New Jersey
APPLESEED

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HAND-DELIVERED

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Re: Proposed Sale of Memorial Hospital of Salem County to Community Health Systems

Dear Deputy Attorney General Siman and Assistant Commissioner Thornton:

In conjunction with today's public hearing regarding the proposed sale of Memorial Hospital of Salem County ("MHSC") to Community Health Systems, Inc. ("CHS"), we are writing to provide our comments pursuant to the Community Health Assets Protection Act ("CHAPA"), N.J.S.A. 26:2H-7.11 *et seq.* These comments are made on behalf of New Jersey Citizen Action, Community Catalyst and the Public Interest Law Center of New Jersey ("New Jersey Appleseed"). Attached are descriptions of each of our organizations.

As currently described in the documents provided by the parties to the Department of Health and Senior Services ("DHSS") and the Attorney General, *the proposed sale is not structured in the public interest. See* N.J.S.A. 26:2H-7.11 b.

The proposed sale is "likely to result in the deterioration of the quality, availability or accessibility of health care services in the affected communities." *Id.* Though more fully explained *infra* at Point I, our chief concerns are as follows:

CHS has not made adequate commitments to serve its fair share of indigent persons in the community; and

There are insufficient guarantees that the community will enjoy continued access to affordable health care services.

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The value of MHSC's charitable assets has neither been properly safeguarded nor irrevocably dedicated for appropriate health care purposes as required by CHAPA. *Id.* As detailed more fully *infra* at Point II, we have the following key concerns:

> **The Salem Health and Wellness Foundation ("Foundation"), which was not represented by independent counsel, has entered into the Definitive Agreement that subjects it to onerous conditions which are likely to limit its ability to serve "the health care needs of the community historically served" by MHSC. N.J.S.A. 26:2H-7.11 h; and**
>
> **The Foundation will not be adequately independent from the operations of the new for-profit hospital.**

I. The Proposed Sale Is "Likely To Result In The Deterioration Of The Quality Availability Or Accessibility Of Health Care Services In The Affected Community."

In January 2002, we provided detailed comments to DHSS expressing many of our concerns. New Jersey Appleseed, New Jersey Citizen Action and Community Catalyst testified at the State Health Planning Board Meeting on March 7, 2002. And, following that testimony, we wrote additional letters to Commissioner Lacy providing further information. In each of these letters, we provided information about the track record of CHS[1] to demonstrate that this transaction warrants further scrutiny by DHSS as well as the imposition of conditions that would serve to protect the quality, availability and accessibility of health care services to the communities served by MHSC, particularly those that are currently underserved. We were pleased that the State Health Planning Board adopted some of our proposals in its recommendation to Commissioner Lacy, but we believe more should be done.

1. CHS Has Not Made Adequate Commitments To Serve Its Fair Share Of Indigent Persons In The Community.

In the parties' Certificate of Need ("CON") application, CHS committed to providing access to free and indigent care at the same levels offered by MHSC prior to the sale but failed to offer unambiguous information about the level it intended to provide. What was clear from the application, however, was that MHSC had significantly reduced its level of charity care over the past three years. Based on this information and CHS' track record on charity care, we urged the State Health Planning Board to hold CHS to a particular level of charity care as a floor, not a ceiling. Instead, the State Health Planning Board merely recommended that CHS must follow the law in New Jersey regarding charity care, and that the level of such services should not be limited to the amount of charity care provided in the past.[2]

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[1] The *Philadelphia Inquirer* highlighted a number of our concerns about CHS' track record in a recent article. Will Van Sant, "Stakes high in for-profit bid for Salem Memorial; The fates of state policy, charity care and the hospital itself await," *PHILADELPHIA INQUIRER*, March 4, 2002.

[2] The State Health Planning Board stated in its recommendation to the Commissioner: "In accordance with N.J.S.A. 26:2H-18.64 and N.J.A.C. 8:43G-5.2(c), CHS shall provide care for all patients who present themselves at Memorial Hospital of Salem County without regard for their ability to pay or payment source. The level of indigent care shall be determined by the dollar value of charity care calculated at the prevailing Medicaid rate, and shall not be limited to the amount of charity care provided historically."

Pursuant to DHSS' obligations under CHAPA, we believe that the issue must be revisited. In order to prevent deterioration in the accessibility of health care services in the affected communities, CHS must be compelled to provide (at least) a minimum level of charity care. If not, we fear, based upon the company's performance elsewhere, that CHS will not assume its fair share of charity care. As we indicated in previous letters, CHS unilaterally terminated its agreement to purchase Victor Valley Community Hospital, a nonprofit hospital in California, after rejecting the California Attorney General's request that CHS provide at least one percent of net revenue in charity care. A further analysis of CHS' charity care track record in California reveals that the amount of charity care it has provided has dramatically declined in past years.[3]

With this track record in mind, we urge the Department to require CHS to commit to spending at least 2% of its annual patient revenue on charity care.

2. CHS Has Failed To Provide Information Indicating That It Will Avoid Conflicts Of Interest In Patient Referrals.

Because this transfer of assets will result in a hospital that will now be accountable to private investors, it is critical that DHSS compel CHS to adopt strict procedures to avoid conflicts of interest in patient referrals. These procedures must be applied if health care providers, physicians, insurers, board members or the staff at MHSC are offered the opportunity to invest or own an interest in CHS or its affiliates. Although the parties have stated that no current physician, board member or employee owns stock in CHS, no information has been provided as to future investment opportunities related to the proposed sale and transfer of ownership to CHS. Again the failure to adopt a conflict of interest policy in patient referrals may have an adverse

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[3] CHS owns, leases or operates three hospitals in California. It has leased Barstow Community Hospital -- a 56-bed facility -- since January 1993, it has operated Fallbrook Hospital -- a 47-bed facility -- since November 1998, and it has owned Watsonville Community Hospital -- a 102-bed facility -- since September 1998. Hospital data provided to the Office of Statewide Health Planning and Development ("OSHPD") for the period 1995 to 1999 indicates a 61% decrease in charity care (in cost) provided at Barstow, a 83% decrease at Fallbrook and a 57% decrease at Watsonville. Office of Statewide Health Planning and Development, *Selected Hospital Annual Financial Data, (Calendar Years) 1995-99* at http://www.oshpd.state.ca.us/hid/infores/hospital/finance/annual_data/index.htm#Database.
The OSHPD data for 2000 indicates that all three CHS hospitals provided far below the statewide average in charity care as a percentage of their operating expenses. While the statewide average was 1.03% of operating expenses, Barstow's amounted to .28%, Fallbrook's was at .01% and Watsonville's was at .38%. Office of Statewide Health Planning and Development, *Hospital Annual Financial Data Profile, 2000* at http://www.oshpd.state.ca.us/hid/infores/hospital/finance/annual_data/index.htm#Database.

impact on the quality of services provided, and must be addressed.

