des Moines, IA*	1984	$16,702,248	Private Foundation	Hospital	Adolescent health, parent and early childhood health, access to health services, preventive health services
The Mt. Sinai Health Care Foundation *Cleveland, OH* www.mtsinaifoundation.org	1996	$142,000,000	Public Charity[3]	Health System	Birth to 3 child development, aging, health policy, capacity building, medical science
Mount Zion Health Fund *San Francisco, CA*	1990	$48,800,000	Public Charity[1]	Hospital	Vulnerable populations, filling funding gaps
North Dade Medical Foundation, Inc. *North Miami, FL*	1997	$34,800,000	Public Charity[2]	Hospital	Health, abuse, awareness, education, general welfare, rehabilitation, remedial learning
Northwest Health Foundation *Portland, OR* www.nwhf.org	1997	$74,000,000	Social Welfare Organization	Health Plan	Rural, access, mental health, children, youth, disease related
Northwest Osteopathic Medical Foundation *Portland, OR*	1984	$9,500,000	Public Charity[1]	Hospital	Families and children, scholarships to osteopathic medical students, training clinics for osteopathic residency programs
Osteopathic Founders Foundation *Tulsa, OK*	1996	$18,908,900	Public Charity[1]	Hospital	Osteopathic medical education, community health
Osteopathic Heritage Foundations *Columbus, OH* www.osteopathicheritage.org	1998	$230,000,000	Public Charity[3]	Hospital	Community health initiatives, osteopathic medical education and research

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Pajaro Valley Community Health Trust *Watsonville, CA* www.pvhealthtrust.org	1998	$9,900,000	Public Charity[1]	Hospital	Diabetes, oral health, farmworkers and their families, youth
Paso del Norte Health Foundation *El Paso, TX* www.pdnhf.org	1995	$211,000,000	Private Foundation	Hospital	Health education and disease prevention
Annie Penn Community Trust *Reidsville, NC*	2001	$28,500,000	Private Foundation	Hospital	Improve health and quality of life
Phoenixville Community Health Foundation *Phoenixville, PA* www.dvm.org	1997	$30,000,000	Public Charity[3]	Hospital	Access to health care; public safety; health education; disease prevention; civil, social, and economic health of Phoenixville
Portsmouth General Hospital Foundation *Portsmouth, VA* www.pghfoundation.org	1988	$18,708,407	Private Foundation	Hospital	Pregnancy prevention, health and the family, indigent care, substance abuse prevention, health education, preventive health programs
Prime Health Foundation *Kansas City, MO* www.primehealthfoundation.org	1989	$9,000,000	Private Foundation	Health Plan	Managed care, health care education, disease management
Quad City Osteopathic Foundation *Bettendorf, IA*	1984	$5,360,505	Private Foundation	Hospital	Scholarships and grants for medical education
Quantum Foundation, Inc. *West Palm Beach, FL* www.quantumfoundation.com	1995	$169,515,631	Private Foundation	Hospital	School health, school-based wellness centers, behavioral health, elder health, health access
QueensCare *Los Angeles, CA* www.queenscare.org	1998	$373,873,000	Private Foundation	Hospital	Health care access, primary care, prevention, wellness, education and outreach
John Randolph Foundation *Hopewell, VA*	1995	$34,465,000	Public Charity[1]	Hospital	Primary care, access to care, needs of children and the elderly
The Rapides Foundation *Alexandria, LA* www.rapidesfoundation.org	1994	$208,000,000	Public Charity[1]	Hospital	Access, behavioral risk reduction, maintenance of health for older adults, early identification of developmental delay
Michael Reese Health Trust *Chicago, IL* www.fdncenter.org/grantmaker/health	1991	$96,300,000	Private Foundation	Hospital and Health Plan	Health care; health education; some limited health research, primarily for public policy and advocacy
John Rex Endowment *Raleigh, NC*	2000	$72,000,000	Public Charity[1]	Hospital	Improving children's access to health services and to a pediatric home
Roanoke-Chowan Foundation, Inc. *Ahoskie, NC*	1997	$16,000,000	Private Foundation	Hospital	Wellness
Rose Community Foundation *Denver, CO* www.rcfdenver.org	1995	$284,000,000	Public Charity[3]	Hospital	Primary prevention; access to care for low-income children, youth, and families; health policy and public health leadership; aging; education; child and family development; Jewish life

