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AHP Journal

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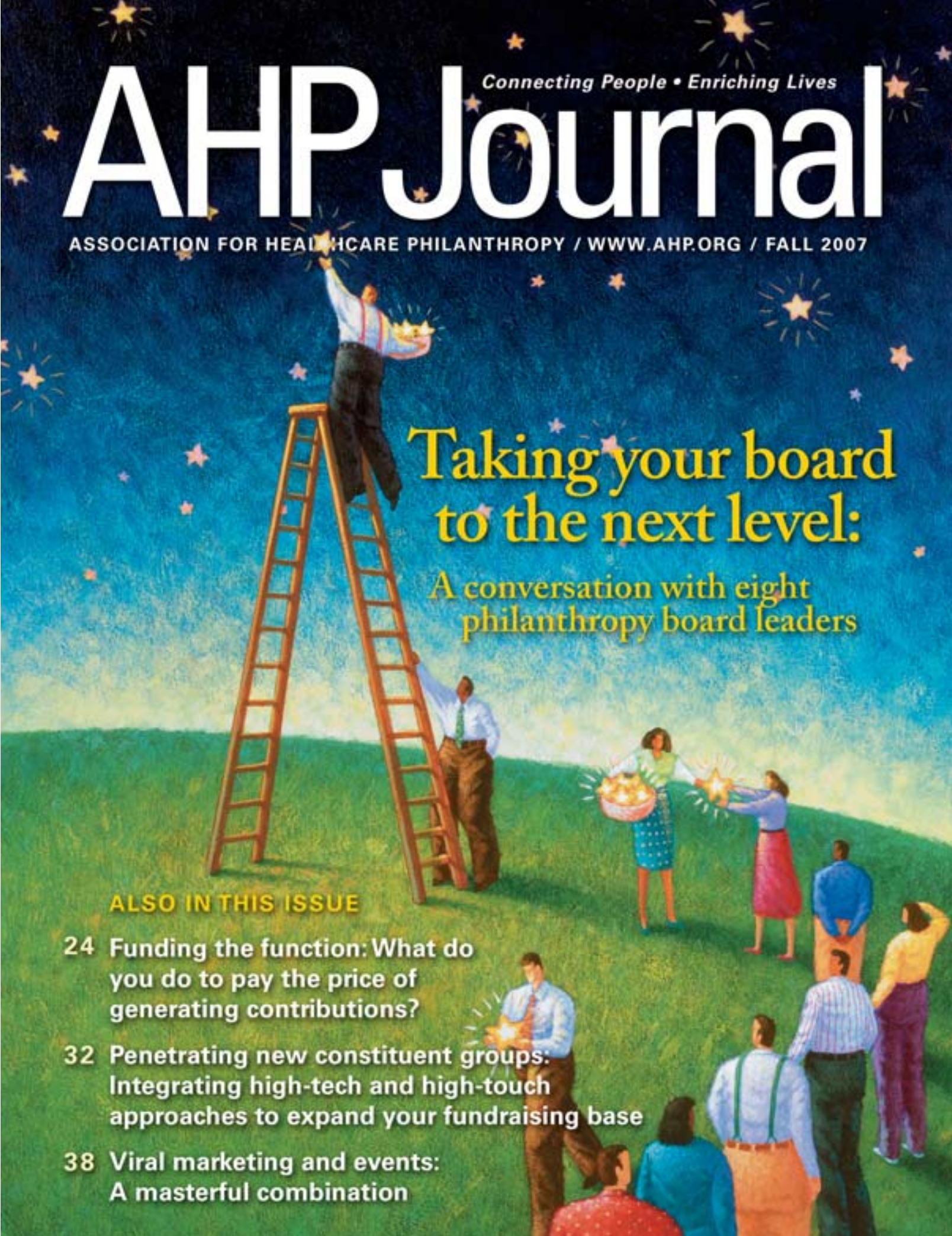