3. CHS Has Not Made Adequate Assurances That Sufficient Employment Levels Will Be Maintained.

Although the State Health Planning Board recommended that the certificate of need application be approved conditioned on CHS hiring "substantially all Memorial Hospital of Salem County employees who are employed at the time of sale, in accordance with section 10.10 of the Definitive Agreement[,]" we remain concerned about CHS carrying levels of employment sufficient to maintain a safe environment. As we indicated in previous letters, CHS received a citation from California regulators in October 2001 for its failure to maintain adequate nursing levels to meet the needs of patients at Watsonville Community Hospital. Further investigation of the Victor Valley transaction referred to above indicates that CHS's reasons for unilaterally terminating its agreement to purchase the hospital included its unwillingness to adhere to nurse-patient ratios that eventually became mandated by California law.[4]

4. DHSS Should Appoint An Independent Health Care Monitor.

CHAPA permits the DHSS to hire an independent health care monitor (paid for by CHS) for a period of three years to monitor and report quarterly on community health care access by CHS, including levels of uncompensated care for indigent persons. N.J.S.A. 26:2H-7.11 i. Although the appointment of a monitor is in the discretion of DHSS, we believe that this acquisition must be conditioned on the appointment of such a monitor for many reasons, namely:

(1) this transaction would result in the first for-profit acute care hospital in the state;
(2) the Department's recent investigation of Memorial Hospital for numerous patient safety violations resulted in its closing for a short time[5];
(3) as noted above, the CON application reveals that Memorial Hospital has provided consistently decreasing levels of charity care;
(4) in other states, CHS has been reluctant to commit – or, as alleged in the lawsuit regarding Watsonville Community Hospital (*see infra* footnote 10), keep its commitments – to maintaining certain levels of charity care;
(5) MHSC has not traditionally served the large non-English speaking community; and
(6) CHS has not committed to adopting a conflict of interest policy in patient referrals or maintaining comparable clinical nurse/patient ratios as MHSC.

All of the above are likely to have an adverse impact on the quality, availability and accessibility of health care in the community currently served by MHSC. An independent health care monitor is the mechanism provided by the Legislature to protect the public from such adverse consequences and thus should be appointed in this instance.

The appointment of an independent health care monitor is not without precedent

[4] Ron Shinkman, "CHS Kills Deal to Buy Calif. Hospital," *Modern Healthcare*, July 26, 1999 at 20.
[5] As indicated by a recent article about the firing of the hospital's CEO and COO, MHSC has yet to fully address the deficiencies found by the Department. Tracy Wiggins, "Trustees sparked hospital change," *Today's Sunbeam*, April 28, 2002.

in other States who have approved the purchase of nonprofit hospitals by for-profit entities. For example, in Massachusetts, the Office of the Attorney General has appointed monitors in the case of a hospital conversion as well as in the case of a HMO receivership. We have previously provided to DHSS the Request For Proposals issued by the Massachusetts Attorney General in those cases.

II. The Value Of MHSC's Charitable Assets Has Neither Been Safeguarded Nor Irrevocably Dedicated For Appropriate Health Care Purposes.

1. Memorial Hospital Failed To Exercise Due Diligence In Deciding To Effectuate The Acquisition, Selecting CHS And Negotiating The Terms And Conditions Of The Acquisition.

The Board and officers of MHSC expended much time and effort over the last few years towards addressing their operational and financial challenges. However, it appears from the documents submitted to the Attorney General's office that CHS was given an advantage that other bidders did not have. First, it had earlier access to MHSC Board members and officers. Second, it appears that it was given confidential information that may have given it an advantage over other candidates. The minutes of the May 4, 2001 South Jersey Health Corporation/MHSC Joint Board Meeting state:

> Mr. Campbell advised that an informal meeting had been held between two representatives of Community Health Services (CHS), Board Chairs, President of Medical Staff and the President/CEO. Although it was a very informative meeting, it was apparent that CHS was privy to information to which it should not have had access. Not only was this a breach in confidentiality, it could ultimately effect the bargaining position of the Hospital regardless of the course of action pursued. (07-00032)

It appears from the documents that the Board succumbed to enormous pressure exerted by certain members of its Medical Staff to meet with CHS. After the Ad Hoc Committee for Merger Possibilities voted in February 2001 to deny an overture by CHS, the Medical Staff Executive Committee arranged for CHS to make a presentation at a special Medical Staff Meeting. (08-01157). This meeting was held on April 2, 2001 and soon thereafter, a group of doctors petitioned the MHSC Board to invite CHS to make a similar presentation directly to the MHSC Board. (08-01157 and 08-01159-62). Although the Ad Hoc Committee decided to complete the "partnership/affiliation" search process that it had already undertaken, it nonetheless agreed to set up a meeting between CHS and MHSC President/CEO, its board chairs and its chief of staff to informally discuss CHS' interest in purchasing MHSC. (08-01158). Soon after this meeting, the Ad Hoc Committee rejected the merger proposals they previously had been solicited from South Jersey Health System and Cooper Health System, and decided to broaden their search to include for-profit entities. (08-01145). The pressure placed upon the Ad Hoc Committee and the sequence of events indicates that the Board may not have given proper consideration to the proposals submitted by South Jersey Health System and Cooper Health System during the first round of proposals in a biased attempt to accommodate CHS.

2. The Sale To CHS Does Not Represent The Only Or Best Alternative To Carry Out Its Mission And Purposes.

Among the review criteria contained in the CHAPA is "[w]hether the nonprofit hospital considered the proposed conversion as the only alternative or as the best alternative in relation to carrying out its mission[.]" N.J.S.A. 26:2H-7.11 d (5). This legislative provision implies a preference for a nonprofit buyer, wherever possible. *Cf.* Attorney General's Opinion Letter dated December 5, 2001, In the matter of the Proposed Transfer of Assets of St. Francis Medical Center to Catholic Health East (emphasizing the importance of transferring St. Francis to another health system with a similar mission and values).

