



THE FOR-PROFIT CONVERSION OF NONPROFIT
HOSPITALS IN THE U.S. HEALTH CARE SYSTEM:
EIGHT CASE STUDIES

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EXECUTIVE SUMMARY

Sixty percent of U.S. hospitals are private, nonprofit organizations. They operate alongside both public and for-profit hospitals. Small numbers of hospitals undergo a change in ownership form every year, usually through the sale of the facility. Although the overall ownership composition of community hospitals has changed only slightly in the past 30 years, some states and cities have been substantially affected by for-profit purchases of nonprofit (and public) hospitals. Examining the 87 for-profit conversions of nonprofit hospitals in the years 1985–1994, we found that more than one-third took place in three states, and nearly half were in the Southeast.

Conversions have also been concentrated in time. Twice in the past 20 years—first in the early 1980s and then again in the mid-1990s—surges in acquisitions by for-profit companies have raised the possibility that a fundamental shift was under way. The surge in the early 1980s ended when Medicare payment methods were changed (Gray, 1991), and the surge of the mid-1990s was slowed significantly when widespread fraud investigations were opened in 1997 on the most acquisitive of companies—Columbia/HCA. The pace may also have been slowed by the passage in at least 19 states of laws governing the sale of nonprofit hospitals to for-profit owners (Fremont-Smith and Lever, 2000). Even so, small numbers of for-profit conversions continue to occur, and the possibility remains that investor-owned companies could again build the capital resources needed to implement a strategy of rapid growth through acquisitions. The causes and consequences of conversion are thus important to understand.

Opponents of conversions have pointed to evidence that, compared to nonprofit hospitals, for-profits provide fewer services that benefit the broader community—care for the uninsured, provision of unprofitable services, medical teaching and research, and accountability to the community (Gray, 1997a; Claxton, et al., 1997; Gray, 1991). Proponents of conversion, however, argue that any community losses from conversion are offset by financially strengthened institutions, an increase in tax revenues, and the movement of nonprofit assets into other charitable purposes. They also maintain that in some over-bedded markets where failing hospitals might be of questionable value to communities, for-profit buyers that own other hospitals in the same markets have claimed credit for shutting down some redundant hospitals that nonprofit boards were unwilling to close. (Gray, 1997b).

In recent years, several researchers have used available data sets and carried out new case studies to study conversions. They have learned that affected hospitals tended to be in

poor financial condition prior to sale, that this condition sometimes improved after the sale, and that little change occurred in uncompensated care provided by the hospitals. These studies have shed much light on the conversion phenomenon, but they have concentrated on relatively short-term consequences.

To expand what is known about the reasons why nonprofit hospitals convert and the economic and social consequences of conversion for the hospitals and the communities in which they are located, the present study examined the experience of eight nonprofit hospitals that were sold to for-profit owners a decade ago. To take advantage of available state data systems, we focused on conversions in Florida, Illinois, and California. Our sole criterion for selection of cases was diversity in size, type of community, and purchaser organization. Five of our hospitals were purchased by investor-owned companies (five different ones) and three by local investors.

Our investigation is distinguished from prior research in that we selected hospitals that sold around the year 1990 in order to observe the long-term impact of conversion on community benefit activities and financial performance. In addition, the use of case-study methodology allowed for the examination of a broader range of outcomes and their potential causes than are available in secondary data sets, like the annual American Hospital Association (AHA) survey of hospitals. Our research thus builds on a small number of available case studies. As a group, these studies are particularly important from the perspective of decision-makers in communities and hospitals who may face future decisions over what to do with struggling institutions. By providing insight into the possible outcomes of conversions under varying circumstances, these case histories are an important resource for decision-makers attempting to structure conversions to achieve a set of desired results.

Findings

Why Nonprofit Hospitals Sell to For-Profit Companies

We found that while financial instability is a common characteristic of hospitals that convert, sale to a for-profit purchaser is rarely the first option considered by boards. Instead, boards in this sample of hospitals tended to exhaust other options, including sale or merger with other nonprofits, before selling to a for-profit company. The process of ownership change was therefore often a long one, with institutional characteristics such as the power of physicians in hospitals, and external circumstances such as state and local politics, exerting significant influence over the course of events.

The Economic Consequences of Conversion

In six of our eight cases, sale to a for-profit owner failed as a permanent solution to the financial decline of hospitals. Although benefits of the purchasers' managerial expertise and access to capital were clear for the one sole community provider in our sample, they did not materialize for most hospitals in over-bedded suburban or urban markets. The multi-hospital systems that bought hospitals in competitive markets generally did not have long-range strategic orientations and made only minimal investments in the aging physical plants of their hospitals. Instead, these purchasers tended to rely on short-term fixes such as cosmetic alterations and changes in billing systems directed towards achieving profit targets and maintaining share price. The hospitals purchased by systems in those environments tended to have high rates of turnover among administrators and were more likely to undergo subsequent mergers or sales than were hospitals purchased by individual investors. For their part, individual investors seemed to want to maintain these hospitals over the long-term and struggled desperately to hold onto them, until bankruptcy or a loss of Medicare-eligibility forced a closure.

Although half of the hospitals in our sample had closed in the years since the sale, we found little evidence to support the notion that for-profit purchasers play the role of *laissez-faire* market planners, who, by virtue of their need to realize a rate of return on assets, will shut down unneeded hospitals that the former nonprofit boards would not close. In most cases, the interval between purchase and closure was several years, allowing for-profit owners time to extract marginal profits, gain a toehold in markets they wanted to enter, or enhance market share in areas where they already owned hospitals. And generally, rather than close down a hospital, the original purchasers simply sold them again. Thus, regarding the closure of institutions whose value to their communities was low, for-profit conversion appears to have served only to prolong their marginal existence.

The Social Consequences of Conversion

Consistent with prior research, we found only scattered evidence of a decline in community benefit activities subsequent to conversion, where those activities are defined as care to the uninsured, teaching and research, high-cost services such as trauma and burn care, programs for special needs populations, and community education and outreach. This was largely because most hospitals in our sample were not organized to provide these services prior to conversion. There were two notable exceptions, however—Michael Reese, a teaching and research hospital in Chicago, and Palo Verde Hospital, a sole community provider in Blythe, California. In these cases, there was evidence of a decline in teaching and research and care to the uninsured in the years since conversion.

We also found that admissions of publicly insured patients (Medicare and Medicaid) rose significantly at some hospitals after conversion. Although care to the publicly insured is a commonly used measure of community benefit in research using secondary data sets, several hospitals in our sample were marginal institutions that increased such admissions by providing non-acute care services of dubious appropriateness to increase profit margin. One hospital that undertook this strategy ended up paying a substantial fine for fraudulent DRG upcoding of Medicare patients. Like previous researchers who have made similar discoveries, we question whether, in certain cases, the types of activities that generated increased Medicare and Medicaid admissions produced any real community benefit.

Finally, conversion resulted in the creation of charitable foundations in just three of our eight cases since most of the hospitals were in such poor shape that their sale price was largely comprised of the assumption of the hospital's debt. In one case, however, a foundation created from the proceeds of the sale probably provided more broad-based community benefit than had the original nonprofit hospital.

Policy Implications

We highlight two important policy implications of this study. First, the findings illustrate how important it is for decision makers at the hospital or community level who are contemplating conversion to move beyond the stereotypic ways in which conversions are often depicted and to recognize that the process and outcomes of conversions vary enormously and are influenced by institutional structures and histories, markets, and purchasers. The findings of the study, for example, challenge conventional wisdom about the ability of for-profit purchasers, whether multi-hospital systems or individual investors, to turn around the fortunes of failing institutions in competitive markets. That often does not happen.

Second, our case histories provide dramatic illustrations of the great challenges faced by financially unstable hospitals in our rapidly changing health care system and highlight the strategies pursued by some hospital leaders post-conversion to ensure their institutions' survival. The pursuit of niche markets and the use of sometimes dubious strategies for increasing admissions of publicly insured patients by some of these hospitals post-conversion should alert regulators to the potential for fraud and abuse among owners of newly converted institutions. Similarly, the failure of some of these institutions to remain accredited or Medicare-eligible post-conversion suggests a need to monitor more closely the medical care provided by financially troubled hospitals.

THE FOR-PROFIT CONVERSION OF NONPROFIT HOSPITALS IN THE U.S. HEALTH CARE SYSTEM: EIGHT CASE STUDIES

Introduction

Twice in the past 20 years—in the early 1980s and again in the mid-1990s—a surge in the number of nonprofit hospitals that were acquired by for-profit purchasers evoked concerns that a fundamental shift was taking place in American health care. The surge in the early 1980s occurred when several investor-owned companies, which had grown rapidly through mergers and acquisitions within the for-profit sector and which had great access to capital as a result, began acquiring nonprofit hospitals. It ended after changes were made in the Medicare payment rules that had inadvertently stimulated for-profit growth (Gray, 1991).