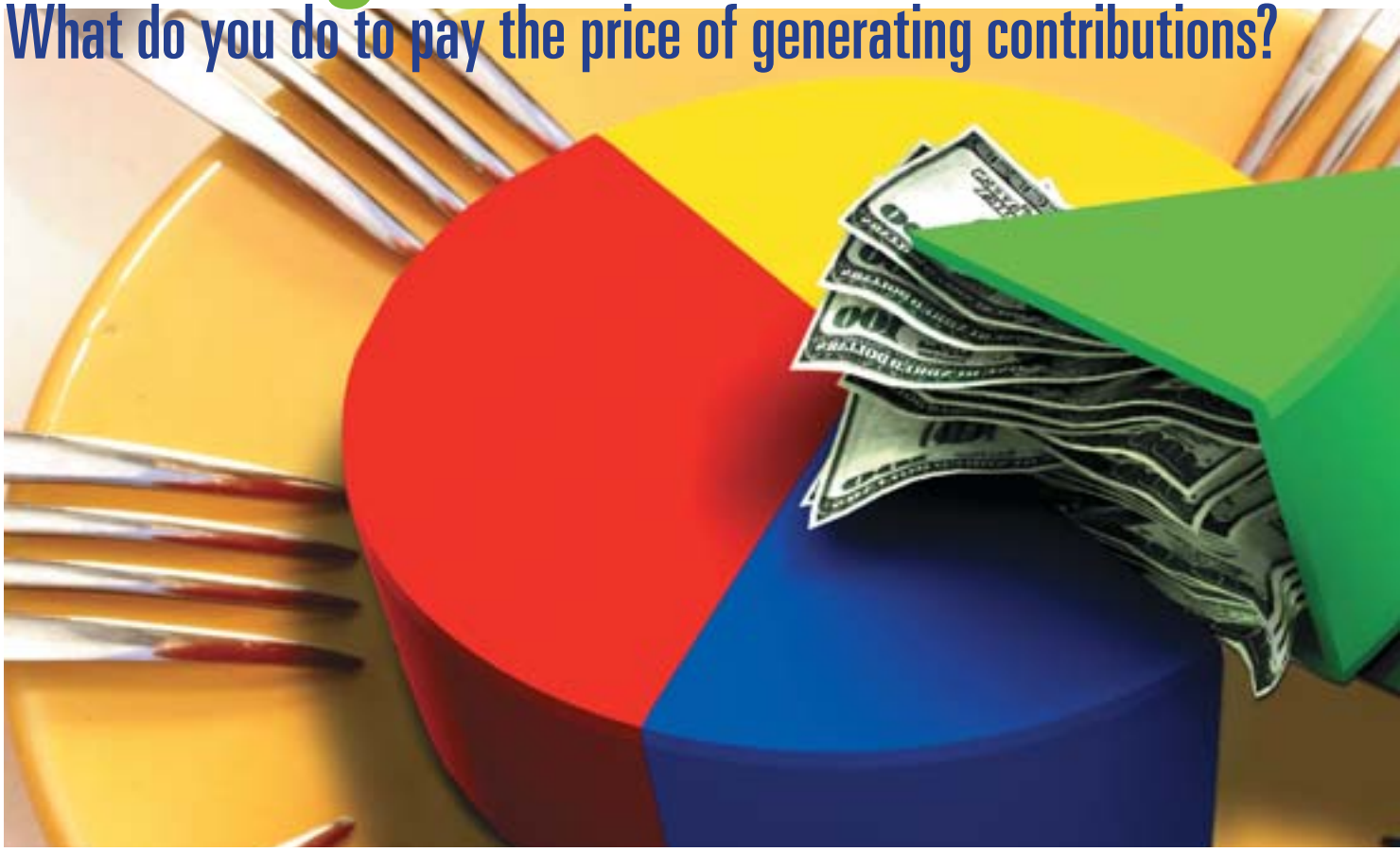
Taking your board to the next level:

A conversation with eight philanthropy board leaders

ALSO IN THIS ISSUE

Funding the function:

What do you do to pay the price of generating contributions?



