

An Analysis of the Impact of Mergers Between Community Development Corporations

by

Shoma S. Haque

B.S., Economics (1996)

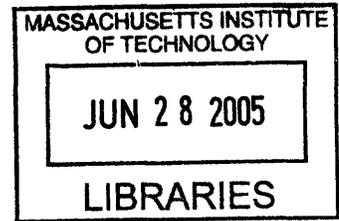
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Submitted to the Department of Urban Studies and Planning  
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**ROTCH**

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## **Abstract**

This thesis explores the occurrence of mergers between community development corporations (CDC's) in the United States in the past five years. The research examines how mergers between CDC's affect their capacity to achieve their mission and serve their constituents. In addition, the author explores the drivers behind CDC mergers, the impacts from those mergers, and the factors that contribute to merger success.

There is currently limited data and literature on CDC and non-profit mergers. This paper uses three case studies of mergers between CDC's to explore how and to what extent CDC capacities changed as a result of the merger. A CDC capacity framework created by Glickman and Servon (1997) is operationalized and applied to each case study to analyze the capacity changes. The results from the case studies and review of the literature show that CDC's can likely benefit the most from a growth in programmatic capacity as a result of a merger.

Thesis Supervisor: Karl Seidman  
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The executive directors and board members of my case study organizations, Neighborhood Housing Services of Orange County, Mutual Housing Association of Southwestern Connecticut, and St. Clair Superior Development Corporation, all deserve my appreciation. They provided countless hours of interview time as well as access to a variety of internal documents. In addition, I would like to acknowledge the contributions of the intermediary funders that I interviewed from LISC and NRC. Thank you for participating in this research.

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## **Chapter 1: Introduction**

Since their inception in the 1960's, community development corporations (CDC's) have played an integral role in the social and economic well-being of urban neighborhoods in the United States. CDC's offer a range of programs and services to the communities they serve, including affordable housing, homeownership loans, workforce development, small business assistance, and a variety of health and human services. According to Peirce and Steinbach (1987), "Whatever the mix, the goal of every CDC is the immediate relief of severe economic, social, and physical distress – and, eventually, wider regeneration of the community."

Over the course of the past four decades, CDC's have grown in number and influence. However, a host of environmental factors, including cuts in philanthropic and public funding, increasing competition, and shifts in federal policy, have been putting increasing pressure on CDC's to address these challenges to their existence. Several CDC's have taken the step to expand their capacity through mergers and alliances with other CDC's. Research by Rohe et al (2003) found that "CDC failures, downsizings, and mergers appear to be widespread and deserve the attention of researchers, policy makers, and CDC intermediaries." CDC's have a vital role to play in the development and revitalization of urban neighborhoods, and the emergence of new trends in the industry, such as mergers, will have serious impacts on their capacity (both positively and negatively) to provide much-needed services to their communities.

There is limited research on the topic of non-profit mergers in general and even less literature on CDC mergers in particular. Thus, this paper will attempt to expand this knowledge by shedding more light on the relatively new concept of CDC mergers and how they impact a CDC's capacity to serve its constituents. More specifically, this research will strive to answer which elements of CDC capacity will most likely be affected by a merger. In addition, this thesis will hopefully provide a better understanding of the drivers behind CDC mergers, their impacts both internally and externally, and the success factors of CDC mergers. Ultimately, this research should provide insights that will inform and guide CDC management, funders and other supporters of CDC's on how to most effectively implement and support mergers between CDC's in order to achieve the most significant increase in CDC capacity.

After reviewing the literature and analyzing the case studies, a number of conclusions regarding CDC mergers came to light. First, the experiences of the CDC's in the case studies show that while each element of capacity changes to varying degrees, CDC's can probably assume that they will gain the most from a merger in terms of expanded programmatic capacity, defined as an increase in programs and services and/or a larger geographic service area . In addition, unlike non-profit mergers in general, CDC mergers seem to be more often driven by pressure from funders. Finally, these consolidations often result from the combination of two struggling CDC's or one strong and one weak organization; they are not the product of two relatively strong organizations merging for strategic reasons.

## **Research Methodology**

In addition to an exhaustive literature review of the existing research in this area, three case studies of CDC mergers were analyzed in this thesis to determine the affect of a merger on a CDC's capacity. These case studies examine the mergers between:

- Neighborhood Housing Services of La Habra and Santa Ana Neighborhood Housing Services to create Neighborhood Housing Services of Orange County
  
- Mutual Housing Association of Southwestern Connecticut and Bridgeport Neighborhood Housing and Commercial Services to create Mutual Housing Association of Southwestern Connecticut
  
- St. Clair Superior Coalition and St. Clair Business Association to create St. Clair Superior Development Corporation

Surveys and interviews were conducted in order to obtain data on each CDC merger. The data was then used to compare the capacity of the CDC pre and post merger to determine how, if at all, the merger affected the CDC's capacity. Pre-merger was defined as the year before the merger was completed and post-merger was defined as the last fiscal year for which the surviving CDC had audited data (2003 or 2004).

In order to identify the three case studies, a list was obtained from previous academic research conducted on CDC mergers. This list was narrowed down based on how recently the mergers occurred, the geographic diversity of the CDC's, how many CDC's were involved in the merger, and whether the CDC was willing to participate in this research. Mergers that occurred prior to 1999 were not included in this study, since it was assumed that it would be challenging to identify and contact original merger participants and that merger participants' memories would begin to fade after more than five years. Case studies that represented mergers located in various regions of the country were also prioritized. Finally, mergers that involved more than two CDC's simultaneously were not included, in order to more easily identify the contributions of each CDC into the merged organization. Each case study involved a merger between two CDC's, and in all cases the surviving CD was the stronger CDC in the merger, and it absorbed or incorporated the weaker CDC into its operations.

Surveys on both pre-merger and post- merger key capacity indicators and merger impact for each case study were completed with the assistance of the executive directors of the surviving CDC. Three methods were used to complete the surveys - speaking with the executive director via telephone, asking the executive director to directly complete the survey questions, and having the principal researcher review internal CDC documents to obtain the relevant capacity data. The survey contained fill-in-the-blank questions regarding pre and post organizational information, open-ended qualitative questions, and a series of questions using a five-point Likert Scale, asking the executive director how the merger affected the organization's various capacities on a scale from "much less capable" to "significantly more capable." The internal CDC documents obtained by the principal researcher included annual reports, major funder reports and proposals, organizational charts, internal budgets, and audits.

Measuring the effects of mergers on CDC capacity is a tricky endeavor. There seems to be no consensus on how capacity can or should be measured. Some feel that capacity measurement should be outcome or output oriented, such as the number of units built, while others believe that the measurement should encompass more holistic indicators of capacity, such as increases in overall homeownership rates (Glickman and Servon, 1997). In addition, it is extremely difficult

to attribute changes in the capacity of an organization solely to a merger, without considering the affects of other external factors such as the real estate market. However, for the purposes of this research, changes in capacity will be measured using Wing's (2004) definition, where he writes that "the general rule about measuring the effectiveness of capacity building would thus appear to be to look for an improvement in the measurement of an aspect of organizational performance judged to be important to the ability of the organization to fulfill its mission."

In this research, Wing's (2004) definition was applied to CDC mergers using Glickman and Servon's (1997) five-element model, encompassing financial, programmatic, organizational, political, and network capacity, described in more detail below. Glickman and Servon (1997) do not define how these elements of capacity should be measured. Thus, a survey to evaluate non-profit capacity created by David Wright of the Rockefeller Institute of Government at SUNY/Albany and based on Glickman and Servon's (1997) five-element model was used in the analysis of the case studies in this paper. Please see the Appendix for the survey instrument titled "CDC Merger Impact Survey" for a complete list of the capacity indicator questions.

In addition to the surveys, key players in each of the CDC mergers were interviewed via telephone in order to obtain qualitative information on the merger's impacts on CDC capacity. For each case study, interviewees consisted of the executive director of the surviving CDC, a board member from the surviving CDC (usually the chairperson), and the funder who represented the intermediary which was most closely involved in the merger (either from LISC or Neighborhood Reinvestment). These interviews provided additional insight into the community's perceptions of the merger, the factors that influenced the CDC's capacity, and lessons learned from the merger. Please see the Appendix for the interview instruments titled "Board Interviews" and "Funder Interviews" for a complete list of the interview questions.

## **Definition of Capacity-Building**

The definition of capacity differs between sources. Living Cities: The National Community Development Initiative, a consortium of community development funders, called capacity-building "creating and otherwise enabling existing CDC's to achieve their mission by providing

the kinds of resources and technical assistance they need to increase production, develop and reinforce board and management skills, and otherwise strengthen organizational capacities” (NCIDI, 1995). Knowledgeplex, a popular website resource for community development professionals created by the Fannie Mae Foundation, defines CDC capacity building as “activities aimed at improving the ability of a CDC to deliver, expand, and adapt in order to achieve its mission and goals, solve problems, and manage solutions.”

Glickman and Servon (1997) argued that the existing definitions of capacity did not encompass the full range of meaning as it relates to CDC’s and expanded the definition of capacity-building by describing five separate measures of organizational performance. Each of these elements of capacity interacts and affects one another.

1. Financial capacity (called resource capacity by the authors) - the ability to obtain funding through grants, contracts, earned income, loans, and other sources. Resource capacity includes multi-year support, funding for stabilization and expansion, development capital, access to funders, and a diverse portfolio of revenue streams.
2. Organizational capacity – the ability to build the organization internally, including staff, management, and board size and experience as well as systems for financial management and information technology. A strong executive director, skilled and stable staff, competent fiscal management, board leadership, planning and project management, and program evaluation are all elements of organizational capacity.
3. Network capacity – the ability to build the organization externally by establishing networks. Strong relationships with funders, community organizations, businesses, and government, effective external promotion of the CDC, access to non-financial resources, and synergistic programs can help the CDC build the network capacity of the organization.
4. Programmatic capacity - the ability to provide the programs and services usually offered by CDC’s, including residential and commercial real estate development, property management, economic development, health and human services programs, and community organizing.

5. Political capacity – the ability to advocate for and garner support on behalf of the community. This includes having community participation, establishing relationships at the city, state, and federal levels to influence public policy, being able to educate constituents and partners about community issues, and mediating conflicting interests externally.

Glickman and Servon's (1997) conceptual framework of CDC capacity is very comprehensive and does an excellent job of describing the various aspects of CDC capacity and the issues related to each aspect. Thus, this more comprehensive definition will be used throughout the remainder of this paper as a framework to describe nonprofit and CDC capacity.

## **Limitations of the Research**

There are a few limitations with the Glickman and Servon (1997) framework that should be mentioned. Since the paper is part of a larger study of community development partnerships (CDP's)<sup>1</sup>, a substantial amount of discussion is devoted to how CDP's can enable CDC's to increase their capacity in each of the areas outlined above, rather than discussing how CDC's that are not part of a CDP network can independently expand their capacity. In addition, in the discussion of programmatic capacity Glickman and Servon (1997) do not include any quantifiable outcomes or impacts as part of their analysis. Thus, there is no mention of how to evaluate, for example, whether a CDC that produces 100 units of housing annually has more capacity than a CDC that produces 50 units annually. Finally, there is no discussion about one of the most important aspects of CDC's, their place-based focus, and how a CDC's service area may affect its capacity.

In order to address the last two issues described above, Wright's original survey was altered to add a section under programmatic capacity asking for data related to "other indicators of impact relevant to your organization's mission (e.g. number of housing units developed, number of housing units under management, number of small businesses assisted, number of home or

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<sup>1</sup> Community development partnerships are part of a Ford Foundation program in which local intermediary funders obtain local, regional, and national funds and allocate them to CDC's.

business loans closed, number of ESL classes offered, etc.)” In addition, a question regarding target markets served, including demographics and service area, was added to the survey under programmatic capacity, since the CDC’s service area directly determines the beneficiaries of the CDC’s programs and services. Finally, Wright’s survey was also modified to include requests for data pre and post merger, not data for one point in time.

Readers should keep in mind that the survey administered to CDC’s was based on Wright’s survey, which in turn was very closely based on Glickman and Servon’s (1997) framework for CDC capacity. While most of the Wright survey was incorporated into the survey used for this research, decisions were made to eliminate or reframe some questions from the Wright survey. For example, the political capacity section originally included many questions regarding testifying before policymakers, becoming involved in elections, organizing voting efforts, and challenging banks and businesses. These questions were not included in the survey in order to make it a manageable length for the survey participants.

In addition, network capacity, one of the five elements in the capacity model, was not separately highlighted in this analysis. The main motivator for this decision was time constraints on the part of the CDC’s and the interviewees, who would have needed to provide more documentation and/or answer additional questions regarding their network capacity. In addition, many non-profits and CDC’s do not consistently track the number and specific names of partners, collaborators, and other community relationships. However, the concept of network capacity was incorporated at a high-level into the survey questions and interviews. Thus, the CDC’s relationships with funders, politicians, and other community stakeholders are discussed extensively throughout the case studies.

The original sample from which the CDC case studies were chosen was not a complete list of all CDC mergers that have occurred since 1998. After some inquiries, it was determined that a comprehensive and up-to-date list of CDC mergers did not exist. Creating such a list would have required a significant number of interviews with intermediaries, academics, and CDC executives who may or may not have been aware of CDC mergers that have occurred recently.

In each case study, only the surviving CDC's materials and merger participants were included in the research. In most cases, detailed information regarding budgets, staff, and programs outputs were not easily obtainable from the weaker or absorbed CDC. In addition, identifying and contacting the former executive directors and former board chairs of a CDC that no longer existed was also a challenge. Thus, it should be noted that individuals from the absorbed CDC who may have had a large role to play in the merger, or who may have conflicting views regarding the merger impacts, capacity, and lessons learned, were not interviewed for this research. However, two of the research participants, who were affiliated with the weaker organization and are now with the surviving CDC, were interviewed for this thesis.

Finally, two concepts were not included as part of this research: the non-profit merger process and the local environmental context in which the mergers took place. The details of the exploration phase, negotiation process, merger implementation, and evaluation are all well documented in studies by Davis (2002), Yankey, McClellan, and Jacobus (2001), and Yankey, Jacobus, and Koney (2001). Since this literature describes the merger processes of several different non-profit organizations in great detail, the decision was made not to revisit the process of CDC mergers. In terms of the context, the intent of this paper was not to analyze the local politics, demographics, and neighborhood trends in great detail. This is an important topic that was briefly discussed in each case study. However, the main the focus of this research was to operationalize and rigorously analyze the capacity elements of each CDC merger.

## **Overview of Chapters**

Chapter 2 begins with an overview of CDC's, their history, and the new focus on CDC capacity-building. Chapter 3 explores the literature of non-profit and CDC mergers, including a definition of the spectrum of non-profit mergers and drivers of CDC mergers. Chapter 4 describes the impacts from these mergers and the factors credited with creating successful mergers. Chapters 5, 6, and 7 relate each of the three case studies of CDC mergers in detail, including the impacts of the mergers on capacity. Chapter 8 provides a brief comparison between each case study and highlights the factors that contributed to each merger's positive and negative outcomes. Finally, Chapter 9 provides conclusions gained from the literature and the case studies with regards to the

affects of mergers on CDC capacity, some additional merger insights, recommendations for funders and stakeholders, and some topics for further research.

## **Chapter 2: CDC History and Capacity-Building**

### **CDC's Defined**

CDC's play an integral role in the socio-economic development of communities across the United States. These non-profit organizations provide affordable housing, build businesses and commercial properties, organize and serve as the voice of their communities, create jobs and provide job training, and strive to increase the quality of life for low-income and disadvantaged populations in their neighborhoods. CDC's "have become a major component of corrective capitalism; in this free enterprise nation they are finding ways to open doors to classes and individuals otherwise excluded from the American dream" (Peirce and Steinbach, 1987). Most CDC's are located in older cities in the Northeast and Midwest. Cities with large numbers of CDC's include Boston, Chicago, Philadelphia, and Cleveland.

While CDC's vary considerably in scope and size, three major characteristics apply to most if not all CDC's – they are locally-controlled, place-based, and provide some combination of housing development, economic development, and community organizing. CDC's were largely born out of a desire for control of neighborhood development by local residents and are usually governed by board members who live and/or work in the community served by the CDC. CDC's are also place-based, meaning they provide programs and services in a specific geographic area, most often urban neighborhoods. Finally, most CDC's provide a combination of housing services (new construction and rehabilitation of rental or homeownership units, property management, homeownership classes, rehab lending, and mortgages), economic development programs (commercial real estate development, technical assistance, business loans, workforce training, and entrepreneurship training), and community organizing. Some CDC's also offer health and human services, such as child care, ESL classes, after school programs, and drug and alcohol abuse programs. These CDC's "have been constitutive of an emerging 'progressive' regime, and they have built an alternative social production process with an ability to attract capital, mobilize government and institutionalize citizen participation in pursuit of neighborhood aims" (Robinson, 1996).

## Neighborhood Housing Services and CDC's

Neighborhood Housing Services organizations (or NHS's) are treated as CDC's in this thesis, mostly since the line between the two types of organizations have blurred in recent years. Some key characteristics of early NHS organizations were (Robison and Ferguson, 1981):

:

- They began as partnerships between local financial institutions, government, and residents working together to improve housing at the neighborhood level.
- Core activities were mostly housing-related, including rehabilitation loans and code enforcement.
- They focused efforts on homeowners who were at least 80% of median income.
- They could be started by city governments, lenders, community organizations, or business/civic associations.
- Expansion into new neighborhoods was not considered to be outside of an NHS's mission. Multi-neighborhood NHS's were not unusual.

Today, the distinction between an NHS and a CDC is becoming harder to define. Trade associations such as the National Congress for Community Economic Development (NCCED) and the Massachusetts Association of CDC's consider NHS's to be CDC's and include NHS's in their organizations. Intermediaries that fund CDC's, such as LISC and Enterprise Foundation, fund NHS organizations as well. Researchers such as Davis (2002), Rohe et al (2003) and Liou and Stroh (1998) treat NHS's as CDC's in their literature. Most NHS's have expanded their programming beyond housing and now offer the same types of services as CDC's, including economic development and community organizing. Like CDC's, NHS's are also targeting lower-income neighborhoods with large populations of renters. Per the chartering guidelines of NHS organizations, there can now only be one Neighborhood Reinvestment Corporation member per geographic area. Finally, like CDC's, the majority of NHS's board members are local residents.

However, some differences still exist, mostly in the way CDC's and NHS's are funded and treated through their intermediaries. Founded in the late 1970's and early 1980's, intermediaries,

such as Local Initiatives Support Corporation (LISC), Enterprise Foundation (EF), and Neighborhood Reinvestment Corporation (NRC), receive funding from the government, foundations, and corporations and use this capital to provide funding, technical assistance, training, and access to networks for CDC's. NRC charters NHS's to become "members" of the NeighborWorks network and NRC regional offices maintain very close ties with its members. Becoming chartered is a rigorous process and members are reviewed periodically to ensure they meet NRC standards for a member. As such, NRC members are part of a network that enables them to incorporate standardized national programs such as HomeOwnership Centers into their offices, unlike most LISC or EF-funded CDC's. While local LISC and EF offices oversee their grantees, neither organization has a chartered network of members like NRC, and they have looser ties with their grantees (Liou and Stroh, 1998).

## **History of CDC's**

CDC's began to form in the late 1960's as government and private programs converged to address the problems of poverty, social unrest, and economic disinvestment in older American cities. The Ford Foundation created the Gray Areas program, which was intended to provide funding to local communities to use their own resources to address these issues. In 1966, Senators Robert Kennedy and Jacob Javitz supported the creation of the Special Impact Program, which provided federal funding for local organizations to expand President Johnson's "war on poverty." The first wave of CDC's born out of these initiatives had roots in community organizing, housing, and economic development, including Bedford Stuyvesant Restoration Corporation in New York, The Woodlawn Organization in Chicago, the Zion Baptist Church in Philadelphia, and the Watts Labor Community Action Committee in Los Angeles (Peirce and Steinbach, 1987).