The second surge occurred in the early to mid-1990s, again led by companies that had grown rapidly through mergers and acquisitions and that had large amounts of capital due to the resulting run-up in their stock prices. The most visible and aggressive of these companies, Columbia/HCA, promoted the idea that nonprofit hospitals were an anachronism and ill-suited to compete in a health care market that was increasingly focused on competition and the bottom line. With a predominantly for-profit managed care industry on the scene, the hospital companies' acquisitions of nonprofit hospitals raised concerns among many observers that the hospital industry was undergoing a fundamental transformation that might not serve communities well (Needleman, 1999; Gray, 1997a; Bell, 1996; Gabay and Wolfe, 1996). The conversion surge of the 1990s slowed significantly when Columbia/HCA became the subject of a series of fraud investigations in 1997. The fall of their stock price, access to capital, and appetite for acquisitions affected the entire industry. In addition, in 1996 and 1997, some 19 states passed laws to regulate the for-profit conversion of nonprofit hospitals (Fremont-Smith and Lever, 2000). The pace of conversions declined markedly. Trade sources counted 58 conversions in 1995 (Kuttner, 1996). By contrast, the American Hospital Association (AHA) Annual Survey of Hospitals shows 18 hospitals that changed from nonprofit ownership in 1997 to for-profit in 1998.

Even though anxieties about conversions and the for-profit dominance of hospital care have cooled somewhat in the past few years, it is important that the causes and consequences of conversions be understood. The number of conversions appears small in relationship to the total number of U.S. hospitals—by one count, 262 for-profit conversions of nonprofit hospitals took place between 1970 and 1995, just 5 percent of U.S. hospitals (Cutler and Horwitz, 2000). However, conversions have been regionally

concentrated: of 87 confirmed conversions that occurred between 1985 and 1994, more than one-third took place in three states and more than 60 percent were in the Southeast (Figures 1 and 2). Prominent nonprofit hospitals in some cities (e.g., Denver, Wichita, Omaha, Oklahoma City, New Orleans, Miami) were among those that converted, as did some hospitals that acted as sole community providers. Thus, the conversion phenomenon can be very important at the state or community level, even if it has had only small effects in national terms.¹ Moreover, circumstances similar to those that led to the first two surges of conversions could recur in the future.

Conversions have generated debate about the role of the nonprofit hospital in local health systems, the impact of for-profit conversions, and the fate of charitable assets. On one side of the policy debate over the likely effects of conversion, opponents have pointed out that unlike for-profit hospitals, nonprofits are required to operate in communities' interests and to generate public benefits in return for tax exemptions and according to the laws under which they are chartered. Nonprofit hospitals historically have been major providers of care for the uninsured and publicly insured (although the role played by public hospitals has been much greater), as well as unprofitable services such as trauma and burn care and programs for special needs populations. In addition, nonprofit hospitals, along with some public hospitals, have dominated medical teaching and research (Gray, 1997a; Claxton, et al., 1997; Gray, 1991) and have provided a host of other community benefits such as community needs assessment, education and outreach, and community control and accountability (Claxton, et al., 1997). Indeed, cross-sectional comparisons of nonprofit and for-profit hospitals in certain states have found that nonprofit hospitals provide significantly more uncompensated care and other community benefits than do their for-profit counterparts (Gray, 1991; Claxton et. al., 1997). Opponents of conversions therefore argue that ownership change will result in reduced availability of such community services and public goods since for-profit hospitals have no incentive or historical mission to provide them.

On the other side of the debate, proponents of conversion have argued that many nonprofits do little to justify their tax exemptions and that there are compelling reasons to encourage for-profit conversions (Gray, 1997b). Communities can benefit from conversions when hospitals are moved onto the tax rolls and when charitable assets are moved into foundations or other nonprofits that support activities such as public health programs that lack clear funding sources. For-profit ownership can enhance an institution's

¹ The percentage of community hospitals that are nonprofit has been about 60 percent since 1965 (Robinson, 2000; Gray and Schlesinger, 2000). The for-profit share has increased, however, if number of beds is used as the unit of measure and if contract-managed and non-acute care hospitals are included.

ability to raise capital, which can save a struggling hospital for the benefit of a community, particularly those in which the hospital in question is a sole community provider. On the other hand, in over-bedded communities, multi-hospital systems have claimed credit for buying marginal institutions in markets where they own several hospitals and then closing them, when nonprofit boards typically seek to avoid closure of hospitals, even in markets where their need is questionable.

Public opinion about conversions reflects these competing views. A 1997 survey sponsored by the Henry J. Kaiser Family Foundation revealed that while majorities of Americans believed that nonprofit hospitals were more helpful to their communities than for-profits, they also believe that for-profits are more efficient and provide better quality care (Kaiser/Harvard Health News Index, August 1997). Still, almost half of those surveyed felt that the trend toward for-profit health care was a bad thing.

Prior Research

In the presence of public debate, several researchers have examined the causes of conversions and their consequences for hospitals and communities. Studies of the impact of conversions have focused primarily on two groups of measures—changes in community benefit activities, which most researchers have defined as uncompensated care, and financial performance post-conversion (Hadley, et al., 2000; Blumenthal and Weissman, 2000; Cutler and Horwitz, 2000; Sloan, et al., 2000; Chollet and Kirk, 1999; Mark, 1999; Mateo and Rossi, 1999; Young and Desai, 1999; Project Hope, 1997; Young, et al., 1997). These studies vary in methodology (analysis of secondary data and case studies), regional focus, and the length of the post-conversion observation period. In broad terms, researchers have found that conversions have had little impact on uncompensated care and other types of community benefit activities. The evidence is mixed, however, regarding the effect of conversion on the financial performance of hospitals.

Why Nonprofit Hospitals Sell to For-Profit Companies

Although there have been some accounts in the trade press of for-profit companies actively scouting for acquisition targets, researchers have found that sales that lead to conversion are typically initiated by hospital management and boards. Financial instability, doubts about future viability, capital needs for improvements, and high debt burdens have led boards to put their hospitals up for sale. Mark (1999) analyzed 33 nonprofit hospitals that converted to for-profit status and 50 for-profit hospitals that converted to nonprofit ownership between 1989–1992 using AHA data and Medicare cost reports. She found that hospitals that converted had significantly lower profit margins than a comparison group of 3,800 hospitals that did not convert and that this was particularly pronounced among

nonprofit to for-profit converters. Manheim et al. (1989), found in an analysis of AHA data that independent hospitals prior to conversion had significantly lower depreciation expenses than a comparison group of hospitals suggesting that these were older facilities that had not been upgraded in some time. In a case study analysis of two hospital conversions, Cutler and Horwitz (2000) found that financial considerations—access to capital, current or expected profit reductions, and relief from debt burden—led nonprofit hospitals to sell to for-profit owners, but that the culture of institutions and their boards was also important. In a study of sales of three academic health centers to for-profit organizations, Blumenthal and Weissman (2000) found that all three boards sought wealthy partners in order to stabilize their financially troubled institutions.

The Impact of Conversion on Community Benefit Activities

Most conversion studies using secondary data have been concerned with the impact of ownership change on the provision of services to the uninsured. Sloan et al. (2000) found no declines in uncompensated care for a sample of hospitals that converted in Tennessee between 1990 and 1996. Young et al. (1997) studied 17 conversions in California that occurred over 1980–1992 and found that uncompensated care levels in the three years prior to conversion were on average the same in the three years following conversion. This finding may be due to the fact that California has an extensive network of public hospitals, reducing the demand for charity care in the state's private hospitals (Gray, 1991; Shactman and Altman, 1997). However, in a more comprehensive study that examined 80 conversions (from both public and private nonprofit ownership) that occurred between 1993 and 1995 in California, Florida, and Texas, Young and Desai (1999) reached similar conclusions. They compared converting hospitals with a randomly drawn control group of 129 matched hospitals three years before conversion and three and six years following conversion. They found no essential differences between conversions and controls with regard to changes in uncompensated care, the price of care, an index of unprofitable services, and community representation on hospital boards.

A possible explanation for Young and Desai's findings is that hospitals that are likely to convert typically do not provide substantial levels of charity care. For-profit investors may not be attracted to hospitals that serve large numbers of uninsured. This notion receives some support from a study by Needleman, Lamphere, and Chollet (1999), who compared 15 hospitals that underwent for-profit conversions in Florida over 1981–1996 with all Florida hospitals that were nonprofits over that time period. They found that nonprofit hospitals that converted had lower levels of uncompensated care than the control hospitals both before and after conversion.