By John Drake, CFRE; Cathy Chrones, CFRE; and Rick Bragga, JD, FAHP

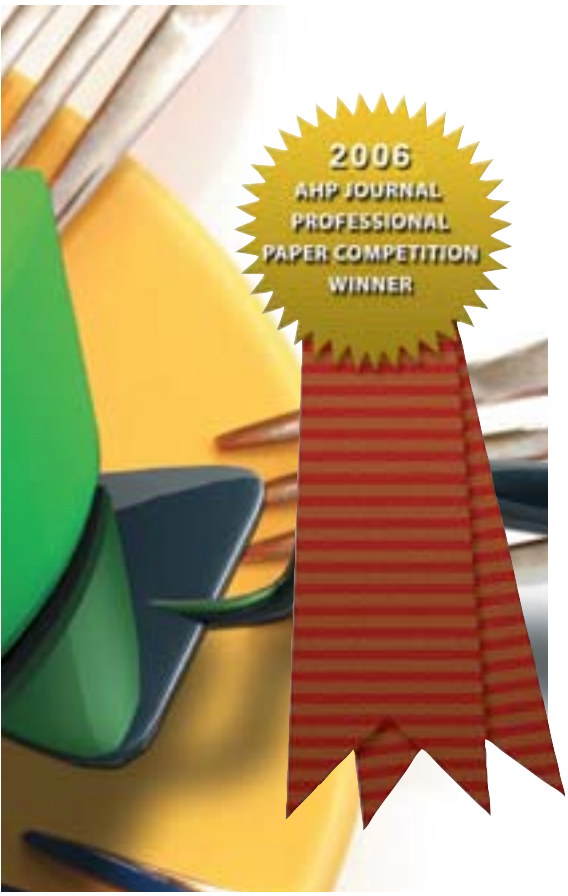
John Drake, CFRE, directs the Irving Healthcare Foundation, a public charity that raises funds for nonprofit, health-related agencies serving a community of 200,000 people located between Dallas and Fort Worth, Texas. Current beneficiaries of the foundation funds include a hospital, a therapy and childcare center for children with medical needs, and a primary clinic for needy residents.

Cathy Chrones, CFRE, is executive director of St. Paul's Hospital Foundation in Saskatoon, Saskatchewan, Canada. A member of the AHP Canada cabinet since 1995, she also chaired the 2002 AHP Canada Regional Conference in Banff, Alberta, and served as acting AHP Canada regional director in 2003–2005.

Rick Bragga, JD, FAHP, is a senior consultant with Corporate DevelopMint in Charleston, S.C., and has more than 30 years of communication/fundraising experience. A past AHP Mid-Atlantic regional director, Rick won the AHP Professional Papers Competition in 1993 and received the first-place award for the 2002 *AHP Journal* competition.

The old maxim, "It takes money to make money" rings true today for fundraising professionals as they search for ways to fund their development functions. Some organizations finance their operations with unrestricted gifts; others receive an allocation from the institution; while still others are using invested funds to generate all or a significant part of their operational costs.

Yet, as the demands on health care philanthropy increase, it is becoming harder to fund growing operating expenses through traditional methods. During the 2003 AHP Canada Regional Conference, five expert panelists, 25 participants, and two AHP representatives met to discuss the question: "Where does an institution get the money to continue raising money?"



The white paper that resulted—*Funding Sources for Foundation Operations in an Era of Designated Gifts: Guidelines and Best Practices*—describes the challenge of "funding the function" this way:

"As foundations strive to meet these increased targets, their operating expenditures, naturally, continue to rise, resulting in considerable strain on budgets. While the models of foundation funding vary considerably across the country, virtually all foundations share two common traits: Funding foundation operations is never an easy task, and the inherent challenges are often not fully understood by the institution, donors, or other stakeholder groups; and the increasing trend towards 'designated gifts,' for which donors expect 100 percent of contributed monies to go towards a specific purpose, has made the funding of foundation operations even more difficult."[1]

Funding source options

Based on their research, the authors of the AHP Canada white paper outline the following eight ways in which health care foundations currently fund operating costs.[2]

Undesignated gifts

All undesignated bequests and gifts are allocated to a fund and assigned to specific projects and uses at the discretion of the foundation board.

Investment income

A percentage of interest—typically 50 percent to 100 percent—earned from specified invested funds is allocated to foundation operations.

Direct institutional funding

The parent institution directly funds all or a portion of the foundation's operations based on a "recognition of value" for services provided and subsequent funds raised.