CDC's continued to grow and receive millions of dollars of federal and foundation support throughout the 1970's. By 1980, more than 1,000 CDC's had formed all over the country to provide low-income housing, social services, economic development programs, and newcomer services. "Community economic development was no longer a tentative, alternative way to help poor communities; it was fast becoming *the* chosen vehicle" (Peirce and Steinbach, 1987).

However, federal support for CDC's soon faced major cutbacks, as the Reagan administration eliminated or cut funding from federal agencies that were crucial to CDC growth and survival, including the Community Services Administration, HUD's Office of Neighborhood Development, and Urban Development Action Grants. CDC's were also finding it more difficult to attract operational support, as more public and private funding was being restricted to project or programmatic work. As a result, CDC's in the 1980's had to become more resourceful in their quests for funding, forging alliances with local agencies, corporations, intermediaries, other non-profits, foundations, and local businesses. Consequently, later generation CDC's were finding that they were less confrontational and more willing to spend time and resources on project-based real estate development work than their 1960-1970's counterparts.

Despite these challenges, CDC's have continued to grow throughout the 1980's, 1990's and early 2000's. According to the NCCED, the number of CDC's has increased substantially, from 200 in the mid-1970's to approximately 3,600 in 1999. These organizations have had a tremendous role to play in the community development of poor urban neighborhoods and have been credited with building 14% of all federally-supported housing between 1960 and 1990 (Walker, 1993). Since then, NCCED estimates that 30,000 to 40,000 additional units of housing are being produced by CDC's each year. According to the most recent research from NCCED (1997), CDC's have been instrumental in the creation of 71 million square feet of commercial/industrial space, 247,000 private sector jobs, and 550,000 units of housing. The result is "that CDC's are now the primary vehicles for development efforts within distressed communities" (Gittell and Wilder, 1999).

### **CDC's and Capacity-Building**

Intermediaries in particular have become crucial to the survival of the CDC movement. In recent years, intermediaries and other non-profit funders have made capacity-building a major funding priority as a means of increasing the effectiveness of their grantees' programs and services. Wing (2004) cites the increasing focus on capacity-building as a major philanthropic trend. According to Light (2002), grants for capacity building activities such as professional

development, technical assistance and program evaluation increased by 33%, from \$300 million to \$400 million, between 1998 and 1999.

Why is capacity building important? According to Light (2004), “there is good reason to suspect that capacity building does, in fact, produce potentially measurable impacts on program outcomes, whether greater management focus, increased accountability, more thoughtful use of funds, or increased productivity.” In a study by McKinsey and Company for Venture Philanthropy Partners (2001) of thirteen non-profits engaged in capacity building efforts, they found that “[the executive directors’] capacity building efforts were critical ingredients in their increased social impact...” Consequently, the authors claim that more non-profits should engage in capacity-building efforts to achieve their missions.

## **CDC Environment Today**

Increasingly, the ability of non-profits and CDC’s to achieve their missions through capacity-building efforts is being threatened by a number of environmental factors. Today, CDC’s, like non-profits in general, are facing a competitive and challenging field that requires them to develop new tools and take actions to successfully adjust to this difficult environment. In Ryan’s (1999) overview of the new landscape for non-profits, he writes, “nonprofits are now forced to reexamine their reasons for existing in light of a market that rewards discipline and performance and emphasizes organizational capacity rather than for-profit or nonprofit status and mission.” More specifically, this “new landscape” includes the following challenges for non-profits:

- Demographic shifts that result from the growing number of immigrants in cities are changing the client mix of CDC’s. According to the 2000 U.S. Census, approximately 10.4% of the U.S. population was foreign-born, up from 7.9% in 1990. The foreign-born population is concentrated in metropolitan areas - 54.5% lived in the 9 largest metro areas, compared to 27.3% of the native-born population (U.S. Department of Commerce, 2000). CDC’s, the majority of which are located in metro and urban areas, are often on the frontlines in terms of providing services to this newcomer population.

- Major changes in federal policy in the past ten years, such as welfare reform, changes in subsidies for public housing, and the devolution of funding from federal to local agencies, are affecting both CDC operations and their constituents (Bratt and Keyes, 1997). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 transformed welfare in the U.S. into what is now known as Temporary Aid to Needy Families (TANF). The act reduced eligibility for welfare benefits to two consecutive years (and five years over a lifetime), after which point recipients must become employed, and it limits SSI (supplemental security income) and food stamp benefits for legal immigrants. In addition, CDC's have witnessed a decrease in Section 8 project and tenant based subsidies as billions of dollars worth of contracts expired in the last three years. This squeeze on housing subsidies has made it increasingly difficult for CDC's to raise the money required to build and manage affordable housing projects, as tenants' ability to pay the rent has diminished. Finally, CDC's are facing a significant change in the federal funding environment, as federal block grants become less project-specific and the decision to distribute those funds becomes more of a state and local, rather than a federal, responsibility.

The block grant program is about to face even more drastic changes, as the Bush administration has announced plans to cut HUD's CDBG program by as much as 50% (almost \$2.5 billion) and move the CDBG, the Brownfields Economic Development Initiative, and the Urban Empowerment Zones programs from HUD to the Commerce Department. Overall, HUD's \$31 billion budget would be reduced by approximately 25% if the new budget is approved by Congress (Weisman, 2005).

- Funders are increasingly looking for more outcome and impact reports from their grantees. These reports involve comprehensive and detailed program evaluations, which require database tracking tools that smaller non-profit organizations may not be able to afford. According to Light (2000), "Even as funders ask for more attention to outcomes, they do so without loosening the reporting requirements and financial disclosures."

- As the market changes, CDC's are being required to expand their services beyond the traditional affordable housing and economic development programs. According to the NCCED, CDC's are finding that they have to provide solutions to barriers to employment, such as child care, transit, and workforce training. This is putting pressure on CDC's to act strategically to provide these new services (Steinbach and Zdenek, 2002).
- Professional development and good executive leadership is becoming even more important, as CDC's provide more services and sophisticated programs, funders require more intensive tracking and evaluation, and hiring competent staff becomes more challenging. However, CDC's typically spend 5 to 10 times less of their budgets on professional development compared to corporations and "management is not a high priority for most community development funders...most would rather put their money instead into CDC projects..." (Steinbach and Zdenek, 2002).
- There is increasing competition between non-profits for funding dollars. Between 1982-1987, the growth rate of non-profits was 5.1% annually, double the rate of the private sector. The number of 501c(3) organizations increased by over 120% between 1982 and 1998 (Independent Sector, 2001). CDC's specifically have experienced enormous growth since they started forming in the late 1960's. Meanwhile, according to Vidal (1997), "public sector resources important to community development will continue to decline and that the need for community-serving institutions in poor neighborhoods will remain great."
- Recruiting and retaining high-quality non-profit managers is becoming increasingly difficult. Competition for highly skilled executive directors is fierce, and CDC's have to compete with the public and private sectors for top talent, including banks and real estate developers. A survey by Peters and Wolfred (2001) of over 1,000 non-profit executives in 5 regions of the US found that 65% were first-time executives and 51% had been in their positions for 4 years or less. High stress and long hours probably have much to do with the findings that only 50% of them plan to be executive directors again. In addition,

many executive directors are in their 50's and 60's, and almost 50% of those 50 and older plan to retire after this position (Peters and Wolfred, 2001).

## **Chapter 3: Non-profit and CDC Mergers**

### **CDC Capacity-Building Through Mergers**

As described in the previous chapter, non-profits and CDC's in particular are facing a number of challenges with regards to the changing face of their constituents, funder expectations, staff capacity, and provision of services in their field. The following chapter will define CDC mergers, provide an overview of the literature on non-profit and CDC mergers, and describe what motivates CDC's to merge.

How are CDC's adapting to the "new landscape" for non-profits? A number of leaders in the non-profit research field state that more non-profits will engage in capacity-building initiatives such as joint ventures, partnerships, and mergers, in order to survive. Yankey, Jacobus, and Koney (2001) believe that "leaders of a growing number of nonprofit organizations are exploring the benefits of mergers and consolidations as they seek to make their organizations, affiliated agencies, and local chapters larger, stronger, or otherwise more sustainable."

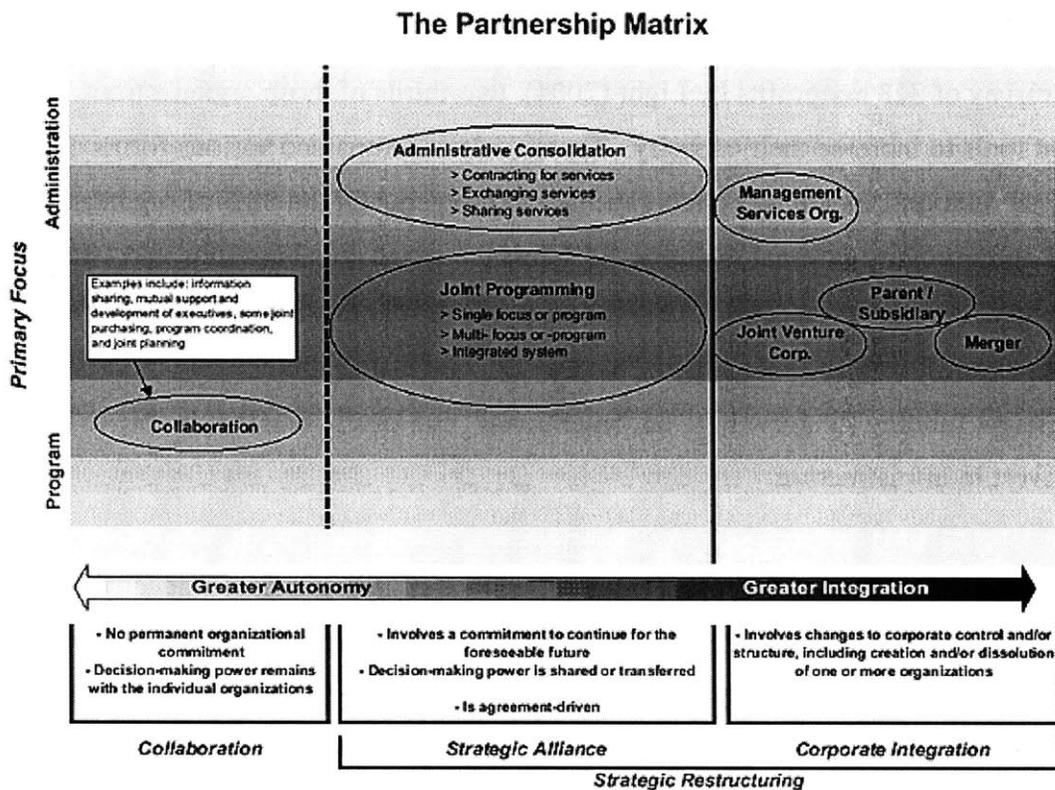
According to a survey of 318 nonprofits by Light (2004), two-thirds of those organizations used an average of ten tools to increase their capacity. These tools encompassed various forms of improving external relations, including collaborations and mergers. Of the 88% of organizations that had worked on improving external relations, 85% had increased collaborations and 10% had engaged in a merger. According to Light's (2004) non-profit development spiral, mergers are often used to move from being an "enterprising" non-profit, one that is stretched by mission creep and insufficient funding for growth, to an "intentional" non-profit, one that is able to focus its efforts and invest in infrastructure.

In a study of the role of Community Development Partnerships (CDP's) in CDC capacity-building, the CDP's felt that "some CDC's are too small and inefficient to produce large amounts of housing and that there is much overlapping turf among the CDC's." Consequently, they believe that mergers are an effective tool to increase CDC efficiency (Nye and Glickman, 1997).

In addition, Bratt and Keyes (1997) believe that “devolution will require greater networking and linkages between organizations as federal roles are replaced by local activities.”

## Definition of Non-profit/CDC Mergers

A variety of terms are currently being used in the field to describe how non-profits and CDC’s partner or consolidate their functions. This research will use the definition of non-profit partnerships provided by Kohm et al (2000) in The Partnership Matrix, shown below. The matrix describes the spectrum of partnerships that can occur in the non-profit sector. Strategic restructuring, including merger, is defined as “when two or more independent organizations establish an ongoing relationship to increase the administrative efficiency and/or further the programmatic mission of one or more of the participating organizations through shared, transferred, or combined services, resources, or programs” (Kohm et al, 2000). The highest degree of autonomy between organizations can be found in a collaboration and the least degree of autonomy (and the highest level of integration) can be found in a merger.



The three case studies in this thesis are examples of CDC mergers. A merger occurs when two or more organizations become fully integrated both programmatically and administratively. Either all participating organizations dissolve and create a new organization or one or more organizations are absorbed into another organization. A merged organization may involve modifications of staffing, programs, resources, names, and governing structure of the predecessor organizations.

While these labels are often used interchangeably in discussions of non-profit mergers, the case studies in this paper do not focus on the following types of non-profit/CDC partnerships:

- Collaboration - a temporary agreement exists between two or more independent organizations to coordinate programming, share data or overhead resources, and/or engage in joint planning or purchasing.
- Strategic alliance – the participating organizations sign an agreement and share decision-making regarding the alliance. Strategic alliances take two forms – administrative consolidations and joint programming. Administrative consolidations involve sharing, exchanging, or contracting overhead functions between organizations. Joint programming involves organizations jointly implementing and managing one or more programs.
- Management services organizations - the predecessor organizations stay intact, and a new organization is formed which incorporates only the administrative functions of the predecessor organizations.
- Joint venture - the predecessor organizations stay intact, and a new organization is formed for the purposes of running a specific program or project.
- Parent/subsidiary structure - achieves administrative and programmatic efficiency and involves the creation of a new organization or designation of one organization to govern the programs and administration of the other(s).

## **Literature on Non-profit Mergers**

There has been only a small amount of research into the prevalence or growth of non-profit mergers and even less focused on CDC's specifically. According to Kohm and La Piana (2003),

“Although some consultants and funders have proclaimed that strategic restructuring...is or will be a wave overtaking the sector, reliable information on the macro and micro impact of strategic restructuring is in short supply.”

However, non-profit mergers have been increasingly mentioned in the literature in the last ten to fifteen years. Perlmutter and Gummer (1994) mentioned the growing evidence of mergers among health and human service organizations as a reaction to financial difficulties. This paper also mentions research by Taylor, Austin, and Caputo (1992) which studied the mergers of sixteen human service agencies. Scheff and Kotler (1996) suggested partnerships and collaborations between arts organizations as a way to weather the increasingly difficult funding climate. The authors write, “...strategic collaborations can help participants achieve their organizational goals and better manage their financial, human, and physical resources” (Scheff and Kotler, 1996).

Light (2000) describes the more recent increase in non-profit mergers as part of a tide for non-profit reform, including a “war on waste.” This war is “driven by the belief that there is a ‘right’ number of people and organizations for doing a specific nonprofit job,” that this number is less than what exists today, and that it “is motivated by the desire for cost savings, whether through downsizings, mergers or outright ‘obliteration’” (Light, 2000). In a survey of nineteen state associations of nonprofit organizations, the author found that 8 reported a “high tide” and nine reported a “rising tide” of non-profit mergers and restructurings. One of these association directors stated, “we do a lot of mergers, partnerships, shared space, and so forth, mostly because funding sources (government and private), tell us to do so in order to get program money.” (Light, 2000). Another association director reported “we have too many nonprofits in this state...there is not as much merger activity as we’d like to see” (Light, 2000).

Strategic Solutions, a study of strategic restructuring conducted by La Piana Associates between 1998 and 2004, found that media coverage of non-profit mergers before the mid-1990’s centered on the healthcare sector. Since then, there has been more coverage of mergers, and perhaps more mergers themselves, in the arts, social services, community development, and environmental fields. In the past two years, a number of articles have been published about non-profits seeking

mergers as a strategic solution to funding or capacity issues, including articles from the Federal Reserve Bank of Atlanta, the Boston Business Journal, and the Irvine Quarterly.

Kohm and La Piana (2003) conducted a survey of 262 non-profits with budgets of \$200,000 or more, located in San Francisco, California and Cleveland, Ohio. 24% of respondents reported experience with some type of strategic restructuring, defined as a strategic alliance or corporate integration in the Partnership Matrix above.

In Kohm and La Piana's (2003) interviews with non-profit and philanthropic leaders, 17 out of 20 predicted that strategic restructuring activity would increase in the next ten years. Most of the explanations given for this view echoed the environmental challenges cited in Chapter 2 and centered on increased competition, either due to changes in public policies, a growing number of non-profits competing for funds, or for-profits entering traditionally non-profit fields, such as health and human service delivery. Another reason given was similar to Light's "war on waste" theory - that funders are pressuring non-profits to become more financially efficient. A few industry leaders did feel this growth in strategic restructuring would be slow, however, due to the lack of knowledge about how and if strategic restructuring addresses the issues faced by non-profits today.

In terms of CDC mergers, an October 2002 chat on KnowledgePlex involving leaders in the CDC field, including Rachel Bratt, professor in the Department of Urban and Environmental Policy at Tufts University and Ellen Lazar, executive director of NRC, acknowledged the growth of mergers. Lazar stated "several of the NeighborWorks organizations are merging," and a NRC report (2004) claims that "in the past few years, several high profile [CDC] mergers have been completed." In addition, according to estimates by Rohe, Bratt, and Biswas (2003), at least 16 CDC's were part of a merger between 2000 and 2003. Davis (2002) predicts that CDC mergers and collaborations will become more prevalent for three reasons: financially, it is becoming more difficult for funders to provide support to multiple non-profits with similar missions in the same area; practically, because "it is proving to be an unusually effective way of achieving greater productivity, efficiency, and sustainability"; and politically, because it may be more acceptable

for funders to ask organizations to merge than to cut funding and thus potentially destroy the organization.

## **Literature on CDC Mergers**

A significant amount of research has been conducted on CDC's and their role in the community. However, very little research exists on mergers between CDC's. According to Rohe et al (2003), "information on the extent and causes of CDC mergers is particularly sparse." Confirming this finding, research for this thesis uncovered only two studies on CDC mergers that have been published to date: Bridging the Organizational Divide: The Making of a Non-Profit Merger (Davis, 2002) and Evolving Challenges for Community Development Corporations: The Causes and Impacts of Failures, Downsizings, and Mergers (Rohe et al, 2003).

The Davis piece is a case study of one merger between two housing-oriented CDC's in New Hampshire - French Hill Neighborhood Housing Services (FHNHS) and the Greater Nashua Housing and Developing Foundation (GNHDF). Davis (2002) describes the five steps involved in a CDC merger – incubation, exploration, negotiation, implementation, and reflection. This paper was very detailed in its explanation of the internal process involved in merging the two organizations, but did not explore impacts from the merger. The result of the merger was a CDC that combined the complementary services of both organizations, including constructing affordable rental housing, running after-school programs, offering homebuyer counseling, providing a purchase, rehab, and resell program, and providing rehabilitation loans for homeowners.

The Rohe et al (2003) piece is broader and covers CDC's closures, downsizings, and mergers. Two CDC mergers were examined in this paper - one merger led to the creation of Albina CDC in Portland and the other merger resulted in Slavic Village Development (SVD) in Cleveland. Most of the analysis focused on the contextual and organizational factors that contributed to the two CDC mergers that were studied, described in more detail below.

## **CDC Merger Drivers**

CDC mergers are often undertaken as a reaction to many of the environmental issues outlined in Chapter 2. The literature on CDC merger drivers is limited to the two studies of CDC mergers conducted by Davis (2002) and Rohe et al (2003). Davis (2002) did not provide extensive analysis of why CDC's would choose to merge. More generally, the author does describe the general environment that would contribute to CDC mergers, where "multiple nonprofits of varying size serve a similar geographic area, each producing a modest but respectable number of housing units; each competing for constituents, funding and development opportunities; each struggling to survive" (Davis, 2002). The two CDC's in his case study reflected the situation he describes above.

Rohe et al (2003) offered an extensive analysis of the motivations for CDC mergers. For the purposes of this research, the drivers of CDC mergers will be organized based on the Glickman and Servon capacity framework (1997). Each merger driver is indicative of a need by the CDC to increase their capacity in the four main capacity areas explored in this thesis. The list below shows that the majority of merger drivers are related to expanding a CDC's financial capacity.