In 2001, after MHSC decided to broaden its options to include for-profit purchasers, inquiries were made to at least twelve potential bidders, of which three were nonprofit. In the end, only CHS and South Jersey Health System, a nonprofit, submitted proposals. It should be noted that South Jersey's mission is quite similar to MHSC's mission which is directed at servicing the health care needs of the local community.[6]

A comparison of the two proposals demonstrates that South Jersey Health System provided a viable nonprofit proposal that emphasized the expansion of community based clinical programs and a commitment to serve low-income residents, whereas CHS promised the expansion of certain high revenue generating procedures such as women's services, cardiac catheterization, state-of-the-art imaging services and orthopedic surgical services. (42-00006). Although CHS offered to spend $30 million over an eight year period on capital expansions, including a physician recruitment program, South Jersey Health System committed to expending a total of $20 million over 10 years on capital expansions and emphasized the benefits of merging with a local hospital that serves a demographically similar and overlapping population.[7] Nonetheless, the ad hoc committee ranked CHS higher in nearly every selection criteria (42-00002-00003) that it used. It appears that the MHSC board was greatly influenced by the fact that CHS offered $10 million more than South Jersey, offered a physician recruitment program, and emphasized expansion of revenue-generating high technology procedures. We believe that such factors unreasonably overshadowed South Jersey

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[6] South Jersey Health System's mission is as follows: "We exist to serve the communities of our service area by working cooperatively with health care organizations to ensure quality, comprehensive and cost-appropriate health services. We believe that providing health care is a privilege and we exist only for the health and well-being of the patients we serve." (42-00288). MHSC's purposes include to "[m]aintain a hospital for the care of the sick and injured as a memorial to all men and women from Salem County who have served their country in time of war or conflict ... [and to] [c]onduct other related charitable, educational, scientific and hospital activities." (04-00007). In fact, South Jersey Health System's proposal emphasized the similarity in mission. *See* South Jersey Health System's proposal, Executive Summary ("We believe SHJS is the best partner for MHSC because we are a locally controlled not-for-profit hospital system with a common culture, our strategic visions combine seamlessly, we are financially strong and we offer quality, continually-improving care and a widening breadth of services.") (42-00162).

[7] *See* South Jersey Health System's proposal, Executive Summary noting that the service areas of MHSC and South Jersey Hospital are contiguous or overlap significantly and that both hospitals serve similar low-income communities. (42-00162). In the Executive Summary, South Jersey Health System also noted that its proposal "guarantees continued local control and representation of the hospital in Salem...not an arrangement where former MHSC board members have a presence on what is, in effect, a local advisory board where true control rests with a distant board or corporation with significant reserve powers." (42-00164),

Health System's commitment to shared mission, community-based clinical programs, and service to the "special needs of the less fortunate."[8]

3. The Foundation Was Not Independently Represented As A Party To The Transaction, And Has Been Subjected To Onerous Conditions That Limit Its Ability To Serve "The Health Care Needs Of The Community Historically Served" By MHSC

A review of the documents submitted by the parties reveals some very disturbing attributes of the proposed transaction from the public's perspective. First and foremost, the Salem Health and Wellness Foundation was incorporated by certain persons affiliated with MHSC[9] one day before the Foundation entered into the Definitive Agreement as a party without independent counsel. *See* Exhibit B, Definitive Agreement (Opinion of Counsel to Seller)(addressed tp MHSC, SJHC and the Foundation). Indeed, a reasonable interpretation of the Definitive Agreement leads one to believe that the Foundation is intended to be included within the definition of the "Seller." As a direct result of the Foundation's merged identity with MHSC, its failure to retain separate counsel from MHSC and its failure to undertake an independent review of the Definitive Agreement, it has assumed obligations that will adversely impact on the Foundation and its ability to serve the health care needs of the residents of Salem and other South Jersey counties.

Certain provisions of the Definitive Agreement need to be renegotiated if the *public's* interest in the charitable assets of MHSC is going to be protected and furthered.

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[8]South Jersey Health System's proposal, Community Service. The proposal specifically states: "SJHS' current facilities are located in an area that is demographically similar to MHSC's service area. SJH is cognizant of the need for the local hospital to work with the community to assist in a variety of endeavors from community education to primary care for low-income residents. SJH knows that a hospital is made strong and serves its non-profit mission by its connection to the community and that the community's health is improved by focusing on the special needs of the less fortunate. Despite the increased focus on business performance and competition at SJH and throughout the non-profit hospital industry, there still exists a market and demonstrable difference in the commitment to community service between non-profit and for-profit hospitals. This commitment at SJH is demonstrated by the services highlighted below as well as by the significant amount of uncompensated care provided at its facilities." It further explains that "SJH provides significant charity care ($5,276,371 net in 2000)...[and] has been able to provide this care to the most needy [while] maintain[ing] a positive operating margin." (42-00175).

[9] Keith Campbell and Edward Dorn are MHSC Trustees, Thomas Wood is a South Jersey Hospital Corporation Director and John Reiss, serves as a consultant and attorney to both organizations. (SD20-0003).

These include:

a. *Foundation Guaranty (§12.25 of the Definitive Agreement)*

Pursuant to the guaranty clause, the Foundation "unconditionally and absolutely guarantees the prompt performance and observation of the Seller for each and every obligation, covenant and agreement of the Seller arising out of" or related to the Definitive Agreement. On its face, this clause is not limited in time, size or scope. It is our understanding, after discussions with several corporate lawyers practicing in the State, that guaranty clauses are typically limited to one to two years after the agreement is consummated and are limited to one-third to one-half the value of the transaction. Limitations are especially called for, as the case herein, where there will be substantial funds ($3.5million) set aside in an escrow account to cover unknown liabilities. Furthermore, if the Foundation had had its own counsel there is little doubt that it would not have agreed to guarantee the "warranties and representations" made by MHSC to CHS concerning matters occurring prior to the Foundation's existence. This provision, as currently drafted, endangers charitable assets and must be renegotiated by the Foundation through independent counsel who has a fiduciary duty to the public, not MHSC.

b. *Seller's Covenant Not to Compete (§9 of the Definitive Agreement)*

This Seller's Covenant Not to Compete clause unnecessarily restricts the Foundation's ability to make grants and conduct activities necessary to fulfill its mission. It is detrimental to the public's interests, and as more fully discussed below (*See infra* at Point II.8), hinders the Foundation's mission and purpose as set forth in CHAPA, N.J.S.A. 26:2H-7.11 h. Thus, the Foundation should not be constrained in the manner negotiated by MHSC's attorneys.

c. *Foundation's Limitation to Grantmaking*

The January 22, 2002 Certificate of Restatement and Amendment by the Incorporator states that the Foundation is incorporated "only to make grants and provide financial assistance which supports, assists and develops the health and wellness of residents of Salem County." (31-00034). CHS' need to restrain competition cannot trump the needs of the community that the Foundation is established to serve. The Board of the Foundation should be making decisions about how to best address the heath care needs of the community and should not be limited to grantmaking in contrast to supporting its own programs. There are a variety of worthwhile projects the Foundation itself could undertake that, although not considered grantmaking, would be deemed as qualifying distributions under Section 4942 of the Internal Revenue Code. These expenditures include hosting conferences, conducting research projects, publication of informational materials or the construction of a building to serve as offices for non-profit organizations. An illustrative example of this type of undertaking can be found in the Foundation for Seacoast Health ("Seacoast"), a New Hampshire foundation created in 1984 after the sale of Portsmouth Hospital to the Hospital Corporation of America. In 1999, Seacoast responded to a community need for affordable space to house health-related non-profit organizations. In that year over $1 million of its $3.5 million in program expenditures went to building a new foundation facility that could also house

several of its grantee organizations. Attached is an article describing this project and the benefits it has provided to both Seacoast and its community.