For example, an institution provides a revenue stream (e.g., from its parking operations) to support the foundation's operations. This is based on a business model, whereby the foundation commits to provide a specified return on the money invested (e.g., $5 raised for every dollar provided to the foundation).

Fund matching

Funds raised for a particular program or condition—through designated or other gifts—are used to help solicit funds from other interested parties, such as condition-specific associations or foundations.

A case in point is a private gift designated for the treatment of lupus that was used to help acquire matching funds from Lupus Canada, with a percentage of these funds being undesignated.

Non-traditional naming/dedication opportunities

A portion of the funds raised through non-traditional naming/dedication opportunities is used to provide funds for other areas of the institution, including foundation operations.

For example, a pre-existing facility, or one that requires minimal upgrade (e.g., a cardiology lounge), is named in honor of a particular donor. While a portion of the gift is used in the upgrade or dedication, remaining funds are used "where they are needed."

Fund "hold-backs"

Funds raised through a foundation's fundraising activities are automatically invested for a set period of time before being forwarded. Investment income from these funds is assigned to the foundation.

For instance, income from all sources (gifts, events, etc.) is invested for a set term (e.g., four months) before being allocated to its specified destination. Interest earned on these funds during the term is allocated to the foundation's operating budget.

Fees on endowments

The foundation charges an administrative fee on all endowments. For example, an annual administrative fee of 2 percent is charged on all endowments managed by the foundation, and this income is allocated to the operational budgets.

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Franchise/retail opportunities

The foundation earns income from the operation of non-medical service franchises, such as a coffee shop, parking operation, fast food outlet, etc., within the institution.

It is an interesting list of options. Now imagine that your source of income to pay expenses for your development department or foundation ended yesterday. What would you do?

Irving Healthcare – a case study

When Irving Healthcare Foundation's fiscal year ended on June 30, 2000, this public charity near Dallas, Texas, had more than $10.6 million in unrestricted assets. Thanks to a talented—and wise—volunteer finance committee a decade before, the foundation's unrestricted bequests, gifts, and annual gala proceeds had been invested. The resulting investment returns were critical for this small nonprofit, which raised $1.2 million to $2.5 million annually during the 1990s.

Fundraising costs during the same timeframe ranged from $535,000 to $1 million. When John Drake, CFRE, joined the foundation in November 2000, administrative costs were covered completely by investment returns. With $10.6 million in unrestricted assets and breathtaking market returns in 1999 and 2000, all gift dollars raised could be donor-restricted.

In fact, there was so much money left over in 1999 and 2000 that the foundation board waived the annual $300,000 operating subsidy offered by the hospital. Then, in 2000, the board earmarked two years of usually unrestricted annual gala proceeds ($250,000 each year) for an upcoming capital campaign, and hired a campaign consulting firm with adjunct staff at a cost of $500,000 over two years.

The foundation's fall 2000 capital campaign began with a bang and within two months, $2 million of the $6 million campaign goal had been collected in leadership gifts.

Things begin to turn—downward

In January 2001, the foundation's campaign was put on hold while the hospital reprioritized its expansion plans. In addition, investment returns began to lag during the first two quarters of 2001. The foundation board soon understood the implications of the financial obligations it had made to cover all operating costs (with no subsidy) and to pay a campaign consultant, and realized that it might have to dip into the $10.6 million in unrestricted dollars to help the foundation through this "bumpy" period.

Then came the 9/11/2001 attacks and in the wake of these horrors, investment returns plunged. Investment returns continued to drop and by 2003 brought a *negative* performance of $85,132. Unrestricted assets shrank from $10.6 million in June 2000 to $7.2 million three years later.

Alternative sources found to fund operations

In 2005, the foundation board agreed to consider ways, other than investment performance, to fund foundation operations. First, it asked the hospital to restore the annual $300,000 operating subsidy.

Second, the board agreed to consider retention of a percentage of each donor-restricted gift to help fund administrative costs. While this is a common practice in higher education, the foundation hoped the same might be true in hospital fundraising shops.

