GRANT MAKERS IN HEALTH

THE BUSINESS OF GIVING

Governance and Asset Management in Foundations Formed from Health Care Conversions

FEBRUARY 2005

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Preface

Since 1996, Grantmakers In Health (GIH) has monitored the development and operations of foundations formed from health care conversions.* These foundations, which now number more than 170 nationwide and hold assets totaling $18.3 billion, are an important part of the philanthropic sector. Although some of these foundations have been in existence for decades, many were formed in the mid-1990s or later, bringing new and valuable philanthropic resources to the states and communities they serve.

GIH conducts regular surveys of foundations formed from health care conversions to document key elements of their structure, governance, accountability, and grantmaking. The resulting reports are disseminated widely to increase understanding among grantmakers, policymakers, and others about the operations and contributions of these foundations. In years past, GIH has documented variation in their structures, their relationships to the organizations that gave rise to them, and the extent of community involvement in the development of their missions and grantmaking agendas.

This year's report breaks new ground in the areas of foundation governance and asset management, and also updates basic information on assets and grantmaking. It presents information from several foundations not included in previous reports, either because they were too new to respond to previous surveys or because they were unknown to GIH.

Thanks go to all the foundations that participated in the survey. GIH deeply appreciates the time that foundation staff devoted to answering the survey. In addition, GIH extends appreciation to several other people. Members of GIH's Board of Directors pretested the survey instrument: Jeannette Corbett, Quantum Foundation, Inc.; Thomas Aschenbrener, Northwest Health Foundation; Kim Moore, United Methodist Health Ministry Fund; Margaret O'Bryon, Consumer Health Foundation; Ann Pauli, Paso del Norte Health Foundation; and Susan Zepeda, The HealthCare Foundation for Orange County. Jennifer Benz of the National Opinion Research Center at the University of Chicago assisted with the analysis of the data from the survey. Jeffrey Leighton of Leighton and Associates and Ira Holtzman of The Health Trust provided advice on the survey and feedback on the survey instrument.

Donna Langill, GIH program associate, and Jack Hoadley, Research Professor at Georgetown University's Health Policy Institute, comanaged the research, analysis, and writing of the report. Tanisha Fuller, administrative assistant, was instrumental in collecting supplemental data. Andrea Kastin of Georgetown University's Health Policy Institute provided valuable assistance with the analysis and writing, and Matt Kanter, also with Georgetown University's Health Policy Institute, prepared the map included as Exhibit 3. Other GIH staff contributing to this report include Lauren LeRoy, Anne Schwartz, and Angela Saunders. Mary Backley of GIH contributed to the development of the survey instrument.

* There is no generally accepted definition of foundations formed from health care conversions, nor is there commonly accepted terminology for referring to these foundations. GIH defines the term, foundations formed from health care conversions, to include foundations created when nonprofit health care organizations convert to for-profit status, foundations created when nonprofit health care organizations are sold to a for-profit company or another nonprofit organization, and existing foundations that receive additional assets from the sale or conversion of a nonprofit health care organization.

About GIH

The mission of Grantmakers In Health (GIH) is to help grantmakers improve the nation's health. Working with over 200 organizations, large and small, both locally focused and national in scope, GIH seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. Meetings, publications, networking, and technical assistance are the vehicles for funders to learn from GIH and from each other.

As the professional home for health grantmakers, our work covers a great deal of territory. We look at health issues through a philanthropic lens, sorting out what works for health funders of different missions, sizes, and approaches to grantmaking. We take on the operational issues with which many funders struggle (such as governance, communications, evaluation, and relationships with grantees) in ways that are meaningful to those working in the health field.

How do we do it? We generate and disseminate information through meetings, publications, and an on-line presence; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct systematic studies of the field.

EXPERTISE ON HEALTH ISSUES

GIH's Resource Center on Health Philanthropy is a source of expert knowledge on different subject areas within health and effective grantmaking strategies. The Resource Center maintains descriptive data about foundations and corporate giving programs funding in health and their grants and initiatives, and synthesizes lessons learned from their work.

Keeping track of the field requires expert staff and powerful tools. After all, health grantmakers work on every issue under the umbrella of health, from improving access to shoring up the public health infrastructure to building healthier communities. With strong experience in public health, health policy, and community work, GIH's staff identify trends and emerging issues, develop programs, and provide advice. The Resource Center's database is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization). The database contains information on thousands of grants and initiatives made by over 300 foundations and corporate giving programs and can be searched by organizational characteristics (such as tax-exempt status, geographic focus, or assets), health programming areas (such as access, health promotion, mental health, and quality), targeted populations, and type of funding (such as direct service delivery, research, capacity building, or advocacy).

ADVICE ON FOUNDATION OPERATIONS

GIH also focuses on operational issues confronting health grantmakers through the work of its Support Center for Health Foundations. The Support Center tackles both fundamental and complex operational issues, such as designing an effective grants program or assessing organizational performance, and puts these in a context that makes sense for those funding in health. We work with foundations just getting started (including dozens of foundations formed as a result of the conversion of nonprofit hospitals and health systems) and with more established organizations. The Support Center's work includes:

- The Art & Science of Health Grantmaking, an annual two-day meeting offering introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments;
- sessions focusing on operational issues at the GIH Annual Meeting on Health Philanthropy;
- individualized technical assistance for health funders; and
- a frequently asked questions feature on the GIH Web site.

CONNECTING HEALTH FUNDERS

When health grantmakers get together, the learning and energy are palpable. GIH creates opportunities to connect colleagues to each other and with those in other fields whose work has important implications for health. GIH meetings, including the Annual Meeting on Health Philanthropy, the Fall Forum (when we focus on policy issues), and Issue Dialogues (intensive one-day meetings on a single health topic) are designed for health funders to learn more about their colleagues' work; talk openly about shared issues; and tap into the knowledge of experts from research, policy and practice. Our audioconference series offer the chance for smaller groups of grantmakers working on issues of mutual interest, such as access to care, overweight and obesity, racial and ethnic disparities, patient safety, or public policy, to meet with colleagues regularly without having to leave their offices.

FOSTERING PARTNERSHIPS

The many determinants of health status and the complexity of communities and health care delivery systems temper health grantmakers' expectations about going it alone. Collaboration with others is essential to lasting health improvements. Although successful collaborations can't be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, work with other affinity groups within philanthropy, and help connect grantmakers to organizations that can help further their goals.

GIH places a high priority on bridging the worlds of health philanthropy and health policy. Our policy portfolio includes efforts to help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. And when there is synergy, we work to strengthen collaborative relationships between philanthropy and government. GIH has established cooperative relationships, for example, with a number of federal agencies, including the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

EDUCATING AND INFORMING THE FIELD

An aggressive publications effort helps GIH reach a large number of grantmakers and provide resources that are available when funders need them. Our products include both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data, sketching out opportunities for funders, and offering examples of how grantmakers are putting ideas into action. The GIH *Bulletin*, a newsletter published 22 times each year, keeps funders up to date on new grants, studies, and people. Periodic feature articles include *Grantmaker Focus* (a profile of one of the many foundations and corporate giving programs working in health), *Views from the Field* (written by health funders about their experiences), and *Issue Focus* (quick insightful analyses of challenging health issues).

GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's frequently asked questions. Key health issue pages on access, aging, children/youth, disparities, health promotion, mental health, public health, and quality provide grantmakers with quick access to new studies, relevant GIH publications, information on upcoming and past audioconferences, and the work of their peers.

Diversity Statement

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

Table of Contents

List of Exhibits

Background and Overview

Foundations created from health care conversions form an important sector within health philanthropy.[1] To date, Grantmakers In Health (GIH) has identified more than 170 foundations that were either newly formed with the assets from health care conversions or received assets generated by conversions. These foundations held approximately $18.3 billion in assets in 2004, up from the $16.4 billion reported in GIH's 2003 report. Although this report includes some new foundations, the increase in total assets also reflects an increase in the assets of individual foundations.

The information in this report shows that the conversion phenomenon is continuing, despite increases in challenges to conversions in particular states and localities. Since the beginning of 2000, 30 new foundations have been formed from health care conversions and there are several pending conversions that may result in the formation of new foundations.

Foundations formed from health care conversions have, in many cases, been subject to close examination, often more than other types of foundations. Because of the way they are formed, these foundations typically receive significant public attention, both during the conversion process and afterwards.

