

Continuity & Change



2001 Annual Report

Twenty years ago, a small group of grantmakers gathered informally to share their knowledge and concerns about health in America and to explore how philanthropy could exert the greatest impact upon growing needs. Out of their dedication and efforts, Grantmakers In Health (GIH) was formed, and a tradition of working together to improve the nation's health began.

On GIH's 20th anniversary, what is most striking is how much has changed—and how much remains the same. Access to health care and racial and ethnic disparities are deeply rooted problems we have yet to resolve. The question of how to accommodate the largest generation of aging Americans is still unanswered. From a few isolated cases in 1981, HIV/AIDS has turned into a global health crisis, affecting 40 million worldwide and defying our best efforts to find a cure. And while some major causes of death and disability have diminished—most notably, smoking among adults and lack of seat belt use—asthma and other conditions considered manageable in 1982 have reached epidemic proportions today. Against this backdrop, the events of 2001 place even new pressures upon the public health system and the nation's capacity to respond to urgent health needs.

Since our founding, GIH has both changed in step with the field and stayed the course when warranted. From an original core of 12 funders, we have evolved into a professionally staffed organization supported by nearly 200 foundations and corporate giving programs. With resident expertise in both health and philanthropy, GIH's products, programs, and services have matured in content and sophistication. As the number and variety of health foundations have grown, so have we, adding more programs and personnel to the mix to encompass the priorities and interests of all health grantmakers—large or small, new or established.

The one constant in this equation is GIH's commitment to health funders. We are the only organization devoted expressly to helping grantmakers interpret the changing landscape of health and philanthropy and apply that knowledge to improve the health of the nation. We were created by health grantmakers, for health grantmakers, and twenty years later, that unique partnership continues to thrive.

Message from the Chair



When last year's annual report was written, the country was nearing the end of one of its strongest periods of economic growth in our history. During the bull market of the 1990s, many foundation portfolios grew dramatically, and more than 100 new health foundations were created with assets of approximately \$13 billion. Unemployment was down, the welfare roster had declined to the lowest level in decades, and large surpluses in federal and state governments allowed for expansion of health and human services.

Economists now tell us that, by March 2001, we had slipped into economic recession. Nowhere was that more apparent than the San Francisco Bay Area where the dot.com revolution that had fueled California's economic expansion melted down almost overnight. In Santa Clara County alone, unemployment rose from 1.6 percent to 6.5 percent over a 12-month period. The horrific events of September 11 exacerbated the already deteriorating economic situation. The tourism industry was especially hard hit, and as major airlines cut services and hotel occupancy rates dropped, hundreds of thousands of employees were laid off.

Today, state and federal governments are facing huge deficits. California projects a \$17 billion dollar deficit for the next fiscal year and has already cut more than \$2 billion from the current budget. The Legislative Analyst Office forecasts additional annual deficits of \$7 billion through 2006 unless spending and/or revenue policies are changed. Since 2002 is an election year, it is highly unlikely that taxes will be raised so the deficit will be made up by reducing spending. As always, these cuts will hit hardest on the most vulnerable of our society.

The preliminary effect of these deficits on health care is already being felt. In Los Angeles County, the Board of Supervisors recently voted to close five health clinics as

the first step in a series of reductions designed to address a projected \$700 million deficit. This scenario is being repeated in cities and counties across the state.

At the same time, the nonprofit sector that provides the safety net for the underserved is reporting significant fundraising shortfalls, due to the recession, the heavy economic costs of the terrorist attacks, severe reductions in public funding, and declines in individual and corporate giving. The end result is that in a time when more people are in need, less and less resources are available.

In view of the current situation, those of us in health philanthropy need to consider how we can be of assistance. The volatile markets of 2000 and 2001 have had negative effects on the investment portfolios of many foundations, including ours. Among my colleagues, there have been discussions of large reductions in grant-making budgets, staffing cuts, and so on. Given our losses, this is prudent fiscal management but given the times, is it what we should do?

At a minimum, I believe we should keep our 2002 grantmaking at the same level as that of 2001. We can't begin to make up for the loss in government funding or individual giving, but—at least for one year—we do not have to add to the problem. We can help nonprofits weather the storm and, more importantly, help keep programs and services in place for the most needy in our society.

When foundation portfolios grew in the 1990s, there were calls for foundations to increase the payout beyond the required minimum of 5 percent. The argument was that when times are good, foundations should give more, but this concept is flawed: As foundation assets grow, foundations *do* give more.

On the contrary, the time for foundations to give more is when times are bad. A recent survey of individuals working in California

Message from the Chair



foundations found that the number one reason they belong to this field is to make a difference. The current situation has created an opportunity for us to do just that—and we have a precedent. The oil shock of 1973 caused a steep decline in the stock market resulting in a loss of nearly 50 percent in The Ford Foundation's investment portfolio. The fiscally prudent action would have been to cut back dramatically on grantmaking, but Ford decided to maintain its commitments for that year.

With the changes over the past year, it's clear that one of the results will be reduced access to health care for underserved populations. Different times call for different actions, and I believe what Ford did in the 1970s was in line with the times and with the heart. Maintaining our grantmaking budgets in 2002 is in keeping with the best values and traditions of philanthropy, and it sends a powerful message that health foundations recognize that this is a time to be of service and give more not less.

There are several other things we can consider that will help support health and human service organizations during these difficult times: (1) forgo our search for the most innovative projects and instead provide funding to maintain current service levels and support core functions with a focus on safety net providers and advocacy organizations; (2) streamline reporting requirements by reducing the length and frequency of progress reports; and (3) provide one-time payments on multiple year grants at the beginning of the award. These simple steps can make a world of difference to nonprofit organizations and allow them to focus more fully on serving those hardest hit by these economic changes.