d. *Foundation's 5% Spending Limitation*

Despite the fact that the Foundation is applying to be a public charity (which would have no minimum payout requirements), it appears that the Foundation is attempting to adhere to the more stringent requirements of a private foundation. The January 22, 2002 Certificate of Restatement and Amendment by the Incorporator states that the Foundation "shall distribute...five percent (5%) of its total assets each year, such distribution to be completed by the end of the following year." (31-00034). Section 4942 of the Internal Revenue Code requires private foundations to payout a minimum of 5% each year in qualified distributions. However, it is meant to be a floor to prevent private persons from using foundation status to accumulate money tax-free. There is no valid reason why the Foundation's incorporators have decided to make it both a floor and a ceiling prior to undertaking any systematic needs assessment of the health status of members of the community the Foundation seeks to serve.

e. *Charitable Assets Given to the Foundation*

Pursuant to CHAPA, N.J.S.A. 26:2H-7.11 g, the Attorney General, "after consultation with the principal parties to the transaction," determines the amount of assets which the Foundation will receive at the time it is created. In this case, the parties have determined the amount that is expected to be received by the Foundation, as set forth in various schedules attached to the Definitive Agreement. One need only take heed of the pending lawsuit against CHS brought by the Pajaro Valley Community Health Trust, a conversion foundation,[10] to urge that the amount endowed to the Foundation, and the time and manner in which it is transferred to the Foundation, be controlled and monitored by the Attorney General.

f. *Foundation as Enforcer of the Definitive Agreement (§10.18 of the Definitive Agreement)*

Following the closing of the sales asset transaction, the Foundation is given the right to enforce the terms of the Definitive Agreement on behalf of the seller. This letter discusses this provision below in greater detail. See infra at Point II.4a. It is simply not within the Foundation's mission as set forth in CHAPA, N.J.S.A. 26:2H-7.11 h.

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[10] In 1998, CHS purchased nonprofit Watsonville Community Hospital for $50 million, subject to certain adjustments. This purchase price was to be transferred to the Pajaro Valley Community Health Trust ("Trust"), a new foundation endowed with the proceeds of this sale. On June 23, 2000, the Trust filed a lawsuit against CHS for breach of fiduciary duty, an accounting, a breach of contract, breach of the implied covenant of good faith and fair dealing and negligence. The controversy relates to the calculation of the adjusted purchase price. Chief among the allegations in the complaint were that (1) CHS held around $400,000 in Medicare and MediCal (the CA Medicaid program) payments belonging to the Trust; (2) CHS misdirected Trust funds to CHS accounts; (3) CHS concentrated on collecting CHS accounts receivable rather than Trust accounts; and (4) CHS had failed to provide records sufficient to substantiate its collection efforts. *See Complaint, Pajaro Valley Community Health Trust v. Community Health Systems*, Case No. 313158, Superior Court of California, City and County of San Francisco, filed June 23, 2000.

g. *Right of First Refusal (§10.21 of the Definitive Agreement)*

The Foundation's right of first refusal is severely limited, and, as discussed below at Point II.6, violates CHAPA.

All of the above provisions adversely impact the operation of the Foundation. There is strong reason to believe that they would look very different if the Foundation had had its own representation looking out for its own interests. The Foundation's lack of independent counsel renders these provisions void, and the Attorney General should compel all the parties to renegotiate these provisions in good faith.

4. The Foundation Will Not be Adequately Independent from the Operations of the New For-profit Hospital

Philanthropic associations such as the Donors Forum of Ohio (*Recommended Principles for Philanthropies Formed from Sales of Nonprofit Health Care Organizations, December 3, 1996*) and the Associated Grantmakers of Massachusetts (*Guidelines for Philanthropies Formed from Sales of Nonprofit Health Care Organizations, May 2, 1996)* (attached hereto) have clearly stated that new health foundations must be autonomous from the new for-profit health care organization. Therefore, several facts emerging from a review of the materials submitted by the parties give us great concern that the Foundation is not structured to operate independent from CHS and thus will not properly satisfy its charitable purposes.

a. *The Foundation Is Responsible for Enforcing the Terms of the Definitive Agreement.*

Pursuant to CHAPA, N.J.S.A. 26:2H-7.11 h the "charitable mission and grant-making functions of [the Foundation] shall be dedicated to servicing the health care needs of the community historically served by the predecessor nonprofit hospital." It is not within the statutory mission parameters set forth in CHAPA nor is it an appropriate role for the Foundation to monitor the for-profit hospital's compliance with free and indigent care policies, and generally enforce the terms of a sales agreement. This monitoring should be left to the appropriate governmental agencies, with the assistance of an independent health care monitor as authorized by CHAPA. It would be contrary to the Foundation's mission to expend its resources on monitoring and enforcement of the terms of the Definitive Agreement, and it would further be impractical to expect that Foundation board members can aggressively enforce the terms of the Definitive Agreement against the national owner and operator of a major economic and social institution in Salem County. The political reality of this proposed transaction requires State regulators to accept their statutory responsibility for ensuring that all the terms of this transaction are enforced for the benefit of the public.

b. *The Definitive Agreement Calls for a Representative of the Foundation To Serve on the CHS Board.*

Section 10.11 of the Definitive Agreement provides that the Foundation will designate one person for appointment to the initial board of the new for-profit hospital. Such an arrangement can be useful when the Foundation owns stock in

the organization after the transaction;[11] however, this is not the case here. Absent stock ownership, there is no reason for a representative of the Foundation to sit on the board of the hospital. It is more important that the Foundation maintain appropriate distance from the buyer as it would from any other organization. A member of an underserved population, however, would be an excellent candidate for this seat on the board. Moreover, the parties' only rationale for the Foundation-designated board member is that the Foundation will have "the accountability and responsibility for ensuring that the SHC Board and CHS abide by their responsibilities pursuant to the Definitive Agreement." (SD5-0002). As stated *supra*, this monitoring is best left to appropriate governmental agencies, as permitted under CHAPA.

c. *Proposed Board Members Appear to View the Foundation as an Extension of the New For-Profit Hospital*

The sequence of events and the manner in which the Foundation was established and its Board members appointed suggest that the Foundation will not operate independently from the for-profit successor as required by CHAPA. For example, Carol Adams, the current chaplain for MHSC, indicates in her board member application that she envisions a close relationship between the Foundation and the hospital. (stating that she "can help in a smooth transition after the sale of the hospital") (31-00075). Similarly, Beth Timberman's application demonstrates that she views the Foundation as a partner of the for-profit hospital. (stating that "[I]t will take the tried and true positive experiences of many citizens in the county before there will be a real partnership established with the community. CHS has experience in rural settings like this one. I am curious to hear what obstacles they have overcome in their history of small hospital acquisitions.") (31-00072). The recommendation of these individuals as Foundation Board members also conflicts with the Foundation's Incorporation Certificate which lists within the Criteria for Serving as Foundation Trustee, "Understand[ing] that once on the Foundation Board of Trustees, one's fiduciary responsibility is to the 'board they are on' not to the mission and membership of other community groups and organizations, or to grant seekers."