The operation of foundations generally has been the subject of increasing discussion in recent years, with much of the attention focused on sensational stories and the few so-called bad apples. From investigations of executive compensation to calls in the U.S. Congress for increased regulation of the field to questions about foundation payout and accountability, philanthropy has been under a microscope. It is clear that more information is needed about how foundations operate and how they make decisions about their grantmaking, their investments, and other matters.

To answer questions about the operations of foundations formed from health care conversions and to provide the staff and leadership of these foundations with information about their peers, GIH focused its 2004 survey on issues related to governance and asset management. In addition to providing basic information about the structure, assets, and grantmaking of foundations formed from health care conversions, the survey examines foundation policies and practices regarding service on boards of directors, as well as the investment and management of foundation assets.

The results of the survey show that, even as new foundations continue to be created from health care conversions, the field has matured. The foundations formed from conversions in the 1990s or earlier have strong structures in place to guide decisionmaking about their grantmaking and

[1] There is no generally accepted definition of foundations formed from health care conversions, nor is there commonly accepted terminology for referring to these foundations. GIH defines the term, foundations formed from health care conversions, to include foundations created when nonprofit health care organizations convert to for-profit status, foundations created when nonprofit health care organizations are sold to a for-profit company or another nonprofit organization, and existing foundations that receive additional assets from the sale or conversion of a nonprofit health care organization.

other programs, as well as the prudent management of their assets. In addition, the field has made modest improvements in the racial and ethnic diversity of boards, increasing the degree to which the boards reflect the communities they serve and society at large. In many ways, foundations formed from health care conversions, particularly those that have been in operation for a decade or more, look very much like foundations that were formed in other ways.

In reporting the results of the 2004 survey of foundations formed from health care conversions, GIH aims to address the questions that are most frequently asked by people both within philanthropy and outside it. Specifically, GIH hopes to:

- update information from previous GIH reports on the basic characteristics of foundations formed from health care conversions;
- provide new information and benchmarks that these foundations can use to assess their governance and asset management practices, and compare them with those of their peers; and
- improve understanding among policymakers, regulators, and others about this important sector of health philanthropy.

Survey Methodology

The data described in this report were obtained primarily through a Web-based survey that was open for foundation response from May 25, 2004 through July 7, 2004. While the majority of respondents used the Web-based system to submit their responses, several mailed their responses using paper versions of the surveys. The responses from these paper versions were then added to the survey database. In previous GIH surveys, data were collected manually by compiling information from paper survey responses sent back via mail or facsimile. The Web-based survey was used to minimize the time needed for foundation staff to respond to the survey and to reduce the need for manual data entry.

Instructions for completing the Web-based survey were sent to 174 foundations identified by GIH. One foundation from the list analyzed in previous GIH studies had gone out of business by the time of the 2004 survey, while several new foundations were identified and added to the list surveyed for this report.

Foundation officials were asked to respond to 83 questions. Survey questions addressed basic structure and operations, foundation assets and expenses, investment policies, governance, asset allocation, use of investment advisors, and auditing practices.

Of the 174 foundations contacted, 76 completed the survey (44 percent) and 37 submitted partial responses, totaling 113 responses (65 percent). Some partial responses, however, had little useful information included. For most questions where the response was not contingent upon a response to a previous question, the number of respondents ranged from about 65 to 79 foundations, leading to an overall effective response rate of 37 percent to 45 percent.

What Are Health Care Conversions?

The past three decades have witnessed unprecedented growth in the number of transactions involving nonprofit hospitals, health plans, and health systems. Often referred to as conversions, many of these transactions involve the transfer of assets from a nonprofit health care organization to a for-profit organization or, less commonly, another nonprofit organization through sales, mergers, joint ventures, or corporate restructuring. For struggling nonprofit organizations, converting can offer a way to preserve their historical missions, gain access to capital, and enhance their competitive positions. For thriving nonprofit organizations, converting can allow nonprofit boards to secure the maximum assets for their communities in the face of increasing uncertainty and competition in the health care market. Conversion options such as mergers and joint ventures may offer nonprofit organizations a way to remain viable and stay competitive while retaining partial ownership in the health care organization.

Some conversion transactions have led to the creation of new foundations, endowed with assets generated by the conversion, that are charged with funding health-related activities in their communities. These foundations are often referred to as health care conversion foundations. This is not a legal term, nor is it adequately descriptive. The Internal Revenue Service (IRS) classifies these entities as private foundations, social welfare organizations, or public charities. Some transactions between nonprofit organizations and municipal health care organizations have also led to the creation of foundations. Creating a new foundation or transferring assets to an existing one are common ways to maintain the level of public benefit presumed to have been provided by the nonprofit organization prior to conversion. Although the degree to which nonprofit providers serve the community (and whether their behavior differs from that of for-profit enterprises) has been much debated, the trend in law and regulation is to require that converted assets be used in a manner consistent with the original nonprofit organization's mission. This trend is supported by the *cy pres* doctrine, meaning "as close as possible"; the doctrine supports an application of the assets to a mission as close as possible to that of the original nonprofit organization.

This rate was somewhat lower than the 65 percent response rate to a survey conducted by GIH in 2001 and reported in GIH's 2002 report, *Assets for Health: Findings from the 2001 Survey of New Health Foundations*. The lower rate may reflect, in part, survey fatigue among respondents, as several other organizations had foundation surveys in the field at the same time as GIH. The lower rate may also reflect the substantially longer survey that respondents were asked to complete. In addition, technical issues arose during the conduct of the Web-based survey. These resulted in the loss of some data on some completed and partially completed surveys, and may have deterred some respondents from completing the survey.

GIH employed several methods to promote full participation in the survey. Reminders were sent via e-mail to foundations that had not opened their on-line surveys or had not completed them. Foundations that had not opened their surveys or had not completed them were also contacted by phone to encourage their participation and to answer any questions about the survey.

Information from public sources or previous GIH surveys was used to supplement survey responses to selected questions for foundations that either did not respond to the survey or did not respond to all questions in the survey. For most nonresponding foundations, GIH was able

to obtain information on assets and expenses from GIH files, publicly available IRS filings, or foundation Web sites. In addition, information on board composition was identified for a smaller number of the nonresponding foundations. Where available, such information was added to the analytical file. This process raised the number of responses for selected questions (such as assets) to about 170 foundations, or an effective response rate of nearly 100 percent.

The foundations that did not respond to the survey or did not fully complete it were smaller, on average, than those responding fully to the Web-based survey. Median assets were $32 million for the nonrespondents, versus $60 million for respondents. As a result, the findings presented here may not fully capture the characteristics of smaller foundations. Respondents and nonrespondents were similar in age, based on their establishment dates. The nonrespondents were more likely to be the result of hospital conversions, as opposed to conversions of health systems or health plans.

Despite the lack of response from some foundations, the results of the survey can provide foundations formed from health care conversions and others with helpful information. Where comparisons with other surveys of foundations are appropriate, the findings from this survey are consistent with those of other surveys; this consistency lends confidence to the results of GIH's survey. Although readers should interpret the results of any survey critically, the results of this survey provide a reasonably accurate picture of governance and asset management in foundations formed from health care conversions.

RESULTS

This report updates information contained in previous reports and presents new information on governance of and asset management by foundations formed from health care conversions. The information is presented in six major sections:

Foundation Structure: this section includes basic information about foundations formed from health care conversions and the transactions that created them.

Foundation Operations: this section includes information on grantmaking and other activities and staff size.

Foundation Governance: this section includes information on foundation boards and board policies.

Foundation Assets and Expenses: this section includes information on foundation assets and expenses.

Investment of Foundation Assets: this section includes information on the allocation of foundation assets within investment portfolios.

Management of Foundation Investments: this section includes information on policies governing investment decisions.

In addition, three appendices present information from the survey. *Appendix I* presents information on foundation governance and asset management by the value of foundation assets. *Appendix II* presents information on the year of conversion, the type of entity converted, and the tax status of foundations formed from health care conversions by the value of foundation assets. *Appendix III* profiles the foundations formed from health care conversions that are known to GIH.

Care must be taken in making comparisons between results from earlier GIH reports and this one. The foundations that responded to this survey include funders appearing in previous reports, as well as foundations surveyed for the first time. In addition, some data were collected from public sources as described in the *Survey Methodology* section of the report. While differences between data from earlier reports and this one can indicate trends or changes, direct comparisons have been made only where appropriate.