Gary L. Yates
President and Chief Executive Officer
The California Wellness Foundation



Message from the President & CEO



Since Grantmakers In Health's founding, we have witnessed both positive changes and disappointing continuity in conditions that affect people's health. The details and magnitude of today's issues may be different, but the underlying themes are often familiar. At the same time, health philanthropy has changed considerably, with many more organizations and increased assets available to chip away at threats and barriers to good health. Such challenges and the unique roles foundations can play have, in turn, attracted growing numbers to the field.

The year 2001 was marked by an unsettling reversal in national priorities and financial health. Foundations are clearly affected, both by the growing need for their support and in their resources to respond. These new pressures are likely to add to the increased public scrutiny organized philanthropy has witnessed in recent years, moving grantmakers to think as much about the elements of effective grantmaking as they do about the issues that they address.

What are those elements? Chief among them are approaching grantees with respect and humility; weighing the pros and cons of operating support versus program grants; thinking up front about sustainability; communicating openly about the foundation's mission, expectations, and lessons learned; maintaining a healthy dose of self-criticism and not being afraid to change; and finally, having a theory of change and relevant methods for assessing a foundation's work.

This last element has become a growing preoccupation in philanthropy. The debate clearly continues on how best

to measure progress and outcomes in order to avoid concentrating on what can be measured rather than what is truly important.

Doing a better job on evaluation is responsible and strategic, but let's be honest about what to expect from our efforts to evaluate and measure. Otherwise, foundations may create unrealistic expectations among their grantees, the public, and their own organizations, and dull the incentive to be imaginative and take risks. Perhaps the first step should be to set realistic standards for the expected return on investment in addressing what are often complex, messy, high-risk problems.

Foundations are in a position to help shape the future by their decisions and actions. How flexible and prescient they are in anticipating issues and needs, how willing they are to be agents of change, and how daring they will be in practicing according to their core values—particularly in difficult times—will ultimately determine their impact and effectiveness.

We owe thanks to the founders of GIH and our Funding Partners over the years for creating and sustaining a forum for grantmakers to raise and debate fundamental issues like these, learn from one another, and stay current on health issues and philanthropic practices. Over time, GIH has purposefully changed to better anticipate and meet the needs of health grantmakers. That change, however, is grounded in the core values of service, knowledge, and partnership which provide continuity in the way we approach our work. As foundations are being challenged to critically assess and improve their performance, GIH is committed to both keeping the tough issues on the agenda and helping health grantmakers do their best to address them squarely and effectively.

Lauren LeRoy, Ph.D.



Continuity & Change

As was true 20 years ago, changes in the health environment continue to alter the parameters of health grantmaking, and novice and veteran practitioners alike struggle to stay current. Yet the sheer volume of new information on both emerging and persistent health concerns makes this a formidable task.

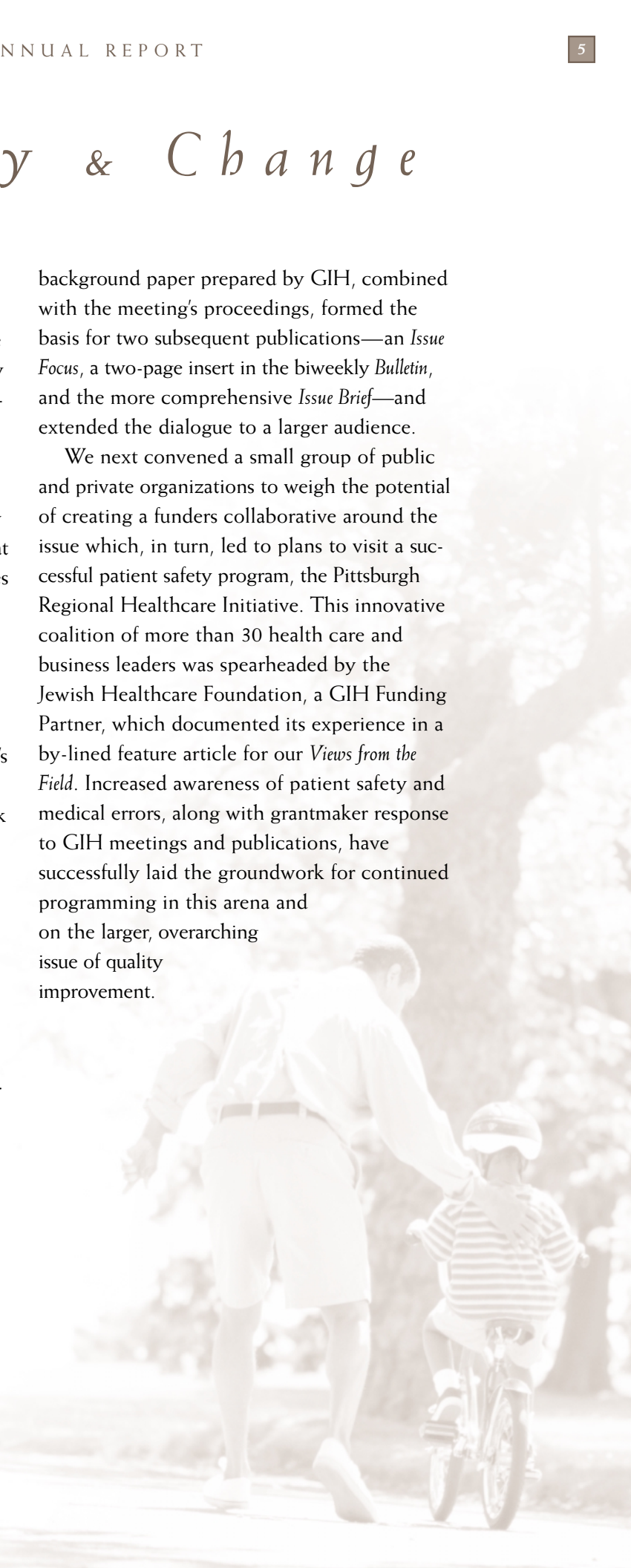
In our role as an educational organization, Grantmakers In Health keeps watch over new developments and helps funders pin down what they need to know for their own circumstances and communities. Designed by professionals with hands-on expertise in public health, provider settings, health policy, and philanthropy, our products and services introduce grantmakers to fresh knowledge and ideas, stimulating philanthropic involvement in today's major health issues.