### *Financial Capacity*

- An example of a financial capacity driver is a change in the market, which sometimes occurs when CDC's are very successful in achieving their mission. As stated by Rohe et al (2003), "The more CDC's succeed in renovating and reselling or renting dilapidated and derelict properties, the more they contribute to community revitalization. This revitalization, in turn, leads to higher house and land prices and fewer vacant properties; thus CDC's are priced out of the market." When a real estate market heats up, there are few affordable properties left for CDC's to develop and thus developer fees, a major component of many CDC budgets, decline. A merger between two struggling CDC's may be a logical step to ensure survival, particularly in cities with high real estate prices such as New York, San Francisco, and Chicago (Rohe et al, 2003).

- Another related financial factor is a change in city policies. Federal funds for CDC's are mostly distributed through local governments. If a city decides to change its funding priorities, for example by supporting mergers between CDC's or by de-emphasizing funding for specific programs, these policy changes could affect the economic viability of CDC's and/or their attitudes towards mergers. Both mergers studied by Rohe et al occurred in a new regulatory environment where the city began to support mergers between existing CDC's rather than fund new CDC's in order "to create fewer, larger, more sophisticated organizations" (Rohe et al, 2003).
- Increased competition for resources is a major economic reason why CDC's choose to merge. In some cities in the US, such as Philadelphia, Cleveland, Boston, and Portland, there has been the perception that there are too many CDC's serving the same neighborhoods and competing for funding. In addition, funders may find that mergers are a way to save the assets of a CDC that is on the brink of financial failure. Vidal (1997) predicts that as a result, in addition to CDC's closing and the creation of more partnerships between CDC's and community institutions, there will be "growing pressure for CDC's to consider joint ventures, consolidations, mergers, and role specialization."
- When a CDC relies on a single funding source, for example city grants or developer fees, for the majority of its funding, it may expose itself to serious organizational risk if the funding were cut or evaporated due to changes in the market. In Rohe et al's (2003) study, overreliance on developer fees led to one of the CDC mergers. Mergers can attract a wider mix of funders to the non-profit by expanding its programmatic capacity through a larger service area, client base, or service offerings. According to Cowan et al (1999), "potential investors may be more willing to fund organizations that, due to their range of activities, have name recognition in the community." More funders can translate into a more diversified and thus stable pool of potential funding for the non-profit, increasing its overall financial capacity.
- CDC intermediaries and other funders have a large role to play in many CDC mergers. While CDC's are non-profit community-driven organizations with independent boards

and executive directors, funders are often very involved in the strategic decision-making of CDC's. Economic drivers have precipitated this activity by intermediaries who are interested in streamlining service delivery by CDC's and are suggesting that they explore options such as collaboration or merger in order to more efficiently provide programs and services in their communities. Economies of scale can be achieved through reduced overhead costs by eliminating staff, combining facilities, combining administrative functions, and increasing purchasing power. According to a survey of 192 non-profits by Kohm et al (2000), increasing efficiency was the number one reason given for strategic restructuring. Funders are becoming more proactive about providing funding, consultants, and sometimes pressure to assist CDC's with their merger process. However, it should be noted that only 30% of responses to Kohm et al's (2000) survey specifically cited funder pressure as an important motivation for merging, making it the least important motivator for non-profit mergers.

### *Organizational Capacity*

- Internal management problems were also cited as contributing factors to Rohe et al's (2003) CDC mergers. The CDC's in Portland experienced a combination of a lack of internal systems, weak development underwriting, problems with property management, and financial mismanagement. These issues could push CDC's towards finding a merger partner that has the capacity to absorb financial problems and increase their overall financial capacity. This is not uncommon, as Grobman (2002) reports that "many, if not most, mergers of nonprofit organizations involve a financially strong organization merging with an organization that is weak in order to stave off bankruptcy or liquidation."
  
- A related merger driver was a lack of staff and/or board capacity, or organizational capacity as defined by Glickman and Servon (1997). This issue is a consequence of the difficulties involved in hiring and retaining high-level non-profit staff, described in the previous chapter. Interviewees felt that Portland-area CDC's competed with banks, private developers, and intermediaries for the most skilled and experienced staff. In addition, replacing executive directors and overworked boards are challenges faced by

several CDC's. Low pay scales and high-stress jobs at non-profit organizations are often cited as reasons for lack of staff capacity and high turnover, which in turn can lead to internal management problems. CDC's that have low staff/board capacity have staff without the experience or training to run sophisticated programs, executive directors who are absent, either because they are removed for their inability to effectively run a non-profit or because they resigned, and/or board members who are ill-suited or ill-prepared to guide the organization. Mergers are a way to take advantage of the stronger leadership and staff of another organization which can stabilize a floundering non-profit and strengthen its organizational capacity (Kohm and La Piana, 2003).

### *Programmatic Capacity*

- A limited mission or scope that no longer fits market realities may lead a CDC to pursue a merger. Yankey et al (1998) describes the "strategic management-social ecology" perspective as non-profit mergers that take place in order to provide organizations with a competitive advantage. For example, when the housing market softens and the organization's programmatic focus does not fit the new environment, a merger may be a solution to change the focus of the organization and create capacity to provide services that respond to the market changes. A merger could allow the CDC to diversify the types of programs it offers, expand its geographic service area, or diversify the income or ethnic groups it serves (Rohe et al, 2003). Expanding its mission this way would enable a CDC to increase its appeal to a wider mix of funders, grow its client base, and insulate itself against downturns in the economy or changes in the marketplace.

### *Political Capacity*

- Enhancing the reputation of an organization was also cited in the Kohm and La Piana study (2003) as one of the key reasons for the strategic restructuring of non-profits. According to Yankey et al (1998), the stronger a non-profit's reputation, the more successful it will be. Thus, "Mergers may result from an organizational realization that institutional legitimacy is a requirement for survival and may not be accomplished without a merger" (Yankey et al, 1998). In two of the cases studied by Kohm and La Piana (2003), enhancing the organization's reputation was a reason for merger.

Community support, funder respect, media recognition, and political support are all aspects of a non-profit's political capacity that can be strengthened through a strategic merger. The downside of this strategy is that if the merger does not succeed or if the merged organizations do not effectively carry out due diligence to uncover any hidden issues, the merger may end up adversely affecting the reputation of one or both organizations.

The desire to increase capacity can be traced back to the challenges faced by CDC's, described in the previous chapter. Increasing financial and political capacity can allow a CDC to address the changes in federal funding policy and compete for fewer funding dollars. Growing programmatic capacity can enable a CDC to provide services to an increasing immigrant population and expand its services beyond housing and economic development. Building organizational capacity will allow the CDC to provide funder impact reports, provide professional development opportunities, and thus recruit and retain their management staff.

This chapter confirms the growing prevalence of non-profit and CDC mergers, particularly as a method for increasing capacity. While there is limited research with regards to CDC mergers, this chapter used the existing literature to describe how the drivers of CDC mergers relate to an anticipated increase in each element of CDC capacity.

## Chapter 4: CDC Merger Impacts and Success Factors

Once the decision is made to merge, what can a CDC expect to experience as a result of the merger? How might a merger affect a non-profit's capacity to serve its constituents? This chapter explores the multitude of impacts, both positive and negative, that result from consolidations between non-profits.

There is limited data on this topic. The only recent large-scale study of the impacts from non-profit mergers was conducted by Kohm and La Piana (2003), and the majority of the merger impact information below was culled from their research. It should be noted that the authors' definition of strategic restructuring includes both mergers and strategic alliances of non-profit organizations. A review of the literature uncovered only two references to impacts from CDC mergers specifically – the Rohe et al (2003) study of the Slavic Village Development (SVD) merger and Cowan et al's (1999) description of a few negative impacts that may result if CDC's explore consolidations or mergers as a way to increase their efficiency<sup>2</sup>. The impacts below are categorized to correspond to Glickman and Servon's (1997) capacity framework and describe the negative impacts followed by the positive impacts.

### Impacts from CDC Mergers

#### Negative Impacts

- Financial Capacity

##### *Financial Costs*

Financial costs from the merger itself, including moving costs, new marketing and print materials, changing information technology systems, including software and hardware, due diligence and legal fees, consulting fees, and human resources costs from integrating new staff or laying off staff can be significant.

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<sup>2</sup> Defined by the authors as the level of inputs (e.g. funding) required to produce the level outputs (e.g. housing units).

### *Loss of Funding*

A merger can actually result in a loss of funding. While not mentioned specifically in the literature, if a funder has a close relationship with one of the CDC's and it is absorbed into a larger CDC or the mission of the organization changes as a result of the merger, the merged organization may lose funding. In addition, if a funder is supporting both organizations pre-merger, it may choose not to give the merged organization the sum of the funding given to the predecessor organizations and view the consolidation as an opportunity to cut funding.

- **Organizational**

### *Low Morale*

Management, staff, and board members can also suffer from low morale as a result of a merger. Lack of communication around merger proceedings, cuts in staff, budgets, or programs that may result from the merger, unwillingness to change the organization's mission, programs, or populations served, and general uncertainty and fear of change can all result in low confidence and morale issues. In addition, the time spent on merger planning and implementation will put enormous work pressures on management and staff, which can negatively affect their feelings about the organization.

### *Leadership Issues*

Staff may also find that leadership of the organization post-merger remains unclear, particularly if the two former executive directors share leadership roles or the organizations are not fully integrated and the staff continues to report to the predecessor management team. When the new leadership is clear, staff must then adjust to the new management team and their leadership style. Executive directors must also learn to lead sometimes much larger post-merger non-profits with new staff, programs, and stakeholders. The result can be executive directors who delegate more responsibilities to staff members who may not be trained or have the time to take on new roles.

### *Cultural Issues & Staff Conflicts*

Integrating two or more organizations' histories, traditions, policies, values, operational styles, and leadership, all considered to be part of a non-profit's culture, can be a difficult and sometimes emotional experience for everyone involved, particularly the staff. This may be an

even greater issue if the two organizations have strong cultures and identities. Kohm and La Piana (2003) found that even though the merging organizations may have similar programs, constituents, and service areas, more intangible aspects of culture such as differences in values and work style could result in staff conflicts among staff and management.

#### *Staff Turnover*

Staff turnover is another potential adverse impact of non-profit mergers. While layoffs affected only 10% of respondents in Kohm and La Piana's study (2003), they reported that those that did occur were a result of "changes in leadership, which in turn led to changes in philosophy or structure, which finally resulted in voluntary and involuntary staff turnover within organizations."

#### *Decreasing Efficiency*

Cowan et al (1999) found that generally larger CDC's were more efficient than smaller CDC's. However, after a certain point, CDC efficiency decreased as staff size increased, pointing to the possibility that there may be diminishing marginal returns as a CDC grows through consolidation.

- Programmatic Capacity

#### *Time Costs*

Planning and implementing a merger can take a great deal of time. Yankey, McClellan, and Jacobus (2001) estimate that a non-profit merger takes an average of eighteen months to plan and complete. Time spent exploring, negotiating, conducting due diligence, and integrating programs, systems, and cultures can be a significant demand on board, management, and staff time, directing their focus away from programs and services. Kohm and La Piana (2003) reported that "chronic underestimation of the time required for various efforts plagued several of the partnerships we studied."

#### *Loss of Services*

A change in service area can result in a loss of services for some neighborhoods or constituents. Cowan et al (1999) were concerned that a CDC consolidation would adversely affect its ability

to serve its constituents, particularly by increasing the gap between the CDC and its community and by reducing the CDC's ability to address individual resident or neighborhood concerns. Thus, "consolidation of CDC's may do more harm than good unless the constituent neighborhoods retain clear avenues to ensure continued input into the CDC's operations" (Cowan et al, 1999). Constituents of place-based nonprofits such as CDC's may be concerned that, "in a new entity with a wider geographic focus, there could be a dilution of services or outright neglect of an area that formerly got exclusive attention from one of the partners" (McLaughlin, 1998).

- Political Capacity

*Losing Identity*

Non-profits spend a considerable amount of time and resources building their reputations, particularly among their constituents, community institutions, local and state government agencies, and funders. An organization's identity, or brand, is often the unifying theme that a non-profit uses to solicit support from its disparate stakeholders. A merger forces an organization, particularly if it is the weaker organization in a merger, to forge a new, joined identity with another organization. This is not an unrealistic concern, as "the stronger organization tends to retain its original mission, staff, board, and culture, incorporating the programs or clients of the failed organization into its existing structure" (LeVeen 2003). A merger also requires the new merged organization to convince those disparate stakeholders, using more time and resources, that the identity of the organization will be identical if not better than the predecessor organizations.

*Losing Political Support*

Similar to losing funding, organizations may also find that they have lost political support as a result of a merger. A disenchanted or diminished membership base or the demise of close connections to local politicians can lead to a loss of some community or political support.

Positive Impacts

- Financial Capacity

*Reducing Costs*

Although the respondents to Kohm and La Piana's (2003) study could not provide hard evidence of cost savings, they cited volume buying, staff reduction through attrition, and employee sharing as the largest contributors to cost savings that were attained as a result of strategic restructuring. Interestingly, an evaluation of the Strategic Alliance Fund conducted by James Meier in 1997 and cited by Kohm and La Piana (2003) found that 60% of the increase in organizational funds came from new income sources, rather than from a reduction in existing costs. Thus, cost reduction may not be the only financial benefit that non-profit merger participants could expect to achieve.

#### *Appealing to Funders*

In Rohe et al's study (2003), the financial capacity of SVD increased since its funders were supportive of the more comprehensive services offered by SVD as a result of the merger.

- Programmatic Capacity

#### *Providing New or Improved Services*

In Rohe et al's (2003) study, the programmatic capacity of SVD increased substantially after the merger. Unlike the predecessor organizations, the merged CDC offered housing, economic development, and community organizing under one roof.

While providing new and/or improved programs and services to clients would be a hoped-for benefit from non-profit mergers, Kohm and La Piana (2003) found that this was not the key reasons that their respondents chose to merge. However, the non-profits did find that this was an added, unexpected benefit of merging.

- Organizational Capacity

#### *Knowledge Sharing*

Kohm and La Piana's (2003) survey respondents also reported that they benefited from the increase in staff knowledge and the opportunity to combine resources that result from merger. Mergers allowed organizations to share the experience of more capable staff, combine information technology tools and expertise, benefit from financial management expertise, and share marketing and client data.

### *Improved Staff Benefits*

For staff members of the smaller or weaker organization, merging with a larger, stronger organization often translated into better benefits, higher salaries, job security, and a more obvious and attainable career path within the new organization (Kohm and La Piana, 2003).

- Political Capacity

### *Increased Stakeholder Visibility*

While not mentioned specifically in the literature, organizations can sometimes benefit from mergers resulting in increased visibility from important stakeholders. This visibility can be attributed to an expanded membership base, more media attention, or a geographic expansion that allows connections to more politicians and community leaders.

## **CDC Merger Success Factors**

The literature points to a variety of opinions and a multitude of factors that contribute to making non-profit, including CDC, mergers successful. These contributing factors, categorized and described in more detail below, include communication with partners and stakeholders, trust between merger participants, strong leadership, compatibility, comprehensive planning, support from funders, and a willingness to respect and meld cultures.

### *Communication*

Transparency and communication between and among the merger participants, staff, and funders is an important contributing factor to the success of non-profit mergers. The willingness to frankly share each partner's strengths, weaknesses, liabilities, and potential roadblocks is crucial to the planning and negotiation process of a merger. Openness in communication between the partner organizations and their funders is also essential. Without this communication, "the nonprofit trying to improve its capacity, the foundation funding the capacity building, and the consultants delivering training or technical assistance may all have different priorities" (Wing, 2004). In addition, Yankey, McClellan, and Jacobus (2001) recommend listening and addressing staff members fears by communicating as often as possible, which can be done through individual conversations, staff meetings, and internal newsletters.

### *Trust*

A related issue is trust, which cannot exist without transparency and communication. Non-profits that are exploring the possibility of merging, and thus are risking their organizational identity and reputation, funding support, culture, programs and services, time and money, and staff turnover, must be willing to trust each other in order to successfully pursue a merger in good faith. This trust needs to exist between and among staff, board, and management throughout the merger process. Kohm and La Piana (2003) found in their case studies that the more the partnering organizations interacted with each other, the more they began to appreciate and respect each other(s) reliability and competence, which led to the development of trust over time.

### *Leadership*

Strong leadership, both from the staff and management, was also cited in the literature as a critical factor for success. “Champions” of the merger, usually executive directors with long histories at their organizations, were indispensable as they were responsible for making difficult decisions for the greater good of the organization(s), negotiating and building trust between parties, and working hard to win stakeholder and staff support for the merger (Kohm and La Piana, 2003). In addition, staff and board must have faith in these champions and show willingness and flexibility to make changes based on the merger. These champions were cited as the most important success factor in a study of non-profit restructurings by Kohm et al (2000).

When considering a merger, Yankey, McClellan, and Jacobus (2001) recommends a time when the organization is experiencing a turnover in leadership. Thus, the question of who will lead the merged organization will not become a struggle of succession between two executive directors. If there are two executive directors, mergers in which the control of the merged organization is determined before the merger is completed do not face the management challenges that come from ambiguous leadership roles or power struggles between executives. According to McLaughlin (1998), “Leadership of the new entity is such a critical question that, if it is not resolved early, the chances of a successful merger are cut by half.”

Finally, non-profit executives and boards should also be strong enough to be in control of the merger discussions, not the funders. Otherwise, “top-down pressure is likely to be resented by the CDC’s involved” (Rohe et al, 2003). While funders should articulate their concerns and provide advice to non-profits, they should not be leading the merger process.

### *Compatibility*

Yankey, McClellan, and Jacobus (2001) also suggest that mergers are more successful if the two merger partners have compatible missions. While these missions do not have to be identical, two organizations that serve similar populations (low-income immigrants, for example) or have similar high-level goals (such as providing access to affordable housing) are more likely to have a smoother merger process and a more compatible merged organization. These organizations will also be more easily able to create and strive to achieve a cohesive mission and vision for the merged organization.

Other indicators of compatibility between merger partners, according to McLaughlin (1998), include the lack of an executive director of one or more of the merger partners, non-overlapping and complementary markets and programs that reduces competitive pressures and creates comprehensive services, and geographic compatibility that allows for an extension of the service area.

### *Comprehensive Planning*

Comprehensively planning the merger through all steps of the merger process, including exploration, negotiation, implementation, and evaluation, was cited extensively as key to a successful merger. Yankey, Jacobus, and Koney (2001) suggest that, “Ideally, organizations look at their internal and external environments as part of strategic planning to determine if they can better accomplish their missions and visions by partnering with one or more other organizations.” If organizations do not have the foresight to include the consideration of mergers in their strategic planning processes, there is still a significant amount of planning that should be done to ensure a successful merger.

In order to set up a successful post-merger organization, La Piana (2004) recommends a merger integration plan, which is a detailed workplan of objectives for each facet of the merged organization and should be completed during merger negotiations. These facets include the management of the merger, board, executive leadership, staff, programs, external marketing, internal systems and policies, and evaluation. The objectives from the integration are determined by defining the desired outcomes, tasks, lead person, team, and start and end date for each facet listed above. Completing a detailed integration plan prior to the consummation of the merger allows the merger to be “actively managed”, a key component to a successful merger (La Piana 2004).

This type of comprehensive planning allows organizations to understand the risks involved in mergers and how to address those risks. The majority of Kohm and La Piana’s (2003) case study subjects conducted almost no research into other cases or models of merger success. Consequently, some found that “deeper consideration of how the partnership would or would not advance the partners’ organizational missions might have helped them to make better decisions about whether and how to move forward” (Kohm and La Piana, 2003). Before non-profits consider whether to merge with another organization, they should gather as much knowledge as possible from funders and other similar non-profits who have been through a merger process in order to obtain a realistic understanding of what it entails. The non-profit should also formalize the goals of the merger from the outset and determine whether those goals could be achieved cost-effectively and within a reasonable amount of time without a merger.