This report uses median values for some variables in the study and mean values for others. Because several responding foundations are considerably larger than the typical foundation, mean values tend to be skewed upward for some variables (for example, the average value of assets). For these variables, median values tend to be better measures of central tendency for the purposes of this report.

For several variables, the measure of the range of the middle 50 percent of respondents is used as a qualitative measure of spread. This measure, sometimes referred to by statisticians as the interquartile range, also provides helpful information about central tendencies. Whereas the overall range (minimum to maximum) can be distorted by one or more outliers at either extreme, this middle 50 percent captures where the middle half of respondents fall.

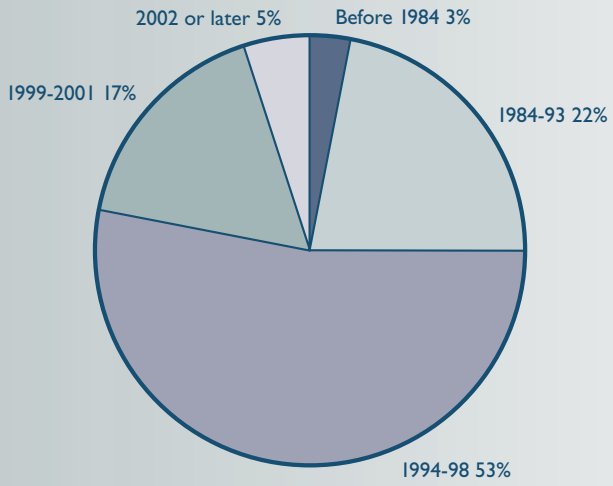
Foundation Structure

This section of the report provides information about the origin and structure of foundations formed from health care conversions, including date of conversion and foundation formation, type of entity converted, ongoing relationships with the converted entity, tax status, and geographic distribution.

Date of Conversion and Foundation Formation

More than half the foundations surveyed (53 percent) were the result of conversions that occurred between 5 and 10 years ago, while just over one-fifth (22 percent) had conversion dates no more than 5 years ago and one-fourth (25 percent) resulted from conversions at least 10 years ago. The busiest period for conversions was from 1994 to 1999, peaking with 26 conversions in 1995. Another period of increased conversion activity was from 1984 to 1986, when 27 conversions occurred.

Exhibit 1. *Date of Conversion of Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=173

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

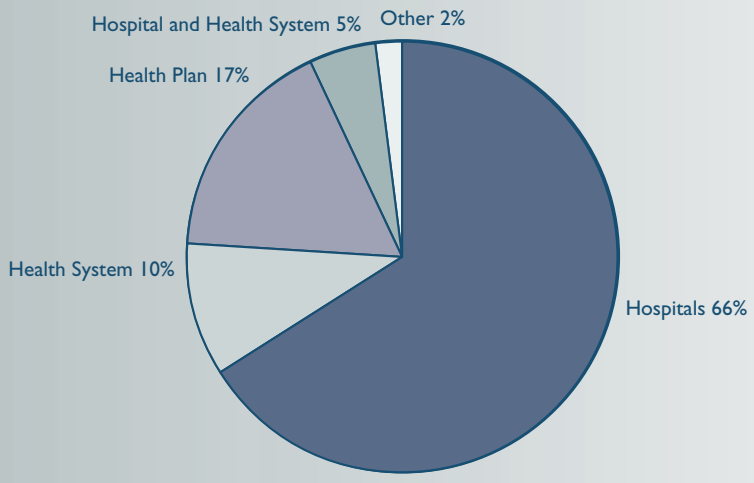
Respondents were also asked to provide the date when the foundation was formally established. For nearly three-fourths of the foundations, the year the foundation was formed and the year the conversion took place were the same. Several foundations, however, cited formation dates a year or two later than the date when the health care conversion occured, reflecting the time it took to structure the foundation and transfer assets. Also, a number of foundations cited dates of formation that were earlier than their conversion dates. Generally, in these cases, the foundations existed prior to the conversion transaction and received an infusion of assets from the conversion.

Type of Entity Converted

Approximately two-thirds of the foundations were created through hospital conversions (Exhibit 2). About 17 percent resulted from health plan conversions, 10 percent from health system conversions, and 2 percent from other types of conversions such as nursing home conversions. A small number were associated with the conversion of more than one type of entity.

For most of the past two decades, hospital conversions have been the dominant event from which foundations were established. Through 1998, hospital conversions were responsible for over two-thirds of the foundations formed. Health plan conversions became more common from 1999 to 2001, accounting for approximately 38 percent of all foundations formed in that period. But only one foundation out of the nine foundations established in 2002 or later resulted from a health plan conversion, and two resulted from health system conversions, a return to the pattern through 1998.

Exhibit 2. *Type of Entity Converted, 2004 (percentage of foundations)*



N=173

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Hospital conversions typically result in smaller foundations, in terms of the value of their assets. Foundations resulting from hospital conversions represent 80 percent of the foundations with assets of less than $20 million. By contrast, of foundations with assets of more than $100 million, half were the product of the conversion of a health system or health plan, with the remainder representing hospital conversions.

Ongoing Financial Relationships with the Converted Entity

Foundations formed from health care conversions are often questioned about their relationship with the converted health care organization. Nearly three-fourths of the foundations that responded to the survey reported that they had no ongoing financial relationship with the converted organization. Of those foundations that reported such a relationship, some indicated that the foundation was still receiving assets from the conversion transaction or substantial donations from the converted entity. Examples of relationships include a foundation that was receiving assets in annual installments over 10 years in addition to a lump sum at the time of the conversion, a foundation that was receiving assets collected as accounts receivable prior to the conversion, and a foundation that was receiving a 50 percent share of the converted hospital's net profits. Two of the responding foundations reported maintaining an ownership arrangement, with one owning stock in the for-profit company and the other sharing ownership of a hospital's joint venture with a for-profit company.

Tax Status

Nearly half of the foundations (46 percent) are designated as private foundations with 501(c)(3) status (defined as grantmaking foundations that have an endowment from a single source such as an individual, family, or corporation and that do not raise funds from the public). Foundations

with this tax status account for over half the total assets held by foundations formed from health care conversions, or about $9.5 billion. Median assets for a private foundation formed from a health care conversion were approximately $60 million.

A majority of the remaining foundations holding 501(c)(3) status are designated as public charities (defined as tax-exempt religious, educational, or social service organizations that receive regular contributions from several sources such as individuals, corporations, private foundations, government, and sometimes fees for services). Foundations that are public charities may be one of three types.

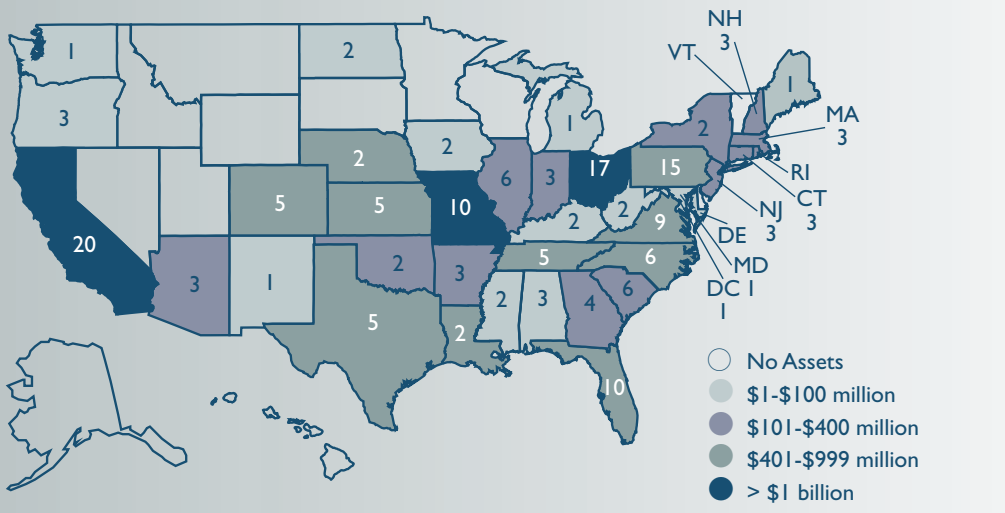
- A traditional public charity under section 509(a)(1) of the Internal Revenue Code (IRC) receives funds from public donations or government. It generally must meet a public support test requiring that, over the most recent four-year period, its support from donations and grants equaled or exceeded one-third of its total support. About 25 percent of the foundations surveyed are traditional public charities. They tend to be smaller foundations with total assets of $2.1 billion and median assets of $23 million.
- A 509(a)(2) gross receipts organization is a public charity that must raise more than one-third of its total support from any combination of gifts, grants, contributions, or membership fees and gross receipts from admissions, merchandise sales, or services provided in relation to its tax-exempt function. Only six foundations (4 percent) fall in this category with total assets of $435 million. The median foundation in this category holds about $40 million in assets.
- A supporting organization under 509(a)(3) of the IRC is a nonprofit corporation that has an established relationship with an existing public charity, often a community foundation or a religious order. Supporting organizations do not have to meet a public support test, and they generally receive grantmaking, investment, and administrative assistance from the nonprofit organization with which they are affiliated. About 21 percent of the foundations surveyed belong to this category, with a total of $2.8 billion in assets. The median foundation in this category holds nearly $60 million in assets, larger than other foundations holding 509(a) status.