A prime example is last year's body of work on medical errors and patient safety. The Institute of Medicine's landmark report, *To Err Is Human: Building a Safer Health System*, galvanized the nation with its estimate that up to 98,000 Americans die unnecessarily in hospitals each year, calling for action from all sectors. At its publication, only a handful of grantmakers were working in the area, yet their approaches were creative and productive. To promote wider foundation awareness and activity and enable others to learn from those already involved, GIH launched a yearlong examination of the issue.

Work began in earnest with a full-day meeting, *Advancing Quality Through Patient Safety*, immediately preceding GIH's 2001 annual conference. Held on February 28, this Issue Dialogue featured leading experts in medical errors and patient safety, illustrating how and where grantmakers could help. A

background paper prepared by GIH, combined with the meeting's proceedings, formed the basis for two subsequent publications—an *Issue Focus*, a two-page insert in the biweekly *Bulletin*, and the more comprehensive *Issue Brief*—and extended the dialogue to a larger audience.

We next convened a small group of public and private organizations to weigh the potential of creating a funders collaborative around the issue which, in turn, led to plans to visit a successful patient safety program, the Pittsburgh Regional Healthcare Initiative. This innovative coalition of more than 30 health care and business leaders was spearheaded by the Jewish Healthcare Foundation, a GIH Funding Partner, which documented its experience in a by-lined feature article for our *Views from the Field*. Increased awareness of patient safety and medical errors, along with grantmaker response to GIH meetings and publications, have successfully laid the groundwork for continued programming in this arena and on the larger, overarching issue of quality improvement.



As another insidious yet controllable health problem—obesity—reached an all-time high, GIH mobilized early on to raise grantmaker interest and engagement. At the end of February, annual meeting participants heard then-U.S. Surgeon General David Satcher call the condition “one of the top 10 preventable threats to health in the nation.” GIH’s Issue Dialogue on the topic, *Weighing in on Obesity: America’s Growing Health Epidemic*, looked at current activities and potential roles for foundation intervention, and included a preview by Dr. Satcher of *The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity*, released in late 2001. Discussions among meeting participants on the health problems created or exacerbated by the condition—along with their ramifications for the future—contributed to two subsequent GIH publications, carrying our work on the topic forward into 2002.

Through these and related activities, GIH explores contemporary health issues and then places them within a philanthropic context. Our one overriding objective is to help grantmakers balance

mounting demands for their time and attention with the need to stay on top of new information and changing health priorities.

STAYING FOCUSED

Despite decades of effort by both the private and public sectors, some of the most serious concerns that gave rise to GIH plague the nation to this day. The special health care requirements of children and the elderly . . . the problem of the uninsured and underinsured . . . and disparities in both physical health and access to quality health care among America’s increasingly diverse racial and ethnic minorities continue to take their toll on individuals and communities. Our changing demographics assure that these issues will only grow in importance, with even larger consequences for the future. Foundations can, and want to, help; yet what impact can philanthropy have upon such intractable problems?

Profound questions demand strategic, sustained approaches, and Grantmakers In Health works to help funders and others further their search for responses that yield results. Through our programs and publications, we keep the needs of vulnerable groups in front of those committed to resolving them, bringing together people, organizations, and ideas around common concerns.



2001 MEETINGS

Advancing Quality Through Patient Safety

FEBRUARY 28, 2001. SAN DIEGO, CALIFORNIA

How to Know When, Why, and If It Makes Sense to Launch a Strategic Initiative

FEBRUARY 28, 2001. SAN DIEGO, CALIFORNIA

Collaborating for Change: Exploring Health Partnerships that Work

Annual Meeting on Health Philanthropy
MARCH 1-2, 2001. SAN DIEGO, CALIFORNIA

Environmental Determinants: What Every Health Funder Should Know

Preconference Session to the Council on Foundations Annual Conference
APRIL 29, 2001. PHILADELPHIA, PENNSYLVANIA

Improving Foundation Performance: A Peer Assessment Model

Conference Session, Council on Foundations Annual Conference
MAY 1, 2001. PHILADELPHIA, PENNSYLVANIA

Chief among these is the disturbing issue of inadequate access to care in one of the world's wealthiest nations. In one form or another, GIH has placed some aspect of the problem under the microscope every year since 1982; last year, we devoted the Washington Briefing—one of GIH's two major annual conferences—entirely to the topic.

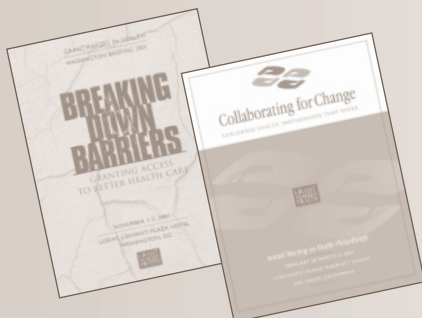
Breaking Down Barriers: Granting Access to Better Health Care examined such factors as cost, culture, communication, and system structure, and how to address each for the benefit of the underserved. To consider at length some of the most critical areas, four of the breakouts were half-day sessions: tackling enrollment in the State Children's Health Insurance Program, Medicaid, and other forms of health insurance for low-income children; the often overlooked issue of children's mental health; emerging concerns in immigrant health; and how communities can mobilize to improve access to care for uninsured residents.