#### *Funder Support*

Yankey, McClellan, and Jacobus (2001) also recommend that non-profits not underestimate the costs involved in planning and implementing a merger. Most non-profits, particularly weaker organizations, do not have the discretionary income in their budgets to fund the costs of a merger. Successful mergers need funder support to ensure that key components of the process, including facilitation, due diligence, moving costs, and staff training, have adequate financial backing. Rohe et al (2003) suggest that funders should also consider maintaining the sum of the operational support of the merged organizations for at least one year after the merger is completed.

### *Cultural Respect*

Non-profit organizations also should not underestimate the affect that differing cultures could have on the success of a merger. Yankey, McClellan, and Jacobus (2001) have remarked that organizations should take time letting go of the old culture and creating a shared post-merger culture. Creating this new culture requires being open to and respectful of different perspectives on operations, management style, values, and traditions.

### **Evaluating Success of CDC Mergers**

Yankey, Jacobus, and Koney (2001) recognize the difficulty in evaluating a non-profit or CDC merger, particularly when considerations such as increased market share or a bigger bottom line, often used in for-profit mergers, are not the benchmarks used to determine whether the merger is a success. When evaluating the success of a CDC merger, senior management, board members, and funders are more focused on the CDC's capacity - whether the organization is able to serve its clients more effectively and efficiently.

Most of the success indicators below are derived from the work of Yankey, Jacobus, and Koney (2001) and La Piana (2004), whose indicators were mostly related to organizational capacity. Unfortunately, neither work described the success factors in any detail. The list below is categorized based on Glickman and Servon's (1997) capacity framework.

The next three chapters are case studies of three CDC mergers in California, Connecticut, and Ohio. These cases provide examples of how and to what extent a CDC merger can affect the five elements of a CDC's capacity and whether the CDC's exhibit some of the merger success factors described below. Due to data constraints from each case, all of these factors cannot be examined in great detail. By using the methodology described in Chapter 1, the capacity indicators with asterisks will be explored in the following three chapters.

## *Merger Success Factors:*

### Financial Capacity

- Attracting new and increased funding sources\*
- Achieving operational efficiencies

### Programmatic Capacity

- Expanding the geographic service area\*
- Broadening the mix of programs and services\*
- Expanding the capacity of existing programs and services\*
- A coordinated group of effective and efficient programs aligned with the merged organization's mission.

### Organizational Capacity

- Improved staff retention
- A cohesive board, management team, and staff that are supportive of each other and have a unified vision of the organization\*
- A clear management structure for the merged organization\*
- A merged mission statement and strategic plan that are supported by the entire organization
- An integrated organizational culture\*
- Unified systems, including human resources, finances, and information technology

### Political Capacity

- Strengthening political influence\*

## Chapter 5: Case Study 1 - Neighborhood Housing Services of Orange County

The following case study describes the 1998 merger between Santa Ana NHS and NHS of La Habra, two neighborhood housing service organizations in Orange County, California. The case provides an example of how a merger can allow programmatic expansion through stronger programs and services to a wider service area. The resulting CDC, Neighborhood Housing Services of Orange County (NHS OC) is a county-wide organization that provides a comprehensive range of programs in homeownership, human services, and community organizing.

### Organizational Background

Santa Ana NHS was formed in 1980 and NHS of La Habra was formed in 1977. These two organizations provided a variety of programs and services, including loans for home rehabilitation, rental housing development, community organizing and neighborhood development initiatives, for predominantly low-income Latino neighborhoods in Orange County.

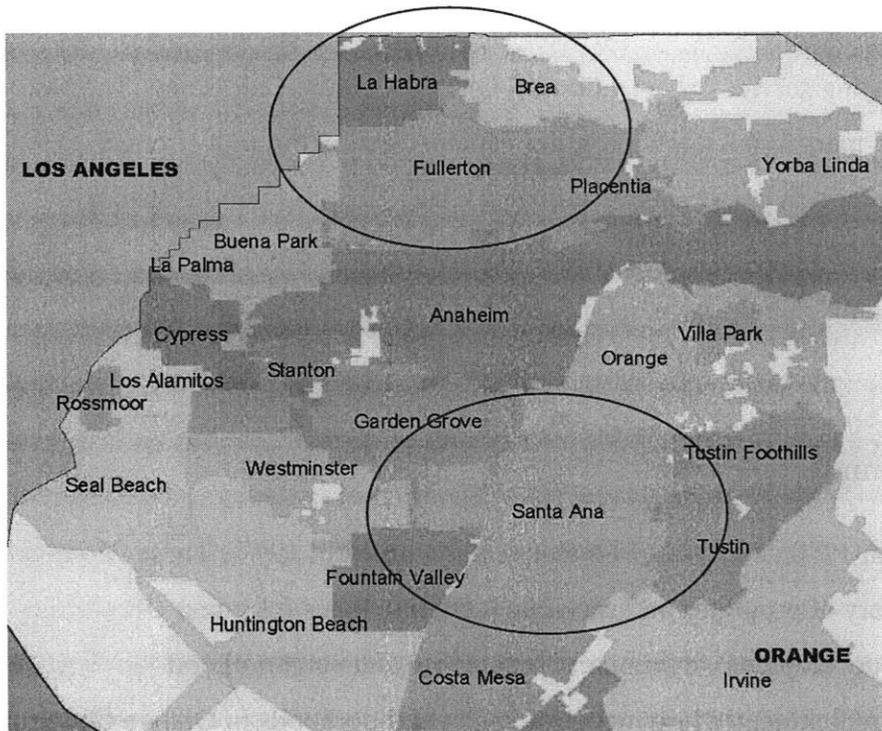
The table below shows a pre-merger snapshot of both organizations. La Habra’s budget and staff size were much larger than Santa Ana’s at the time of the merger.

*Table 1: Pre-merger snapshot of NHS of La Habra and Santa Ana NHS*

	<b>NHS of La Habra</b>	<b>Santa Ana NHS</b>
Budget	\$1,417,028	\$220,608
Service Area	La Habra, Brea, and Fullerton	Santa Ana
Staff Size	7 FT, 0 PT	1 FT, 1PT
Programs	Home rehabilitation loans, rental housing development, community organizing and neighborhood development	Home rehabilitation loans, rental housing development, community organizing and neighborhood development

While both organizations provided similar programs, their service areas differed – La Habra served north Orange County and Santa Ana served central Orange County. As shown in the map below, the service areas of the two organizations did not overlap. La Habra’s service area, including the cities of La Habra, Brea, and Fullerton, were on the far northwest corner of Orange

County, separated from the city of Santa Ana in Central Orange County by the cities of Anaheim, Garden Grove, and Orange.



Red circles highlight the service areas of Santa Ana NHS and NHS of La Habra in Orange County, CA

During the 1990's, Orange County experienced tremendous economic growth. It was the sixth largest county in the nation by 2000 and is now home to almost 3 million people. While the strong economy in the area has kept unemployment at a low 4% in recent years, the downside of this growth has been increased competition for a limited supply of housing. The result has been home prices that are some of the highest in the nation, and the lack of affordable housing is seen as one of the top issues faced by new businesses in the area. The median home price of a single-family home in Orange County is reported to be over \$600,000 (NHS OC Strategic Plan, 2002).

Demographic changes in the area included a rising Latino population, particularly in the service areas of La Habra and Santa Ana. In Santa Ana 76% of the population was Latino in 2000, representing approximately 40% of all Latinos in Orange County (Maher, 2003). Many of these Latinos were new immigrants attracted to the area due to the number of jobs available in the garment, food, and service industries. North and central Orange County were also experiencing

a housing shortage, housing deterioration and increasing crime rates. In addition, municipal financial support for organizations such as Santa Ana and La Habra were eroding at the same time as the need for their services was increasing.

By the late 1990's, the two organizations found themselves in very different circumstances. NHS of La Habra was fiscally and organizationally stable, with a strong board and executive director. Santa Ana NHS on the other hand, was foundering. In addition to programmatic and fundraising challenges, the organization lost its executive director in 1996. As an interim solution to this problem, the executive director of NHS of La Habra, who had been at the helm for 17 years, stepped in and led both organizations for approximately one year.

In 1998, the boards of both organizations began discussions to merge the two organizations and by September of that year, the merger was official -- NHS of Orange County was formed. Post-merger, the decision was made to maintain the existing offices in La Habra and Santa Ana and to open an Anaheim office to house all shared administrative functions and the new NeighborWorks HomeOwnership Center.

Today, NHS OC provides a range of programs and services to northern and central Orange County. The NeighborWorks HomeOwnership Center offers resources for first-time homebuyers and homeowners, including home ownership seminars, home rehabilitation loans, and home mortgages. Community programs are designed to increase resident and stakeholder involvement in improving the quality of life in Orange County neighborhoods. These programs include:

- Neighborhood Pride Day: Targeted neighborhood improvements including exterior painting, landscaping, trash clean-up, and minor exterior repairs.
- Resident Leadership Development Program: Identifies and trains resident leaders in leadership skills and advocacy.
- Rosie's Garage: After-school tutoring program for children K-12.

- Community Street Fair: Promotes community awareness and community building; participants include local children and adults, community service groups, and cultural arts groups.
- Neighborhood Block Cleanup: Community volunteers, NHS board members and NHS staff participate in 2-3 neighborhood cleanups annually.

## **Merger Driving Forces**

The driving forces for the merger echoed the motivations cited in Chapter 3, particularly Santa Ana's lack of staff capacity and lack of funding. Santa Ana NHS's absence of an executive director was the most obvious and urgent reason for why the two organizations joined forces initially. In addition, once the executive director of La Habra began leading both organizations, the boards soon recognized that maintaining two separate organizations, with two sets of systems, staffs, funders, etc. was not tenable in the long-term.

The Boards discussed the possibility of a merger and found that a merger between the two organizations had many advantages. Both organizations provided comparable products and services to similar constituents in the same county, they shared a connection to Neighborhood Reinvestment, they would achieve cost savings by combining administrative functions, and a merged organization would have a county-wide presence. The board felt that being affiliated with an entire county, rather than just two communities, would increase the visibility of the organization for new funding opportunities.

While NRC did not place pressure on either organization to pursue a merger, it did offer support for the merger process. NRC provided technical assistance as well as funding to develop the merger plan, hire consultants, facilitate discussions between the two groups and provide on-going goal setting and evaluation services.

## Merger Capacity Impacts

### *Conclusions from Pre and Post Merger Data and Interviews*

An analysis of interviews, budgets, audits, grant proposals, and organization charts from the pre-merger La Habra (the more dominant of the two original organizations) and the post-merger NHS OC shows a much stronger post-merger organization. The following tables highlight the changes in financial, organizational, programmatic, and political capacity pre and post merger. Pre-merger data was obtained from La Habra materials dated 1998 while post-merger data was taken from NHS OC materials dated 2003. An analysis of the data and the perception of the executive director, board chair, and intermediary funder with regards to each type of capacity is included after each table.

*Table 2: NHS OC Financial Capacity*

<b>Financial Capacity</b> Source: NHS OC 2003 Audited Financial Reports and La Habra 1998 Audited Financial Reports	Pre-merger (FY1998)	Post-merger (FY2003)	% Change
1. Total annual budget	\$1,417,028	\$1,599,524	13%
2. Total administrative budget (admin & fundraising staff salaries, overhead, and fundraising activities)	\$158,049	\$226,923	44%
3. Number of foundation funders	0	0	0%
4. Number of corporate funders	24	29	21%
5. Number of government funders	2	4	100%
6. Number of individual donors (mostly board)	5	25	400%
<b>Percent of budget raised from the following sources:</b>			
7. Total Foundation support	7%	27%	286%
National or community foundations	0%	0%	0%
Corporate foundations	7%	27%	286%
8. Total Government support	5%	14%	180%
Local Government	5%	3%	-40%
State Government	0%	8%	-
Federal Government	0%	3%	-
9. Intermediaries (e.g. LISC, NeighborWorks, or Enterprise Foundation)	7%	10%	43%
10. Individual donors	<1%	<1%	0%

11. Earned income - real estate developer fees	39%	4%	-90%
12. Membership dues (if applicable)	N/A	N/A	N/A
13. Investment income	13%	12%	-8%
14. Other income (please specify)	Property management = 15%	Property management = 16%	7%
	Program service fees = 2%	Program service fees = 9%	350%
	Loan servicing fees = 0%	Loan servicing fees = 4%	-
	Other = 6%	Other = <1%	-83%

The financial changes resulting from the merger were both positive and negative, and on the whole, the post-merger NHS OC exhibits a stronger financial picture than pre-merger La Habra. The budget increased 13% to almost \$1.6 million dollars, but this amount is actually the sum of the La Habra and Santa Ana budgets, and does not necessarily prove that the budget actually expanded as a result of the merger. The number of corporate funders grew 21%, and total foundation support increased by approximately 286% (from 7% to 27% of the total budget). Government funding sources doubled, from 2 to 4 grants. This translated to a new state and federal grant post-merger and a net 180% increase in government support (from 5% to 14% of the budget). NHS OC also experienced a slight increase in support from its intermediary, Neighborhood Reinvestment. Earned income from real estate development fees experienced a 90% drop, from 39% to just 4%. Finally, program service fees increased from 2% to 9% of the budget and loan servicing fees increased from 0% to 4%. The interviewees felt that this was a more stable financial picture for NHS OC, which allowed it to reach a wider market in Orange County.

The perception that a merger always results in increased operational efficiency is not validated by the pre and post merger budgets. As a percentage of La Habra's and then NHS OC's total budget, administrative expenses, including staff and overhead, increased from 11% to 14% post-merger. This may be due to the fact that three different offices are now being maintained by NHS OC in Anaheim, Santa Ana, and La Habra (this issue is described in more detail in the Other Impacts section below).

Table 3: NHS OC Organizational Capacity

Organizational Capacity	Pre-merger (FY1998)	Post-merger (FY2003)	Number Change	% Change
1. Number of full-time paid staff	7	10	3	43%
2. Number of part-time paid staff	0	2	2	-
3. Number of board members	15	17	2	13%
4. Number of volunteers/unpaid interns	21	40	19	90%
5. Total number of fundraising staff (in FTE's)	0	0.75	0.75	-
6. Board composition:				
# of residents of the community	8	5	-3	-38%
# of non-residents of the community	7	12	5	71%
# of government officials	1	3	2	200%
# of business owners, lawyers, accountants, bankers, engineers, or other "professionals"	6	8	2	33%
# of religious leaders	0	0	0	0%

In terms of organizational capacity, NHS OC is also slightly stronger post-merger. While staff size increased from 7 to 10 full-time employees, Santa Ana only contributed 1 full-time employee at the time of the merger. However, an interviewee reported that more funding support meant that maintaining a stable staff was not as challenging. Two part-time staff people were also added post-merger. Part of the staff changes included adding a .75 FTE whose primary focus is fundraising for NHS OC. The number of volunteers almost doubled post-merger, to 40 people in 2003.

There are now also 17 board members, representing a 13% increase. The composition of the board has shifted to include 38% fewer residents of the La Habra/Santa Ana neighborhoods, 71% more residents of the rest of Orange County, and a 33% increase in the number of professionals on the board. While there are fewer local residents on the board, which can be perceived as a negative impact by a CDC constituent, the skills and resources of the board have grown due to its increased "professionalization."

Table 4: NHS OC Programmatic Capacity

Programmatic Capacity	Pre-merger (FY1998)	Post-merger (FY2003)	Number Change	% Change
1. List of programs & services provided to constituents/clients	<ul style="list-style-type: none"> <li>▪ Property development (single family)</li> <li>▪ Rehab lending</li> <li>▪ First-time homebuyer education</li> <li>▪ Community organizing</li> <li>▪ Tutoring</li> </ul>	<ul style="list-style-type: none"> <li>▪ Property development (single family &amp; multi-family)</li> <li>▪ Rehab lending</li> <li>▪ Expanded first-time homebuyer education</li> <li>▪ Community organizing</li> <li>▪ Tutoring</li> <li>▪ Anti-predatory lending program</li> <li>▪ Financial fitness</li> </ul>	N/A	N/A
2. Target markets served (including service area and demographics)	Cities of La Habra, Fullerton, and Brea	All of Orange Co.	N/A	N/A
3. Other indicators of impact relevant to your organization's mission (e.g. number of housing units developed, number of housing units under management, number of small businesses assisted, number of home or business loans closed, number of ESL classes offered, etc.):				
Impact 1: # of loans from revolving loan fund	7	17	10	143%
Impact 2: # of community organizing events	4	8	4	100%
Impact 3: # of community organizing participants, e.g. neighborhood events/festivals, clean-up projects, leadership training	NA	1078	N/A	N/A
Impact 4: # of homebuyer education participants, e.g. HomeBuyers Club, foreclosure prevention, lead poison prevention	855	1063	208	24%
Impact 5: # of human services participants, e.g. adult education, job training	12	36	24	200%
Impact 6: # of tutoring participants	150	250	100	67%
Impact 7: # of IDA participants	0	36	36	

Impact 8: # of housing services participants (e.g. downpayment assistance, disposition of foreclosed property, tool lending	101	35	-66	-65%
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Both the data and the perception of the interviewees support the fact that La Habra programs expanded considerably post-merger. In terms of development, NHS OC continues to do property development of single family homes, rehab lending, and first-time homebuyer education. However, NHS OC now develops both multi-family and single-family homes. Most importantly, it established a NeighborWorks HomeOwnership Center, through which NHS OC has grown its first-time homebuyer education program, offers new lending products (including first and second mortgages and anti-predatory lending), and provides a financial literacy program.

In addition, the service area of La Habra expanded substantially as a result of the merger. NHS OC can now present itself as a county-wide organization and serve a wider base of communities in need. Whereas the previous focus of La Habra was the cities of La Habra, Fullerton, and Brea, the addition of Santa Ana and Anaheim has expanded the organization's reach to include most of north and central Orange County. Since Orange County does not have any major cities that are associated with it, being affiliated with only one small city, such as La Habra, did not give it the visibility it could achieve from being a county-wide organization. Both the executive director and board chair of NHS OC felt that having a county-wide presence allowed the organization to increase its visibility, appeal to more funders, lenders, and collaborators, and thus attract a wider and more stable stream of funding.

Almost all of La Habra's non-development programs also grew post-merger as a result of its expansion into low-income communities that needed housing and community development programs. The number of loans from the revolving loan fund increased from 7 to 17, a 143% increase. The number of community organizing events doubled (although it is unknown how much organizing participation has increased). Participation in homebuyer education services, such as the HomeBuyers Club, foreclosure prevention, and lead poison prevention, also increased by 24% to 1063 people in 2003. The number of people in adult education and job

training programs increased 200%, from 12 to 36. Tutoring also grew to include 250 participants post-merger. NHS OC added an IDA program post-merger, which had 36 participants in 2003. The only post-merger programmatic decrease was in the number of participants in housing services, such as downpayment assistance and disposition of foreclosed property, which declined 65% to include only 35 participants in 2003.

*Table 5: NHS OC Political Capacity*

<b>Political Capacity</b>	<b>Pre-merger (FY1998)</b>	<b>Post-merger (FY2003)</b>	<b>Difference</b>
1. Number of political events or initiatives planned/hosted by the organization (e.g. policy panels, meet your legislator event, etc.)	1	3	200%
2. Number of high-level appointed or elected speakers from a public office or agency that have spoken at your CDC events	1	2	100%
3. Number & type of services/programs conducted by the CDC with local, state, or federal government (e.g. CDC services contracted by the government)	2	4	200%
4. Does the organization belong to a political advocacy coalition? (Yes or No). If "Yes", please provide the name of the coalition.	Yes - Kennedy Commission	Yes - Kennedy Commission	None
5. Does the organization publish articles on public policies affecting its constituents (e.g. in a newsletter or on a website)? (Yes or No)	Yes – newsletter	Yes - website, newsletter, CalNet (California NWO's)	Addition of website and CalNet
6. Describe other ways the organization engages with or receives support from policy-makers or public officials	Contact w/ local council members	Meets with local, state, and federal legislators	Expansion of legislative contact to state and federal levels

The political capacity of NHS OC is moderately stronger post-merger. The organization has added one to two more political events or initiatives, political speakers, and programs it does in

conjunction with the government. It has also become more active in informing its constituents about important public policies that would affect them. Most significantly, the organization now has the capacity and visibility, presumably, to meet with policy-makers at the city, state, and federal levels – a post-merger expansion of the number and degree of NHS OC’s legislative contacts.