There was little information on the topic to be found, but the foundation was able to identify some health care philanthropy organizations that were retaining an administrative allocation, ranging from as little as 3 percent to as much as 30 percent. The board voted to retain 10 percent of donor-restricted gifts to help cover the foundation's administrative costs.

Foundation sees happy ending

Today, the foundation is able to cover all of its annual administrative costs by adding the hospital's restored operating subsidy to the foundation's annual gala proceeds and by including the 10 percent administrative allocation. In addition, all of the foundation's investment returns for the last two years have been reinvested, and its unrestricted assets have grown back to $8.6 million.

Irving Healthcare Foundation has found that most donors understand and accept the administrative allocation as a normal business practice and there have been no issues in the two years since the foundation instituted their assessment.

Sample administrative fee language

The Irving Healthcare Foundation established a policy in January 2006 to retain 10 percent of the restricted gift dollars it raises to help pay for fundraising expenses. This policy is disclosed in its marketing and collateral materials and in grant proposals. The following language appears on the foundation's giving envelopes:

"All gifts given to the Irving Healthcare Foundation remain in the community to benefit health programs and services in our community. Ten percent of restricted contributions help support Foundation programs and operations."

AHP member survey on administrative fees.

An Internet survey of AHP members was conducted in March 2007 to further investigate the issue of administrative fees. Four hundred and twenty-three AHP members completed the survey, representing a 10.3 percent response rate. When asked if they charge an administrative fee, an overwhelming 91 percent of respondents said they do not, while the remaining 9 percent do charge a fee.

Organizations using administrative fees: Demographics

According to the survey results, those reporting use of an administrative fee were 52 percent urban, 17 percent suburban, and 31 percent rural. All geographic areas are having success with charging this type of fee, and the use of a fee is fairly evenly distributed between single hospitals (58 percent) and multi-hospital systems (42 percent). The largest group using a fee by bed size was the 500+ category, with 41 percent of the respondents in this category. The next largest group was the 100–300 bed category, accounting for 30 percent of respondents.

Types of administrative fees

How is this type of fee implemented? According to the survey, 26 percent of those using a fee were charging it on all gifts, and 74 percent were only charging the fee on some gifts. Ninety percent charged a fee based on a percentage of the gift, while the other 10 percent charged a flat fee.

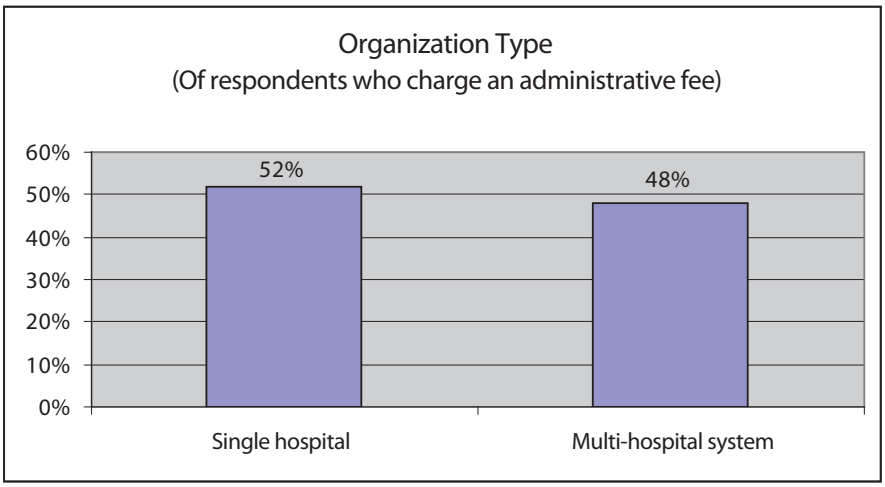
The percentages among those assessing a fee were as varied as the number of responses. The median for the respondents was 5 percent, with an average of 7.4 percent.