The final category of foundations formed from health care conversions fall under section 501(c)(4) of the IRC. These tax-exempt organizations are known as social welfare organizations. They are not obliged to spend any portion of their income or endowment on charitable activities and are not required to report the same detailed information as private foundations. Only six of the foundations surveyed (4 percent) were in this category, but they include some large foundations. They hold a total of $2.3 billion in assets, with median assets of $190 million. All the foundations with this tax status are the result of health plan conversions; their status as social welfare organizations may reflect the tax status of the converted entity and the manner in which the transaction occurred.

Geographic Distribution of Foundations

Foundations formed from health care conversions are located in 37 states and the District of Columbia (Exhibit 3). Of these, 15 states have just one or two foundations. The largest number (20) is in California. Other states with large numbers of foundations are Ohio (17), Pennsylvania (15), Missouri (10), and Florida (10). Foundations in California and Missouri hold the most assets, with assets totaling $5.8 billion for those in California and $1.9 billion for those in Missouri. The variation in the number of foundations located in particular states results, in part, from differences in the regulatory environment and the structure of the health system across states.

Exhibit 3. *States with Foundations Formed from Health Care Conversions, by Number and Total Assets, 2004*



N Number=174, N Total Assets=172

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Foundation Operations

No two foundations look exactly alike in terms of their operations. Every foundation has its own approach to fulfilling its mission, with resulting variations in their grantmaking styles, funding priorities, and staffing patterns. Foundations formed from health care conversions are no different: each has taken its own path to achieving its mission. The foundations surveyed were asked to provide information about their operations by answering questions about whether they focus primarily on grantmaking or operating their own programs. They were also asked about the number of staff and their grantmaking areas.

Focus on Grantmaking versus Direct Operation of Programs

A large majority of the foundations surveyed (68 percent) focus primarily on grantmaking (meaning that they award grants from their trust funds to outside organizations after those organizations undergo a selection process). Some foundations, however, operate their own

programs directly. According to the survey, 24 percent of the responding foundations operate their own programs in addition to making grants, while 6 percent focus primarily on operating their own programs.

Foundations that focus primarily on grantmaking differ in several respects from those that operate their own programs. The grantmaking foundations tend to be smaller, with median assets of about $60 million. By contrast, those foundations that operate their own programs, in addition to making grants, have median assets of almost $120 million. Overall, the latter foundations hold total assets of $5.6 billion, while the foundations engaged primarily in grantmaking hold $7.0 billion in assets. The small set of foundations that focus primarily on operating their own programs hold a total of just $133 million in assets.

The tax status of foundations formed from health care conversions was also correlated with the focus of foundations on grantmaking versus operating their own programs. Traditional public charities were most likely to be operating their own programs (58 percent). Supporting public charities and private foundations were less likely to be operating their own programs, with 29 percent and 20 percent, respectively, operating their own programs.

Number of Staff

There was considerable variation in the size of the staffs maintained by the foundations responding to the survey (Exhibit 4). The median foundation has a staff of 4 full-time equivalents (FTEs), while the average is 11 FTEs.[2] Half the responding foundations have between two and eight full-time staff members. One of the foundations reported having no staff, while the largest number of staff reported for a single foundation was 162 FTEs.

There is a strong relationship between the value of assets and staffing. Nearly all responding foundations with under $50 million in assets had five or fewer FTEs, whereas nearly all those with over $100 million had more than five staff members. Foundations with under $50 million in assets had a median staff size of two full-time employees and a mean staff size of three. By

Exhibit 4. *Number of Staff in Foundations Formed from Health Care Conversions, 2004 (number and percentage of foundations)*

Staff Size	Number of Foundations	Percentage of Foundations
1 FTE or fewer*	8	10
Between 1.1 and 5 FTEs	37	48
Between 5.1 and 10 FTEs	15	19
More than 10 FTEs	17	22

N=77

** An FTE, or full-time equivalent, is a measure of staff hours equal to those of a full-time employee. For example, two people working half time equal one FTE.*

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

[2] A full-time equivalent is a measure of staff hours equal to those of a full-time employee, so two people working half time equal one full-time equivalent or FTE.

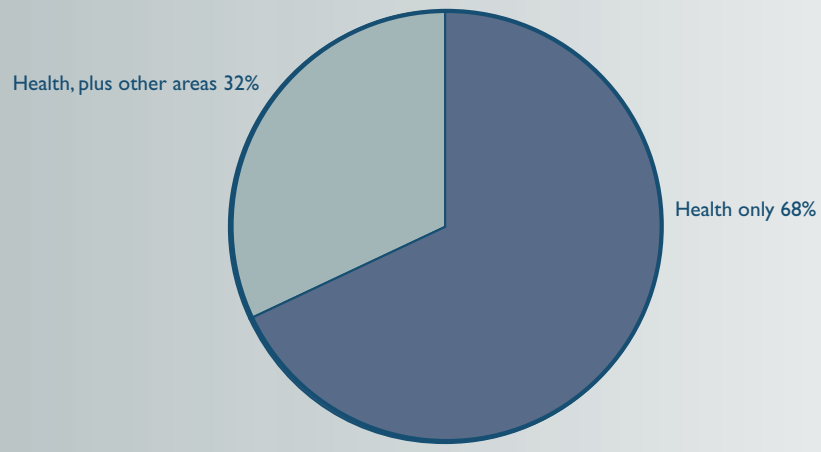
contrast, foundations with over $100 million in assets had a median of 12.1 full-time employees on staff and a mean of 23.4. Those foundations holding between $50 million and $100 million in assets had a median staff size of 4.5 and a mean of 7.1 full-time employees.

Foundations that characterize themselves as focusing primarily on operating their own programs or that operate programs in addition to making grants tend to employ more staff. Such foundations had a median staff size of 12 full-time employees compared with 3.4 full-time employees for foundations that engaged primarily in grantmaking (means of 24.3 and 6.0). This difference presumably reflects the more diverse set of activities conducted by foundations operating their own programs, work that necessitates larger staffs.

Grantmaking Areas

Most of the responding foundations (68 percent) make grants exclusively in health (Exhibit 5). The most frequently cited areas included health education and prevention, community health, and access to care. Many foundations focus on specific populations such as the elderly, youth, or indigent populations. Others focus on specific health concerns such as oral health, cardiovascular health, behavioral health, or communicable diseases.

Exhibit 5. *Grantmaking Areas of Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=78

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

About one-third of responding foundations fund at least some areas other than health. Among these are education, human services programs, arts and culture, leadership development, faith-based and congregation-specific initiatives, and other community and economic development programming.

Foundation Governance

Every foundation has a board of directors that is responsible for the governance and supervision of the foundation, its committees, and its officers. Survey respondents were asked to provide information about board terms and term limits, board composition, compensation and reimbursement of board members, the use of board committees, and auditing practices.

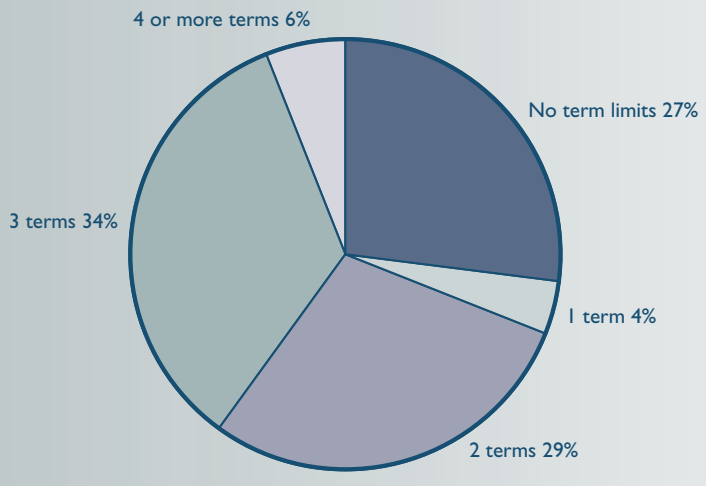
Board Terms and Term Limits

Approximately three-fourths of foundations formed from a health care conversion reported that the term of a board member was three years. Another 12 percent of foundations reported board terms of four to six years, while 4 percent did not specify their board members' term length. Except for one foundation that appointed its board members for life, the longest term reported was six years.