As a companion to the Washington Briefing, GIH held an Issue Dialogue that, in part, considered the subject from another angle. *Training the Health Workforce of Tomorrow* looked at ways to improve health care access in underserved areas, increase the number of minority practitioners, raise provider competency in caring for the elderly, and address a perennial problem, the nursing shortage. Later in the



year, the meeting's topics were featured in a two-page article in the *Bulletin*, leading up to the 2002 publication of a full meeting report.

Lack of access is a key culprit in another condition that disproportionately affects minorities, low-income populations, children, and the elderly—poor oral health—and GIH's work in this area demonstrated the wealth of ways in which grantmakers could help. We trace our involvement to the previous year, when GIH participated in initial efforts to create a national agenda, contributing to a heightened understanding of the relationship between oral health and overall health. Building upon that earlier work, we brought together grantmakers, policymakers, and oral health experts in the spring of 2001 for an Issue Dialogue designed to explore approaches to help those most at risk. *Filling the Gap: Strategies for Improving Oral Health* aroused more



Filling the Gap: Strategies for Improving Oral Health
MAY 16, 2001. WASHINGTON, DC

**Weighing in on Obesity:
America's Growing Health Epidemic**
OCTOBER 31, 2001. WASHINGTON, DC.

Training the Health Workforce of Tomorrow
OCTOBER 31, 2001. WASHINGTON, DC

**Breaking Down Barriers:
Granting Access to Better Health Care**
Washington Briefing
NOVEMBER 1-2, 2001. WASHINGTON, DC

foundation interest in the topic and shaped the development of a subsequent *Issue Focus* and an *Issue Brief*.

By directing philanthropy's attention to the big issues in health—and the intertwining influence of economics, demographics, policy, and culture—GIH helps grantmakers turn overwhelming problems into opportunities to make a difference at the local, regional, and national levels.

RAISING STANDARDS

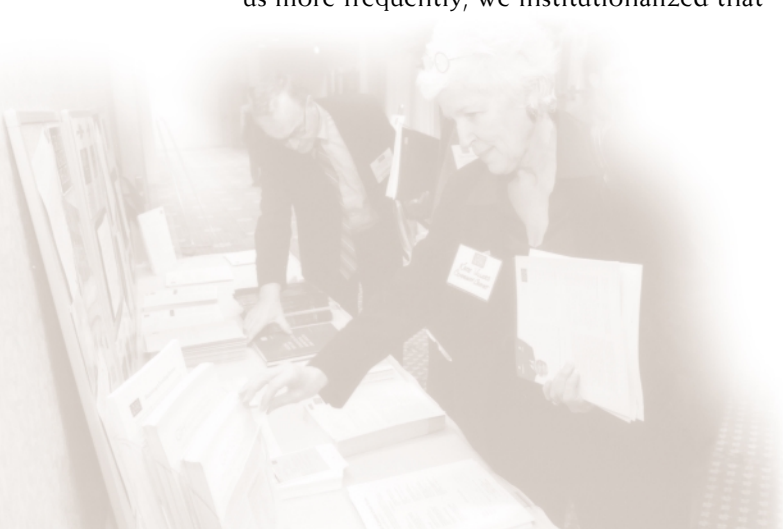
From its early days, GIH has helped grantmakers strengthen their effectiveness, efficiency, and accountability by allowing them to learn from the successes and failures of others. As both health and operational issues became more intricate, and as more grantmakers turned to us more frequently, we institutionalized that



process through the Support Center for Health Foundations and the Resource Center on Health Philanthropy.

Originally conceived to address the operational concerns of the spreading ranks of new health foundations, the Support Center today assists health grantmakers at any stage of development, including individuals new to the profession as well as those seeking to freshen existing skills. Our objective is to help health grantmakers become better and more strategic at what they do by providing technical assistance and instruction to staff and boards through workshops, meetings, and publications.

Support Center services are built around five major functions—grantmaking, governance, communication, finance and administration, and evaluation—and our 2001 programming touched upon each. As a prelude to the annual meeting, we held a daylong workshop, *How to Know When, Why, and If It Makes Sense to Launch a*



2001 PUBLICATIONS

REPORTS

Strategies for Reducing Racial and Ethnic Disparities in Health

JANUARY 2001

Long-Term Care Quality: Facing the Challenges of an Aging Population

MARCH 2001

A Profile of New Health Foundations

MARCH 2001

Progress and Peril: Examining Antibiotic Resistance and Systemic Contaminants

APRIL 2001

Early Childhood Development: Putting Knowledge into Action

AUGUST 2001

Advancing Quality Through Patient Safety

SEPTEMBER 2001

Filling the Gap: Strategies for Improving Oral Health

NOVEMBER 2001

Strategic Initiative, followed by sessions on foundation-focused evaluations, mission-related investments, funding collaboratives, and peer assessment. GIH's pilot work on the latter, combined with heightened foundation interest in accountability, earned a session at the Council on Foundation's 2001 annual meeting as well, reaching a broader universe of grantmakers.

New to the Support Center in 2001 was the introduction of a Frequently Asked Questions (FAQs) section to our Web site. Designed to respond to the rising volume of requests for technical assistance and to improve our productivity and timeliness in furnishing similar information sought by many, this section now features advice, resources, and referrals on the most common queries GIH receives, with more scheduled for the future. Some topics currently online include establishing board committees and effective governance; how others have involved the community in their mission development or conducted a site visit; and advice on staff compensation, job descriptions, and performance reviews. By making information available at the click of a mouse, anytime, from anywhere, the FAQs section can successfully streamline grantmakers' access to the information they need, enhancing GIH's ability to be of service to the field.