In a less comprehensive analysis using California state data, Mateo and Rossi (1999) found decreases in charity care at five hospitals in the first year following conversion. This decline, however, was accompanied by an increase in bad debt, suggesting either that the new owners pursued payment for services that would previously have been provided charitably or that they changed the way hospitals coded their uncompensated care.

The flexibility of case study methodologies has allowed the exploration and identification of a broader set of measures of community benefit. In case studies of ten hospitals, two of which converted in the late 1980s allowing examination of longer-term outcomes, Project Hope (1997) found that for-profit acquisition had not led to reduced charitable care or unprofitable services. Similarly, in another recent set of case studies, Chollet and Kirk (1999) found no reductions in charity care post-conversion, primarily because the hospitals involved had not provided much charity care prior to conversion. Studying randomly selected hospitals in seven different states that converted between 1983 and 1994, the authors also found that, in most cases, hospitals maintained emergency, trauma, and obstetrical services. Some hospitals disbanded some specialty services, such as inpatient psychiatric services, but expanded others such as substance abuse treatment. The study by Blumenthal and Weissman (2000) of three sales of academic health centers to for-profit institutions, found negligible effects of ownership change on teaching, research, and indigent care, primarily because of contractual provisions that had been negotiated with the prior owners, all of which were universities.

The Impact of Conversion on Financial Performance

The evidence as to whether for-profit conversion improves profitability and other measures of financial performance is mixed. Contrary to the heady claims of Columbia/HCA in the early 1990s, there is little evidence that the for-profit hospitals have achieved lower costs in the delivery of services than nonprofits and several studies have shown that the cost to purchasers is higher when buying from for-profits (Gray, 1991; Coalition for Nonprofit Health Care Research and Development Foundation, 1999). Acquisitions in the health care sector, as in other industries, have often led to an increase in a company's share price, but analysts find little to support that higher stock valuations are the result of enhanced operational efficiencies or improved profitability (Reinhardt, 2000; Lee and Alexander, 1999; Manhiem, et al., 1999).

Sloan et al. (2000) found slight increases in the profitability of converted hospitals in a sample of Tennessee hospitals. However, in ten case studies in North and South Carolina, the authors found low overall rates of return on investments in nonprofit hospitals by for-profit purchasers. In their two case studies in Wichita and Denver, Cutler and Horwitz (2000) analyzed Medicare cost reports and found that new owners cut costs and provided capital to relieve hospitals' debt burdens. They found, however, that new owners relied on revenues from publicly insured patients to increase profits, exploiting loopholes in the Medicare program and possibly engaging in DRG upcoding. Chollet and Kirk (1999) found that most hospitals, post-conversion, experienced much more management instability than was the case prior to conversion.

The Present Study

This study sought to expand what is known about conversions with an in-depth analysis of eight hospitals that were sold to for-profit purchasers around 1990. Much of the evidence from the existing empirical research is so aggregated—treating converted hospitals as an undifferentiated group—and narrowly focused that local decision makers who are considering what to do with a failing hospital may find little guidance on what may be expected from a decision to sell to a for-profit purchaser or how a conversion might unfold over time (King and Avery, 1999). We hoped that our study would help move the discussion of for-profit hospital conversions beyond such basic (though very important) outcome measures, such as financial viability and the provision of uncompensated care, towards a fuller and more nuanced understanding of how conversions affect communities. Our case studies, in combination with others in the literature, allow for the identification and examination of a wider array of causes and consequences than are available in secondary data sets. By design, our study also benefits from a much longer post-conversion observation period than most prior research. We hoped that our findings would enable more realistic deliberations of options by boards of struggling nonprofits and more informed policy debates about the outcomes of conversion.

A secondary focus of our study is of a methodological nature. It grew from the need to identify candidate hospitals for our case studies and to pin down the year of conversion for the statistical component of the project.³ We undertook an extensive effort to examine whether hospitals shown in AHA data to have changed from for-profit to nonprofit between 1985 and 1994 had actually converted and, if so, when. This validation

² The percentage of community hospitals that are nonprofit has been about 60 percent since 1965 (Robinson, 2000; Gray and Schlesinger, 2000) The for-profit share has increased, however, if beds is used as the unit of measure and if contract-managed and non-acute care hospitals are included.

³ This project had a companion study—a statistical analysis directed by Jack Hadley of Georgetown University. Unanticipated logistical complications prevented the degree of synergy between the case studies and statistical analysis that had been planned for.

study raises caveats regarding the most widely used methods to identify converted hospitals for research purposes.

The Validation Study

To identify potential conversion cases for study, we began by using AHA directory information to make a list of community hospitals that were listed as nonprofit one year and for-profit the next. This is the method that has been used in most studies of hospital conversion. For our case studies, we sought hospitals that had converted around 1990, and for the related quantitative study (see Hadley et al. 2000), we sought to identify all community hospitals that converted in the years 1985 through 1994. Because the design called for examination of data before and after conversion, we also needed to know the “year pair” of conversion.⁴

After the list was compiled, our efforts to learn more about the candidate hospitals for case studies led to the discovery of several cases in which the AHA ownership information was incorrect. These included cases in which no conversion had occurred, cases in which conversion had occurred several years before it showed up in AHA directories, and cases in which hospitals shown as nonprofit were actually public hospitals. This perhaps should not have been surprising. The ownership information that AHA publishes is based on their annual surveys of hospitals. Several sources of error can be identified. First, the persons completing surveys for hospitals may make mistakes regarding the hospital’s ownership form, particularly in cases in which the hospital is under contract management.⁵ Second, every year many hospitals do not complete the survey (this may be particularly common in hospitals that have undergone a recent change in ownership). In such instances, the ownership form shown in the AHA directory is based on the ownership form last reported in a survey. Ownership changes thus may not be reported until several years after they have occurred.

Because of the errors found in the data used to select our eight case study hospitals, we undertook a case-by-case review of the hospitals that appeared to convert in the AHA data over the years 1985 through 1994, since this was the time period selected for the related quantitative study on hospital conversion. The purpose of the review was to determine whether these hospitals did, in fact, convert and the year in which they did so. We also took the opportunity to learn whether converted hospitals had subsequently

⁴ Hospitals listed as nonprofit one year and for-profit the next could have converted in either of the two years. Thus, we thought of the time of conversion in terms of the “year pairs” in which they occurred.

⁵ A nonprofit’s hiring of a for-profit management firm does not constitute a change in ownership form. However, we treat the leasing of a nonprofit hospital by a for-profit firm as a conversion.

changed ownership or closed, since the occurrence of such changes is important to understanding the outcomes of conversions.

Methodology

The process of verifying whether and when a conversion occurred consisted of several levels of investigation. We used an ownership change indicated in the AHA data as our starting point and examined the ownership history of each hospital looking for odd ownership patterns in the data, particularly one-year flip-flops in ownership (almost certainly an error in the data) and hospitals that failed to report during crucial periods of change, i.e., years of a likely conversion period. We then sought corroboration from annual directories published by the Federation of American Hospitals (FAHS, formerly the Federation of American Health Systems, the trade association of investor-owned hospitals). The first appearance of a hospital in the directories was confirmatory evidence about the fact and year-pair of conversion. Again, however, there may be a lag in the appearance of a converted hospital in the directories, particularly of hospitals acquired by for-profit purchasers who are not members of FAHS, as may be the case with individual investors.

We also sought corroboration by doing extensive searches of newspapers and other literature using Nexis and Internet search engines such as ProQuest. Where uncertainty remained, we made calls to state agencies with jurisdiction over hospital licensing or to current and former administrators, medical staff, trustees, local libraries, and newspapers. We eliminated from the list hospitals that did not fit our criteria—hospitals that had erroneously been listed as nonprofits or for-profits, and hospitals whose conversion had occurred outside our 1985–1994 time frame.

We used the opportunity of the verification project to also collect information about the fate of the hospitals that converted during those years. We used the AHA data and other sources to determine whether in the years subsequent to conversion these hospitals had closed, been sold to another for-profit purchaser, had converted back to nonprofit ownership, or had become other than an acute care hospital through the year 1998.

Findings from the Validation Study

Using the AHA data, we identified 137 hospitals that appeared to have changed ownership from private, nonprofit status to for-profit between 1985 and 1994. These hospitals would all be included in the conversion category in any study whose samples are based on year-to-year changes in ownership form.

Our case-by-case review identified 29 hospitals, or 21 percent of the apparent converters, that had actually not converted from nonprofit to for-profit. These included hospitals that had been public prior to conversion or that had been nonprofit or for-profit through the entire period. In addition, we found that, on average, conversion dates based on year-pairs in the AHA data were a year later than the actual conversion. Errors regarding year of conversion ranged as high as four years in three cases. Of those hospitals that actually converted, the AHA data yielded inaccurate conversion dates for 52. The lagged reporting errors meant that 21 hospitals fell out of the 1985–1994 range that we planned to study.⁶ Once these and the misclassified hospitals were eliminated, we were left with 87 hospitals that converted in 1985 through 1994, a number that was 36 percent smaller than the AHA data had indicated. We believe that errors of this magnitude raise questions about the validity of studies that relied solely on AHA to identify converting hospitals.