About three-fourths of all responding foundations have limits on the number of terms board members could serve (Exhibit 6). The majority of those that set term limits impose a two-term limit (29 percent of all respondents) or a three-term limit (34 percent), with the remainder split relatively evenly between one-term, four-term, or five-term limits. A few foundations noted other rules governing term limits for board members, for example, applying the term limit only to consecutive terms or not applying term limits to founding board members.

The maximum number of years of service on foundation boards is a function of the length of the terms and any limits on the number of terms. Nearly one-third of responding foundations limit total board member service to six years or fewer. Another third limit board members' total service to seven to nine years. About one-tenth of foundations allow at least 10 years of service.

Exhibit 6. *Board Term Limits in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=58

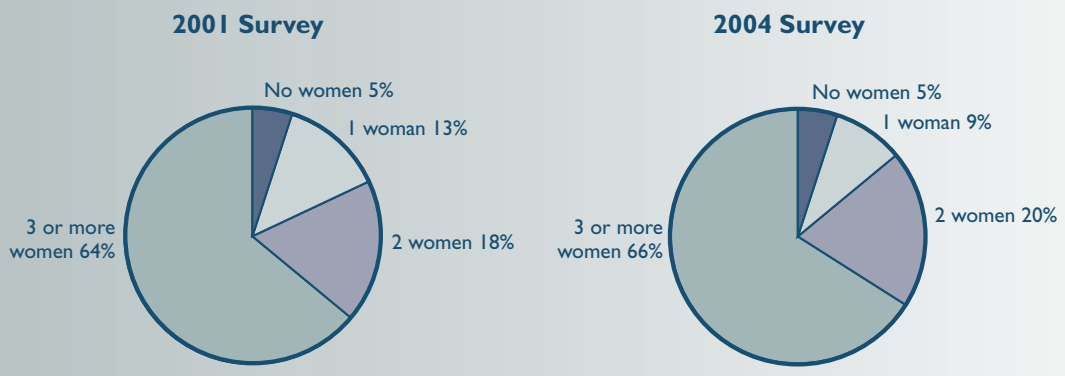
Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Board Size and Composition

The median board size for a foundation formed from a health care conversion is 13 members.[3] Half the boards have between 9 and 15 members. There is wide variation in board size, however, with the smallest board composed of 5 members and the largest board composed of 35 members.

The typical (or median) foundation board is about two-thirds male and one-third female. Only 5 percent of those surveyed have no women on their boards, while 17 percent have a majority female board. Overall, the division between men and women among foundations responding to the 2004 survey was virtually unchanged from that observed in the survey GIH conducted in 2001 (Exhibit 7).

Exhibit 7. *Number of Women on Boards of Foundations Formed from Health Care Conversions, 2001 and 2004 (percentage of foundations)*



N 2001=130, N 2004=79

Sources: Grantmakers In Health, *Survey of New Health Foundations, 2001* and Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

As the nation's population becomes more diverse, many foundations are working to increase the diversity on their boards. In a typical (or median) foundation formed from a health care conversion, about one-fifth of board members are members of racial and ethnic minority groups. In approximately 7 percent of foundations, board members from racial and ethnic minority groups represent 50 percent or more of the entire board. In 2004, however, almost one-fourth of foundations had no minority board members. On boards with minority members, those members were most likely to be African American or Hispanic.

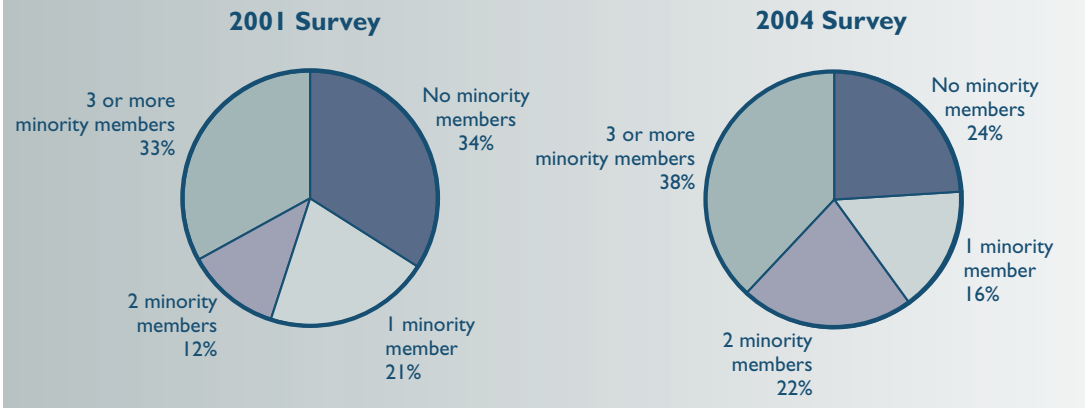
Board diversity for foundations formed from health care conversions improved modestly from 2001 to 2004 (Exhibit 8). The number of foundations with at least two minority board members grew from 45 percent to 60 percent between 2001 and 2004.

Compensation and Reimbursement of Board Members

Compensation of foundation directors has been the subject of widespread debate recently. While compensation of directors is relatively common in the for-profit sector, it is much less common in the nonprofit sector.

[3] Some information on board composition was obtained from public sources for foundations not responding to the survey.

Exhibit 8. *Number of Members from Racial/Ethnic Minority Groups on Boards of Foundations Formed from Health Care Conversions, 2001 and 2004 (percentage of foundations)*

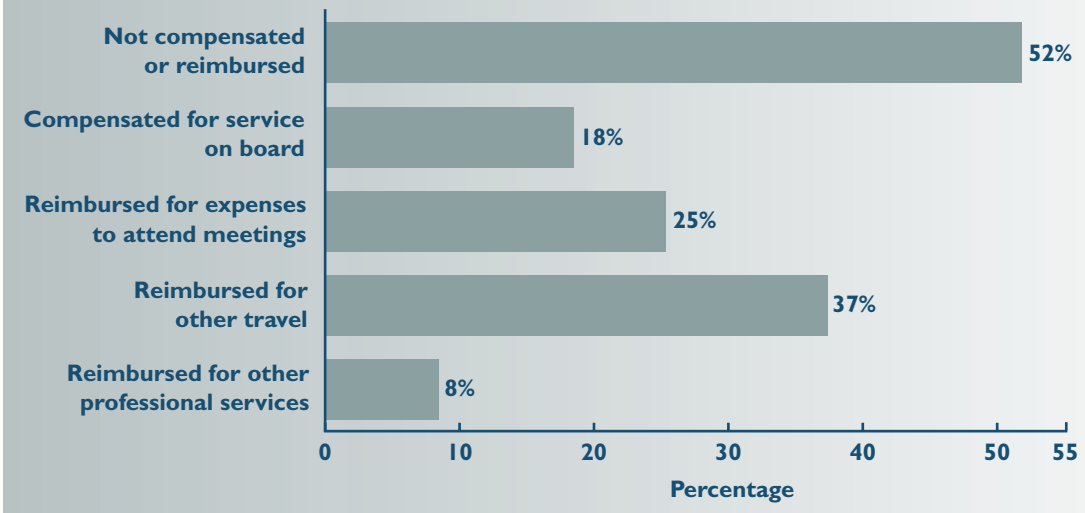


N 2001=109, N 2002=79

Source: Grantmakers In Health, *Survey of New Health Foundations, 2001* and Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

More than half the foundations surveyed do not provide any type of compensation to board members for their service, although some provide reimbursement for travel to board meetings or other foundation-related trips (Exhibit 9). Only 18 percent provide compensation to board members for their service on the board.

Exhibit 9. *Compensation and Reimbursement of Members of Boards of Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=79

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

For those that provide compensation to board members, average total foundation spending on board compensation increased with the amount of foundation assets. Foundations with assets under $50 million that provide board compensation spent an average of approximately $9,000

for this purpose. This compares with average spending on board compensation of $14,000 by foundations with assets totaling between $50 million and $100 million. For foundations with assets over $100 million, an average of $87,000 was spent on board compensation.