Similarly, the Resource Center on Health Philanthropy is a source for grantmakers seeking programming answers, direction, and lessons from the advice and experience of others. With the right combination of both staff and technology, the Resource Center can identify who is doing what, what works, and what doesn't, and convey that knowledge to our constituency.

A major objective for 2001 was expanding and refining the Resource Center's electronic database, which now features more than 7,000 grants and initiatives from 200 health funders and is updated regularly. Designed by GIH, the database is the only one focusing solely on health programming activities from the smallest, local foundations to the nation's most established,



ISSUE FOCUS

**Systemic Contaminants:
Making Sense of an Environmental Health Threat**
JANUARY 2001

Advancing Quality Through Improved Patient Safety
MARCH 2001

Clearing the Air: Addressing Asthma in America
APRIL 2001

Filling the Gap: Strategies for Improving Oral Health
JUNE 2001

Promoting Diversity in the Health Workforce
NOVEMBER 2001

national philanthropies. Its depth and breadth of content give us the information we need to respond to inquiries from grantmakers and others, and to guide the concept and development of our meetings, health-related forums, and publications.

For example, *Findings from the GIH Resource Center*—companion references to the annual meeting and Washington Briefing—are built exclusively from information captured on the database. These reports illustrate the range of strategies employed by different health funders to tackle the topics featured at the conference, and remain useful long after the meeting has

ended. In 2001 alone, *Findings* covered more than 30 topics, including aging, asthma, biomedical research, environmental health, mental health, and drug use and HIV, among others. In addition to being distributed at the meetings, the reports are subsequently posted to our Web site so that those who could not attend can still benefit from the information.

Through such programs and services, GIH keeps funders up-to-date with activities and trends in health philanthropy, and provides workable solutions to operational and programming concerns.

BUILDING RELATIONSHIPS FOR RESULTS

By working collectively, the originators of Grantmakers In Health believed they could both strengthen their individual grantmaking programs and deepen their combined efforts to improve the nation's health. Throughout our history, that founding principle has guided GIH, and during 2001 the importance of collaboration, partnerships, and involving others was a constant theme.

Our annual meeting, *Collaborating for Change: Exploring Health Partnerships that Work*, was dedicated exclusively to the topic, examining the benefits and pitfalls of pooling intellectual and financial resources in the pursuit of effective solutions. Putting collaboration in action,



2001 PUBLICATIONS

VIEWS FROM THE FIELD

Grantmakers are from Mars, Policymakers are from Venus: Is There Hope for this Relationship?

Mark Smith, California HealthCare Foundation
FEBRUARY 2001

Ad-Venture Philanthropy: Creating the Community Campus - A Work in Progress

Susan R. Bunting, Foundation for Seacoast Health
MAY 2001

Funding in Biomedical Research: A David in Goliath's Field

Tina M. Erickson, The Blowitz-Ridgeway Foundation
JULY 2001

Congregations as Health Service Partners

Kim Moore, United Methodist Health Ministry Fund
AUGUST 2001

What Patient Safety is Teaching Us

Karen Feinstein and Ken Segel,
Pittsburgh Regional Healthcare Initiative
SEPTEMBER 2001

Putting Knowledge to Work for Mental Health

Laurie R. Garduque,
The John D. and Catherine T. MacArthur Foundation
OCTOBER 2001

GIH sought grantmaker-designed sessions for the first time, resulting in foundation colleagues contributing more than half of the conference's final agenda. Altogether, the meeting looked at a variety of possible partnerships and the special considerations of each, including corporations and businesses, school districts and public health departments, faith-based organizations, hospitals, universities, and medical schools, in addition to other grantmaking organizations. Through plenary sessions, roundtable discussions, and site visits, participants gained a deeper appreciation of what it takes to collaborate successfully in their own communities.

Over the course of the year, GIH also actively sought out opportunities to promote collaboration among health funders and with other private and public health organizations that would advance shared goals. Patient safety is a prime example. On this one subject alone, representatives from government, including the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services; organizations such as The Leapfrog Group and the National Patient Safety Foundation; and a number of foundations of differing size and focus came together around a mutual concern, with each adding its own resources and perspectives. Similarly, our work on oral health stemmed from a partnership with the nonprofit Children's Dental Health

Project and the federal Health Resources and Services Administration.

In sum, GIH meetings, publications, and Web site create the right environment for grantmakers to identify and cultivate potential relationships with academia, the media, government, and other funders. Our intent? To improve the probability of successful partnerships that produce results. Only by working together can we stretch the collective impact of the nation's resources and, by extension, multiply the long-term value of philanthropy's investments in the common good.