5. Four Of The Nine Proposed Foundation Board Members Have Been Directors, Agents Or Employees Of MHSC During The Preceding Three Years

CHAPA states that "[n]o officer, director or senior manager of the [charitable foundation] shall have been a director, officer, agent, trustee, or employee of the nonprofit hospital during the three years immediately preceding the effective date of the acquisition " N.J.S.A. 26:2H-7.11 h (1). As submitted by the parties, four of the nine proposed board members for the Foundation have either been officers, agents or trustees of the hospital.

(1) **Keith Campbell** has been on the MHSC Board since 1992. He served as the

11 Consumers Union of U.S., Inc. and Community Catalyst, *Building Strong Foundations: Creating Community Responsive Philanthropy in Nonprofit Conversions* (2000) at 9 ("if the foundation's endowment is primarily in the form of stock in the for-profit successor, a director or executive of the foundation may be named to the board of the for-profit company in order to represent the foundation's financial interests.")

Vice Chair of the Board from 1996 to 1998, and as the Chair from 1999 to 2000. Mr. Campbell was also intimately involved in the various ad hoc committees formed to discuss and evaluate merger and acquisition proposals. He was part of a group that met with CHS prior to the final evaluation of the nonprofit merger proposals.

(2) **Ross Levitsky** is the current Chair of the MHSC Board. Mr. Levitsky has served on the MHSC Board since 1992 and has been a member of the various ad hoc committees formed to discuss and evaluate merger and acquisition proposals.

(3) **Raymond Rivell** is a doctor affiliated with MHSC and thus for some purposes is its agent. He was the second signatory of the petition from the medical staff urging the MHSC Board to meet with CHS, thereby demonstrating his strong interest in supporting the operation of MHSC by CHS. This interest is likely to compromise his dedication to the mission of the Foundation.

(4) **Carol Adams** is currently employed as the chaplain for MHSC.

6. The Parties Have Failed To Provide The Foundation With An Adequate Right Of First Refusal To Repurchase The Assets If, Following The Acquisition, MHSC Is Subsequently Sold To, Acquired By Or Merged With Another Entity

For a period of ten years following the closing of the sale, the Foundation will have a right of first refusal to repurchase the hospital if CHS decides to sell it to a third party. If all or a portion of the purchase price of an offer to purchase the hospital from the buyer is to be paid in consideration other than cash, the fair market value of the non-cash consideration will be determined and the Foundation will be required to pay the equivalent in cash in order to exercise its right of first refusal. More importantly, this right of first refusal does not apply if the hospital is sold as part of a package of health care facilities where the hospital does not produce at least 25% of the aggregate cash flow generated by all of the health care facilities to be sold for the preceding fiscal year. Given the nature of CHS' business, there is a strong likelihood that it would package the several small rural hospitals it has acquired when marketing MHSC to potential buyers.

In addition, the Foundation's right of first refusal does not apply if the transaction is entered into by CHS with one or more of its affiliates; pursuant to a merger or acquisition involving CHS or a substantial portion of its assets or business; sold to a real estate investment trust or other financial buyer; or involves involuntary transfers such as bona fide foreclosures and deeds in lieu of a bona fide foreclosure.

All these limitations weigh against approving the proposed transaction as currently structured. *See* CHAPA, N.J.S.A. 26:2H-7 d (3).

7. The Parties Have Not Adequately Insured That the Trustees and Senior Management of MHSC Will Be Prohibited From Investing In CHS.

The severance packages proposed to outgoing management personnel appear reasonable on their face. Nonetheless, we are concerned that the application does not indicate whether stock options or other investment opportunities will be available to

existing management, including physicians in management positions, and Board members. CHAPA is very clear that "the trustees and senior managers of the nonprofit hospital are prohibited from investing in the acquiring entity for a period of three years following the acquisition." N.J.S.A. 26:2H-7 j. The Attorney General must compel the parties to comply with this provision.

8. The Charitable Mission And Grant Making Functions Of The Foundation May Be Impaired By The Covenant Not To Compete

The restrictions placed on the Foundation by the "Seller's Covenant Not to Compete" clause is overly broad, contrary to the Foundation's statutory mission as set forth in CHAPA, and against public policy. Pursuant to Section 9 of the Definitive Agreement, the Foundation cannot offer a competing health service without the buyer's written consent. The Foundation is not a hospital, so a provision prohibiting it from competing with CHS is unnecessary. Even if it is able to offer some of the same services, it would be doing so to fulfill its charitable mission, not to capture market share.

Furthermore, the Foundation cannot provide financial support to any entity that is a "competing business" with the buyer. This provision would prevent the Foundation from providing grants and funds to another hospital that may offer the best conduit to achieve the Foundation's charitable mission. Thus, the ultimate effect of this provision is a license for CHS to obstruct the Foundation's effort to pursue its charitable mission if the money to fund such efforts goes to a CHS competitor. A Foundation's authority to provide grants should only be restricted by the benevolent focus of a contributor, not the profit motives of a publicly traded for-profit corporation. Philanthropy experts have denounced this very practice.[12]

Finally, this provision is contrary to New Jersey case law. "A restraint clause to be reasonable must be such only as to afford a fair protection to the interests of the party in favor of whom it is given and not so large as to interfere with the interests of the public." *Irving v. Gordon,* 3 N.J. 217, 221 (1949) (quoting *Voice, Inc. v. Metal Tone Mfg. Co., Inc.,* 119 N.J. Eq. 324, 330 (Ch. 1936)). *See also Berkeley Development Co. v. The Great Atlantic & Pacific Tea Company,* 214 N.J. Super. 227, 238 (Law Div. 1986) (citing *Irving*). The entity that will receive the proceeds of this acquisition will be a charitable foundation with a charitable mission, not a for-profit health care concern with a profit motive. This provision not only limits the efforts the Foundation may provide directly to the community, it also limits the organizations it may engage to fulfill its charitable mission. The protections this clause provides to CHS are far beyond what is needed to protect its interests, and the clause also restricts the efforts of the Foundation in a way that severely interferes with the interests of the public.