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Saint Ann Foundation *Cleveland, OH* www.socstannfdn.org	1973	$30,700,000	Public Charity[3]	Hospital	Human services
St. David's Foundation *Austin, TX* www.sdsys.org	1996	$95,731,000	Public Charity[1]	Hospital	Access and prevention programs, behavioral health, parenting, life skills, violence prevention, teen pregnancy prevention, medical education, research
The St. Joseph Community Health Foundation *Fort Wayne, IN*	2000	$26,656,540	Public Charity[3]	Hospital	Access to care, disease prevention and health promotion, donor-restricted health interests
St. Joseph's Community Health Foundation *Minot, ND*	1998	$2,063,539	Public Charity[1]	Hospital	Mental, physical, and spiritual well-being
St. Luke's Foundation *Bellingham, WA* www.stlukesfoundation.org	1983	$10,500,000	Public Charity[2]	Hospital	Health care
Saint Luke's Foundation of Cleveland, Ohio *Cleveland, OH* www.stlukesfoundcleveland.org	1987	$75,000,000	Public Charity[3]	Hospital	General health and wellness, health and medical education, medical research, behavioral health, health care delivery, human services, education
St. Luke's Health Initiatives *Phoenix, AZ* www.slhi.org	1995	$100,000,000	Public Charity[3]	Health System	Access to care, mental health, health policy, emerging issues
San Angelo Health Foundation *San Angelo, TX* www.sahfoundation.org	1995	$66,694,980	Private Foundation	Hospital	Community health and well-being
San Luis Obispo Community Health Foundation *San Luis Obispo, CA*	1998	$2,400,000	Private Foundation	Blood Bank	Issues surrounding community blood supply: amount, safety, education and awareness of blood-transmitted diseases
SHARE Foundation *El Dorado, AR*	1996	$65,400,000	Public Charity[1]	Hospital	Health education, humanities, disease prevention, hospice, medical clinic, drug prevention, chaplaincy, scholarships
Sierra Health Foundation *Sacramento, CA* www.sierrahealth.org	1984	$168,643,990	Private Foundation	Health Plan	Children's health and other health-related projects
J. Marion Sims Foundation *Lancaster, SC*	1994	$81,000,000	Private Foundation	Hospital	Health, human services, economic and community development
Sisters of Charity Foundation of Canton *Canton, OH* www.csahealthsystem.org/phil.asp	1995	$73,619,077	Public Charity[3]	Hospital	Alcohol and drug abuse, prescription assistance, oral health, mental health
Sisters of Charity Foundation of Cleveland *Cleveland, OH* www.socstannfdn.org	1995	$42,000,000	Public Charity[3]	Hospital and Health System	Improving access to affordable, quality health care; education
Sisters of Charity Foundation of South Carolina *Columbia, SC* www.sistersofcharitysc.com	1995	$95,000,000	Public Charity[3]	Hospital	Health care access, root causes of poverty