What became of these 87 institutions? We found that of the 87 hospitals, nearly 60 percent either changed ownership at least once subsequent to the original conversion (44 percent of the total), closed (13 percent), reconverted to nonprofit ownership (seven percent), or changed their acute care mission (three percent). Six hospitals experienced two or more of these changes. Similarly, four of our eight case study hospitals changed ownership; three were sold twice after the original change in ownership. Half of our case study hospitals had closed by the end of the decade. We do not know, however, whether converting hospitals are more or less unstable with respect to these outcomes than a similar group of hospitals that remain nonprofit. In the related quantitative study, Hadley et al. (2000) found that there was no difference between nonprofit hospitals that converted and those that had a high probability of converting with regard to the likelihood of operating as a short-term general hospital at the end of the period of observation.

The Case Studies

Methodology

This study used qualitative research methods to examine the long-term impacts of conversion on a variety of measures and to identify the factors behind decisions to sell nonprofit hospitals to for-profit purchasers. We therefore focused on conversions that occurred around 1990. Since we were interested in examining the impact of conversion on the provision of service to the uninsured, we selected case study hospitals in those states

⁶ Our case study research made us aware that conversions are sometimes an extended process, rather than discreet events. Accordingly, we thought it prudent to treat the first year that a hospital was officially for-profit as the end of a *two-year* conversion period. We interpreted this to mean that hospitals that first showed up in 1985 as for-profit had probably begun the conversion process in 1984 and therefore fell out of the 1985–1994 study range.

for which we had state discharge data.⁷ Except for California, Florida, and Illinois, these states had few or no for-profit hospitals and had experienced almost no conversions around 1990. We therefore decided to choose our case study hospitals from those three states.

We selected hospitals within those states in order to create a sample with variance in size, location, and type of purchasing organization (Table I). We did not exclude hospitals that closed or were sold again subsequent to conversion. The eight hospitals we selected ranged in size from 55–600 beds at the time of purchase—three hospitals had 100 beds or less, four hospitals had 100–200 beds, and one hospital had 600 beds. With respect to community type, four hospitals were located in suburban, mostly white, middle-class communities, three were in inner-city neighborhoods with predominantly minority, low-income residents, and one hospital was a sole community provider in an isolated rural town of 10,000. Aside from the sole community provider, all hospitals were located in competitive, over-bedded markets. Five hospitals were initially sold to investor-owned companies that owned multiple hospitals, and three were sold to individual investors.

The case studies are based on an extensive literature and document search, in addition to interviews conducted during site visits and over the telephone. Online searches yielded an enormous amount of information on the history of hospitals located in the larger metropolitan areas, notably Chicago, Miami, and Los Angeles. We used this information not only to develop detailed profiles of the hospitals prior to the site visits but also to identify potential key informants. Initial leads from the database searches were important because three of the case study hospitals are now closed and because most current and former executives of hospitals purchased by chains (Healthsouth, Columbia/HCA, Vencor) declined to be interviewed.

In addition to the database searches, we identified some key informants through the American College of Healthcare Executives, the AHA guides, the American Medical Association, and state and local health departments. We found potential interviewees through these initial sources who then referred us to other knowledgeable people.

⁷ These include California, Florida, Illinois, Massachusetts, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. We used the self-pay category of discharges as a measure of care to uninsured patients.

Table 1: Case-Study Hospitals*

Burbank Community Hospital, Burbank, California

- 100 beds, purchased by local physicians in 1991, sold again to an independent investor (1995)
- lost Medicare license and closed (1997)
- sold to Vencor, Inc.(1997), which opened it briefly in 1998 and then closed it again (1998)

Good Samaritan Hospital, Bakersfield, California

- 64 beds, purchased by 3 independent investors, 1989
- marginal presence in overbedded market, pursued niche markets including psychiatric care for elderly
- currently financially unstable, license has been in jeopardy

Palo Verde Hospital, Blythe, California

- 55 beds, leased by Brim, Inc. with an option to buy, from a district board, 1992
- sole community provider, isolated desert town of 10,000
- currently financially stable and has community support

Victoria Hospital, Miami, Florida

- 200 beds, sold to Columbia Hospital Corp. and physician investors, 1988
- low-income community in Miami's Little Havana, near Jackson Memorial, a sprawling public hospital
- Columbia bought nearby Cedars Medical Center in 1993, consolidated the two hospitals, and closed Victoria that year

Doctors' Hospital, Coral Gables, Florida

- 157 beds, sold to Healthsouth Corp. in 1992
- located in affluent neighborhood
- post-conversion expansion of sports medicine, financially stable

Metropolitan General, Pinellas Park, Florida

- 155 beds, sold to Community Health Systems, 1992
- flawed physical structure, over-bedded market, financially unstable post-conversion
- Columbia/HCA acquired hospital in a swap with CHS in 1996 and closed it

Michael Reese Hospital, Chicago, Illinois

- 600-bed prominent teaching hospital, on the near South Side, purchased by Humana in 1991 as part of deal to purchase the hospital-owned HMO
- subsequently owned by Galen Health Care (1994), Columbia/HCA (1994–1997), a physician partnership/health care investment company (1998–present)
- now 150 beds, no teaching/research, financially unstable

Doctors' Hospital of Hyde Park, Chicago, Illinois

- 200-bed South Side hospital purchased out of bankruptcy in 1992 by a controversial ophthalmologist and owner of eye surgery clinics
- pursued community outreach as a strategy for survival, nursing home affiliations, home visit program, chronic care services
- paid \$4.5 million to Medicare after whistleblower suit for DRG upcoding in 1999
- declared bankruptcy in 2000 and closed.

* Names shown are as at the time of purchase.

We conducted 90 interviews with hospital CEOs and other administrators from both the case study hospitals and competing hospitals, board members, physicians, public health officials, representatives of local hospital trade associations, nurses, and union officials. We interviewed people who knew about events leading up to the sale, as well as people who were informed about the hospitals' performance over the following years. The majority of the interviews were conducted in person during site visits to the communities in which the hospitals were located, though some interviews were conducted over the phone because several informants, particularly former administrators, had moved to other cities. The interviews followed an open-ended question format and usually lasted about an hour. Sara Collins and Bradford Gray were both present during most interviews and both took detailed notes. We did not tape the interviews because of the sensitivity of some of the material that was discussed. However, only a few interviews were conducted off the record.

In addition to the interviews, the case studies relied on any documents that we collected during the site visits and quantitative data including state discharge, AHA, and Medicare data. Documents collected during site visits included records from state licensing agencies, hospital financial records, legal documents, annual reports, consultants' reports, and clerk-of-court records. The state discharge data was our primary source of information regarding pre- and post-conversion changes in uncompensated care and payer mix.

Findings of Case Studies

In the case studies, we sought answers to two broad questions—1) Why do nonprofit hospitals convert, and 2) what are the economic and social consequences of conversion? Our findings are organized accordingly.

Why Nonprofit Hospitals Sell to For-Profit Companies

Like other research on conversions, we found that prior to selling to for-profit purchasers, all the hospitals in our sample suffered from varying degrees of financial instability caused by a variety of factors, including inability to adapt to the change to prospective reimbursement in the Medicare program, technological change in patient care and the consequent decrease in inpatient admissions and length of stay, and the increase in competition that accompanied the introduction of managed care. Changes in payer mix (often as a result of local demographic change), aging physical plants, high debt loads, and limited access to capital exacerbated poor financial situations. In addition, three hospitals had struggled to maintain accreditation and their Medicare licenses prior to conversion.

Ultimately, however, we found that the reasons why the hospitals were sold to for-profit organizations were not straightforward but were rooted in complex dynamics created by the often conflicting objectives of trustees, medical staffs, and administrators. In most cases, the sale to a for-profit institution had not been the first option considered by trustees, and, indeed, other options were actually voted on and pursued, only to be rejected by members of the medical staff or hung up by external circumstances. Some boards had attempted to negotiate mergers with other nonprofit or public institutions, and some hospitals had contracted with management companies prior to conversion. The board of one desperate institution, under threat of bankruptcy, drew up a detailed restructuring plan with signed agreements from physicians indicating the number of patients they would try to admit in the coming year. We highlight here the powerful role of physicians and local politics in determining the course of events once a board has decided that the institution can no longer continue to operate on its own.