OTHER

Collaborating for Change: Exploring Health Partnerships that Work

Annual meeting reference book and Findings from the GIH Resource Center
MARCH 2001

Patient Safety: Grantmakers Join the Effort to Reduce Medical Errors

By Lauren LeRoy and Katherine M. Treanor
Health Affairs
MARCH/APRIL 2001

GIH 2001 Funding Partner Directory


Collaborating for Change in Public Health
Selected remarks by David Satcher, M.D.,
from GIH's annual meeting
NOVEMBER 2001

Breaking Down Barriers: Granting Access to Better Health Care

Washington Briefing reference book and Findings from the GIH Resource Center
NOVEMBER 2001

22 issues of the *Bulletin*





Independent Auditors' Report

*Board of Directors
Grantmakers In Health
Washington, DC*

We have audited the accompanying statements of financial position of Grantmakers In Health as of December 31, 2001 and 2000, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Grantmakers In Health as of December 31, 2001 and 2000, and the results of its activities and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Sarafino and Rhoades, LLP

January 16, 2002

Grantmakers In Health

Statement of Financial Position

| ASSETS | <u>DECEMBER 31, 2001</u> | <u>DECEMBER 31, 2000</u> |
|--|--------------------------|--------------------------|
| CURRENT ASSETS | | |
| Cash and cash equivalents (Notes 1 and 7) | \$ 815,819 | \$ 499,921 |
| Pledges receivable, current portion (Note 2) | 871,700 | 362,800 |
| Prepaid expenses and other | 58,437 | 14,659 |
| TOTAL CURRENT ASSETS | \$ 1,745,956 | \$ 877,380 |
| OTHER ASSETS | | |
| Pledges receivable (Note 2) | \$ 409,286 | \$ 356,653 |
| Investments (Note 3) | 1,605,586 | 2,099,268 |
| Deposit | 8,931 | 8,931 |
| TOTAL OTHER ASSETS | \$ 2,023,803 | \$ 2,464,852 |
| PROPERTY AND EQUIPMENT (Notes 1 and 4) | \$ 156,429 | \$ 42,847 |
| TOTAL ASSETS | \$ 3,926,188 | \$ 3,385,079 |
| LIABILITIES AND NET ASSETS | | |
| CURRENT LIABILITIES | | |
| Accounts payable | \$ 54,679 | \$ 36,045 |
| Deferred lease benefit (Note 5) | 16,867 | 13,753 |
| Deferred revenue | 15,275 | — |
| TOTAL CURRENT LIABILITIES | \$ 86,821 | \$ 49,798 |
| COMMITMENTS (Note 5) | | |
| NET ASSETS (Notes 1 and 6) | | |
| Unrestricted: | | |
| Undesignated | \$ 395,317 | \$ 451,070 |
| Board-designated | 1,684,672 | 2,129,758 |
| Temporarily restricted | 1,759,378 | 754,453 |
| TOTAL NET ASSETS | \$ 3,839,367 | \$ 3,335,281 |
| TOTAL LIABILITIES AND NET ASSETS | \$ 3,926,188 | \$ 3,385,079 |

Grantmakers In Health

Statement of Activities

| | FOR THE YEARS ENDED | | | | | |
|--|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| | DECEMBER 31, 2001 | | | DECEMBER 31, 2000 | | |
| | Unrestricted | Temporarily Restricted | Total | Unrestricted | Temporarily Restricted | Total |
| SUPPORT AND REVENUES | | | | | | |
| Grants and contributions (Notes 1 and 2) | \$ 1,271,595 | \$ 1,647,138 | \$ 2,918,733 | \$ 768,980 | \$ 565,921 | \$ 1,334,901 |
| Investment income | 58,642 | — | 58,642 | 203,312 | — | 203,312 |
| Unrealized loss on investments | (393,100) | — | (393,100) | (383,342) | — | (383,342) |
| Registration fees | 206,555 | — | 206,555 | 151,740 | — | 151,740 |
| Net assets released from restrictions | 642,213 | (642,213) | — | 1,054,888 | (1,054,888) | — |
| TOTAL REVENUES | <u>\$ 1,785,905</u> | <u>\$ 1,004,925</u> | <u>\$ 2,790,830</u> | <u>\$ 1,795,578</u> | <u>\$ (488,967)</u> | <u>\$ 1,306,611</u> |
| EXPENSES | | | | | | |
| Programs | \$ 1,768,792 | \$ — | \$ 1,768,792 | \$ 1,506,081 | \$ — | \$ 1,506,081 |
| General and administrative | 391,737 | — | 391,737 | 386,419 | — | 386,419 |
| Fundraising | 126,215 | — | 126,215 | 73,245 | — | 73,245 |
| TOTAL EXPENSES | <u>\$ 2,286,744</u> | <u>\$ —</u> | <u>\$ 2,286,744</u> | <u>\$ 1,965,745</u> | <u>\$ —</u> | <u>\$ 1,965,745</u> |
| CHANGES IN NET ASSETS (Note 2) | \$ (500,839) | \$ 1,004,925 | \$ 504,086 | \$ (170,167) | \$ (488,967) | \$ (659,134) |
| NET ASSETS, BEGINNING OF YEAR | <u>2,580,828</u> | <u>754,453</u> | <u>3,335,281</u> | <u>2,750,995</u> | <u>1,243,420</u> | <u>3,994,415</u> |
| NET ASSETS, END OF YEAR | <u>\$2,079,989</u> | <u>\$1,759,378</u> | <u>\$3,839,367</u> | <u>\$2,580,828</u> | <u>\$ 754,453</u> | <u>\$3,335,281</u> |