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Sisters of Mercy of North Carolina Foundation, Inc. *Charlotte, NC* www.somncfdn.org	1995	$239,106,484	Public Charity[3]	Health System	Social services, education, health care
The Sisters of St. Joseph Charitable Fund *Parkersburg, WV* www.ssjcharitablefund.org	1996	$22,400,000	Public Charity[3]	Hospital	Healthy senior citizens, healthy communities, healthy families
South Lake County Foundation *Clermont, FL*	1995	$13,665,000	Public Charity[1]	Hospital	Youth and family services, health and wellness, arts and culture, education, community economic development
Spalding Health Care Trust *Griffin, GA*	1984	$28,271,546	Public Charity[3]	Hospital	Free health clinics, emergency equipment for fire departments, capital projects, education, social and human services
Taylor Community Foundation *Ridley Park, PA*	1997	$10,000,000	Public Charity[1]	Hospital	Scholarships, community support, Taylor Hospital support
Truman Heartland Community Foundation *Independence, MO*	1994	$18,305,386	Public Charity[3]	Hospital	Nutrition, public health programs, dental health, economic and community development, education, arts and humanities
Tucson Osteopathic Medical Foundation *Tucson, AZ* www.tomf.org	1986	$13,634,104	Private Foundation	Hospital	Scholarships for osteopathic students, substance abuse, health care programs
Tuscora Park Health and Wellness Foundation *Barberton, OH*	1996	$5,118,123	Private Foundation	Hospital	Primary care for the underinsured and underserved, health education, safety
UniHealth Foundation *Woodland Hills, CA* www.unihealthfoundation.org	1998	$394,415,000	Private Foundation	Health System	Health education, disease prevention, direct services
Union Labor Health Foundation *Eureka, CA*	1997	$6,000,000	Public Charity[3]	Hospital	Enhancing the physical, mental, and moral well-being of people within Humboldt County
United Methodist Health Ministry Fund *Hutchinson, KS* www.healthfund.org	1984	$58,000,000	Public Charity[3]	Hospital	Primary care access, oral health, health ethics, congregational health and wellness, child care
Valley Care Association *Sewickley, PA*	1999	$6,965,480	Public Charity[1]	Nursing Home	Aging, intergenerational programs
The Valley Foundation *Los Gatos, CA* www.valley.org	1984	$60,855,846	Private Foundation	Hospital	Research, education and social service agencies dealing with health issues
The Venice Foundation *Venice, FL* www.tvf.org	1995	$159,329,573	Public Charity[1]	Health System	Developmental disabilities, frail and elderly, family services, youth activities, affordable housing
Washington Square Health Foundation, Inc. *Chicago, IL* www.wshf.org	1985	$31,533,710	Private Foundation	Hospital	Primary care, medical and nursing education, medical research

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Welborn Foundation *Evansville, IN* www.welbornfdn.org	1999	$90,985,000	Private Foundation	Hospital	School-based health and social service centers, healthy adolescent development, promotion of healthy lifestyles, improvements in community health status, education, social services
Westlake Health Foundation *Oakbrook Terrace, IL* westlakehf.com	1998	$89,000,000	Private Foundation	Hospital	General health
Williamsburg Community Health Foundation *Williamsburg, VA*	1996	$69,300,000	Public Charity[3]	Hospital	Primary care, prevention, senior health and wellness, community health initiatives
Winter Park Health Foundation *Winter Park, FL* www.wphf.org	1994	$125,000,000	Private Foundation	Hospital	Youth, older adults, access to primary care for the uninsured
Woodruff Foundation *Cleveland, OH*	1986	$13,193,338	Private Foundation	Hospital	Mental health and addiction services
Wyandotte Health Foundation *Kansas City, KS*	1977	$47,039,000	Public Charity[1]	Hospital	Primary care, disease prevention, health education

*Year that foundation received assets; not necessarily year of conversion.
**Endowment created as a result of the conversion of a municipal hospital to nonprofit status. This endowment makes grants for health and human services but is not a foundation in the traditional sense, as its assets are controlled by the city government.

[1]Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(1) traditional.
[2]Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(2) gross receipts.
[3]Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(3) supporting organization.

APPENDIX 2

Tax Status of New Health 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 new health 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 percent 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 new health 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.

About half of the foundations responding to the Grantmakers In Health 2001 survey of new health 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 payout requirement of a private foundation.

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