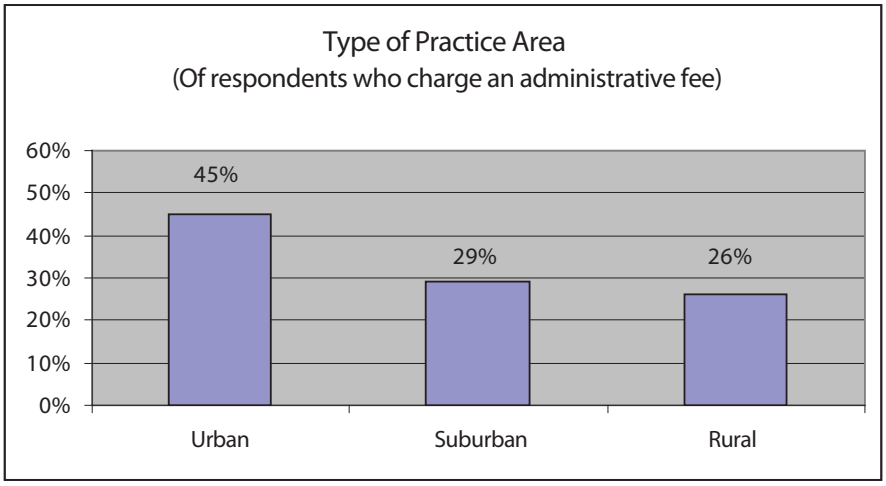
Most interesting among the comments shared by respondents were the choices and exceptions upon which the fees were assessed. Some institutions charge fees only on unrestricted gifts, temporary and permanent restricted funds, campaign-designated gifts, grants, restricted

contributions, and one-time charges to endowment funds. Others exempt memorial gifts and employee campaigns.

There were two survey responses that outlined very unique approaches to this issue. One institution charges varied fee percentages based on whether a gift is categorized as unsolicited, acquisition, or solicited. The other institution's fee assessment—neither a flat fee or a percentage—is more cost-accounting based in that the institution determines all financial management-based costs and adds to it selected financial charges, and then deducts this total from all funds except permanent endowment as part of the year-end audit-closing process.

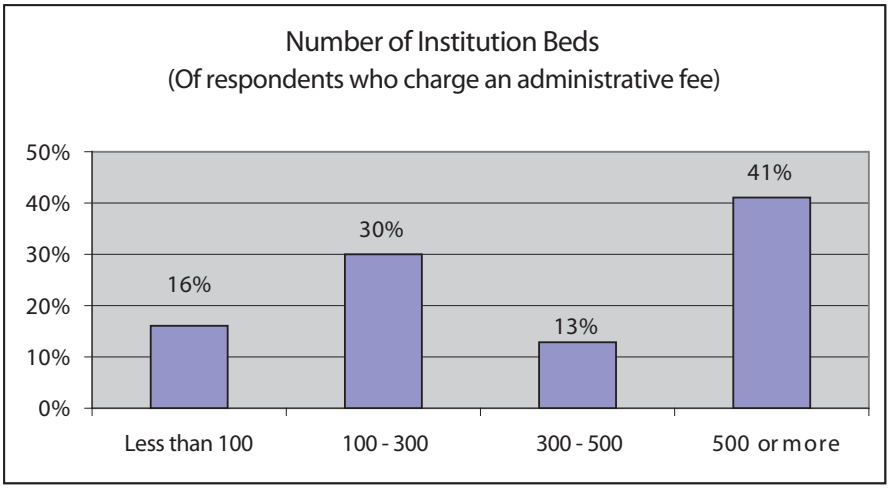
According to the survey, the amounts generated by administrative fees are closely associated with the size of the institution(s) and the amount of the assessment. Total dollars generated ranged from $19,000 to $7 million.





A surprising number were in the low to mid six-figure range. Because of the wide disparity in dollar amounts and the number of variables, these answers did not lend themselves to average or median analysis.

The majority of the other comparison factors closely mirrored the percentage of overall respondents by demographic category.



Donor reaction to administrative fees

One might think that there would be a huge donor backlash to the implementation of a "tax on gifts." In fact, the survey respondents agreed with our presupposition of this public relations nightmare, with 85 percent expressing their belief that their donors would object to the imposition of such a fee. Yet, those who have initiated such programs have not experienced a significant backlash.