The Veto Power of Physicians. In half of our cases, the actions of physicians had a powerful influence on the ultimate decision by boards to sell to for-profit purchasers by thwarting other options that had been preferred by trustees. An overriding impulse among physicians was the desire to maintain their autonomy in institutions they had grown accustomed to. For example, physicians at both Victoria Hospital in Miami and Burbank (California) Community Hospital, exercised power unique to the bylaws of their organizations and vetoed board decisions to merge with public or nonprofit institutions. In both cases, the physicians ultimately formed partnerships with which to purchase the hospital themselves (in partnership with Columbia Hospital Corporation in the case of Victoria). As one former Burbank physician told us, “A group of family practitioners closed ranks and decided to form a limited partnership to buy the hospital. They were physicians like myself who were trying to carve out a niche in a crowded market and thought they could do it with this hospital.”⁸

At Michael Reese Hospital in Chicago, a once proud teaching and research institution that was sold (along with Reese’s HMO) to Humana, Inc., in 1991, a mid-1980s merger plan with the University of Chicago Hospitals was abandoned after initial approval by both boards because of conflict among physicians over leadership roles in key clinical departments. Michael Reese’s medical staff were physicians in private practice, while the medical staff at the university hospital were salaried and research oriented. By all accounts, this created income disparities between chief of services in the two institutions (Reese being higher), clashing institutional cultures, and a perceived sense of superiority

⁸ Interview with Keith Emmons, MD, Encino, California, 11/11/98, Bradford Gray and Sara Collins.

among the physicians in the university hospital. After a conflict that included trades of insults in the press, the merger attempt fell apart in 1986.

Politics. State and local politics also played decisive roles in the two Chicago cases. In 1991, the board of Doctors' Hospital of Hyde Park on Chicago's South Side declared bankruptcy. Two potential purchasers were interested in acquiring the hospital—the nearby University of Chicago and James Desnick, a politically savvy and well-connected ophthalmologist who owned a string of outpatient cataract surgery centers. Dr. Desnick gained the support of the influential leaders of the South Side chapter of the NAACP and Operation Push (and the bankruptcy judge) by promising to continue the hospital's operation as an acute care institution, and thus maintain the jobs of the hospital's 450 employees. The University of Chicago, with the support of Doctors' Hospital's lead lending institution, sought to buy the hospital and transform it into a state-of-the-art psychiatric teaching facility and thus lay off most of its employees. The value of the competing bids was nearly identical but the judge, in a courtroom packed with cheering Hyde Park employees, awarded the hospital to Dr. Desnick. When Desnick took control of the hospital, he hired the head of the South Side chapter of the NAACP as a spokesperson and appointed the co-chairwoman of Operation Push to the hospital's advisory board.

Politics, combined with a staff of enraged physicians, also prevented the board of Michael Reese Hospital from consummating a second merger attempt, this time with the University of Illinois Medical School on Chicago's West Side. The deal designated Michael Reese as the medical school's primary teaching facility and would have replaced the current department chairs at the University with Michael Reese's counterparts. The University of Illinois planned to lease its own hospital to public Cook County Hospital. The deal was negotiated by the boards and leaders of the three institutions without the knowledge of either medical staff, but, because the University and its hospital were state owned, approval by the legislature was necessary. When the proposal became public, leaders of the University's medical staff became politically active in opposition. They were joined by community advocates and the leader of Rush-Presbyterian Hospital who accused the university of abandoning its responsibility to poor residents in the community and increasing the burden on Rush-Presbyterian in the process. The legislature blocked the deal.

These incidents illustrate that the road to a for-profit conversion can be a long one, strewn with lost opportunities and the dashed desires of boards, medical staffs, and community leaders. In nearly all our cases, serious financial problems appeared years before

the conversion occurred and then festered as boards deliberated over remedies and then faced opposition in implementing their decisions. When for-profit owners finally purchased these institutions, the value of the charitable assets in most cases had dried up, many of the physical plants had suffered severe deterioration, and in many cases public confidence in the hospital's quality of care had eroded. In competitive markets in particular, the purchasers faced enormous challenges in attempting to stabilize these institutions.

The Economic Impact of Conversion

This section discusses observed financial outcomes of conversion for the eight hospitals and the external and internal factors that appeared to play important roles in those outcomes. Our understanding of hospitals' financial situations is based on interviews with former administrators, board members, physicians, and heads of local hospital associations. We highlight findings on the profitability of hospitals post-conversion, whether institutions benefited from the managerial expertise of their new owners, the degree to which purchasers invested capital in declining physical plants, and whether conversion acted as a kind of *laissez-faire* planning mechanism—saving hospitals where the need for them was clear and shutting down hospitals of questionable utility to community health systems.

Profitability. Two institutions, Palo Verde Hospital (Blythe, CA) and Healthsouth Doctors' Hospital (Coral Gables, FL) flourished under for-profit control, but most of the hospitals continued to struggle financially after they had been sold. Four of the eight hospitals had subsequent changes in ownership and four are now closed (two of these closed subsequent to the beginning of our study). Such a high rate of closure in this sample of hospitals is consistent with research by Lee and Alexander (1999), who found that ownership change of any type increases the probability that a hospital will close.

In some of our cases, the change in ownership brought a failing hospital into the black for one or two years before fundamental problems that had plagued it prior to conversion again destabilized it. But in some cases, close observers had concerns about the methods by which this was achieved. For example, at the time of its sale in 1991, Metropolitan General Hospital in Pinellas Park, Florida was in danger of not being able to pay its employees' health benefits, but it realized a profit in 1992 under the new ownership of Community Health Systems, Inc. The profit margin, however, was largely attributable to a substance abuse treatment program for pregnant Medicaid beneficiaries, many of whom were brought in from out of state. The program was run within the hospital's walls by an outside organization. The first CHS administrator tried to expand

the size of the program before an ongoing fraud investigation into the program by both state and federal prosecutors forced CHS to cancel its contract. Although the hospital avoided indictment in the scandal, it entered a financial downward spin in 1994 that ultimately resulted in a strategic trade of facilities with Columbia/HCA, which already owned several nearby competing hospitals, and immediately closed Metropolitan in 1997.

The profit picture was also distorted in the first few years of Humana's ownership of Michael Reese Hospital on Chicago's Near South Side. In the first year that Humana owned Michael Reese, it turned a profit of \$12 million compared to a \$27.6 million loss the previous year.⁹ Yet, as part of the sale, Humana had negotiated a four-year, front loaded \$54 million subsidy to be paid by the Michael Reese Health Trust.¹⁰ Most people with whom we spoke attributed the turnaround in part to the gift in that year from the Trust. In fact, according to Enrique Beckmann, the current chief of pathology at Reese and a board member of the Trust, the hospital was never profitable once the foundation payments ended.¹²

Managerial expertise. We found little support for the argument that the expertise of a for-profit organization can turn around the fortune of a failing hospital over the long-term. Only in one case, the lease of Palo Verde Hospital to Brim, Inc., was there a clear improvement in the operation of the facility post-conversion. Though some community members complained about the loss of community control when Brim took over the management of the hospital, there was widespread agreement that Brim introduced sophisticated administration and control in an organization that had been previously run by an inexperienced board, administration, and medical staff whose practices had raised ethical and quality concerns in the local press.

But in most of our cases, the inability of purchasers, particularly multi-hospital systems, to enhance profitability over the long-term appeared to be the result of both the institutions' fundamental problems and a short-term strategic orientation by the purchaser. Rather than engage in long-range strategic planning and substantial capital investment, some of the national systems, particularly those that purchased hospitals in competitive urban markets, relied mostly on short-term fixes such as changes in billing systems directed towards achieving quarterly profit targets and maintaining share price. The hospitals purchased by systems in those environments tended to have high rates of turnover among

⁹ Telephone interview with Sam Holtzman, April 6, 1999, Bradford Gray and Sara Collins.

¹⁰ Interview with Larry Haspel, MD., Chairman, Metropolitan Chicago Healthcare Association, Chicago, Illinois, April 12, 1999, Bradford Gray and Sara Collins.

¹¹ Telephone interview with Sam Holtzman, April 6, 1999, Bradford Gray and Sara Collins.

¹² Interview with Enrique Beckmann, MD, Ph.D., Chicago, Illinois, April 12, 1999, Bradford Gray and Sara Collins.

administrators and were more likely to undergo subsequent mergers or sales than the hospitals purchased by individual investors. Such churning in the leadership of these hospitals had destabilizing effects on institutions, created cynicism among staff, and further weakened long-range planning efforts.

For example, after conversion, Michael Reese underwent three ownership changes and several changes in administration under each of its owners—Humana, Galen, Columbia/HCA, and Doctors' Community Healthcare Corporation. Constant turnover in CEOs made it nearly impossible for the administration to develop long-range planning with the medical staff, and even minor problem solving became difficult, according to those we spoke with. "Just when we would start to make headway with one administrator," said a department chief, "we found ourselves with a new CEO."