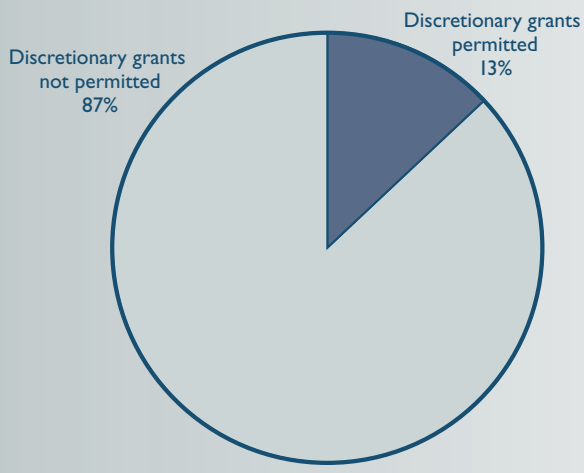
A higher proportion of the larger foundations compensate board members (36 percent versus 11 percent for smaller foundations). Larger foundations also provide higher compensation for each board member (an average of $22,000 per member versus $8,000 per member for the smallest foundations providing board compensation).[4]

The 14 foundations that compensate board members for their board service were asked to provide additional detail about their compensation policies. Six of these stated that they do not provide this compensation to board members who also serve as the organization's president or CEO. One foundation indicated that compensation for board service is not provided if a board member is a government official. Foundations were also asked whether some board members decline compensation that is available to them. About one-fourth of the foundations answering this question reported that one or more board members declined compensation.

Discretionary Grants by Board Members

Some foundations permit board members to award grants at their own discretion, rather than through a formal selection process guided by the foundation's predetermined priorities. Among foundations formed from health care conversions, about one in eight permit individual board members to make discretionary grants (Exhibit 10). Among these foundations, the median amount made available to each board member for discretionary grants was $50,000. Nearly all of the foundations (9 of 10) that give this authority to board members have conflict of interest policies that limit the involvement of board members in decisions about grants when the board member has a material interest in the potential recipient.

Exhibit 10. *Foundations Permitting Board Members to Make Discretionary Grants, 2004 (percentage of foundations)*



N=76

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

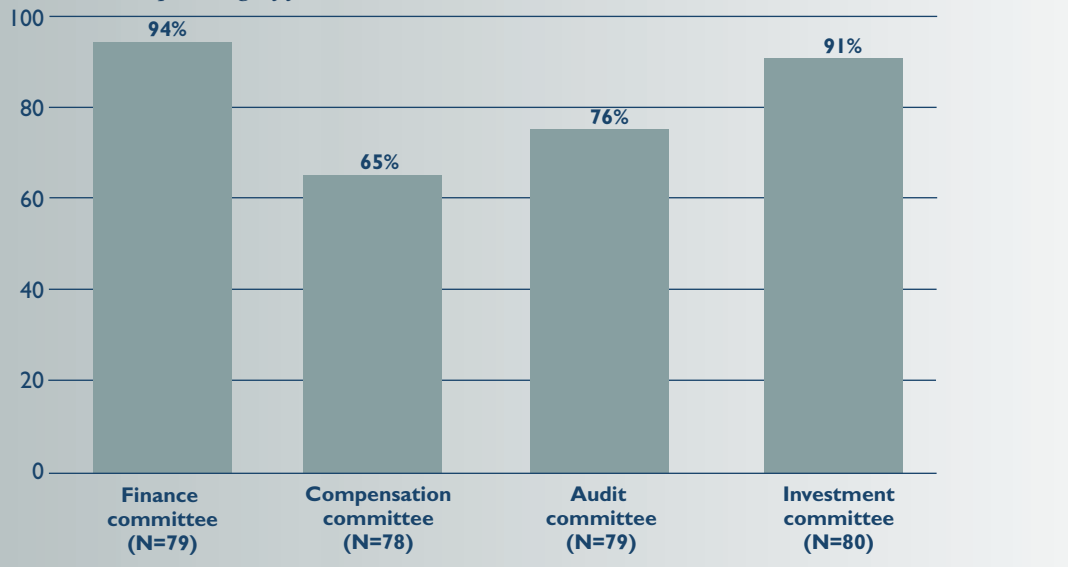
[4] These average per-member compensation levels should be interpreted with caution, since they mask substantial variations among foundations in each category.

Use of Board Committees

Foundation boards often use committees composed of board members (and sometimes others) to monitor aspects of foundation operations. This survey questioned foundations on the use of committees to monitor foundation finances, audits, investments, and compensation.

Nearly all – approximately 94 percent – foundations have a finance committee (defined as a committee that monitors the organization's budget, and secures and may review the services of outside auditors) (Exhibit 11). About two-thirds (65 percent) of foundation boards with a finance committee give that committee decisionmaking authority on budget matters, while the remainder use the finance committee to advise the full board, which is responsible for decisionmaking.

Exhibit 11. *Use of Board Committees by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=80

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Approximately 76 percent of foundations have an audit committee (defined as a committee that secures and reviews the performance of auditors, and oversees the audit of the foundation). Just over half (58 percent) operate that committee as a subcommittee of their finance committee; for the remainder, the audit committee is a freestanding, independent committee.

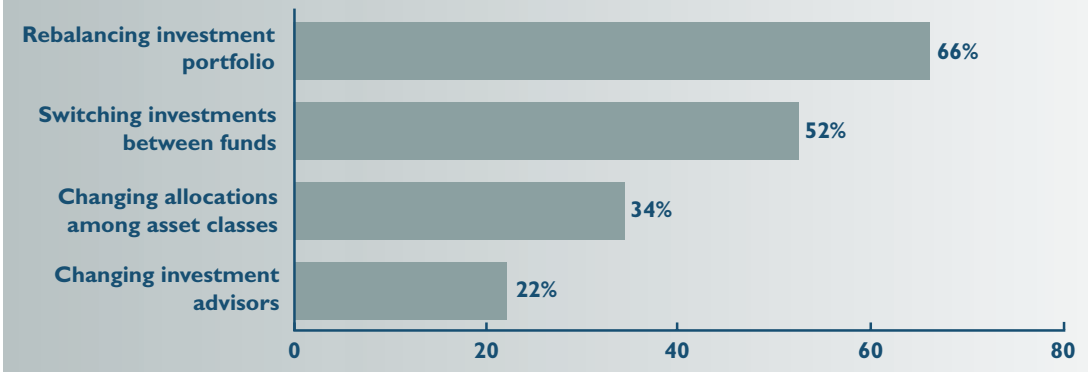
Most foundations (91 percent) reported having an investment committee (defined as a committee that oversees the management of the foundation's endowment). Finally, of the foundations that responded to the survey, approximately 65 percent have a compensation committee (defined as a committee that monitors and sets strategy for how the foundation's executives and board members are compensated).

Functions of the Investment Committee

Foundations vary as to what decisionmaking authority they grant to their investment committee. Among foundations with investment committees, decisionmaking authority is most commonly given for decisions on rebalancing portfolios (66 percent) and switching

investments among funds (52 percent) (Exhibit 12). Other areas where investment committees have decisionmaking authority include changing allocations among asset classes (34 percent) and changing investment advisors (22 percent).