Respondents of the survey shared the following experiences:

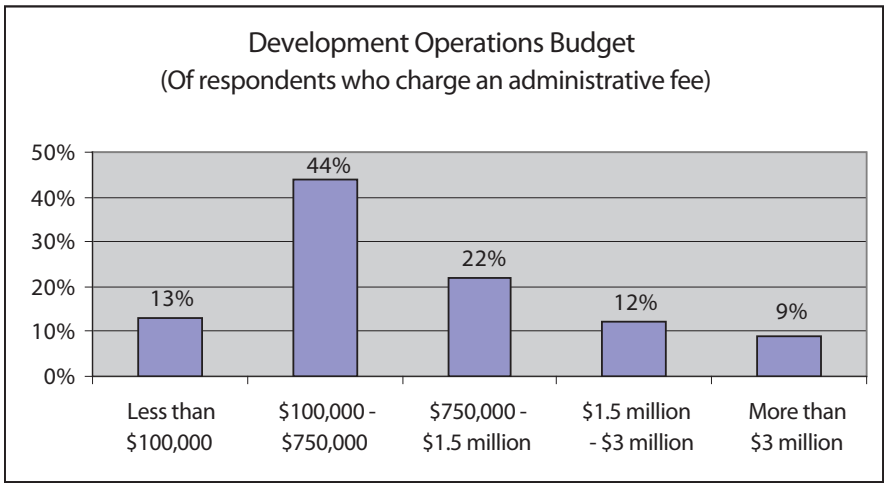
Ingrid Perry-Peacock of North York General Hospital in Toronto, Ont., said that her foundation "has received minimal feedback from donors," and that most seem to think that an administrative fee is reasonable. The foundation communicates with donors about the assessment in its donor newsletter, annual report, financial statements and web site. Most of this communication is focused on major donors and is included in donor agreements.

Perry-Peacock noted that the hospital's auxiliary requested an exemption from the assessment because it believes that the foundation incurs no costs related to auxiliary activities even though the auxiliary channels its gifts through the foundation. The auxiliary was exempted from the assessment.

A development officer from a medical university in southern California said that her institution has had no reaction from donors after the initiation of an administrative assessment on all gifts. The only "push back" received was from physicians who were making or generating gifts for their own projects. Because the physicians believed that the money they were accessing for their projects should not be diminished, the institution did not assess a fee on the funds.

A development officer from an institution in its seventh year of charging an assessment has found that most donors don't ask about the fee, and when they do, he explains how cost-effective the foundation is in regard to national standards.

Mark Larkin of CentraCare Health Foundation in St. Cloud,



Minn., shared the importance of openness and transparency. According to Larkin, "Each year, as we present our budget to the foundation board for approval, we discuss the fee and review the industry benchmarks for cost-per-dollar raised and return on investments. When the board approves the budget, it also sets the fee. We print our entire balance sheet, with cost, in the annual report; we are one of the few in our community that does. I have been working in various non-profits for 20 years. In health care, we focus on asking for major gifts, and this type of donor is more like an investor and wants to see the return on investment in human terms. They rarely ask about overhead costs."

These comments, along with many others received similar to these, indicate that while donors are generally understanding of administrative assessments, it is more difficult for internal audiences such as physicians, managers and auxiliary members to accept. It is also clear that open and transparent communication using a variety of vehicles is important.

Conclusion

The authors of the 2003 AHP Canada white paper concluded that "…there are a variety of proven and innovative approaches to securing funding for foundation operations in an environment of designated gifts, and more will emerge as foundation professionals continue to share their experiences and creativity. Implementation of these approaches will be their most effective when it is clearly understood by all stakeholders that operational funding is a vital factor in fundraising success and the secure future of the institution."[3]

It is often said that "it's not as much what you say as how you say it." Careful communication and full disclosure of any assessment of contributed funds must be implemented with the utmost planning, care, and education.

1 *Funding Sources for Foundation Operations in an Era of Designated Gifts: Guidelines and Best Practices*, Association for Healthcare Philanthropy Canada, Leadership Forum, Annual Conference, June 16, 2003, p. 2.
2 Ibid., pp. 4–6.
3 Ibid., p. 6.

Editor's note: To view the complete survey findings, please visit the supplemental AHP Journal section of the AHP website at www.ahp.org/ahpjournal.