In addition, purchase by national systems carried a variety of inherent disadvantages including a lack of knowledge about local markets and remoteness of managerial control. Corporate purchasers encountered enormous difficulties when they entered markets with substantially different characteristics than those of the markets in which they had traditionally operated. Before Community Health Systems purchased three hospitals in the Tampa-St. Petersburg market in the 1980s, it had primarily owned and managed sole community providers in rural communities. Unable to compete in an overbedded market, Community Health Systems ultimately traded the three hospitals to Columbia/HCA in the mid-1990s in exchange for two hospitals in less competitive markets.

Similarly, the purchase of Michael Reese brought Humana into the Chicago market, where it tried to follow strategies it had pursued in smaller cities where it had bought flagship hospitals and then organized networks of care around them. A former post-conversion Reese administrator told us:

It was very different running a hospital like that in Chicago as compared to Dallas, for example, and I don't think anyone [at Humana] had a clue as to how different it was going to be. Nebraska [where Humana owned hospitals] had two medical schools and Indiana had one. But Chicago has six medical schools by itself and they will kill you for a patient. I don't think anyone in the company understood that the three markets of Los Angeles, New York, and Chicago were different from anyplace else in the country. They went in totally unaware or unknowing of what they were getting into.

¹³ Telephone interview with Nancy S. Carlstedt, President and CEO of Bloomington Hospital, Bloomington, Indiana, March 24, 1999, Bradford Gray and Sara Collins.

Compounding Humana's inexperience in a competitive market was the fact that Michael Reese had established teaching and research programs, with a medical staff that was highly committed to both. Although Humana at the time was also operating a teaching hospital at the University of Louisville under a lease agreement, members of the Michael Reese teaching faculty reported to us that Humana never really established how to run a large academic institution effectively. One former department chief said, "Humana never understood that in buying an educational institution, they were buying a second line of business that requires a different commitment and program than running a hospital. Humana never quite understood what my goals were or what my role was. [Department chiefs] were not included in strategy sessions or the management of the hospital." ¹⁴

Access to capital. Despite the argument that for-profit conversion will improve institutions' access to capital, only a few new owners undertook substantial capital improvement programs. As prior research has found, the poor financial conditions that marked all of these hospitals before their conversion had prevented boards from making needed capital improvements. As a result several purchasers found themselves with aging physical plants, many of which required substantial capital investments to make them attractive to patients, physicians, and payers. This occurred in two cases. When Brim leased Palo Verde Hospital in Blythe, California, the building had not been examined structurally for some time. Brim replaced the air-conditioning system, updated parts of the roof, and added an intensive care unit. In addition, through contracts with hospitals in other cities, Brim arranged for monthly "visits" by MRI machines and CAT scans. Similarly, Healthsouth made long-neglected capital improvements and even made a controversial multi-million dollar investment in a Gamma Knife in 1993, just a year after its purchase of Doctors' Hospital.

In several cases, purchasers made substantial cosmetic improvements to the facility. An example was Doctors' Hospital of Hyde Park, where the interior physical improvements made by Dr. Desnick were a source of pride to the medical staff we spoke with.

However, new owners of hospitals that needed substantial capital outlays generally did not make improvements on the requisite scale, either because they sold the hospital too quickly to make changes, believed that the costs of investments outweighed the business value of the hospital to the company, or, in the case of individual investors at two

¹⁴ Interview with William Chamberlin, M.D., Chicago, Illinois, April, 15, 1999, Bradford Gray and Sara Collins.

small marginal institutions in California, simply could not afford them. Sam Holtzman, the first Humana CEO of Michael Reese, told us that in 1991, when Humana purchased the hospital:

There wasn't a single aspect of the hospital that wasn't a problem. Name it and it was. There were numerous environmental issues that were open-ended. It had asbestos problems in virtually every building. There were some 2,700 buried underground fuel tanks, over half of which were leaking, that had to be remedied. Most people don't realize the extent to which Humana cleaned up the site. We found explosives in abandoned labs that had to be taken out by bomb squads. Eighty percent of the air-conditioning units didn't work. Maintenance was a huge problem. One building had scaffolding all the way around it covering the sidewalks. I wondered what they were there for, since I couldn't see any construction. I found out that they were not building anything. Brick was crumbling off the top of the building and falling to the sidewalk, and they didn't want anyone to get hit. We spent \$1 million the first year, tearing the parapet off and replacing it.

But Humana did not carry through on many of its facility improvement plans. Said Holtzman:

Our plan was to abandon the oldest buildings, consolidate patients in the newest building, and tear down the old buildings. But that changed. We did abandon four buildings and closed them up tight, but we never tore them down. We didn't have time to do it [before Humana spun off its hospital business as Galen Health Care in 1994]. Most of the buildings were full of asbestos and would have required extensive remediation if torn down. So we abandoned them. We turned off the lights, the power, and the AC, and saved additional money on security and cleaning.¹⁵

After Columbia acquired Michael Reese through a merger with Galen in 1994, it, too, avoided substantial capital investment in the hospital's crumbling plant. Columbia purchased six general hospitals in the Chicago area, as well as some psychiatric hospitals.¹⁶ But Larry Haspel, Chairman of the Metropolitan Chicago Healthcare Association and a former CEO of Chicago Osteopathic Hospital, told us that in 1999, save for the purchase of the hospitals themselves, Columbia did not invest much in the Chicago area. Said Haspel:

¹⁵ Telephone interview with Sam Holtzman, April 6, 1999, Bradford Gray and Sara Collins.

¹⁶ Interview with Larry Haspel, M.D., Chairman, Metropolitan Chicago Healthcare Association, Chicago, Illinois, April 12, 1999, Bradford Gray and Sara Collins.

The changes needed at Reese were system changes and capital investment. For all their talk, Columbia did not put much capital into any hospital in the Chicago area. The company had \$6 billion in cash allegedly, but it did not go to LaGrange or Michael Reese, or any of the other hospitals. They made some capital investments but did not pour any significant money into the facilities.¹⁷

Similarly, Metropolitan General in Pinellas Park, Florida, had severe physical problems when Community Health Systems purchased it in 1992. It had a roof that leaked to the extent that when it rained, the staff placed buckets in the hallways and strung up drapes in the operating room. The air-conditioning and heating system had to be completely overhauled, and the layout of the hospital reflected a corridor-by-corridor construction history that rendered the hospital highly inefficient. Though CHS invested \$10 million in the hospital over the four-year period that they owned it, adding new tiles and painting the walls, the company decided to sell the hospital rather than undertake a full-fledged overhaul that would have required an additional \$20 million commitment. When Columbia/HCA took over the three CHS hospitals in Pinellas Park following the swap with CHS, it immediately closed Metropolitan General, citing the state of its physical plant.¹⁸

Conversion as a *laissez-faire* planning mechanism. The survival of Palo Verde Hospital, a sole community provider in an isolated community, illustrates the fact that for-profit conversion can stabilize a failing hospital for the benefit of a community. Brim, and its successor, Province Healthcare, improved the hospital's profitability, brought valuable managerial expertise to a community that had been unable to attract high quality administrators, made significant capital investments in the facility, and undertook a successful physician recruitment effort that benefited not only the hospital but the broader community. The circumstances were unusual, however. The hospital was under unusually close scrutiny, not only because of Blythe's small-town nature, but also because an elected district board continued to have an oversight role for the hospital.

Our evidence to support the opposite proposition—that sale to for-profit purchasers of marginal hospitals in over-bedded markets is an effective catalyst leading to the closure of unnecessary facilities—is, at best, mixed. While conversion did lead to closure in half the cases, the time between conversion and closure was generally

¹⁷ Interview with Larry Haspel, M.D., Chairman, Metropolitan Chicago Healthcare Association, Chicago, Illinois, April 12, 1999, Bradford Gray and Sara Collins.

¹⁸ Interview with Dan Friedrich, former CEO of Pinellas Community Hospital 1994–1996, and current CEO of St. Petersburg General Hospital, which is owned by Columbia, St. Petersburg, Florida, February 12, 1999, Bradford Gray and Sara Collins.

considerable, allowing for-profit owners time to extract marginal profits, gain a toehold in markets they desired to enter, or enhance share in markets in which they owned other hospitals. In two cases, the first purchasers sold the hospitals a second time before they closed; that may also prove to be the case with Michael Reese Hospital, which has been sharply downsized and continues to struggle under its fourth owner. Individual investors, whom Sloan et al. (2000) refer to as a vanishing breed, sought to maintain these hospitals over the long-term and struggled desperately to hold onto them, until bankruptcy or loss of a Medicare license caused their closure.