## **Other Impacts**

### *Change in Mission*

It could be argued that constituents in Santa Ana are better served post-merger, since a much stronger organization is now serving those neighborhoods. Another perspective is that the merger has changed the mission of the organization to be less community-oriented and that some constituents may prefer the old mission. According to the interviewees, NHS OC has significantly increased its scope regarding real estate development and unlike La Habra, is no longer as focused on community organizing and neighborhood-based activities. One wonders whether the addition of real estate activities would have happened regardless of the merger, particularly since the serious need for affordable housing in Orange County would probably have pushed La Habra into real estate development.

### *Governance Issues*

Pre-merger, the board of directors of La Habra was very much involved in day-to-day neighborhood-based activities. After the merger, the two offices were known as chapters and an advisory board was established for each chapter. There was a struggle to effectively define the role of the advisory boards, which initially saw their roles in terms of a governing capacity, rather than in an advisory role. “A bit of a turf war” ensued between the advisory boards and the board of directors as they determined their roles within the organization. It has taken three years to establish the advisory boards in an advisory capacity and the board of directors of NHS OC in a governing capacity for the entire organization.

### *Integration Struggles*

Another effect of the county-wide expansion is that the struggles of integrating the two organizations into one still seem to be in evidence. NHS OC is effectively running three different offices – one headquarters in Anaheim and one programmatic office each in Santa Ana and La Habra. There also still seems to be an “us” and “them” mentality in the minds of the interviewees with regards to La Habra and Santa Ana, which seems to be reinforced by the fact that there are essentially separate offices and advisory boards in two different cities.

### *Loss of Services*

Finally, interviewees mentioned that community residents and leaders in both cities were concerned that moving the new headquarters to a third city would result in reduced services to their community (which was not the case according to the interviewees or according to the post-merger data). A corollary fear of both residents and city officials was that their influence over the merged organization would decrease since the headquarters would be located elsewhere. While the interviewees acknowledged that there will be some perceived loss in any merger, the data and the interviews could not confirm if this loss of influence actually occurred.

## **Lessons Learned**

According to one interviewee, the merged organization could have benefited from more municipal financial support. This person suggested that perhaps engaging local government leaders in the merger process and establishing a stronger relationship with them could have built a foundation for more financial assistance for the organization in the future.

## **Conclusion**

Has NHS OC’s capacity grown as a result of the merger? After reviewing its financial, organization, programmatic, and political data, it can be concluded that NHS OC is a stronger organization more capable of achieving its mission than its predecessor organization, NHS of La Habra. Most of this strength and growth in capacity resulted from expanded programs, increased

outputs, and larger service area, which contributed to its increased visibility to funders and policymakers.

- Financial

NHS OC experienced mostly a change in the makeup of its budget sources, rather than a real growth in its financial resources. More importantly the number of funders increased and support from foundations, government, and intermediary sources increased substantially. This growth was credited to the service area expansion as a result of the merger. However, the merger did not translate into efficiency gains, as the existence of three separate offices increased its operational costs.

- Organizational

The capacity of the staff, volunteers, and board members grew slightly post-merger. The staff growth was not necessarily a direct result of the merger. However, the diversification of the board was achievable because of the larger service area of NHS OC.

- Programmatic

NHS OC experienced significant programmatic capacity growth post-merger. The combination of La Habra and Santa Ana's programs allowed a substantial increase in both development and non-development services. In addition to residential development, a new HomeOwnership Center provides a range of housing services. Existing programs in community organizing, home ownership services, adult education, tutoring, and job training have also grown post-merger. Finally, and maybe most importantly, NHS OC's service area has almost tripled in size, allowing it to provide programs to underserved populations in north and central Orange County.

- Political

NHS OC is now moderately more politically active post-merger. It has slightly increased the number of events and programs that have a political connection. The major growth in political capacity, NHS OC's visibility to policy-makers at all levels of government, is mostly attributable to its new county-wide presence.

- Other Issues

NHS OC has struggled with some issues related to the merger. The expansion of NHS OC's mission, the challenge to define the advisory board's role, the effort to integrate the two cultures and offices, and addressing the fear of loss of services in Santa Ana, have all been addressed to varying degrees of success since the merger.

Overall, the merger between NHS of La Habra and Santa Ana NHS was very successful in terms of creating a merged organization with more capacity than the predecessor organizations. The factor that probably contributed most to this outcome was its growth in programmatic capacity. This allowed NSH OC to market itself to collaborators, funders, and policy-makers as an organization with a large constituent base, comprehensive programs, and influence in the field of community development. NHS OC senior management believed that merging sooner would have been even more beneficial. One interviewee described NHS OC as "greater than the sum of the chapters."

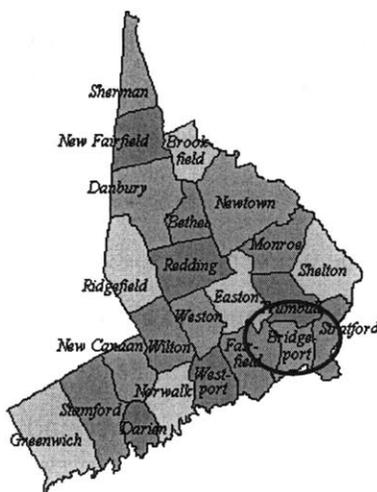
## Chapter 6: Case Study 2 - Mutual Housing Association of Southwestern Connecticut

Mutual Housing Association of Southwestern Connecticut (MHA) absorbed Bridgeport Neighborhood Housing and Commercial Services, Inc. (NHS) in 2000. While the merger did not result in an increase in financial, organizational, or political capacity, the addition of NHS allowed MHA to grow its homeownership-related programs and expand its service area into Bridgeport.

### Organizational Background

MHA was formed in 1990 with the goal of providing affordable housing in Fairfield County. Its programs centered around creating affordable rental housing and community organizing. NHS focused its services on Bridgeport's West End neighborhood in Fairfield County. Its main program was providing grants and loans for home rehabilitation and purchase (including first and second mortgages). It also provided some homeownership counseling services, specification writing and construction monitoring services, and community organizing activities.

The map below shows the service area of both organizations. While NHS was focused on one part of Bridgeport within Fairfield County, MHA's service area covered all of Fairfield County.



Map of Fairfield County, CT  
Red circle shows town of Bridgeport within Fairfield County  
Source: [www.town-usa.com](http://www.town-usa.com)

The table below shows a pre-merger snapshot of NHS and MHA. MHA’s budget was twice as large and its staff was three times as large as NHS’s. In addition, while NHS’s range of programs were more expansive than MHA’s, in reality its rehabilitation loan program was its primary service.

*Table 1: Pre-merger snapshot of Bridgeport NHS and MHA*

	<b>Bridgeport NHS</b>	<b>MHA</b>
Budget	~ \$266,000	\$594,085
Service Area	Bridgeport’s West End	Low-income communities in Fairfield County
Staff Size	2 FTE (ED under contract)	7 FTE
Programs	<ul style="list-style-type: none"> <li>• Primarily grants and loans for home rehabilitation and purchase</li> <li>• Homeownership counseling services</li> <li>• Specification writing and construction monitoring services</li> <li>• Community organizing</li> </ul>	<ul style="list-style-type: none"> <li>• Affordable rental housing development</li> <li>• Community organizing</li> </ul>

There were two distinct economic stories in Fairfield County during the 1990’s. Bridgeport suffered through a very weak economy and a population decline due to cutbacks in defense spending, a loss in manufacturing jobs, and a high crime rate. In 1999, Bridgeport’s West End housing was 73% renter-occupied and the majority of homes were in multi-family buildings. Median household incomes at the time were approximately \$32,600, which was \$4000 less than the city of Bridgeport and \$20,700 less than the Bridgeport MSA (Mutual Housing Association & Bridgeport Neighborhood Housing & Commercial Services, 2000).

Meanwhile, lower Fairfield County’s proximity to New York City made it a very attractive location for homebuyers, resulting in high purchase prices and rental rates during the 1990’s. In 2000, the median income in all of Fairfield County was \$65,249 and the median value of an owner-occupied housing unit was \$288,900, substantially higher than in Bridgeport’s West End neighborhood (Mutual Housing Association & Bridgeport Neighborhood Housing & Commercial Services, 2000). Throughout Connecticut, however, there were significant cut-

backs in state funding for affordable housing and very little operating support from the city for affordable housing developers.

## **Merger Driving Forces**

In early 2000, NHS was in dire straits in terms of organizational and financial capacity. Development cost overruns were threatening the long-term financial viability of the organization. A historically active board and staff were in decline and a new board chair was forced to lay off two of the three remaining staff, including the executive director, resulting in a serious lack of staff capacity. In order to save its strong lending programs, NHS contracted temporarily with Bridgeport Neighborhood Trust. For two years, NHS and the Trust discussed the possibility of a merger with each other, which ultimately fell through.

NHS's NeighborWorks charter was soon to be revoked, and NRC did not want its one network member in Bridgeport to become defunct. As both organizations were members of the Neighborhood Reinvestment network, NRC made a suggestion to NHS to consider merging with MHA. A merger between the organizations seemed to be a good fit. MHA had already developed two large projects in NHS's service area and thus had a presence in the neighborhood. They had complementary services – MHA developed rental housing and NHS had a strong rehab lending program.

Merger negotiations commenced and according to the Merger Plan (2000), “the intent of the merger is to expand, create or revitalize homeownership services around the following areas: education, lending, construction and rehab services, and community organizing.” The merger was completed in December 2000; NHS was dissolved and its assets were incorporated into MHA.

## Merger Capacity Impacts

### *Conclusions from Pre and Post Merger Data*

An analysis of interviews, budgets, audits, grant proposals, and organization charts from the pre-merger MHA (the more dominant of the two organizations) and the post-merger MHA shows a post-merger organization that only seems to have changed programmatically as a direct result of the NHS merger. The following tables highlight the changes in financial, organizational, programmatic, and political capacity pre and post merger. Pre-merger data was obtained from MHA materials dated 1999-2000 while post-merger data was taken from materials dated 2003-2004. An analysis of the data and the perception of the executive director, board chair, and intermediary funder with regards to each type of capacity is included after each table.

It must be noted that MHA completed another merger with Norwalk NHS in 2003. Thus, it was difficult to separate the impacts from the Norwalk merger from the post-Bridgeport merger using solely the capacity indicators from the data. The impacts from the Bridgeport merger are more accurately portrayed in the perceptions of the intermediary funder, board chair, and executive director interviews.

*Table 2: MHASWCT Financial Capacity*

<b>Financial Capacity</b>	<b>Pre-merger (FY1999-2000)</b>	<b>Post-merger (FY2003- 2004)</b>	<b>% Change</b>
1. Total annual budget	\$594,085	\$1,242,294	109%
2. Total administrative budget (including estimated admin & fundraising staff salaries, overhead, and fundraising activities)	\$236,800	\$628,500	165%
3. Number of foundation funders	11	9	-18%
4. Number of corporate funders	17	6	-65%
5. Number of government funders	1	1	0%
6. Number of individual donors (mostly board)	1	2	100%
Percent of budget raised from the following sources:			
7. Total Foundation support	17%	20%	17.6%
National or community foundations	N/A	15%	-
Corporate foundations	N/A	5%	-
8. Total Government support	0%	4%	-

Local Government	0%	0%	0.0%
State Government	0%	0%	0.0%
Federal Government (Norwalk CDBG)	0%	4%	-
9. Intermediaries (e.g. LISC, NeighborWorks, or Enterprise Foundation)	6%	3%	-50.0%
10. Individual donors	<1%	<1%	0.0%
11. Earned income, including real estate developer fees	35%	28%	-20.0%
12. Membership dues (if applicable)	0%	0%	0.0%
13. Investment income	0%	2%	-
14. Other income (please specify)	Property management fees = 8%	Property management fees = 10%	25%
	Resident organizing fees = 16%	Resident organizing fees = 8%	-50.0%
	MHA Realty (sales and marketing) = 0%	MHA Realty (sales and marketing) = 11%	-
	Capital Fund Transfer = 11%	Capital Fund Transfer = 0%	-100.0%
	Capital Contribution = 0%	Capital Contribution = 10%	-
	Other = 7%	Other = 3%	-57.1%

At first glance, it would seem that MHS increased its financial capacity substantially post-merger – the budget has doubled since 1999. However, the number of funders has not shown a corresponding increase. Foundation funders decreased by 18%, corporate funders decreased by 65%, and government funders have stayed stable. However, total foundation support has increased overall by almost 18%. MHA has never received operating grants from the government, and the 4% of federal funding represents CDBG funding from Norwalk NHS. Intermediary support has decreased by 50%, down to 3% of the total budget. Earned income and resident organizing fees have also decreased post-merger, by 20% and 50% respectively. However, these reductions have been offset by a 25% increase in property management fees, 11% in income from MHA realty, 10% in income from a capital contribution, and the 18% increase in foundation support. Finally, the proportion of estimated administrative costs increased from 39% of the total budget to 50% of the total budget. It should be noted that the

financial picture of MHA was probably most affected by its merger with Norwalk NHS, which is not included as part of this case study. Thus, a completely accurate picture of the financial affects of the Bridgeport merger should be not assumed from this data.

According to most of the interviewees, corporate funders, especially banks, saw the merger as an opportunity to decrease their total giving within the community. They maintained their funding levels to MHA but dropped the funding previously provided to the NHS. As one interviewee put it, “Mergers are a mixed blessing. You merge and you’re treated as one organization.” The Bridgeport merger left MHA with expanded programs and staff but without funding to cover this increase in expenses. While a one-time grant by NRC covered part of this gap in funding, one could argue the merger actually decreased MHA’s capacity to raise funds.

*Table 3: MHASWCT Organizational Capacity*

<b>Organizational Capacity</b>	<b>Pre-merger (FY1999- 2000)</b>	<b>Post-merger (FY2003- 2004)</b>	<b>Number Change</b>	<b>% Change</b>
1. Number of full-time paid staff	7	12	5	71%
2. Number of part-time paid staff	0	0	0	0%
3. Number of board members	19	15	-4	-21%
4. Number of volunteers/unpaid interns	0	0	0	0%
5. Total number of fundraising staff (in FTE’s)	0	0	0	0%
6. Board composition:				
# of residents of the community	9	9	0	0%
# of non-residents of the community	10	6	-4	-40%
# of government officials	2	2	0	0%
# of business owners, lawyers, accountants, bankers, engineers, or other “professionals”	2	4	2	100%
# of religious leaders	0	0	0	0%

The merger with NHS did not have a substantial effect on the organizational capacity of MHA. NHS only had one full-time employee at the time of the merger and thus did not contribute significant staff capacity to MHA. However, MHA did have to hire two new staff positions, a Director of Homeownership Programs and Director of Real Estate, in order to expand MHA’s

real estate programs into Bridgeport. The rest of the increase in full-time staff post-merger would be attributable to the Norwalk merger and organizational growth.

The number of board members has decreased by 21% since the NHS merger. This decrease was mostly reflected in the decline in non-residential board members. The only other notable change in board members was that the number of “professionals” on the board doubled from 2 to 4 post-merger, which could be attributable to the Norwalk merger as well.

According to two interviewees, the board and staff retention and management issues that might otherwise exist within a typical merger were not factors in this merger. The boards blended together well and staff issues were minimal since there was only one staff person to absorb. However, one person noted that there may have been pressure on staff to expand MHA and its programs into Bridgeport. Since NHS only brought one full-time staff person to MHA, it did not provide existing MHA staff with significant new resources with which to expand their range of services into a new service area.

Table 4: MHASWCT Programmatic Capacity

Programmatic Capacity	Pre-merger (FY1999)	Post-merger (FY2003-2004)	Number Change	% Change
1. List of programs & services provided to constituents/clients	<ul style="list-style-type: none"> <li>▪ Affordable housing (rental)</li> <li>▪ Resident and community organizing</li> </ul>	<ul style="list-style-type: none"> <li>▪ Affordable housing (rental &amp; ownership)</li> <li>▪ Resident and community organizing</li> <li>▪ Lending, including rehab, second mortgages, and down payment assistance</li> <li>▪ Homebuyer education</li> <li>▪ MHA Realty – real estate brokerage</li> <li>▪ IDA program</li> </ul>	N/A	N/A
2. Target markets served	Low-income communities in Fairfield County	Low-income communities in Fairfield County, with a stronger presence in	N/A	N/A

		Bridgeport		
3. Other indicators of impact relevant to your organization’s mission (e.g. number of housing units developed, number of housing units under management, number of small businesses assisted, number of home or business loans closed, number of ESL classes offered, etc.):				
Impact 1: Rehab lending	0	2	2	-
Impact 2: Community organizing	N/A	N/A	N/A	
Impact 3: Homebuyer education	N/A	N/A	N/A	
Impact 4: Housing units built	N/A	N/A	N/A	

MHA’s programmatic capacity did increase post-merger. One major positive programmatic impact was that NHS brought a complementary program, rehab lending, to MHA. At the time of the merger, NHS’s main asset and program activity was their lending program. As of early 2000, NHS had 42 loans outstanding at \$1,161,000. The merger allowed the program to continue under the auspices of MHA. As one interviewee put it, “It was a rescue mission on the part of MHA.” However, the rehab lending program did not grow to the extent that the stakeholders of MHA had hoped, and as of 2003-2004 the number of rehab loans had stayed stable at two per year.

At the time of the merger, MHA was already in the process of building up its own homeownership, lending, and counseling capacity. However, the absorption of NHS’s lending program did position MHA for later growth, particularly by making the transition to homeownership easier. MHA has since offered MHA Realty, Connecticut’s first non-profit real estate brokerage company, residential development including homeownership and rental, home rehabilitation, homeownership education and counseling, and loans for second mortgages, rehabilitation, and down payments. Thus, an indirect and long-term programmatic result of the merger was that local residents had a wider spectrum of affordable housing options available to them.

The most significant programmatic impact from the merger was geographic expansion - joining with NHS allowed MHA to have a much stronger presence in Bridgeport, one of the poorest cities in Connecticut at the time of the merger. The rest of Fairfield County, including the towns of Trumbull, Greenwich, and Stamford, is considered to be one of the wealthiest counties in Connecticut. This made a larger presence in Bridgeport especially important in terms of increasing its visibility in Bridgeport and validating MHA’s commitment to bringing affordable housing to poor urban communities. One interviewee stated that MHA’s main goal for the merger was in fact geographic expansion, not programmatic expansion, and explained, “It was an easy way for immediate geographic growth which is what many funders are looking for right now.”

It should be noted that MHA is still in the process of putting impact measures in place to better evaluate its programs. Thus, data on community organizing and affordable housing programs were difficult to obtain.

*Table 5: MHASWCT Political Capacity*

<b>Political Capacity</b>	<b>Pre-merger (FY1999)</b>	<b>Post-merger (FY2003-2004)</b>	<b>Difference</b>
1. Number of political events or initiatives planned/hosted by the organization (e.g. policy panels, meet your legislator event, etc.)	0	0	0%
2. Number of high-level appointed or elected speakers from a public office or agency that have spoken at your CDC events	1	1	0%
3. Number & type of services/programs conducted by the CDC with local, state, or federal government (e.g. CDC services contracted by the government)	0	0	0%
4. Does the organization belong to a political advocacy coalition? (Yes or No). If “Yes”, please provide the name of the coalition.	No	Yes	Now belongs to political advocacy coalition, but not as a result of the merger

5. Does the organization publish articles on public policies affecting its constituents (e.g. in a newsletter or on a website)? (Yes or No)	Yes	Yes	No change
6. Describe other ways the organization engages with or receives support from policy-makers or public officials	Advocacy around relevant issues	Advocacy around relevant issues	No change

MHA’s political capacity also did not change as a result of the merger. The number of political events, the number of political speakers, and the number of programs in which MHA partnered with the government (zero, one, and zero, respectively) were the same pre- and post-merger. The MHA did join a political advocacy organization post-merger, but it was not as a direct result of the merger. Finally, MHA today continues to publish public policy articles and engage in political advocacy relevant to its constituents, as it did before the merger with NHS.