Grantmakers In Health

Statement of Cash Flows

| | FOR THE YEARS ENDED | |
|--|----------------------------|--------------------------|
| | DECEMBER 31, 2001 | DECEMBER 31, 2000 |
| CASH FLOWS FROM OPERATING ACTIVITIES | | |
| Cash received from contributors and registrants | \$ 2,563,755 | \$ 1,855,607 |
| Cash paid to suppliers and employees | (2,272,531) | (1,921,927) |
| Interest and dividends received | 58,642 | 177,187 |
| NET CASH PROVIDED BY OPERATING ACTIVITIES | \$ 349,866 | \$ 110,867 |
| CASH FLOWS FROM INVESTING ACTIVITIES | | |
| Proceeds from investments | \$ 110,628 | \$ 104,143 |
| Purchases of investments | (10,047) | (115,175) |
| Purchases of property and equipment | (134,549) | (16,525) |
| Payment of security deposit | — | (627) |
| NET CASH USED IN INVESTING ACTIVITIES | \$ (33,968) | \$ (28,184) |
| NET INCREASE IN CASH | \$ 315,898 | \$ 82,683 |
| CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR | 499,921 | 417,238 |
| CASH AND CASH EQUIVALENTS, END OF YEAR | \$ 815,819 | \$ 499,921 |
| RECONCILIATION OF INCREASE IN NET ASSETS TO NET CASH PROVIDED BY OPERATING ACTIVITIES | | |
| Increase (decrease) in net assets | \$ 504,086 | \$ (659,134) |
| Reconciliation adjustments: | | |
| Depreciation | 20,420 | 18,880 |
| Loss on disposal of assets | 548 | 1,750 |
| Realized and unrealized losses on investments | 393,100 | 357,217 |
| Changes in assets and liabilities: | | |
| Pledges receivable | (561,533) | 368,967 |
| Prepaid expenses and other | (43,778) | (5,191) |
| Accounts payable | 18,634 | 25,264 |
| Deferred lease benefit | 3,114 | 3,114 |
| Deferred revenue | 15,275 | — |
| NET CASH PROVIDED BY OPERATING ACTIVITIES | \$ 349,866 | \$ 110,867 |

Grantmakers In Health

Notes to Financial Statements

December 31, 2001 and 2000

These notes are an integral part of the financial statements.

NOTE 1.

ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization Grantmakers In Health (the Organization) is an educational organization serving trustees and staff of foundations and corporate giving programs. Its mission is to help grantmakers improve the nation's health by building philanthropic knowledge, skills, and effectiveness and by fostering communication and collaboration among grantmakers and with others. The Organization accomplishes its mission through a variety of activities, to include technical assistance and consultation, convening, publishing, education and training, conducting studies of the field, and brokering professional relationships.

Basis of Presentation The financial statements of the Organization have been prepared on the accrual basis of accounting. Revenues and expenses are recognized and recorded when earned or incurred. The financial statements reflect unrestricted, temporarily restricted, and permanently restricted net assets and activities. Net assets of the two restricted classes are created only by donor-imposed restrictions on their use. All other net assets, including board-designated or appropriated amounts, are reported as part of the unrestricted class.

Contributions are recognized when the donor makes a promise to give to the Organization that is, in substance, unconditional. Donor-restricted contributions are reported as increases in temporarily or permanently restricted net assets depending on the nature of the restrictions. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets.

Use of Estimates Preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Investments Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair market value in the Statement of Financial Position. The realized and unrealized gains and losses on investments are reflected in the Statement of Activities.

Cash and Cash Equivalents For purposes of the Statement of Cash Flows, the Organization considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents.

Property and Equipment Property and equipment is recorded at cost. Depreciation is provided over estimated useful lives of five years using the straight-line method.

The cost and accumulated depreciation of property sold or retired is removed from the related asset and accumulated

depreciation accounts, and any resulting gain or loss is recorded in the Statement of Activities. Maintenance and repairs are included as expenses when incurred.

Income Taxes The Organization is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. The Organization did not have any unrelated business income.

Expense Allocation The costs of providing various programs have been summarized on a functional basis in the Statement of Activities. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

NOTE 2.

Pledges Receivable Pledges receivable represent promises to give which have been made by donors but have not yet been received by the Organization. Pledges which will not be received in the subsequent year have been discounted using an estimated rate of return which could be earned if such contributions had been made in the current year. The Organization considers pledges receivable fully collectible; accordingly, no allowance for uncollectible pledges has been provided.

Due to the nature of these pledges, significant increases and decreases in net assets may occur. These significant fluctuations can arise as contributions are recognized as support in the fiscal period in which they are pledged, but the expenses incurred with such contributions occur in a different fiscal period. During 2001, the Organization collected \$314,968 of pledges which had been recognized as support in previous years, as follows:

| Recognized as revenue in | 2000 | 1999 | 1998 | Total |
|--------------------------|-----------|------|-----------|-----------|
| | \$143,500 | — | \$171,468 | \$314,968 |

In addition, \$871,210 of pledges recognized as support in 2001 is expected to be collected in future periods.

Total unconditional promises to give were as follows at December 31, 2001 and 2000:

| | 2001 | 2000 |
|------------------------------------|--------------------|------------------|
| Receivable in less than one year | \$871,700 | \$362,800 |
| Receivable in one to five years: | | |
| Total | \$429,750 | \$400,000 |
| Less discount to net present value | 20,464 | 43,347 |
| Net long-term pledges receivable | \$409,286 | \$356,653 |
| TOTAL PLEDGES RECEIVABLE | \$1,280,986 | \$719,453 |

In 1998, a \$1,000,000 pledge was recognized from The Robert Wood Johnson Foundation. At December 31, 2001, \$400,000 of this pledge was outstanding.

Grantmakers In Health

Notes to Financial Statements

December 31, 2001 and 2000

NOTE 3.

Investments Investments consist of mutual funds, and are carried at fair market value. Cost and market values as of December 31, 2001 and 2000 are summarized as follows:

| | 2001 | 2000 |
|--|---------------------|---------------------|
| MARKET VALUE: | | |
| Dreyfus Premier Third Century Fund—Class Z | \$ 1,126,502 | \$ 1,620,301 |
| Dreyfus A Bonds Plus Fund | 237,163 | 242,042 |
| Dreyfus U.S. Treasury Intermediate Term Fund | 241,921 | 236,925 |
| TOTAL | \$ 1,605,586 | \$ 2,099,268 |
| Aggregate cost | \$ 1,579,463 | \$ 1,681,606 |

NOTE 4.