The Social Consequences of Conversion

Consistent with prior research, we found only insubstantial evidence of a decline in community benefit activities such as care to the uninsured, teaching and research, high-cost services such as trauma and burn care, programs for special-needs populations, and community education and outreach. This was largely because most hospitals in our sample were not organized to provide these services prior to conversion, although there were two notable exceptions. We also found that services to publicly insured patients *increased* at several hospitals post-conversion, contrary to expectations, but consistent with the study by Cutler and Horwitz (2000). And finally, conversion resulted in the creation of charitable foundations in three of the eight cases.

Uncompensated care, teaching, and research. The majority of the hospitals we studied avoided providing services to the uninsured prior to conversion due to location, lack of an emergency department, or the general attitude of the board towards the community. For example, there was agreement among those we interviewed in Florida that neither Victoria Hospital in Miami nor Doctors' Hospital in Coral Gables had ever provided significant levels of uncompensated care prior to conversion. Victoria, though it was located in Little Havana, a neighborhood that had come to be dominated by a poor immigrant population, served a generally affluent patient population that had long since moved away from the immediate community. The hospital did not have an emergency room, and indigent patients in the community went to Jackson Memorial Hospital, a sprawling public hospital located just a few blocks from Victoria. Victoria, now closed, lured patients back downtown with specialty services such as reconstructive surgery. It was, said Gerard Kaiser, Senior VP of Medical Affairs at Jackson Memorial, "a community hospital without a community."¹⁹

¹⁹ Interview with Gerard A. Kaiser, M.D., Senior VP of Medical Affairs, Jackson Memorial Hospital, and Deputy Dean for Clinical Affairs, University of Miami, Miami, FL, February 8, 1999, Sara Collins.

In a different sort of community, Doctors' Hospital, now Healthsouth Doctors' Hospital, sits on a golf course in an upper-income neighborhood in Coral Gables. Though it was originally incorporated as a nonprofit, the hospital behaved more like a doctor-owned facility, providing little charity care and performing few community-oriented services before it was sold to Healthsouth in 1992. Eighty percent of the board was comprised of physicians who had active practices at the hospital.²⁰ Said Linda Quick, president of the South Florida Hospital and Healthcare Association and a former director of Miami's Health Planning Agency:

Even when it was physician dominated, it was not a community hospital. The hospital was developed in a quiet, affluent residential area which, meant that by definition they were hoping never to get people who were not affluent at the hospital. They never advertised, never did any community services, and were never a sponsor of community organizations. It was literally a doctors' hospital, and I am not sure that the public didn't know that the doctors didn't own it. Someone must have told the doctors they should incorporate as a nonprofit.²¹

Three hospitals in our sample—Palo Verde Hospital, Michael Reese and Doctors' Hospital of Hyde Park—by virtue of the communities in which they were located and because of their original missions, were prominent players in their local communities for both care to vulnerable populations and teaching and research. In the case of Palo Verde Hospital and Michael Reese, community benefit appeared to decline post-conversion. Doctors' Hospital, in contrast, concentrated its efforts on reaching out to the community to increase admissions of public-pay patients.

Palo Verde Hospital is the sole community provider in Blythe, California, an isolated town of 10,000 on the California-Arizona state line. Brim, Inc., an investor-owned hospital chain, now a subsidiary of Province Health Care, leased Palo Verde with an option to buy in 1992. State discharge data indicate that self-pay discharges declined just prior to the time of conversion and never regained pre-conversion levels. Interviews with the administrator who came in with Brim and has remained under the Province Health Care ownership, revealed that financing care of the uninsured was a concern of the owners and that they transferred uninsured patients to Riverside, a county hospital 90 miles away, whenever possible. Said the administrator:

²⁰ Telephone interview with Norman Kenyon, M.D., February 22, 1999, Bradford Gray and Sara Collins.

²¹ Interview with Linda Quick, President, South Florida Hospital and Healthcare Association, Coral Gables, FL, February 9, 1999, Bradford Gray and Sara Collins.

I think the hospital has potential, unless patients don't have insurance. That continues to be a problem since we are so close to the border. We treat anyone who comes here but do MIA (a state-financed program for medically indigent adults) if it can help them get to Riverside. We will do this and so will other hospitals. The county will allow us to do this, so if there is room in the county hospital, we will move them there.²²

At Michael Reese Hospital, a 100-year-old teaching and research hospital that was established to train Jewish doctors and serve what was a predominantly Jewish community on the Near South Side of Chicago, the teaching and research activities went into a decline after Humana purchased the hospital in 1991. Neither Humana, nor its successor, Columbia/HCA, had substantial experience running a teaching hospital and their management de-emphasized that aspect of Reese's activities. As part of its teaching/service mission, Reese had also operated several specialty outpatient care clinics that served the local community. Humana management consolidated and closed some of the clinics.²³ Said one observer, who asked not to be identified, "Reaching out to the homeless and a variety of other populations more likely to be uninsured is not something Humana did. You can create barriers to entry by not interacting with the community."

Care of publicly insured patients. Care provided to publicly insured patients has been used as a measure of community benefit in some studies of hospital conversions that use secondary data. Some researchers, however, have noted that the reliance by for-profit purchasers on revenues from publicly insured patients to bolster profit margins may not necessarily be in the public interest (Cutler and Horwitz, 2000). Based on the findings of our research, we echo those concerns.

In three of our case study hospitals, state discharge data indicate that Medicaid and/or Medicare admissions increased dramatically post-conversion. In two of those cases, declining private-pay admissions led the new owners, both individual investors, to create specialty niches that would bolster their sagging medical-surgical businesses. Each of these hospitals developed or expanded product lines such as psychiatric care for elderly patients, SNFs, chemical dependency treatment centers, and ventilator units. Doctors' Hospital of Hyde Park, which reportedly developed a feeder network of physicians who would refer nursing home residents to the hospital, was also fined \$4.5 million by HCFA for having enhanced its Medicare revenues by illegitimately upcoding the DRGs assigned for pneumonia admissions.

²² Interview with Victoria Clark, Blythe, California, November 13, 1998, Bradford Gray and Sara Collins.

²³ State discharge data, however, show little provision of uncompensated care either before or after conversion, possibly because most of the population in the immediate community qualifies for Medicaid.

Prior research has found that for-profit hospitals in poor financial condition often provide chronic care services to increase patient revenues. Wheeler et al. (1999) examined ownership differences and the provision by hospitals of sub-acute care services such as rehabilitation services; chronic disease care; hospice; inpatient psychiatric and alcohol/chemical dependency treatment; care for persons who are developmentally disabled; skilled nursing and intermediate care facilities; and residential care/housing for the elderly. The authors found that poor financial performance was a predictor of whether investor-owned, but not nonprofit, hospitals diversified into these services. In addition, financial risk, or large fluctuations in financial performance, at investor-owned hospitals increased the level of subacute care services at hospitals.

In their case studies of converting hospitals, Cutler and Horwitz (2000) found that for-profit purchasers increased revenues in their newly acquired hospitals by exploiting Medicare loopholes and possibly engaging in DRG upcoding. The new owners added rehabilitation services for Medicare patients as a way of unbundling an inpatient admission, which is paid prospectively, from rehabilitation services which Medicare pays for separately when the services are provided independent of a hospital admission. However, Cutler and Horwitz did not have direct evidence to support their theory that owners inflated revenues by upcoding.

In our study, Good Samaritan Hospital, a marginal institution in an overbedded market in Bakersfield, California, was purchased by a private investor in 1989. Between 1988 and 1991, the hospital suffered a 70 percent decline in private-pay discharges. In 1992, with the hospital nearly bankrupt and in danger of losing its accreditation and Medicare license, the owner invited a local psychiatrist to become part owner of the hospital. The psychiatrist had a large practice comprised of elderly patients with both psychiatric and medical needs, and he took the lead in developing an inpatient capacity for such patients at the hospital. Psychiatric admissions rapidly grew to comprise 50 percent of the hospital's patient base.²⁴ However, after some of the unit's claims for payment failed to meet HCFA's criteria for exclusion from the prospective payment system in 1998, HCFA rescinded Good Samaritan's exemption, substantially weakening the program and the hospital's revenue stream.²⁵ ²⁶ Throughout the 1990s, the hospital struggled to maintain its accreditation.

²⁴ Interview with Robert Orr, current administrator of Good Samaritan Hospital, Bakersfield, California, November 10, 1998, Bradford Gray and Sara Collins.

²⁵ Telephone interview with Lanna Pimbley, District Manager, Ventura District Department of Health, November 19, 1998, Sara Collins.

²⁶ Interview with Robert Orr, current administrator of Good Samaritan Hospital, Bakersfield, California, November 10, 1998, Bradford Gray and Sara Collins.