Exhibit 12. *Functions of Investment Committees in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



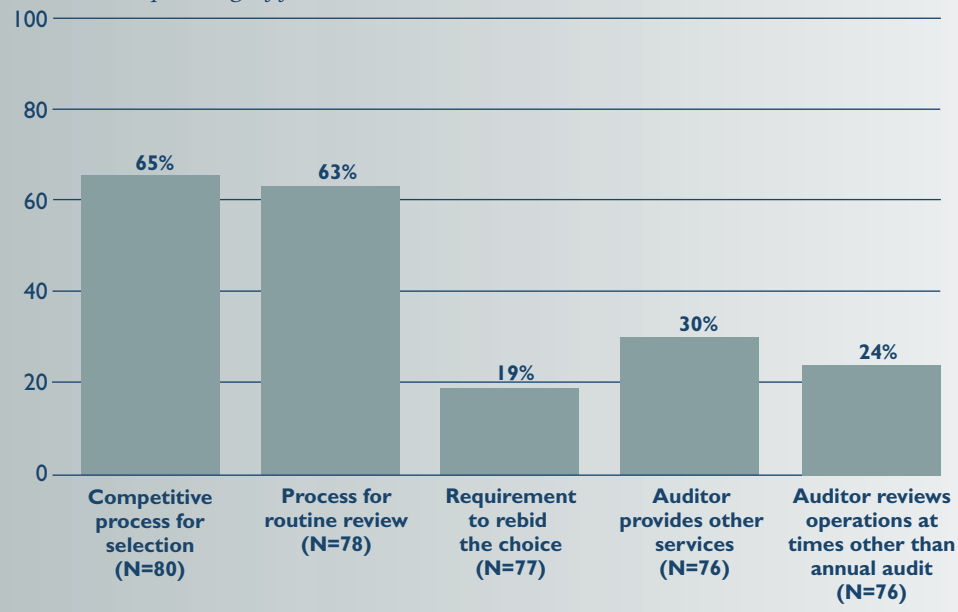
N=73

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Foundation Auditing Practices

Auditing is a key function and legal requirement for foundations and their boards. Nearly two-thirds of foundations formed from health care conversions reported having a competitive process for selecting their auditor (65 percent) and a process for routine review of their auditor's performance (63 percent) (Exhibit 13).

Exhibit 13. *Auditing Practices in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*

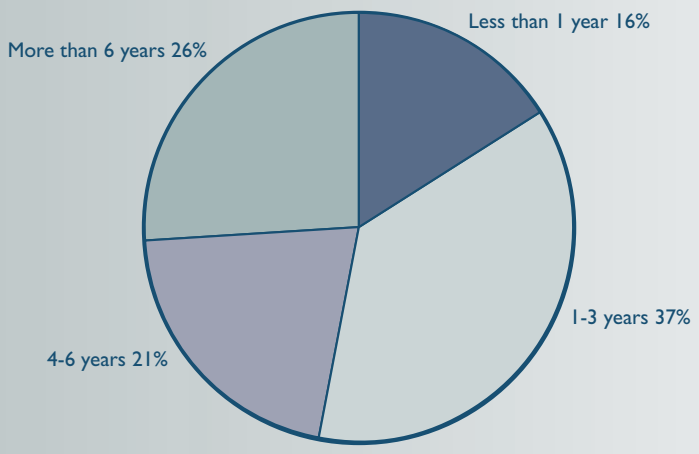


N=80

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Foundation practices regarding auditor selection varied. Only about one in five (19 percent) have a requirement to solicit competitive bids for the selection of the auditor on a regular schedule. Those foundations that had such a requirement typically require a competitive bidding process every three to five years. About one-half have used their current auditor for three or fewer years (Exhibit 14). Since about two-thirds of the foundations reported completing a competitive bidding process since 2001, this suggests that some foundations did not select a new auditor, but instead awarded a new contract to their previous auditor. About one-fourth of the foundations have not changed auditors for at least seven years.

Exhibit 14. *Years with Same Auditor in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=77

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

About one in four foundations (24 percent) indicated that their auditors review foundation operations at times other than during the annual audit. In just under a third of the foundations (30 percent), auditors also provide other services (such as consulting) to the foundation.

Foundation Assets and Expenses

Some of the most commonly asked questions about foundations concern their assets and how much they spend on administration. To gain a picture of spending in foundations formed from health care conversions, the survey contained questions about foundation assets, spending policies, and reporting, as well as questions about the amount spent by foundations on administration.

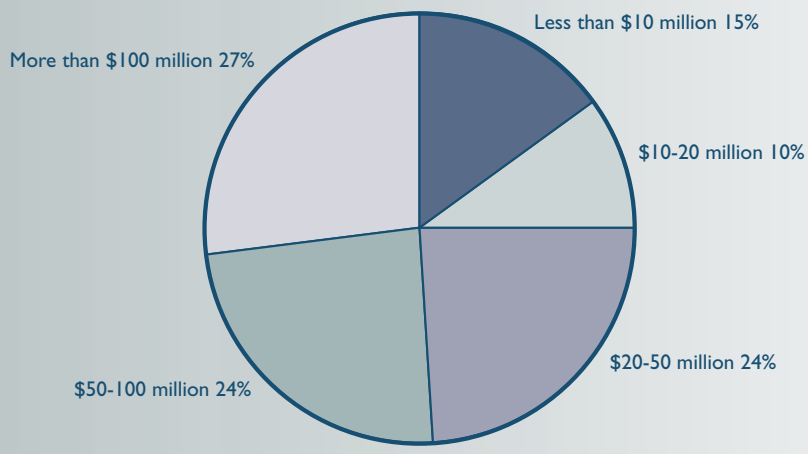
Assets Held by Foundations Formed from Health Care Conversions

Foundations formed from health care conversions hold a combined total of approximately $18.3 billion. Of the 174 foundations surveyed, information about assets was available for 172. Most of the foundations responding to the survey provided information on total assets with a

record date between June 2003 and June 2004. For most of the rest of the foundations, especially those for which GIH had to rely on information in the public record, the record date for total assets was in 2002.[5]

There is wide variation in the value of the assets held by foundations formed from health care conversions (Exhibit 15). Those foundations that responded to the survey had assets ranging from $54,800 to $2.8 billion, with the middle half of the foundations falling between $19.8 million and $106.0 million. The median asset value for all 172 foundations was

Exhibit 15. *Value of Assets Held by Foundations Formed From Health Care Conversions, 2004 (percentage of foundations)*



N=172

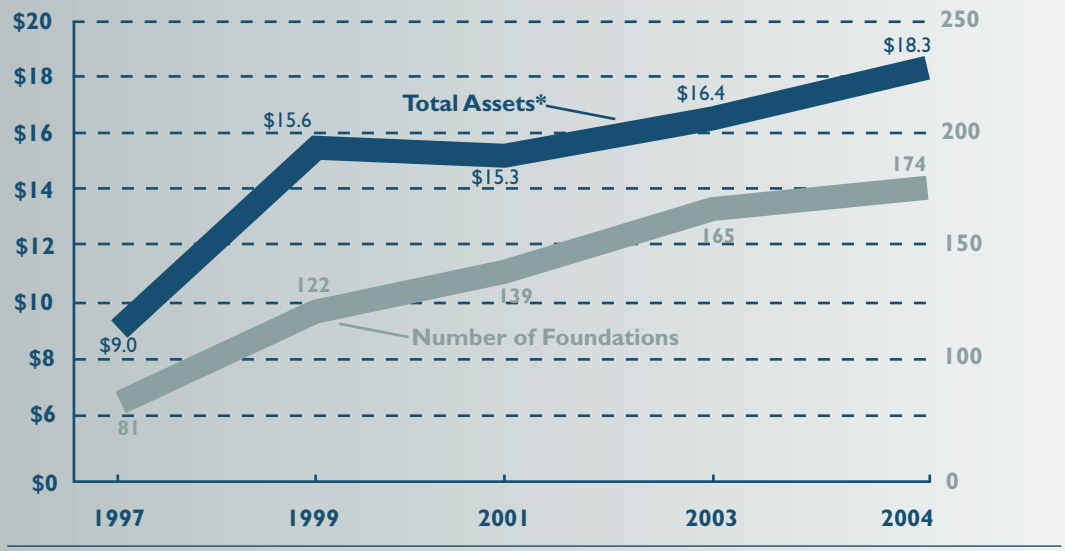
Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

$53.0 million, while the average asset value was $106.3 million. Among the foundations that responded to the survey (thus excluding those for which public information was used), the median foundation had assets of $64.4 million, while the average foundation had $167.5 million in assets. The difference reflects, in part, the lower response to the survey by smaller foundations.

The total number of foundations formed from health care conversions and the total assets these foundations hold have both grown over the past several years (Exhibit 16). The number of foundations increased by 9 since GIH's 2003 report, *A Profile of New Foundations*, and has more than doubled since 1997. Total assets held by these foundations has also doubled since 1997. The total value of assets grew by 12 percent from 2003 to 2004, reflecting both the addition of new foundations and improvements in the financial markets. The total value of assets held by foundations formed from health care conversions fluctuated from 1997 to 2004, corresponding to changes in the nation's economy as a whole and changes in returns on foundation investments.

[5] The assets held by foundations with record dates of 2003 or 2004 may reflect the relatively better performance of the stock market during those years, while the assets held by foundations with record dates of 2002 may reflect the relatively poor performance of the stock market in that year. GIH was not able to estimate what the total assets held by foundations formed from health care conversions would be if more current information were available for all foundations.