For all the above reasons, we believe that the transaction, as structured, cannot be approved by the Attorney General and DHSS under CHAPA. The State has an obligation to assure the public that there is no deterioration in health care services as a result of the conversion, and that the resulting charitable foundation is totally independent from the for-profit hospital. Unfortunately, it is apparent from the application submitted to

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12 *See id.* at 20.

the Attorney General that the parties envision the Salem Health and Wellness Foundation as an extension or affiliate of the hospital --- an affiliate that will enforce the Definitive Agreement, monitor the operations of the hospital and support the health care services offered by the new for-profit entity. The restricted role given the Foundation pursuant to the Definitive Agreement and the failure of CHS to commit to providing its fair share of charity care are clearly unacceptable and violate the criteria set forth in CHAPA.

Respectfully submitted,

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Attachments

SIGNATORY ORGANIZATIONS

Public Interest Law Center of New Jersey ("New Jersey Appleseed"). The Public Interest Law Center of New Jersey is a nonprofit organization established to provide legal advocacy that addresses systemic social and political problems facing residents of New Jersey. The Center has initiated a broad advocacy project regarding the restructuring of nonprofit health organizations, insurance companies and hospitals upon the conversion of such entities from nonprofit to for-profit status or the acquisition of such entities by companies with different corporate missions. Pursuant to that project, New Jersey Appleseed was active as counsel to *amici* in the judicial proceedings initiated by BCBS of NJ three years ago, participated in litigation surrounding the privatization of Bergen Pines Hospital, obtained documents underlying the HIP-PHP transaction through the judicial process, negotiated an approved court settlement with the NJ Department of Banking an Insurance to investigate the charitable trust issues arising from the State's approval of the HIP-PHP transaction, and represented several women's organizations, with the NJ-ACLU, in a successful court action that obtained a charitable trust settlement as a result of the merger between St. Elizabeth and Elizabeth General Hospitals.

Community Catalyst. Community Catalyst is a Boston-based national advocacy organization that builds consumer and community participation in the decisions that shape our health system to ensure quality affordable health care for all. Since 1996, it has worked with Consumers Union on the Community Health Assets Project ("CHAP"). CHAP is a national effort that seeks to preserve community health assets at risk in health sector restructuring, with a particular focus on the conversion of nonprofit health care institutions to for-profit status. To date, the project has provided information and technical assistance to community groups, philanthropic leaders, regulators, legislators and the media in 35 states.

NJ Citizen Action. New Jersey Citizen Action is the largest citizen watchdog organization in the State, representing over 60,000 family members and 100 affiliated labor, tenant, religious, senior, civic and community organizations. In conjunction with the Citizen Policy and Education Fund of New Jersey, NJ Citizen Action is one of the primary leaders in the fight for universal access to quality health care for New Jerseyans. It has focused on the lack of adequate health insurance, especially for low-income families and children, and has worked to expand the state's KidCare and FamilyCare programs. It worked diligently to pass and implement the Community Health Care Assets Protection Act ("CHAPA"), which has put in place strong oversight when nonprofit hospitals change their status to for-profit thus protecting public accountability, quality of care, and millions of dollars of charitable health care dollars.

VIEWS FROM THE FIELD
MAY 7, 2001
GRANT MAKERS HEALTH

Ad-Venture Philanthropy

Creating The Community Campus: A Work in Progress

SUSAN R. BUNTING, ED.D.
President/CEO Foundation for Seacoast Health

INTRODUCTION

In late 1999, the Foundation for Seacoast Health celebrated the grand opening of a noble experiment: The Community Campus, home to health-related nonprofits, public programs, and the Foundation. The road that led to this decision to build and share space with grantees was long and winding, leading us to question if we'd ever get there.

As we settle into our new home and face the financial and logistical realities of being the owner and landlord of an 80,000 square foot building, the way ahead is still marked by bumps and potholes. Yet it also offers a fabulous view. Toddlers and teens, doctors and patients, families, citizens, and community leaders come together at the Campus to work and play, meet and learn in open, sunlit facilities. The entry walls are adorned by artwork from the children and adolescents who make this place their "home away from home." The Community Campus says to families and children, and the modestly paid and often under appreciated staff who work with them: "You are important."

This article explores the difficult route to our final destination, shares some of the lessons we've learned (and are still learning), and concludes with a frank discussion of the challenges ahead.

EXPANDING OUR VISION

In the mid-1990s, the Foundation began to explore the possibility of buying or building a new home for a Foundation-funded program, New Heights – a wildly popular teen center housed in the basement of a leaky municipal building. The scope of the project soon expanded, however, in view of the facility needs of several other Foundation-supported agencies. Being ousted from their locations because of lease expirations, these agencies covered the gamut of health services including a major community health center, Families First of the Greater Seacoast; the Portsmouth Early Education Program (PEEP), a preschool program for learning delayed youngsters; the community's Head Start program; and the only nonprofit child care center in Portsmouth.

But what was originally a crisis for space-hungry nonprofits turned into a unique opportunity for the Foundation: how to address the inefficiency of providing health, educational, and social services to many of the same children and families at different sites. The agencies were quickly invited to become anchor tenants in the proposed child-centered facility, with the Foundation's caveat that they work and plan together to reduce duplication of services, increase resource sharing, and maximize program effectiveness.

BREAKING NEW GROUND, IN MORE WAYS THAN ONE

After several years and several false starts, the Trustees located 100 acres in a centrally located but industrially zoned site. They began the very long and tedious process of evaluating the buildable acreage, the feasibility of filling in a defunct quarry, and the willingness of the Portsmouth City Council to change the zoning to accommodate medical, recreational, and child care entities.

Simultaneously, we began intensive planning with each agencies' board of directors and executive staffs, engineers, architects, and attorneys. The Foundation's Facility Committee, composed of Foundation Trustees and community members, met once a week for three years to address the many issues facing what often seemed like an impossible venture. But the collective vision of supportive, accessible, family-friendly services pushed us onward.

In October 1998, dignitaries for the groundbreaking ceremony were upstaged by thirty toddlers from the Portsmouth Community Child Care Center, complete with plastic hardhats and shovels, happily digging in the pile of sand that would become a hub for health-related programs on the Seacoast.

SURVIVING AND CELEBRATING OUR FIRST YEAR

Even though the facility was not completely finished, by late November 1999, all original agencies and the Foundation moved to the Community Campus. They

were followed by two new tenants: InfoLink, a community information and referral service, and the Seacoast Child Advocacy Center. While the vision of a Community Campus made the abstract ideal of collaboration come alive, it wasn't always a smooth ride, particularly in the beginning. Continuing construction; plumbing problems; and erratic heating, security, and computer systems caused months of frustration, friction, and unwelcomed surprises.