## **Other Impacts**

### *Network Capacity Impacts Remain Unclear*

Two interviewees felt MHA was now significantly more capable of collaborating with other organizations. However, the reasons offered for MHA’s new ability to collaborate differed. One interviewee believed that while MHA already had a presence in Bridgeport, the merger with NHS enabled it to adopt a long-standing neighborhood-oriented connection to the area. This new relationship with Bridgeport allowed MHA to expand its partnership opportunities with local organizations. Another interviewee felt the Bridgeport merger opened the door for more partnerships, particularly the Norwalk merger, because it expanded the board’s recognition of the value of collaboration, not because of the geographic expansion.

One interviewee was not as convinced that the merger had such positive outcomes in terms of collaboration. This person asserted that NHS’s main asset, rehab lending, is only somewhat more useful in collaborations because most collaborations revolve around new housing development.

### *Significant Costs*

MHA experienced significant financial and time costs related to the NHS merger. MHA applied for an emergency \$75,000 grant from NRC to pay for merger costs, such as hiring two new real estate staff positions, audits, legal filings, training costs, new promotional materials, and office renovation. Creating merger plans, due diligence, and training new boards and staff also required significant attention from the executive director, board members, and staff. As one interviewee put it, “In retrospect, it would have been less time consuming to start a rehab loan program from scratch.”

### *Governance Issues*

There was also some initial concern regarding Bridgeport’s representation on MHA’s board and committees. There was residual anxiety from the aborted Trust merger, which may have contributed to NHS’s fear that MHA would absorb NHS without regard to the concerns and opinions of NHS’s residents and board members. However, this concern was soon alleviated, as the interviewees confirmed that MHA valued the contribution that NHS’s constituents made to MHA and the boards and staff combined relatively painlessly.

## **Lessons Learned**

While staff and board issues were minimal, there were some human resource improvements that needed to take place in order to meld the two organizations successfully. The merger required the NHS board members and staff person to strengthen their skill sets to include mutual housing and expand their focus to be countywide. MHA board members and staff needed to add a homeownership rehab and lending program. The complexity of the new programs required more oversight from the executive director and board and more training for both board and staff to ensure that they understood the new programs and could make informed program-related decisions.

The original merger goal of expanding the rehab lending program was not achieved and today, the rehab lending is a relatively minor program within MHA. While hiring a new staff person to oversee the program could have given it the resources it needed to grow, it was considered too

risky for fear that the program would not expand enough to support the new position. In retrospect, it may have been worth the risk to hire a new staff person in order to give the program a chance to achieve its potential and for the merger to realize its programmatic goals.

Finally, the interviewees all agreed that strong leadership is essential, and without the guidance of the executive director, board, and NRC, the merger would not have been accomplished. A skilled and experienced executive director was at the helm of MHA and the leadership and vision of two NHS board members made a successful merger with MHA possible. In addition, the two boards had the same vision of providing affordable housing in Fairfield County and were committed to achieving a seamless transition between MHA and NHS's programs and staff. Finally, NRC provided a facilitator for merger negotiations, training, and funding.

## **Conclusion**

Has MHA's capacity grown as a result of the merger? After reviewing its financial, organizational, programmatic, and political capacity, it seems that the merger only increased MHA's programmatic capacity as a result of its geographic expansion into Bridgeport and its growth in homeownership development and services.

- **Financial**

While MHA did experience gains in total foundation support and increases in earned income sources post-merger, these increases could not be attributable to the merger. In addition, merging with NHS did not necessarily mean that MHA would receive the sum of the funding or funders from the two pre-existing organizations. Thus, the financial capacity of MHA was not necessarily improved by the merger.

- **Organizational**

The merger also did not have a significant positive affect on the organizational capacity of MHA. While MHA did have to hire new staff to expand its programs, NHS only had one staff person to integrate into MHA, and the board changes since the merger were not substantial.

- Programmatic

MHA benefited the most from the merger in terms of programmatic capacity. Even though NHS's rehab lending program did not achieve its potential, it did position MHA for future growth in affordable homeownership development, brokerage services, homebuyer education, and other lending programs. In addition, the most important impact of the merger on MHA's programmatic capacity was that it provided MHA with a strategic geographic expansion opportunity and a legitimate claim to Bridgeport as part of its service area.

- Political

MHA's political capacity did not expand as a result of the merger. MHA's political activities remained relatively status quo post-merger.

- Other Issues

Non-capacity related issues that resulted from the merger include the unanticipated time costs, concerns about NHS representation on the merged board and committees, and uncertainty regarding the merger's affects on MHA's ability to form collaborations with outside organizations.

Despite these issues, all of the interviewees agreed that overall, the merger between MHA and NHS was still successful. While the merger did not result in increasing all of the facets of MHA's capacity, the main goals related to programmatic capacity, growing MHA's homeownership programs and expanding much needed services into Bridgeport, were both achieved.

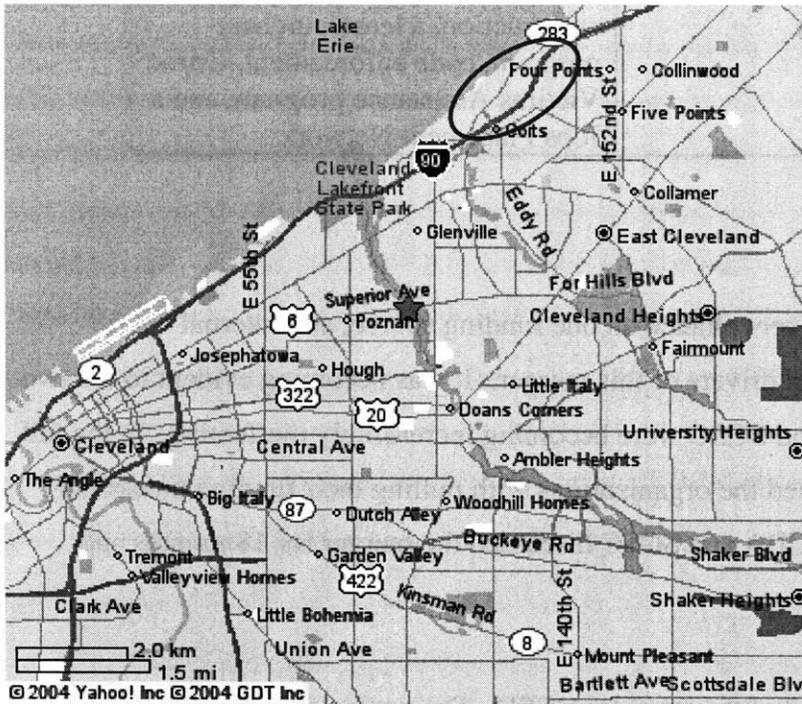
## **Chapter 7: Case Study 3 - St. Clair Superior Development Corporation (SCSDC)**

St. Clair Superior Development Corporation (SCSDC) of Cleveland, Ohio was formed in 1999 as a result of the merger between two community-based organizations, St. Clair Business Association (SCBA) and St. Clair Superior Coalition (SCSC). After a long merger integration process, a strong executive director, board and staff stepped in to transform SCSDC into a cohesive, mission-oriented CDC that is in the process of growing its capacity to serve its constituents.

### **Organizational Background**

SCBA was formed in 1970 to serve the needs of local business owners. SCBA's programs included storefront rehabilitation, streetscape improvements, and a newsletter. SCSC was founded in 1976 as a grassroots, advocacy organization dedicated to representing the social justice concerns of the residents. Programs included lead exposure prevention, community organizing block clubs and issue committees, property management, rehabilitation and sale of housing, new housing construction, a lease/purchase program, code enforcement, Crime Victims Assistance program, and a Jobs Placement Network.

The inner-city Cleveland area has a similar history to many older, Midwestern cities. After the factories and manufacturing plants in the area moved to the suburbs, the population's ethnic makeup altered dramatically. A neighborhood of predominantly white and European residents transformed into an immigrant-rich, diverse population of Asians, Africans, Hispanics, Eastern Europeans, and African-Americans. In 2003, approximately 76% of the population was non-white, compared to the rest of the U.S. which was approximately 25% non-white. The area has been slowly losing population – there were 14,797 residents in 2004, down from 15,771 in 2000. The median household income in 2003 was \$19,569, much lower than the U.S. median which was \$45,128. The near east side is now home to factories, educational institutions, locally-owned businesses, and aging housing stock. The median housing value in 2000 was \$52,067, and 4.3% of all housing units in the service area were subsidized, higher than other Cleveland neighborhoods. The homeownership rate for 2000 was 31% (SCSDC, 2004).



Red circle shows service area of SCBA & SCSC in Cleveland's St. Clair Superior neighborhood

SCBA and SCSC were two very different organizations by 1999. SCBA was a largely ineffective business association. It had shrinking services, most of its funding came from one source, the City of Cleveland, and it had a declining membership base. SCSC spent 25 years organizing and mobilizing area residents regarding a variety of issues. Externally, it developed a reputation as a confrontational and anti-establishment organization. As a result, it did not have strong relationships with funders, government officials, or business leaders. Internally, SCSC focused on its community organizing activities, rather than on developing organizational infrastructure. Thus, it lacked financial systems, strategic planning, and procedures for evaluation and reporting.

Table 1: Pre-merger snapshot of SCBA and SCSC

	SCBA	SCSC
Budget	~\$150,000	\$226,141
Service Area	Cleveland's near east side neighborhoods	Cleveland's near east side neighborhoods
Staff Size	2 FT	9 FT, 1 PT
Programs	Storefront rehabilitation, streetscape improvements, and a newsletter	Lead exposure prevention, community organizing block clubs and issue committees, property management, rehabilitation and

		sale of housing, new housing construction, a lease/purchase program, code enforcement, Crime Victims Assistance program, and a Jobs Placement Network
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## **Merger Driving Forces**

Funder pressure, limited missions, over-reliance on one funding source, and internal management problems were the main drivers of this merger. It was becoming evident to the two organizations' funders that SCBA and SCSC were becoming increasingly ineffective. In the fall of 1998, a City Councilman threatened the organizations with pulling their funding unless they merged. Left with no alternative, SCBA and SCSC discussed the merger for 18 months and finalized the union in January 2000.

However, the merger was not the end of the story for SCSC. The person appointed to be executive director of the merged organization was an existing staff person from SCSC with little management experience. During this time, there were reporting delinquencies and confrontations with local organizations. The board was faced with the decision to terminate the executive director after two years. From February to September 2002, another staff person served the role of interim executive director. Finally, in September 2002, a permanent executive director was hired and now leads the organization known as St. Clair Superior Development Corporation (SCSDC).

Today, SCSDC provides a range of programs and services, including:

- Community organizing – block clubs, issue committees, and neighborhood planning
- Real estate development – rental, homeownership, and property management
- Business development – Re\$Store Cleveland and storefront renovation
- Housing Services – lead hazard control, brokering neighborhood services, and code enforcement

## Merger Capacity Impacts

### *Conclusions from Pre and Post Merger Data*

An analysis of interviews budgets, audits, grant proposals, and organization charts from the pre-merger SCSC (the more dominant of the two original organizations) and the post-merger SCSDC shows a significantly stronger post-merger organization. The following tables highlight the changes in financial, organizational, programmatic, and political capacity pre and post merger. Pre-merger data was obtained from SCSC materials dated 1998-1999 while post-merger data was taken from materials dated 2004. An analysis of the data and the perception of the executive director, board chair, and intermediary funder with regards to each type of capacity is included after each table.

*Table 2: SCSDC Financial Capacity*

<b>Financial Capacity</b>	<b>Pre-merger (FY1998-1999)</b>	<b>Post-merger (FY2004)</b>	<b>% Change</b>
1. Total annual budget	\$226,141	\$803,016	255%
2. Total administrative budget (including staff salaries, overhead, and fundraising activities)	\$53,235	\$280,120	426%
3. Number of foundation funders	4	11	175%
4. Number of corporate funders	1	4	300%
5. Number of government funders	5	5	0%
6. Number of individual donors	0	16	-
Percent of budget raised from the following sources:			
7. Total Foundation support	19%	31%	63%
National or community foundations	18%	24%	33%
Corporate foundations	1%	7%	600%
8. Total Government support	52%	50%	-4%
Local Government	29%	10%	-66%
State Government	1%	4%	300%
Federal Government	22%	36%	64%
9. Intermediaries (e.g. LISC, NeighborWorks, or Enterprise Foundation)	1%	4%	300%
10. Individual donors	0%	<1%	-
11. Earned income - real estate developer fees	0%	8%	-

12. Membership dues (if applicable)	N/A	N/A	0%
13. Investment income	<1%	<1%	0%
14. Other income (please specify)	Gain from sale of investment = 13%	Gain from sale of investment = 0%	-100%
	Miscellaneous = <1%	Miscellaneous = 0%	-
	Religious organization = 4%	Religious organization = 0%	-100%
	Temporary funds transfer = 10%	Temporary funds transfer = 0%	-100%
	Fundraising event = 0%	Fundraising event = 1%	-
	Rental income = 0%	Rental income = 1%	-
	Newspaper ad revenue = 0%	Newspaper ad revenue = 1%	-

The financial capacity of post-merger SCSDC improved dramatically post-merger. The budget increased by 255% to \$803,016. The number of foundation and corporate funders also experienced a substantial rise of 175% and 300% respectively. Consequently, total foundation support increased 63% to cover 31% of the budget. The majority of this support was from national or community foundations, such as the Gund Foundation, COSE Foundation, and NPI of Pew Charitable Trusts. According to the interviewees part of the reason that funding opportunities have expanded since the merger is the new executive director and board, who have improved SCSDC's reputation, brought credibility to SCSDC in the eyes of funders, and attracted more resources and people who believe in the organization's abilities to deliver on its mission.

While local government support decreased by 66%, state and federal support increased by 300% and 64%, respectively, and covered the shortfall by providing a combined 40% of the budget. Intermediaries, particularly LISC and Enterprise Foundation, also increased their support of SCSDC post-merger. Another noteworthy contributor to the budget was earned income from developer fees and property management fees, which was 8% of the budget post-merger versus 0% of the budget pre-merger. Finally, the proportion of estimated administrative costs increased, from 24% of the total budget to 35% of the total budget.

It should be noted that two large sources of revenue pre-merger, a gain from sale of an investment and a temporary funds transfer, were one-time or temporary funding sources.

Table 3: SCSDC Organizational Capacity

Organizational Capacity	Pre-merger (FY1998-1999)	Post-merger (FY2004)	Number Change	% Change
1. Number of full-time paid staff	9	7	-2	-22%
2. Number of part-time paid staff	1	0	-1	-100%
3. Number of board members	19	16	-3	-16%
4. Number of volunteers/unpaid interns	N/A	3	N/A	N/A
5. Total number of fundraising staff (in FTE's)	0	0	0	0%
6. Board composition:				
# of residents of the community	18	8	-10	-56%
# of non-residents of the community	1	8	7	700%
# of government officials	0	0	0	0%
# of business owners, lawyers, accountants, bankers, engineers, or other "professionals"	2	9	7	350%
# of religious leaders	1	1	0	0%

An accurate picture of the organizational growth of SCSDC post-merger cannot be obtained by only analyzing staff and board numbers. The number of full-time staff, part-time staff, and board members all declined post-merger. More importantly, the board and staff composition changed substantially post-merger, which provides a more accurate sense of the degree to which the organizational capacity of SCSDC has improved post-merger.

One of the immediate adverse affects of the merger was a shakeup in the staff and board structure. Disagreement and suspicion between SCSC and SCBA board members led to an almost 100% turnover of board members from SCBA, loss of some SCSC board members, and a 100% turnover of the staff post-merger.

According to the interviewees, there was a fear of change among the principal actors in the organization that led to this loss; it was difficult for the original SCSC board and staff to accept

the changing focus of the organization. Since businesses and institutions were perceived to be part of the establishment that SCSC was fighting against, a merger with a business organization was considered antithetical to the mission of SCSC. As one interviewee put, the merged organization could not serve the interests of business owners with a staff that was oriented towards residents and actively organized against the establishment.

However, the interviewees ultimately saw the turnover as “a healthy shakeup.” The new staff has no historical loyalties to the original organizations or boards, are trained professionals in their field, and are dedicated to SCSDC’s entire mission – not specifically to community organizing or business development.

In addition, the board that has been developed over the past two years is also dedicated to moving the organization forward. The infighting and distrust that characterized the board during the time of the merger has been replaced by a board that is cohesive and mission-oriented. The depth and breadth of the composition of the board has expanded, allowing for more experienced and capable leadership of the organization. The number of professionals on the board increased by 7, or 350%, (mostly business owners who are also local property owners). According to one interviewee, the board understood for the first time their responsibilities and roles, the finances of the organization, the division between staff and board, and their liabilities as board members.

In addition, reporting systems, financial procedures, audits, strategic planning, and neighborhood planning are all new organizational activities that have enabled the organization to track impacts and prove its performance to funders and community stakeholders. The successful track record of the organization since the new executive director was hired has allowed SCSDC to establish new partnerships (e.g. with LISC and Cleveland Housing Network) and gain credibility and capacity for more collaborations.

*Table 4: SCSDC Programmatic Capacity*

<b>Programmatic Capacity</b>	<b>Pre-merger (FY1998-1999)</b>	<b>Post-merger (FY2004)</b>
1. List of programs & services provided to constituents/clients	<ul style="list-style-type: none"> <li>▪ Lead exposure prevention</li> <li>▪ Community organizing – block clubs, issue committees</li> <li>▪ Court Watch</li> <li>▪ Real estate development – property management rehab</li> </ul>	<ul style="list-style-type: none"> <li>▪ Community organizing – block clubs, issue committees, neighborhood planning</li> <li>▪ Real estate development – rental, homeownership,</li> </ul>

	<p>&amp; sale (affordable housing), new housing construction, lease/purchase program</p> <ul style="list-style-type: none"> <li>▪ Code enforcement</li> <li>▪ Crime Victims Assistance program</li> <li>▪ Jobs Placement Network</li> <li>▪ Community Youth Crew</li> </ul>	<p>property management</p> <ul style="list-style-type: none"> <li>▪ Business development – Re\$Store Cleveland, storefront renovation</li> <li>▪ Housing Services – lead hazard control, brokering neighborhood services, code enforcement</li> </ul>
2. Target markets served (including service area and demographics)	<p>Cleveland’s near east side (3.41 sq. mi)</p> <p>Service Area:</p> <ul style="list-style-type: none"> <li>▪ East – MLK Dr.</li> <li>▪ North – Lake Erie</li> <li>▪ South – Superior Ave.</li> <li>▪ West – E. 30th. St.</li> </ul> <p>Similar demographics pre- &amp; post-merger</p>	<p>Cleveland’s near east side (3.41 sq. mi)</p> <p>Same service area post-merger</p> <p>16,000 residents:</p> <ul style="list-style-type: none"> <li>▪ 60% African American</li> <li>▪ 23% White</li> <li>▪ 6% Hispanic</li> <li>▪ 7% Asia Pacific</li> </ul>
3. Other indicators of impact relevant to your organization’s mission (e.g. number of housing units developed, number of housing units under management, number of small businesses assisted, number of home or business loans closed, number of ESL classes offered, etc.):		
	<p>Very few statistics available. A review of pre-merger SCSC documents (which cannot be attributed solely to 1999) show:</p> <p>4 homeownership units developed  14 homes rehabbed and sold  80 residents placed in full-time positions  12,000 households provided with brochures on lead exposure and prevention  40 residents attended an environmental community meeting</p>	<ul style="list-style-type: none"> <li>▪ 7 rehabilitations of commercial properties</li> <li>▪ 33 businesses created or expanded</li> <li>▪ 35 units weathered or lead abated</li> <li>▪ 200 residents involved in community organizing</li> <li>▪ \$1.3 million in storefront renovations</li> <li>▪ \$51 million in real estate development pipeline</li> <li>▪ 28 housing units built</li> <li>▪ 10 housing units redeveloped</li> </ul>

While the pre and post merger organizations served the same neighborhoods in Cleveland’s near east side, the programs and services changed substantially. The old focus on community organizing and block clubs was giving way to a new mission that was expanded to increase real

estate development and add business development to SCSC’s existing community development and organizing activities.