Doctors' Hospital of Hyde Park became similarly dependent on marginal product lines designed to increase Medicare and Medicaid admissions after its purchase by ophthalmologist James Desnick in 1992. Dr. Desnick built a successful network of nearly 20 cataract surgery centers in the Midwest in the late 1980s and early 1990s, attracting Medicare patients from nursing homes and housing projects to his surgery centers with free rides and carefully targeted telemarketing. Numerous press accounts, malpractice suits, and a class action suit alleged that the centers were providing unnecessary surgery and led to a state investigation in which Desnick was accused of false advertising and unethical telemarketing activities. He gave up practicing medicine in the mid-1990s after the state suspended his medical license. By all accounts, however, in operating his hospital Dr. Desnick followed many of the strategies that had made his cataract surgery business so successful, in particular, relying on revenues from publicly insured patients.

After purchase, Dr. Desnick added a 30-bed psychiatric unit, expanded the hospital's detox unit to include public-pay patients, opened a 40-bed partial hospitalization/skilled-care unit with ventilators, and updated the physical and occupational therapy departments, primarily to serve post-stroke patients. The detox unit proved to be particularly stimulative of admissions. In 1997, drug dependence was the leading cause of inpatient admissions among Medicare patients at Doctors' Hospital, accounting for nearly 15 percent of all cases.²⁷ A former admitting physician at the hospital told us that the basis of Dr. Desnick's strategy was the recognition that the hospital could never be profitable if it continued to emphasize acute care services. "Acute care these days is not really an option if you are going to keep a hospital open," he said. "You go with chronic care patients who will be there for long periods of time."

The hospital also recruited physicians with large chronic-care practices, particularly nursing home practices, and used a home visit service to treat chronically ill homebound patients, a strategy not uncommon among Chicago-area hospitals. Claudia Fegan, M.D., a medical director at Michael Reese Hospital who was on the Doctors' Hospital of Hyde Park staff briefly in 1989–90, made this observation when we spoke with her in 1999: "How do you generate census in the city of Chicago? Nursing homes. Everyone who comes from a nursing home is anemic, and they all need an endoscopy, and if you have scarring on a chest x-ray, you can admit patients with pneumonia. And then you can wait three or four months and do it again."²⁸

²⁷ CaduCIS Net Facility Case Mix Report. Medicare Inpatient–HCFA, 1997.

²⁸ Interview with Claudia Fegan, M.D., Chicago, Illinois, April 14, 1999, Bradford Gray and Sara Collins.

The hospital also engaged in DRG upcoding. In 1996, a suburban Philadelphia software company, Health Outcomes Technologies, which specializes in identifying fraudulent activity in the Medicare program, filed a whistle-blower suit under the False Claims Act against Doctors' Hospital and several other hospitals across the country. The company claimed that the hospitals had collected higher payments from Medicare for pneumonia admissions by using the DRG code for serious bacterial pneumonia for patients who actually had less serious forms of the illness.²⁹ The company found that excluding the hospitals named in the suit, the nationwide average of bacterial pneumonia cases under the Medicare program in 1993 and 1994, as a percentage of the total number of pneumonia cases billed by hospitals, was about 2.4 percent.³⁰ The average at Doctors' Hospital was 39.3 percent in 1993 and 77.8 percent in 1996.³¹ Though it denied allegations of wrongdoing, Doctors' Hospital agreed to settle the case in 1999 by paying Medicare \$4.5 million, one of the largest settlements in the suit.³² In 2000, Doctors' Hospital declared bankruptcy and closed.

Creation of a Foundation. The poor financial straits of most of the case study hospitals meant that the sale price mostly covered debt, leaving little money for other purposes. However, three of the conversions resulted in the creation of charitable trusts—Michael Reese Hospital (\$85 million, mostly due to the value of the HMO that was sold with the hospital), Healthsouth Doctors' Hospital (\$15 million), and Burbank Community Hospital (\$2 million). All three of the foundations continue today and have made contributions to their communities through grants to a wide range of community organizations. In fact, the foundation created by the sale of Doctors' Hospital probably has provided more community benefit, largely through its grants to programs for children with special needs, than did the original hospital.

Conclusion and Policy Implications

Summary of Findings

In this study, we sought to expand what is known about the reasons why nonprofit hospitals convert and the economic and social consequences of conversion for the hospitals

²⁹ U.S. Department of Justice, U.S. Attorney, Northern District of Illinois. "Doctors' Hospital of Hyde Park to Pay U.S. \$4.5 Million Settlement." Press Release. May 27, 1999.

³⁰ United States, *ex rel* Health Outcomes Technologies v. Easton Hospital; Springfield Hospital; Doctors' Hospital of Hyde Park; Louis A. Weiss Memorial Hospital; Palm Springs General Hospital; (remaining defendants excised). United States District Court, Eastern District of Pennsylvania, 1999.

³¹ United States, *ex rel* Health Outcomes Technologies v. Easton Hospital; Springfield Hospital; Doctors' Hospital of Hyde Park; Louis A. Weiss Memorial Hospital; Palm Springs General Hospital; (remaining defendants excised). United States District Court, Eastern District of Pennsylvania, 1999.

³² U.S. Department of Justice, U.S. Attorney, Northern District of Illinois. "Doctors' Hospital of Hyde Park to Pay U.S. \$4.5 Million Settlement." Press Release. May 27, 1999.

and their communities. Our data from all U.S. hospitals that converted from nonprofit to for-profit in the period 1985 through 1994, show that at least 60 percent underwent a subsequent major transition such as resale, a change in purpose, or closure within just a few years. We also examined in depth the experience of eight hospitals that were sold to for-profit purchasers a decade ago. We found that financial distress was a common characteristic of such hospitals and that sale to a for-profit owner was rarely the first option considered by boards. Most boards had first exhausted other options including sale or merger with other nonprofits. Institutional characteristics such as the power of physicians in hospitals and external circumstances such as state and local politics exerted significant influence over the course of events.

In six of eight cases, sale to a for-profit owner at best only temporarily arrested the financial decline of hospitals. Although the benefits of the purchaser's managerial expertise and access to capital were clear for the sole community provider in our sample, they did not appear to materialize for most hospitals in over-bedded suburban or urban markets. Multi-hospital systems that bought hospitals in competitive markets generally did not have long-range strategic orientations and invested as little as possible into the aging physical plants of their hospitals. Individual investors seemed to want to maintain their hospitals over the long-term and struggled desperately to hold onto them, until bankruptcy or a loss of Medicare-eligibility shut them down.

Although half of the hospitals in our sample closed, there is little evidence in this study to support the notion that for-profit purchasers function as *laissez-faire* market planners, possessing a unique incentive to shut down hospitals of questionable need when nonprofit boards could not. If anything, for-profit conversion prolonged the life (or the death) of many institutions whose value to their communities was low.

Consistent with prior research, we found only scattered evidence of a decline in community benefit activities. This was largely because most hospitals in our sample had not provided such services prior to conversion. In two cases, however, there was some evidence of a decline in teaching and research activities and care to the uninsured. We also found that admissions of publicly insured patients rose significantly at some hospitals. But while care to the publicly insured is a commonly used measure of community benefit in research using secondary data sets, the hospitals in our sample appeared to rely on non-acute care services geared towards publicly insured patients to increase profit margins in marginal institutions. Like previous researchers who have made similar discoveries, we question whether this type of activity does indeed benefit communities.

Finally, conversion resulted in the creation of charitable foundations in just three of the eight cases, since most hospitals were in such poor shape that their sale price largely covered debt. In the case of one foundation, a focus on small grants to local public health programs has probably yielded more community benefit than did the original nonprofit hospital, which lacked a community-oriented mission.

Policy Implications

We highlight two important policy implications of this study. First, the findings illustrate how important it is for decision makers at the hospital or community level who are contemplating conversion to move beyond the stereotypic ways in which conversions are often depicted and to recognize that the process and outcomes of conversions are influenced by institutional structures, markets, and purchasers. The findings of the study, for example, challenge conventional wisdom about the ability of for-profit purchasers, whether multi-hospital systems or individual investors, to turn around the fortunes of failing institutions in competitive markets. Second, our case histories provide dramatic illustrations of the enormous challenges faced by financially unstable hospitals in our rapidly changing health care system and highlight the dubious strategies pursued by some hospital leaders post-conversion to ensure their institutions' survival. The pursuit of niche markets, and questionable strategies for increasing admissions of publicly insured patients by some of these hospitals post-conversion, should raise concerns among regulators about the potential for fraud and abuse among owners of newly converted institutions. Similarly, the failure of some of these institutions to remain accredited or Medicare-eligible post-conversion suggests a need to monitor more closely the medical care provided by financially troubled institutions.

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