Despite a bumpy start, today the Community Campus is functioning as envisioned: a closely-knit collaborative community boasting a broad array of services for more than 3,500 children and their families. Together, the Foundation and tenant agencies created a comprehensive Campus Handbook that includes common intake and outcome assessment tools, emergency procedures, accident and incident reporting guidelines, and the successful sharing of space and personnel. The well-designed conference rooms, gymnasium, teaching kitchen, greenhouse, and computer and art rooms are used to capacity by tenants and at no cost to other nonprofit agencies. The Campus Resource Center is helping both campus tenants and other Seacoast nonprofits identify and pursue funding and technical assistance opportunities. The miles of wheelchair-accessible trails with fitness stations donated by Portsmouth Hospital will be completed this spring.

The synergy of having a continuum of services available under one roof is beginning to pay off. Teen participants are guest readers in the Community Child Care Center. Parents whose children receive primary and preventive care at the Families First Health Clinic often attend GED or ESL classes, or parent support groups. Head Start, PEEP, and Community Child Care are planning a major collaborative initiative, scheduled for next fall, to expand interactive child care opportunities for families.

What we had hoped for has happened: the development of a more seamless system of services for children and families.

TURNING RISK INTO REWARD

We are learning as a team now – the Foundation and grantees in partnership. While we still have far to go to maximize economies of scale and to lessen each tenant's dependence on Foundation financial support, we are working on it – together. Along the way, we've learned some important lessons:

- This project was vastly more complicated than envisioned. What we thought would take three years to complete took nearly a decade. The cost in staff, board, and volunteer leadership time was incalculable.
- Early, continuous, and frequent communications and planning among all players are critical to success. Even though we involved tenants in every aspect of the design of the Campus and its facilities, we still endured several costly and time-consuming mistakes.
- Operating a facility of this scale is more complex and expensive than estimates indicated. The Foundation as landlord and its accessibility to grantees has created many challenges as we grapple with ways to cut facility costs and prod tenants to generate new funding streams.
- An investment of this magnitude attracts significant public attention. While there are many people who disagreed with our investment in bricks and mortar, there are more who believe we have created an invaluable resource that will greatly enhance the quality of life in our community for future generations.
- The Community Campus solved our tenant agencies' space needs, but created significant new challenges for them. Their public visibility and the appeal of this facility have spiked the demand for agency services. Higher operating costs and the need for more staff have put enormous pressure on tenants to find additional funding sources.
- Collaboration is difficult and extremely time-consuming, but worth the effort when the goals are clear. Collaboration among Campus tenants and offsite nonprofit agencies is resulting in tangible and meaningful results where it counts: in the lives of children and families.

FOLLOWING A NEW PATH

Creating the Community Campus forever changed the Foundation for Seacoast Health. We grew from a staff of two to five full-time and two part-time employees. While we formerly operated quietly behind the scenes, today the community looks to us for advocacy and leadership on a local, regional, and national level. The Foundation is challenged to increase the financial independence of its grantees and reduce the cost of the Campus facility itself in order to maintain our investment in new and innovative initiatives.

We embarked on this project without a blueprint or a role model to guide us and took a risk, not only with our assets but also with how we define ourselves as a private foundation. Only time will measure the return on this investment. If we've succeeded in creating a better model for reaching and serving our community's most vulnerable families, the rewards will be well worth it. Call us in five years, and we'll let you know.

Susan R. Bunting, Ed.D., is President and CEO of the Foundation for Seacoast Health, the largest private charitable foundation in New Hampshire. Its mission is to support and promote health care in the cities and towns in the New Hampshire/Maine Seacoast area.

VIEWS FROM THE FIELD is an occasional series offered by GIH as a forum for health grantmakers to share insights and experiences. If you are interested in participating, please contact Leslie Whittinger, GIH's director of communications, at 202 452 8331 or lwhittinger@gih.org.

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Recommended Principles for Philanthropies Formed from Sales of Nonprofit Health Care Organizations

Introduction

The Board of Trustees of the Donors Forum of Ohio (DFO) endorses public oversight in the sale of nonprofit health care and health care related institutions to for-profit entities and in the use of assets resulting from these sales. Such assets result in part from the tax benefits, voluntary contributions, and other economic benefits attached to the converted institutions' prior not-for-profit status. It is therefore appropriate that these assets continue to be used for the public benefit. The assets resulting from a nonprofit health care conversion should be expended in a manner that:

1. bears neither the appearance nor the reality of gain for the new corporate entity
2. is independent of political interests
3. is responsive to the priorities of the communities served by the former nonprofit institution.

Based on these principles, we propose the following recommendations for the creation of new philanthropic entities or funds within existing philanthropic entities using the assets derived from nonprofit health care and health care-related institution sale or conversions. Assuming the Office of the Attorney General has determined that the sale is based on an appropriate valuation of the nonprofit, these principles address issues raised by the formation of new nonprofit philanthropies.

1. Creation of the Philanthropic Mechanism

The full fair market value of the nonprofit should be directed toward or invested in an existing or new philanthropic entity whose primary purpose is to benefit the communities which the nonprofit health organization formerly served in order to:

a. protect the original and present charitable intent and other restrictions and designations placed by donors on the use of voluntarily-contributed funds
b. ensure ongoing benefit to the public from assets derived from nonprofit tax status and voluntary contributions
c. permit and encourage the philanthropy to act autonomously from the new service providing entity.

2. Mission/Charitable Purpose

Approval of the sale by the Attorney General, as well as development of mission, bylaws, and governance structure, should include obtaining broad community input, especially from at-risk

segments of the community. The process of formulating the mission and charitable purpose should:

a. acknowledge and recognize the fact that some of the assets derived from the sale of the nonprofit have been heretofore used for particular charitable purposes, often for the clear purpose of providing health care and meeting public health needs in the community
b. incorporate public input in determining how the philanthropic entity will serve the community
c. design and implement an organizational structure and process which ensures and provides for public accountability, involvement, and accessibility
d include development of guidelines broad enough to be sustained in perpetuity, but narrow enough to clarify funding priorities
e. assure that foundation assets will not subsidize the operations of the new for-profit hospital or health organization, or underwrite unfair competitive advantage
f. not replace or underwrite any uncompensated care requirements which the new for-profit hospital or health organization has offered or negotiated as part of the acquisition process
g. not supplant ongoing government health and health care services

The Donors Forum of Ohio realizes that, with the exception of donor designated or donor restricted assets, the proceeds from the sale of a nonprofit health care institution can be used for a broad range of charitable purposes. Nonetheless, because in most cases these assets were once used for purposes of serving the health care and public health needs of particular communities, the Donors Forum suggests that objectives consistent with this continued focus may include:

a. to ensure essential, affordable, accessible, high quality health care services, equipment, and facilities within the community, especially those needs of vulnerable populations and "medically homeless" individuals and families who are uninsured, uninsurable, or otherwise unable to insure themselves or compensate providers for health care services and treatment
b. to provide for community-based research, education and training in health care and public health
c. to foster community-based solutions and options and to encourage and strengthen the community's capacity for shaping, influencing, and controlling its own health care agenda, services and institutions (including hospitals, clinics, public health programs, health care alliances, physicians networks, managed care systems, health maintenance and prepaid premium organizations etc.)