Property and Equipment Components of property and equipment include the following as of December 31, 2001 and 2000:

| | 2001 | 2000 |
|--------------------------------------|-------------------|-------------------|
| Furniture and equipment | \$ 219,534 | \$ 93,272 |
| Leasehold improvements | 8,315 | 8,315 |
| Total property and equipment | \$ 227,849 | \$ 101,587 |
| Less accumulated depreciation | 71,420 | 58,740 |
| Net property and equipment | \$ 156,429 | \$ 42,847 |

Depreciation expense for the years ended December 31, 2001 and 2000 amounted to \$20,420 and \$18,880, respectively.

NOTE 5.

Commitments The Organization entered into an eight-year lease for office space in March 1997. As part of the agreement, the Organization received an abatement of rent of one month per year over the first five years of the rental agreement. The total rent abatement of \$41,518 is being amortized over the life of the rental agreement in the amount of \$432 per month. Total rent expense under the office lease for the years ended December 31, 2001 and 2000 was \$106,009 and \$97,641, respectively.

The Organization also leases office equipment under operating leases.

The future minimum rental payments under the Organization's leases are as follows:

| Year ended December 31, | Office Lease | Equipment | Total |
|----------------------------|-------------------|------------------|-------------------|
| 2002 | \$ 107,177 | \$ 6,778 | \$ 113,955 |
| 2003 | 107,177 | 9,662 | 116,839 |
| 2004 | 26,794 | 9,662 | 36,456 |
| 2005 | — | 8,876 | 8,876 |
| Thereafter | — | 5,356 | 5,356 |
| TOTAL | \$ 241,148 | \$ 40,334 | \$ 281,482 |

NOTE 6.

Net Assets Temporarily restricted net assets were as follows at December 31, 2001 and 2000:

| | 2001 | 2000 |
|--|---------------------|-------------------|
| Pledges receivable—operations | \$ 427,236 | \$ 38,500 |
| Support Center | 400,000 | — |
| Resource Center | 390,475 | 556,653 |
| Community Evaluation Project | 195,000 | — |
| Issue Dialogues | 138,750 | 16,800 |
| Peer Assessment Project | 79,917 | 100,000 |
| Art & Science Workshop | 42,000 | — |
| Annual Meeting | 31,000 | — |
| Test NSPH Model | 25,000 | 25,000 |
| Community Health Care Access Project | 20,000 | 7,500 |
| Collaborative Initiative Among Community Foundations | 10,000 | 10,000 |
| TOTAL | \$ 1,759,378 | \$ 754,453 |

Board-designated funds consisted of the following at December 31, 2001 and 2000:

| | 2001 | 2000 |
|----------------------------|---------------------|---------------------|
| Endowment fund | \$ 1,509,672 | \$ 1,954,758 |
| Future program development | 175,000 | 175,000 |
| TOTAL | \$ 1,684,672 | \$ 2,129,758 |

NOTE 7.

Concentration of Credit Risk Financial instruments which potentially subject the Organization to concentrations of credit risk include cash deposits with a commercial bank and a brokerage firm. The Organization's cash management policies limit some of its exposure to concentrations of credit risk by maintaining a primary cash account at a financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). However, cash in excess of \$100,000 per institution is generally not covered by the FDIC.

NOTE 8.

Retirement Plan The Organization maintains a noncontributory defined contribution pension plan, qualified under Internal Revenue Code 403(b), for the benefit of its eligible employees. Under the plan, a predetermined contribution is made to the account of each individual employee based on annual compensation. Contributions to the plan for the years ended December 31, 2001 and 2000 were \$68,924 and \$58,539, respectively.



Funding Partners

Funding Partners—those foundations and corporate giving programs that annually contribute unrestricted or program grants—are GIH's primary source of income, supplemented by fees for meetings, publications, and special projects. Their support is instrumental in enabling GIH to address the needs of the many grantmakers, both new and established, who turn to us for continuing education programs, materials, advice, and technical assistance throughout the year.

We are pleased to recognize the Funding Partners listed below (current as of March 31, 2002).

| | | |
|---|---|---|
| AARP Andrus Foundation | The California Wellness Foundation | Max Factor Family Foundation |
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GIH came into being through the commitment and contributions of individuals, and twenty years later, we continue to seek the involvement of those we serve. We listen to their needs and concerns, and rely upon their opinions and advice to help us deliver pertinent, meaningful, and useful products.

In practice and philosophy, GIH embraces health philanthropy's increasing diversity, creating programs that will resonate with every health funder at some point throughout the year. We attempt to plan programming that will meet the needs of organizations and individuals at different stages of professional development, cutting across philanthropy's broad continuum of age and size. We work with grantmakers who focus on a single area, facilitating their ability to come together around a common interest and identifying intersections between that interest and those of the broader field. And through all our products, we strive to keep grantmakers connected to us and to each other as a means to promote collaboration, exchange, and action.

During 2001, GIH benefited from the input and investments of many, including a dedicated board representing the great diversity of the field, and our many Funding Partners whose general and programmatic support advanced the profession by making our activities and achievements possible. They were joined by others who freely offered their time and talents, submitting sessions for the annual meeting . . . serving on review committees . . . nominating colleagues to the board . . . selecting the recipient of The Terrance Keenan Leadership Award in Health Philanthropy . . . and sharing their expertise and experience through GIH meetings and publications. Their interest and efforts carried forth a long tradition of service to the field, and GIH is the richer for it.

As we look to the year ahead, Grantmakers In Health will work to advance its standing as the best resource nationwide for intelligence, analysis, and strategic advice on health philanthropy's changing environment. With our constituency's continuing engagement, we will work together to effect positive change and fulfill our mutual mission—improving the nation's health.



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