SCSDC has consolidated its programs to focus on four key areas. It has incorporated and expanded SCBA’s business development programs to include Re\$store Cleveland, a comprehensive commercial district revitalization approach similar to Main Streets. While it still provides community organizing, which includes the original block clubs and issue committees, it has expanded its efforts by adding neighborhood planning. Its real estate development activities are similar, but include more projects (as reflected in the increase in property management and developer fees in the budget). Housing services now incorporates the original programs in lead hazard control, neighborhood services brokering, and code enforcement, but has either outsourced or eliminated a few original SCSC programs, including the Crime Victims Assistance program, Jobs Placement Network, and the Community Youth Crew.

While SCSDC seems to have established a strong record in its four key programs areas in 2004, it is impossible to ascertain from the documentation whether SCSDC is actually accomplishing more programmatically than SCSC, because SCSC did not keep comprehensive records of its neighborhood impact. An obvious outcome from the merger is that the new organization is now spending resources on tracking its neighborhood impact, unlike its predecessor.

*Table 5: SCSDC Political Capacity*

<b>Political Capacity</b>	<b>Pre-merger (FY1999)</b>	<b>Post-merger (FY2004)</b>	<b>Difference</b>
1. Number of political events or initiatives planned/hosted by the organization (e.g. policy panels, meet your legislator event, etc.)	0	0	None
2. Number of high-level appointed or elected speakers from a public office or agency that have spoken at your CDC events	1	1	None

3. Number & type of services/programs conducted by the CDC with local, state, or federal government (e.g. CDC services contracted by the government)	0	1 (storefront renovation)	One new program
4. Does the organization belong to a political advocacy coalition? (Yes or No). If “Yes”, please provide the name of the coalition.	No	No	None
5. Does the organization publish articles on public policies affecting its constituents (e.g. in a newsletter or on a website)? (Yes or No)	No	No	None
6. Describe other ways the organization engages with or receives support from policy-makers or public officials	No	SCSDC staff attend monthly Ward meetings	One new activity

The political capacity of SCDC has not changed dramatically post-merger. Two new programs and activities post-merger include working with the City of Cleveland to implement a store-front improvement program (which was an existing program from SCBA) and attending monthly Ward meetings. SCDC has not increased its political presence by, for example, joining a political advocacy coalition or engaging more political speakers at organizational events. However, it should be noted that the new management of SCDC has worked to establish stronger relationships with stakeholders within the community, including politicians, who may have been alienated by SCDC’s confrontational roots. The organization is trying to shed its reputation externally as an organization that focuses its energies on confrontation rather than production and outcomes.

## Other Impacts

### *Long, Arduous Post-merger Integration*

The most obvious post-merger outcome was the merger integration itself. The result of combining two somewhat ineffectual and dysfunctional organizations was the creation of a

bigger organization with the same issues but on a larger scale. Once the merger was finalized, the next two and a half years saw the loss of board members, staff, and two executive directors. In addition, internal documentation, financial reporting, relationships with community stakeholders, and the reputation of the organization were all adversely affected by the management, board, and staff's inability to lead and operate the merged organization. The lack of adequate planning, conviction, and leadership from both organizations led to the creation of a merged organization that seemed to be on the brink of failure several times over the course of two years.

## **Lessons Learned**

There were a variety of factors that contributed to the eventual success of this merger. The most essential component to ensuring the merger succeeded was its leadership. The merged organization did not begin to achieve its potential before a permanent and competent executive director was hired, who then went on to replace every staff person with a skill set that fit the needs of the new organization. In addition, the board had an integral role to play in the merger. A core group of original board members and new board members were committed to the vision of the merged organization. The success of SCSDC, in terms of continued funding, serving an expanded client base, and providing much-needed programs and services, was due to the new board, staff and executive director rather than to the consolidation of SCSC and SCBA.

In terms of the role of funders and other stakeholders, the case of SCSDC illustrates how risky mergers are when funders force the situation upon two organizations. As one of the interviewees said, "Mergers are best when they're organic." SCBA and SCSC were both community development organizations, but the cultures, missions, and personalities involved were not compatible. However, given the choice to merge or lose funding, the two organizations made what seemed like a logical choice at the time. While the SCSDC merger was eventually successful, the means to that success was a painful integration process that led to massive staff, board, and executive director turnover.

Another result of a forced merger was that the organizations' boards were forced to make false claims in order to sustain their funding. Both CDC's stated that they believed in an expanded mission, would compromise, and successfully complete a merger. However, in retrospect, it seems evident that the principal actors would have said whatever was necessary to the City to ensure continued funding. According to one of the interviewees, there was a lack of honesty in the initial merger proceedings with regards to the board's willingness to take the steps necessary to create a successful merged organization.

It should be noted that SCSDC received substantial support, both financial and operational, from its funders. LISC and the City provided funding, mediators, and professional development training opportunities. However, one interview suggested another opportunity for funders to support mergers more effectively. While the City provided funding for a mediator to be involved in the merger process, the mediator's role was complete at the conclusion of the merger. A means of preventing post-merger conflicts may be for funders to offer mediation services for several months after the merger, particularly in the board room.

Perhaps because the merger was not proposed by either organization and they were faced with an ultimatum that they could not refuse, neither organization had laid out concrete goals for the merger. Some documents provide overarching statements about "creating a unified voice" and "strengthening the programs and services," however, none of the interviewees were aware of any specific merger goals. Despite this, all of the interviewees were confident that the merger had achieved, if not surpassed, the general goal of creating a functional, financially stable merged organization that could better serve the entire community. However, after reviewing the data and the interviews, it seems that the executive leadership of SCSDC had the most impact on the organization's eventual success and that the merger merely served as a catalyst to obtain strong leadership for the two organizations.

## Conclusion

Has SCSDC's capacity grown as a result of the merger? Both the data and the interviews confirm that the financial, organizational, programmatic, and political capacity of the organization has grown, in some cases substantially, post-merger.

- Financial

SCSDC's financial capacity improved significantly post-merger. The number of funders, the amount of support the organization received from corporate, public, and intermediary sources, and its earned income all increased post-merger. The new executive director and board had a large role to play in improving SCSDC's reputation with funders and in creating revenue-generating programs.

- Organizational

The organizational capacity has also improved dramatically post-merger. While SCSDC suffered from drastic post-merger organizational turnover, the new staff, board, and executive director bring a wealth of experience, leadership, vision, and commitment to a stronger merged organization. Without their leadership, the merged organization may have lost funding and been forced to close. In addition, the organizational infrastructure improved significantly post-merger with new systems for timely reporting and accurate financial management.

- Programmatic

SCSDC's programmatic offerings have also expanded considerably since the merger. While SCSC's original focus was on community organizing, housing and community services, and some real estate development, it has grown those programs and added economic development. The improvement in financial and human resources has also allowed SCSDC to increase its programmatic output substantially since the merger. The end result is an organization that serves the needs of both business owners and residents in the community.

- Political

While the level of political activities has not increased substantially post-merger, SCSDC's main political accomplishment seems to be its focus on repairing past political relationships and building new ones. SCSDC has recognized that it must increase its engagement with policy makers in order to bolster support for its programs on behalf of its constituents.

- Other Issues

In order to achieve a successful merger, SCSDC did have to endure a long and challenging merger integration process. SCSC and SCBA were not ideal merger partners; thus, a significant amount of time, human resources, and money was spent in order to successfully combine the two organizations.

In conclusion, the merger between SCSC and SCBA was incredibly successful. However, the positive outcomes of this merger are mostly attributable to the strong leadership of the organization two years after the merger was complete. Despite the initial post-merger challenges, SCSDC managed to stay intact, maintain the missions of both organizations, and expand the number of programs and services delivered to its clients. The end result is a CDC that has substantially increased its capacity to improve the lives of residents and business owners in the near eastside neighborhoods of Cleveland.

## Chapter 8: Case Study Analysis

This short chapter will conclude the analysis specific to the case studies by comparing the contributing factors to the positive and negative outcomes from each merger and the driving forces behind each merger. Kohm and La Piana (2003) reported that respondents in their six case studies found that it was easier to report on why the strategic restructuring took place and its impacts than on what made their experience successful or not successful. The same can be said of the three case studies in this research.

### Merger Driving Forces

The internal and external motivations for each merger are summarized in the table below:

	SCSDC	MHASWCT	NHS OC
<b>Driving Forces Behind Merger</b>	<ul style="list-style-type: none"> <li>▪ Ultimatum from funder</li> <li>▪ Limited missions</li> <li>▪ Limited funding sources</li> <li>▪ Internal management problems</li> </ul>	<ul style="list-style-type: none"> <li>▪ NHS’s lack of staff and executive leadership</li> <li>▪ NHS’s financial difficulties</li> <li>▪ Suggestion from funder</li> </ul>	<ul style="list-style-type: none"> <li>▪ Santa Ana’s lack of executive director</li> <li>▪ Santa Ana’s lack of funding sources</li> </ul>

Both predecessor organizations in the SCSDC merger suffered from narrow missions, overreliance on a few funding sources, and a lack of organizational capacity. The result was an ultimatum from the City of Cleveland to merge or lose funding. Neither SCSC nor SCBA would have approached the other if they were not forced to consider a merger. Several negative impacts were the result, described in more detail below in the section titled “Factors that Adversely Affect CDC Capacity.”

The MHASWCT merger resulted from weaknesses in NHS’s organizational and financial capacity, namely the lack of an executive director and staff and development cost overruns that threatened its survival. A timely suggestion by its intermediary, NRC, led it to merge with MHA.

The story was similar in the case of the NHS OC merger, where Santa Ana’s lack of executive director and fundraising challenges led it to merge with La Habra. Interestingly, the lack of staff and executive capacity were actually factors that contributed to the positive outcomes from these two mergers, described in more detail in the next section.

### Factors that Positively Affect CDC Capacity

The success factors in the three case studies confirm the success factors cited in both the non-profit and CDC merger literature. These factors are summarized in the table below:

	SCSDC	MHASWCT	NHS OC
<b>Contributing Factors for Positive Capacity</b>	<ul style="list-style-type: none"> <li>• Strong executive leadership</li> <li>• Funder support</li> </ul>	<ul style="list-style-type: none"> <li>• Strong executive leadership</li> <li>• Compatible programming</li> <li>• Compatible service area</li> </ul>	<ul style="list-style-type: none"> <li>• Strong executive leadership</li> <li>• Compatible programming</li> <li>• Compatible service area</li> <li>• Funder support</li> </ul>
<b>Other Contributing Factors for Positive Capacity</b>	<ul style="list-style-type: none"> <li>• New professional staff</li> </ul>	<ul style="list-style-type: none"> <li>• Executive director vacancy</li> <li>• Strong absorber CDC</li> </ul>	<ul style="list-style-type: none"> <li>• Executive director vacancy</li> <li>• Strong absorber CDC</li> </ul>

All three case studies had strong executive directors and board members who were instrumental in leading the merged organizations. In both the MHA and NHS OC mergers, the smaller organizations, Bridgeport NHS and Santa Ana NHS, respectively, were without a permanent executive director. The executive directors of the stronger organizations were seasoned

professionals and thus easily transitioned to become the leader of the merged organizations. Meanwhile, SCSDC's negative experiences with staff, management, and board turnover immediately after the merger highlight the importance of strong leadership for positive merger outcomes.

The NHS OC and MHA mergers also allowed two organizations with compatible programs to combine their efforts. NHS's rehab lending program was a nice complement to MHA's affordable housing development. In the case of NHS OC, Santa Ana and La Habra provided many of the same services, but their service areas did not overlap. Consequently, in both cases the two merged organizations had a relatively smooth programmatic absorption and human resources transition.

The organizations in the MHA and NHS OC mergers were also geographically complementary, which allowed them to expand their service areas. MHA's presence in Bridgeport was minimal and La Habra and Santa Ana did not have overlapping service areas. Both organizations have benefited from the increased visibility with stakeholders that resulted from becoming larger organizations with stronger presences in predominantly low-income communities.

Funder support had a large role to play in the success of the SCSDC and NHS OC mergers. NHS OC's county-wide presence enabled it to increase its appeal to funders. SCSDC was able to use its comprehensive focus on community revitalization and its new leadership to appeal to a wider range of funders.

There were other factors that contributed to the positive outcomes of each merger. SCSDC would not have experienced a turn-around if not for the skills and vision of its new staff. Both MHA and NHS OC did not have to face the struggles related to leadership issues since their merger partners did not have permanent executive directors. Finally, the cultural clashes that can result from two strong organizations merging did not exist for MHA and NHS OC since they both involved a stronger organization absorbing a weaker one.

## Factors that Adversely Affect CDC Capacity

Ideally, the case study mergers would have resulted in CDC's that had significantly greater capacity in all four areas – financial, programmatic, organizational, and political. When any of the non-profit merger success factors is missing from a CDC merger, it can lead to a null or adverse affect on capacity post-merger. The chart below summarizes the issues that contributed to each CDC merger's adverse impacts on capacity.

	SCSDC	MHASWCT	NHS OC
<b>Contributing Factors for Null or Adverse Capacity</b>	<ul style="list-style-type: none"> <li>• Lack of honesty and trust between merger participants</li> <li>• Seemingly incompatible cultures, programs, and constituents</li> <li>• Lack of concrete merger goals</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate understanding of merger costs</li> <li>• Lack of corporate funder support</li> </ul>	<ul style="list-style-type: none"> <li>• Ill-defined roles for advisory and board members</li> <li>• Weak marketing effort leading to fears of loss of control/services and change in mission</li> <li>• Incomplete integration between two offices</li> </ul>

The two predecessor organizations in the SCSDC merger, SCSC and SCBA, had clashing cultures, distinct programs, and different constituents but were forced to merge. Consequently, the merger participants did not trust one another, were incompatible, did not respect their cultural differences, and did not devote the time and energy required to comprehensively plan merger goals or a shared vision for the merged organization.

In the MHA merger, there was an incomplete understanding of the costs and benefits that would accrue from the merger. This may have been prevented if MHA had been able to accurately foresee the time and costs involved in merging with NHS through a more comprehensive planning process. In addition, MHA's lack of corporate funder support has resulted in less financial capacity post-merger than the other two case studies. The merger gave overlapping funders the excuse to reduce their funding dollars to the merged organization. As a result, MHA was not able to capitalize on its geographic expansion by increasing its programmatic, political or financial capacity.

The NHS OC merger suffered from ambiguous leadership, insufficient communication to stakeholders, and a breakdown in comprehensive integration planning. The initial power struggle between the advisory board and board of directors hurt its organizational capacity in the short term. In addition, the financial efficiencies that may have been gained as a result of the merger were not realized since the organization has not fully integrated the offices, an issue that may have been foreseen through a more comprehensive planning effort. Finally, the reputation of the organization, an important element in pursuing non-profit mergers, may have been hurt initially due to the miscommunication that resulted in fears that the Santa Ana neighborhoods would lose their services.

## **Chapter 9: Conclusions**

This thesis closes with some conclusions regarding how a CDC's capacity is affected by a merger, in addition to some insights about the conditions under which CDC mergers occur. Based on the literature and the case studies, this chapter also includes some recommendations on how funders and other stakeholders can make CDC mergers more successful. Finally, the paper concludes with some predictions on how the field will be affected by CDC mergers as well as some suggestions for topics for further research.

### **Affect of CDC Mergers on Overall Capacity**

Overall, research in the field and the case studies in this thesis point to the conclusion that mergers do increase the capacity of CDC's, particularly in terms of programmatic capacity. Depending on the circumstances surrounding each CDC merger, described in more detail below, every CDC merger will experience capacity changes to varying degrees in every capacity category, as defined by Glickman and Servon (1997).

#### *SCSDC*

The merger between SCSC and SCBA was very successful in terms of increasing the organization's capacity to serve its clients and realize its mission. The merged organization combined the services of both organizations, appealed to a wider range of funders, and attracted an effective executive director, board, and staff, all contributing to a SCSDC that was much stronger financially, organizationally, and programmatically. Programmatically, the organization now offers both more and stronger programs to its residential and business constituents. Politically, the predecessor CDC's were weak and thus, the merger itself would not have been able to contribute to a more politically-savvy organization. It will probably require more years of relationship-building and interaction with policy-makers before SCSDC realizes stronger political capacity.

#### *MHASWCT*

Unfortunately, the absorption of NHS by MHA did not enable MHA to realize capacity increases in any areas other than programmatic. Financially, the merger resulted in a reduction of

corporate funders. Organizationally, the NHS only brought one new staff person to MHA. MHA has not been able to capitalize on its geographic expansion by becoming more politically involved. Programmatically, while the rehab lending program fell short of expectations, it allowed MHA to open the doors to significantly expand its homeownership programs. In addition, an equally if not more important programmatic capacity increase was the geographic expansion into Bridgeport, which conceivably should allow MHA to serve a broader base of constituents, appeal to a wider range of funders in the future, and enhance its visibility as a community developer in Connecticut.

### *NHS OC*

NHS OC's capacity has grown to various extents in each of the four capacity categories. Financially, it has benefited from its expansion in Orange County by appealing to a wider mix of funders. The organizational capacity has increased slightly, since the merger allowed a diversification of the NHS OC board. The areas where the organization benefited the most from the merger were its programmatic and political capacities. Programmatically, the merger allowed for an expansion of homeownership programs, and the service area increased substantially to become county-wide. This geographic expansion increased NHS OC's visibility amongst policy-makers and allowed the organization to build new relationships in the political arena.

## **Affect of CDC Mergers on Programmatic Capacity**

It is impossible to make generalizations based on three case studies, especially since the circumstances and lessons from each merger cannot necessarily be applied across the board to all CDC mergers. However, there is an interesting lesson here that warrants further scrutiny and that could be used to evaluate other CDC mergers. According to Yankey, Jacobus, and Koney (2001), "An executive director may believe that a merger makes sense because it enables the organization to do more, to do it better, or to do it more efficiently." In the case of the CDC case studies in this research, the mergers seemed most likely to allow a CDC to do more. Each of the three case studies experienced moderate or substantial growth in programmatic capacity, whether due to a geographic expansion, a joining together of complementary programs and services, or

both. Thus, this research concludes that in a CDC merger, programs and services seems to be the most likely category in which CDC capacity will grow. This experience is echoed by Kohm et al's research (2000), which found that the number one benefit from non-profit restructurings was an increase in programmatic and service capacity.

Growth in financial capacity is not guaranteed. As mentioned in the MHASWCT merger, combining two organizations does not necessarily translate into an aggregation of funding or the number of funders but may actually result in a cut in funding, what Davis calls the "merger penalty" (Davis, 2002). In addition, if the integration of the predecessor organizations is not comprehensively planned and implemented, the cost efficiencies that were an initial goal of the merger may not be realized, resulting in duplication of staff, administration, offices, and other overhead expenses, which occurred in the NHS OC merger.

Organizationally, CDC mergers do not often involve two robust, fully-staffed organizations combining forces. Rather, a more likely scenario is that a stronger organization is absorbing a weaker organization or two struggling, understaffed organizations are consolidating (this is described in more detail in the "Additional CDC Merger Insights" section below). Thus, from the point of view of the stronger organization, a merger will probably not result in a significantly larger or more robust staff. The most positive organizational outcome is probably one in which the board is refreshed or diversified by new board members from the weaker merger participant.

Political strength has not been a priority or a major asset of any of the merger participants. Especially when a CDC is already weak, it may not have any political assets to bring to the merger table. Mergers that result in service area expansion will probably be most likely to benefit from increased visibility and access to policy-makers. However, this is not always the case, particularly if the stronger CDC is not already actively engaged in the political arena and does not prioritize political activity post-merger, as was observed in the MHA merger.

Thus, there is no guarantee that financial, organizational, and/or political capacity will grow as a result of a merger. The segment of capacity that will probably be most positively affected by a merger is programmatic. When two organizations consolidate, it is not likely that they will cut

all of the programs and services of either organization but will instead combine and perhaps expand them in order to provide more services to their constituents, as was the case with the three case studies. This consolidation may also include a geographic expansion, often a goal of CDC mergers. Thus, at the very least, every CDC merger will likely result in an expansion of programs and services, if not a larger service area as well.