3. Structure

The control of these assets should be in the form of a 501 (c) (3). The organizational structures into and through which these assets may be transferred and administered include, but may not be limited to one or more of the following options, in no particular order of preference:

a. supporting organization of a public charity or charities, including an existing community foundation

b. private grantmaking foundation, also known as an independent foundation
c. component or other fund within a community foundation
d. operating foundation
e. new public charity or community trust, including a community health care foundation
f. multiple endowment funds in two or more not-for-profit public charities

Many health care entities are supported by existing institutionally-related foundations (formally known as "supporting organizations" and informally known as "provider foundations, public foundations, or fund raising public charities"). Should these particular health care entities receive proceeds from a sale, they could direct those assets into their existing institutionally-related foundation, were it re-organized and transformed through one or more of the options above.

4. Governance/Administration

The philanthropy's trustees should be independent of the new for-profit entity and representative of the community in order to ensure:

a. that there is a clear separation of the functions of trustees of the philanthropic entity and directors of the new for-profit organization to assure objective, responsible, and accountable grantmaking and credible representation of community interests and needs
b. that there is neither the appearance, nor the existence of, any conflict of interest
c. that compensation of staff, and compensation of trustees, if any, is based upon best practices of foundations of comparable size and function

The new philanthropic entity would be in a position to adopt and implement other policies and practices representative of grantmaking foundations throughout the State of Ohio and the United States. Several resource organizations, including the Donors Forum of Ohio, Grantmakers in Health and the Council on Foundations, are available to assist these conversion philanthropies as they organize and mature over coming years.

The Donors Forum of Ohio believes that these new philanthropic entities are best begun when the "converting organizations endow the foundation with more than money" -- by also endowing the new entity with a legacy, a mission, and positive, strong relationships within the community it will serve.* The Donors Forum of Ohio further believes that new philanthropic entities created as a result of health care conversions in Ohio should be governed and led by people who believe in the power and potential of grantmaking foundations.

Note: These recommended principles do not pertain to funds held in trust by others for which the nonprofit entity is a current or future beneficiary.

Approved by the DFO Board of Trustees on December 3, 1996.

* Monroe, Ann F. "Remarks, New Foundations from Health Care Conversions," Conference Report, Grantmakers in Health and Council on Foundations, Atlanta, April 21, 1996.

References

The Donors Forum of Ohio is indebted to the following organizations and individuals for sharing information and insights related to this issue.

Associated Grantmakers of Massachusetts
Guidelines for Philanthropies Formed from Sales of Nonprofit Health Care Organizations, May 2, 1996.

Association for Healthcare Philanthropy
A New Environment for Health Care Philanthropy, 1996.

Council of Michigan Foundations
The Sale of Nonprofit Hospital Assets to For-Profit Corporations: Philanthropic Options for Community Decision Makers, June 1996.

Grantmakers in Health
New Foundations from Health Care Conversions: A Dialogue on Building a Philanthropic Organization and Program, April 21, 1996.

12/4/96

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Guidelines for Philanthropies Formed from Sales of Nonprofit Health Care Organizations

Introduction

The Board of Directors of Associated Grantmakers of Massachusetts (AGM) endorses public oversight in the sale of nonprofit health care institutions to for-profit entities and in the use of assets resulting from these sales. Such assets result in part from the tax benefits, voluntary contributions, and other economic benefits attached to the converted institutions' prior not-for-profit status. It is therefore appropriate that they continue to be used for the public benefit. Moreover, the assets should be expended in a manner that (1) bears neither the appearance nor the reality of gain for the new corporate entity; (2) is independent of political interests; and (3) is responsive to the priorities of the communities served by the former nonprofit institution.

Based on these principles, we propose the following guidelines for the creation of new philanthropic entities using the assets derived from nonprofit hospital and HMO sales or conversions. Assuming the Office of the Attorney General has determined that the sale is based on an appropriate valuation of the nonprofit, these guidelines address issues raised by the formation of new nonprofit philanthropies.

1. Establishment of the New Philanthropy

The full fair market value of the nonprofit should be transferred to a philanthropic entity whose primary purpose is to benefit the communities which the nonprofit health organization formerly served in order to:

a. protect the charitable intent and use of the funds
b. ensure ongoing benefit to the public from assets derived from nonprofit tax status and voluntary contributions
c. permit the philanthropy to act autonomously from the new service providing entity

2. Mission/Charitable Purpose

Approval of the sale by the Attorney General, as well as development of mission, bylaws, and governance structure, should include obtaining broad community input, especially from at-risk segments of the community. The process of formation of the new philanthropic entity, including its mission and charitable purpose, should:

a. acknowledge the critical difference in the nature of "public" and private assets and the obligation of these philanthropies to create a structure that is accountable and accessible to community input and changing needs
b. incorporate continuous public input regarding the health and public health needs of the community, and a publicly accountable organizational structure

over

c. include development of guidelines broad enough to be sustained in perpetuity, but narrow enough to clarify funding priorities
d. focus on the enhancement and expansion of community health rather than supplanting ongoing government services; however, such enhancement should not preclude joint efforts with government to better serve community needs
e. assure that foundation assets will not subsidize the operations of the new for-profit hospital or health organization, or underwrite unfair competitive advantage
f. not replace or underwrite any uncompensated care requirements which the new for-profit hospital or health organization has offered or negotiated as part of the acquisition process

3. **Governance/Administration**

The new philanthropy should have a broadly constituted governing board with a variety of skills appropriate to its grantmaking role. The philanthropy's trustees should be independent of the new for-profit entity and representative of the community in order to ensure:

a. that there is a clear separation of the functions of trustees of the new philanthropic entity and directors of the new for-profit organization to assure objective, responsible, and accountable grantmaking and credible representation of community interests and needs
b. that there is neither the appearance, nor the existence of, any conflict of interest
c. that compensation of staff and trustees is based upon best practices of foundations of comparable size and function

4. **Structure**

The new philanthropy should be a 501 (c) (3). Structural choices include, but are not limited to:

a. establishing a private foundation
b. establishing a "supporting organization" of a community foundation or other public charity or charities
c. transferring assets to a community foundation or other public charity
d. establishing a public charity focused on health grantmaking
e. establishing an operating foundation

Approved by the AGM Board of Directors on May 2, 1996