After reviewing the results from the cases, it becomes clear that executive directors, boards, and funders should be asking themselves whether mergers are indeed the best vehicle to achieve their goal of increasing capacity. Could the stronger CDC's in the case studies have reached the higher levels of capacity without a merger?

In the case of MHA and NHS OC, both organizations could probably have increased its programmatic capacity by adding the new programs and services, such as rehab lending and financial literacy, without the merger. Alternatively, MHA and La Habra could have pursued a strategic alliance with another CDC to jointly provide those services to its constituents. However, the merger did allow a geographic expansion that resulted in increased stakeholder support and an expanded client base, which would not have been easy to accomplish without merging with an organization that had an existing presence in the new area. This expansion allowed NHS OC specifically to realize a gain in financial, organizational, and political capacity as well.

In the SCSDC merger, SCSC would not be the organization it is today without the merger. SCSC would probably have lost funding and ceased to exist as an organization. However, the key to SCSC's turnaround and subsequent capacity increases was not the merger itself but the executive leadership that resulted from the merger. The merger merely served as the catalyst that allowed the organization to seek new leadership.

To a certain extent, these cases serve as a cautionary tale to stronger CDC's that are considering a merger with a weaker organization. CDC's that are expecting to see gains in financial, organizational, or political capacity as a result of a merger may be disappointed with the actual outcome, particularly in light of the time and cost involved in merging. After carefully

reviewing the programmatic benefits that may be achieved from merging, a CDC may find that it can just as easily provide programs and services by pursuing a less drastic form of CDC partnership, such as collaboration, strategic alliance, or joint venture. However, if geographic expansion is the CDC's goal, then a merger with a CDC with a complementary service area may be the best option available.

## **Additional CDC Mergers Insights**

Based on the literature and the case studies, there are two additional topics with regards to CDC mergers that should be highlighted: the viability of the organizations involved in CDC mergers and how funders influence CDC mergers.

According to Kohm et al's survey (2000), "it seems that respondents are more often entering into strategic restructuring to improve the quality or range of what they do and the efficiency with which they do it than because of any immediate threats of closure or pressure from funders." However, CDC mergers do not seem to occur very often between two healthy organizations that are seeking merger partners for strategic reasons. Instead, there is often one strong CDC incorporating the assets, programs, and staff of one weak CDC or two struggling organizations that combine to create a new organization. When reviewing Rohe et al's (2003) case studies, Davis' case study (2002), and the case studies in this research, it became evidence that three out of the six case studies, SVD in Cleveland, MHASWCT, and NHS OC, involved a failing CDC on the brink of closure being absorbed by a larger, stronger organization. NRC supports this conclusion by stating that "more often than not...non-profit 'mergers' are executed as dissolutions, with one non-profit succeeding the dissolving one" (NRC, 2004). The other three, SCSDC, NHSGN in Nashua, and Albina CDC in Portland, involved equally struggling organizations.

In addition, pressure from funders is a much more important motivator in CDC mergers than in non-profit mergers as a whole. In reviewing the case studies provided in this research, as well as those described by Rohe et al (2003) and Davis (2002), city and intermediary funders either pressured or played a large role in the mergers in all of the case studies except for NHS OC. Davis (2002) echoes this sentiment by saying "collaboration is being proposed with increasing

frequency by funders, policy makers, and practitioners across the country as a preferred strategy for addressing weaknesses arising within the nonprofit housing sector.”

## **Recommendations for Successful CDC Mergers**

There are a number of actions that can be taken by CDC’s to make their mergers more successful. Since these internal success factors were described in detail in Chapter 4, this section will focus on how the outside community, particularly funders and other stakeholders, can better support CDC’s in their efforts to realize significant capacity growth via mergers.

### *CDC Funders*

- Provide merger information to CDC’s

Local intermediary offices should be well-prepared to inform a CDC considering a merger about how to plan and implement a merger. While mergers are not ‘one size fits all’, a “merger manual” that includes merger process steps, sample merger budgets, integration plans, case studies, best practices, lessons learned, and resources would be an invaluable resource for CDC’s that are in the process of exploring a merger. This manual should be available on intermediary websites as well as in hard copy. Training sessions and workshops would also be a beneficial resource for CDC executives.

- Provide sufficient financial support and technical assistance

Most of the CDC merger experiences highlight the extensive financial support and technical assistance, in the form of consultants and advisors, that CDC funders and intermediaries provide to CDC’s in a merger process. This type of support was identified as being essential to the success of CDC mergers. However, funders also need to be realistic about merger costs. If the merged organization has increased its programming and staff, the funders need to be prepared to increase their financial support. In addition, providing consultants or mediators for six months after the merger is complete, in order to help the organizations integrate fully and address post-merger conflicts, would be a welcome form of additional support for CDC’s.

- Take a supportive, not directive, role in a CDC merger

According to one interviewee, funders should take a stronger supportive role in merger processes from the very beginning. In addition, funders and other stakeholders should not assume that mergers are indicative of failure or bad decision-making. Instead, they should encourage CDC's to consider mergers as they would any other strategic business decision and understand that the decision not to merge is acceptable. At the same time, funders must "find a balance between allowing CDC's autonomy to fulfill their mission as they see fit and imposing conditions for support" (Rohe et al, 2003). Funders should provide support and advice, but leave the direction of the merger process to the boards and executive leadership of the merging organizations.

- Be realistic about outcomes and timeframes

Funders should recognize the significant amount of time required to realize a successful merger. Without giving the merged organizations ample time to adjust to their new situation and begin to see capacity improvements, funders may be disappointed by the CDC's seeming lack of progress in realizing its post-merger potential. Instead, "Foundations and non-profit executives who believe in the value of capacity building... would do well to be conservative in estimating the timeframes involved" (Wing, 2004).

### *CDC Stakeholders*

- Create new structures to support CDC mergers

Other than technical and financial support from intermediaries and a few funders, there is no extensive support network for CDC's engaged in mergers. An interesting example of support that could be emulated in other states or regions across the U.S. is the Maryland Association of Nonprofit Organizations' Management Innovation Program. Created in 1998, the program is designed to fund strategic restructuring efforts of small to medium non-profits in Maryland. The fund is supported by corporate and foundation funders and provides technical assistance grants for \$10,000 to \$100,000.

- Track the prevalence and importance of CDC mergers in the field

There should be better tracking of CDC mergers in order to inform CDC practitioners, funders, researchers, CDC's, and the non-profit industry as a whole. The process of identifying CDC

mergers was very challenging, mainly due to the fact that there was no national clearinghouse or main source of information regarding the number of CDC mergers that have occurred, their locations, the CDC's involved in the mergers, best practices, and lessons learned. A national CDC organization such as NCCED should consider incorporating a bi-annual survey of CDC mergers into their research efforts.

- CDC's should be informed and involved in influencing city policies

Cities that are considering major policy shifts with regards to affordable housing and neighborhood revitalization should consider including the city's CDC leadership in the discussion, perhaps through a community development advisory committee. While the city may choose not to incorporate the CDC's opinions into its decision-making, it is important for CDC's to be politically active and inform city leaders about how policy changes may affect their capacity to serve their neighborhoods (Rohe et al, 2003).

### **Affect of CDC Mergers on the Field**

Most of the impacts described in this paper are internal to the merger participants, stakeholders, and their community, and do not address the affects of non-profit mergers on the sector as a whole. In Kohm and La Piana's (2003) interviews with non-profit leaders, many of them believed that strategic restructurings would lead to more efficient non-profits or the delivery of more and/or improved services. The interviewees did express concern that fewer non-profits may result in more underserved communities. They also wondered how the sector would be affected if there were fewer smaller non-profits and more larger non-profits as a result of strategic restructurings. They were worried that this environment would make it more difficult for new non-profits to establish themselves and expressed fear that larger non-profits are less responsive to community needs. Some interviewees also felt the increasing focus on cost savings, outcomes, and efficiency may result in non-profits and CDC's that are losing sight of their mission, values, and constituents.

While the findings in this paper cannot shed light on all of the views expressed by the interviewers, the cases do contribute some evidence both in support of and contrary to their

predictions. The cases certainly point to mergers resulting in CDC's that deliver more and expanded services. It is unclear whether those programs are improved or whether those organizations are more "efficient" at providing those programs. In addition, it will take more time to determine whether the mergers in these communities are creating a challenging environment for CDC start-ups. The cases did not confirm that the larger, merged organizations were less responsive to their communities. Instead, the mergers created CDC's that were bringing much-needed programs to underserved neighborhoods. According to the interviewees, these CDC's had not lost touch with their constituents. Comments such as, "Residents were pleased with the merger. The [NHS's] lack of capacity left them out – now there was a place for them to go" gave the impression that the larger organizations were just as committed to improving the economic and social well-being of their neighborhoods as they were pre-merger.

## **Areas for Further Research**

There are a number of areas in which additional research could contribute to this topic. The creation of a more rigorous method of quantifying CDC capacity would be beneficial in order to better understand how mergers affect CDC capacity. A tool that helps CDC's create a short and long term cost-benefit analysis of a merger would also be helpful to identify when a merger may not achieve enough capacity gains to outweigh the merger costs. It would also be useful to gain a better understanding of how increased CDC capacity from mergers translates into greater social impact in their communities.

In addition, an in-depth survey of several CDC mergers, including more case studies, is needed in order to identify the impacts of CDC mergers, identify the conditions under which those impacts are most likely to occur, and provide best practices for CDC mergers. Other questions that may be answered with this survey include:

- Under what circumstances and in what environment is a merger a good strategic choice for a CDC?
- Are CDC's with a development focus any more likely to merge than CDC's with a community organizing focus? If so, why and how do those mergers differ?
- What is the profile of a CDC that would be a good candidate for a merger, including staff size, budget, programming, service area, and funder support?

- To what extent do CDC's engage in types of strategic restructuring other than merging, such as joint programming or administrative consolidation? Would engagement in these activities make them more likely to merge or more successful merger participants?
- How do differences in the merger process affect the outcome, i.e. a merged CDC's capacity?
- How would the local context affect a merged CDC's capacity?
- How would a CDC with an intermediary such as LISC or Enterprise Foundation approach a merger versus a CDC in the NRC network?
- How would geography affect a CDC merger? For example, how would a merger in a county system differ from a merger that takes place in a neighborhood or city system?

CDC's have a vital role to play in creating economically and socially healthy urban communities. Understanding how and to what extent an organization's capacity will change as a result of a merger will enable CDC's to act strategically to ensure their survival in the increasingly challenging climate for non-profits. Hopefully, this research has provided CDC practitioners and funders with some insights into how mergers affect CDC capacity and how to best support CDC mergers in the future.

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Neighborhood Reinvestment Corporation

[www.nw.org](http://www.nw.org)

LISC

[www.lisc.org](http://www.lisc.org)

Enterprise Foundation

[www.ef.org](http://www.ef.org)

National Congress for Community Economic Development

[www.ncced.org](http://www.ncced.org)

## Appendix

## CDC Merger Impact Survey

### **A. Organizational Description**

4. What were the names of the two original organizations that chose to merge?

Organization 1: \_\_\_\_\_

Organization 2: \_\_\_\_\_

5. Name of organization (post-merger): \_\_\_\_\_

6. Current contact information:

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Website: \_\_\_\_\_

7. Name of Executive Director: \_\_\_\_\_

8. Is this a membership organization? Yes                      No

9. What is the new organization's mission?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. What month & year did the organization officially complete its merger? \_\_\_\_\_

11. How many years and/or months was the merger process (from the first merger discussion to official completion of the merger)? \_\_\_\_\_

12. What factors led your organization to merge with another organization? Please rank the three most important reasons/factors that led to the merger with a 1, 2, and 3:

- Pressure from funders
- Lack of staff or board capacity
- Internal management problems
- Fiscal difficulties
- Fundraising challenges
- Changes in regulatory environment
- Need to broaden organizational mission/scope
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

13. What goals did your organization identify for the merger?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **B. Capacity Changes**

Please provide the following information for your organization pre-merger and post-merger. Pre-merger information should be obtained for the last full fiscal year prior to the merger – please fill in the

“FY\_\_\_\_\_” with the appropriate year in the table below. Post-merger information should be obtained for fiscal year 2003.

**Financial Capacity**

	Pre-merger (FY_____)	Post-merger (FY2003)
14. Total annual budget	\$_____	\$_____
15. Total administrative budget (including staff salaries, overhead, and fundraising activities)	\$_____	\$_____
16. Number of foundation funders		
17. Number of corporate funders		
18. Number of government funders		
19. Number of individual donors		
<b>Percent of budget raised from the following sources:</b>		
20. Total Foundation support	_____ %	_____ %
• National or community foundations	_____ %	_____ %
• Corporate foundations	_____ %	_____ %
21. Total Government support	_____ %	_____ %
• Local Government	_____ %	_____ %
• State Government	_____ %	_____ %
• Federal Government	_____ %	_____ %
22. Intermediaries (e.g. LISC, NeighborWorks, or Enterprise Foundation)	_____ %	_____ %
23. Individual donors	_____ %	_____ %
24. Earned income, including real estate developer fees	_____ %	_____ %
25. Membership dues (if applicable)	_____ %	_____ %
26. Investment income	_____ %	_____ %
27. Other income (please specify)	_____ %	_____ %

**Organizational Capacity**

	Pre-merger (FY_____)	Post-merger (FY2003)
28. Number of full-time paid staff		
29. Number of part-time paid staff		
30. Number of board members		
31. Number of volunteers/unpaid interns		
32. Total number of fundraising staff (in FTE's)		

33. Board composition:		
# of residents of the community		
# of non-residents of the community		
# of government officials		
# of business owners, lawyers, accountants, bankers, engineers, or other "professionals"		
# of religious leaders		
Other (please specify)		
_____		
Other (please specify)		
_____		

**Programmatic Capacity**

	Pre-merger (FY _____)	Post-merger (FY2003)
34. List of programs & services provided to constituents/clients		
35. Target markets served (including service area and demographics)		
36. Other indicators of impact relevant to your organization's mission (e.g. number of housing units developed, number of housing units under management, number of small businesses assisted, number of home or business loans closed, number of ESL classes offered, etc.):		
Impact 1: _____		

_____		
Impact 2: _____		
Impact 3: _____		
Impact 4: _____		
Impact 5: _____		

**Political Capacity**

	Pre-merger (FY _____ )	Post-merger (FY2003)
37. Number of political events or initiatives planned/hosted by the organization (e.g. policy panels, meet your legislator event, etc.)		
38. Number of high-level appointed or elected speakers from a public office or agency that have spoken at your CDC events		
39. Number & type of services/programs conducted by the CDC with local, state, or federal government (e.g. CDC services contracted by the government)		
40. Does the organization belong to a political advocacy coalition? (Yes or No). If "Yes", please provide the name of the coalition.		
41. Does the organization publish articles on public policies affecting its constituents (e.g. in a newsletter or on a website)? (Yes or No)		
42. Describe other ways the organization engages with or receives support from policy-makers or public		

officials		
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43. In the last 5 years, how have local demographic and economic trends impacted CDC's and their activities in this city?

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44. In the last 5 years, how have political events impacted CDC's in the city?

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45. What kinds of support do CDC's receive at the municipal level?

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46. Please briefly describe the merger process.

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47. How has the merger affected your organization's capacity to serve its constituents/clients? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
-------------------	-----------------------	-----------	-----------------------	----------------------------

48. Why do you feel this way?

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49. How has the merger affected your organization's capacity to collaborate with or participate in activities with other organizations? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
-------------------	-----------------------	-----------	-----------------------	----------------------------

50. Why do you feel this way?

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51. How has the merger affected your organization's capacity to raise funds? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
-------------------	-----------------------	-----------	-----------------------	----------------------------

52. Why do you feel this way?

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53. Please describe any adverse impacts from the merger.

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54. Please describe any positive impacts from the merger.

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55. Are there any other impacts from this merger that you would like to share?

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56. What were the most important factors that contributed to the merger's positive impacts?

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57. What were the most important factors that contributed to the merger's negative impacts?

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58. How did other institutions react to the merger (e.g. City Hall, funders, state/federal agencies)?

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59. Overall, what were the CDC's constituents' responses to the merger initially?

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60. How do the constituents view the merger today?

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61. What should funders or other agencies do to support mergers more effectively?

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62. Does your organization feel that it achieved its goals for merging? Why or why not?

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63. What could the organization have done differently to better achieve its merger goals?

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**\*\*\*\*\*Thank you for your time!\*\*\*\*\***

## Board Interviews

Interviewee:

Date:

### Merger Overview

1. How, if it all, were you involved in the merger between X and Y CDC?
2. What internal and external factors do you think led the CDC to merge with another CDC? (e.g. pressure from funders, lack of staff or board capacity, management problems, fundraising difficulties, nature of the housing market, changes in regulatory environment, etc.)
3. How did the merger affect the board (including the makeup and its focus)?
4. How did the merger affect the organization's mission?

### Merger Impacts

5. How has the merger affected the organization's capacity to serve its constituents/clients? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
----------------------	--------------------------	-----------	--------------------------	-------------------------------

6. Why do you feel this way?

7. How has the merger affected the organization's capacity to collaborate with or participate in activities with other organizations? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
----------------------	--------------------------	-----------	--------------------------	-------------------------------

8. Why do you feel this way?

9. How has the merger affected the organization's capacity to raise funds? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
----------------------	--------------------------	-----------	--------------------------	-------------------------------

10. Why do you feel this way?

11. How did other institutions react to the merger (e.g. City Hall, other funders, state/federal agencies)?

12. Overall, what were the CDC's constituents' responses to the merger initially?
13. How do the constituents view the merger today?
14. Please describe any adverse impacts from the merger.
15. Please describe any positive impacts from the merger.
16. Are there any other impacts from this merger that you would like to share?
17. What were the most important factors that contributed to the merger's positive impacts?
18. What were the most important factors that contributed to the merger's negative impacts?
19. What should funders or other agencies do to support mergers more effectively?
20. Do you think the CDC achieved its goals for merging? Why or why not?
21. What could the organization have done differently to better achieve its merger goals?

## Funder Interviews

Interviewee:  
Title:  
Funder Name:  
Date:

### General Background

1. In the last 5 years, how have local demographic and economic trends impacted CDC's in this city?
2. In the last 5 years, how have political events impacted CDC's in this city?
3. What kinds of support do CDC's receive from your organization?
4. How long has your organization been funding XYZ CDC?
5. Did your organization fund both X and Y CDC before the merger?
6. How, if at all, were you or your organization involved in the merger between X and Y CDC?
7. What factors do you think led the CDC to merge with another CDC? (e.g. pressure from funders, lack of staff or board capacity, management problems, fundraising difficulties, nature of the housing market, changes in regulatory environment, etc.)?

### Merger Impacts

8. How has the merger affected the organization's capacity to serve its constituents/clients?  
(please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
-------------------	-----------------------	-----------	-----------------------	----------------------------

9. Why do you feel this way?

10. How has the merger affected the organization's capacity to collaborate with or participate in activities with other organizations? (please circle one answer)

Much less capable	Somewhat less capable	No affect	Somewhat more capable	Significantly more capable
-------------------	-----------------------	-----------	-----------------------	----------------------------

11. Why do you feel this way?

12. How has the merger affected the organization's capacity to raise funds? (please circle one answer)

Much less capable

Somewhat less  
capable

No affect

Somewhat more  
capable

Significantly more  
capable

13. Why do you feel this way?

14. How did other institutions react to the merger (e.g. City Hall, other funders, state/federal agencies)?

15. Please describe any adverse impacts from the merger.

16. Please describe any positive impacts from the merger.

17. What were the most important factors that contributed to the merger's positive impacts?

18. What were the most important factors that contributed to the merger's negative impacts?

19. What should funders or other agencies do to support mergers more effectively?

20. Do you think the CDC achieved its goals for merging? Why or why not?

21. What could the organization have done differently to better achieve its merger goals?