Exhibit 16. *Growth in Total Assets and Number of Foundations Formed from Health Care Conversions from 1997 to 2004 (billions of dollars and number of foundations)*



* N 1997=80, N 1999=122, N 2001=139, N 2003=164, N 2004=172

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Administrative Expenses

The median foundation reported spending about $400,000 on operating and administrative expenses in the most recently completed fiscal year, or about 1.2 percent of total assets (the mean was $1.2 million).[6] The range in administrative costs was from 0.1 percent to 13 percent, with half the foundations falling between about 0.7 percent and 2.2 percent.

Personnel costs accounted for a little over half of foundation administrative expenses. The median amount spent on personnel costs was 0.62 percent of assets on personnel costs, with half the foundations spending between about 0.4 percent and 1.2 percent of assets (or between $126,000 and $568,000) (Exhibit 17). The maximum amount spent on personnel costs was $16.2 million, while the highest proportion was 12.8 percent of total assets.

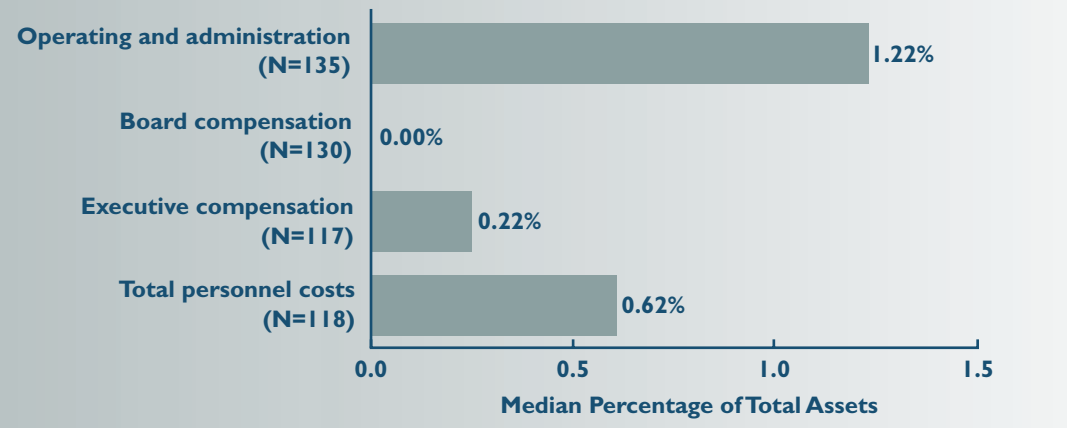
Executive compensation typically accounted for about one-third of overall personnel costs (0.22 percent of total assets). Half the foundations spent between $60,000 and $160,000 on executive compensation, with median spending of $105,000. The highest amount spent on executive compensation was $1.45 million, while the lowest amount was zero.

Foundation Spending Policy

Overall, about half of foundations have an explicit spending policy (defined as a policy that specifies the percentage of a foundation's assets that can be spent each year for all expenses, including both grantmaking and administrative expenses). Foundations that focus primarily on operating their own programs are more likely to have an explicit spending policy (60 percent)

[6] Fiscal years for the foundations participating in the survey varied. Of the 149 foundations for which information was available, 82 reported using the calendar year as their fiscal year (55 percent), 39 used a fiscal year starting July 1 (26 percent), and 18 used a fiscal year starting October 1 (12 percent). The remaining ten foundations (7 percent) used fiscal years starting on other dates.

Exhibit 17. *Annual Administrative Expenses as a Percentage of Total Assets in Foundations Formed from Health Care Conversions, 2004*



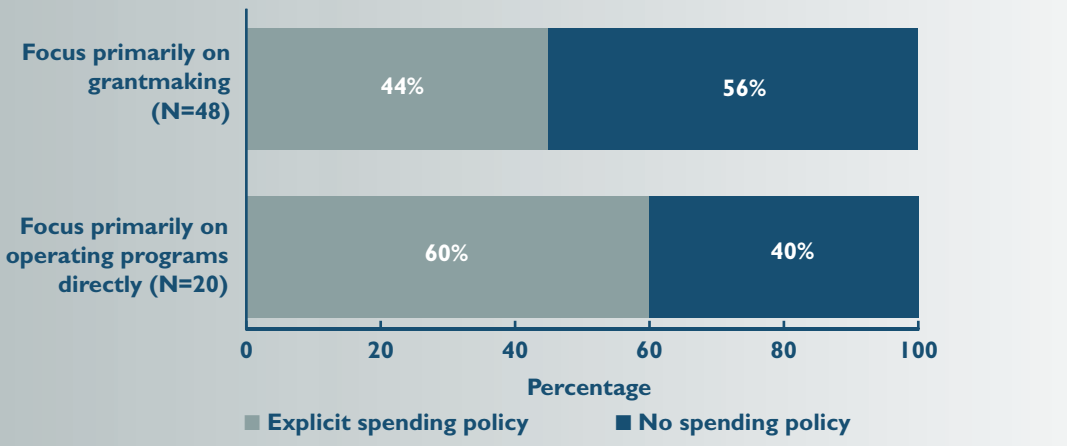
N=135

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

compared with those that characterize their role as primarily grantmaking (44 percent) (Exhibit 18). Public charities that act as supporting organizations to other nonprofit organizations were most likely to have an explicit spending policy compared with those in other tax status categories.

For foundations that have a spending policy, the most common (median) spending target is 5 percent of total assets. The median target spending is also 5 percent for foundations that operate programs in addition to making grants, as well as for those that are primarily focused on grantmaking. Similarly, there was no difference in target spending rate for foundations with different tax status categories.

Exhibit 18. *Spending Policies in Foundations Formed from Health Care Conversions, by Focus on Grantmaking versus Operating Programs Directly, 2004 (percentage of foundations)*



N=68

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Availability of Annual Reports with Audited Financial Statements

Annual reports are one way that foundations can communicate with the communities they serve about their missions and funding priorities. Over one-third of foundations (38 percent) produce an annual report that contains audited financial statements and make the report available as a printed document and as a downloadable document on the foundation's Web site. In addition, just under one-third produce annual reports available in only one format, either as a printed document (21 percent) or as an electronic document (8 percent). The remaining third (34 percent) do not make available an annual report with an audited financial statement.

Investment of Foundation Assets

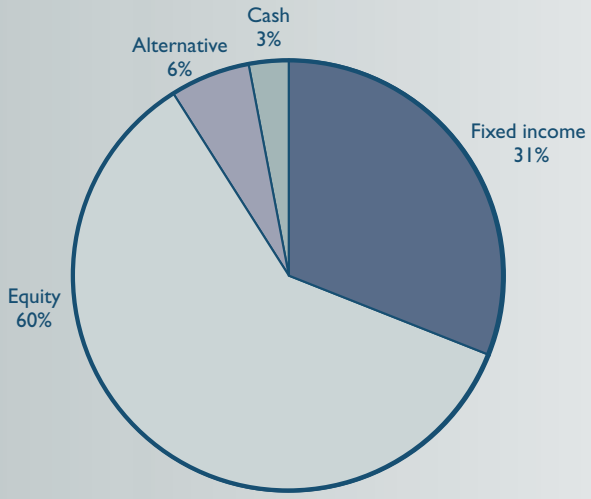
A critical concern for most foundations is how to maintain or increase the value of their portfolios, and considerable attention is given to investing the portfolio wisely. Like all investors, foundations must balance the potential benefits of investing conservatively to sustain the value of their assets over time with the potential benefits of investing more aggressively to increase the value of their assets. The survey asked foundations about their investment styles and the allocation of their assets, including the types of investments comprising a foundation's portfolio.

Asset Allocation

Among the surveyed foundations, over half (60 percent) of the average foundation's financial portfolio was in equity investments (stocks and stock funds) with nearly one-third (31 percent) in fixed income investments, such as bonds or annuities (Exhibit 19). A much smaller amount was placed in alternative investments (6 percent) or in cash (3 percent).

The data show, however, that there is considerable variation around these averages. Although about half the foundations maintained equity investments at between 58 percent and 69 percent of their portfolios, equity may represent as little as zero or as much 92 percent of a foundation's financial portfolio. The range of fixed income investments for the interquartile range (or middle

Exhibit 19. *Asset Allocations by Foundations Formed from Health Care Conversions, 2004 (percentage of assets in average foundation)*



N=75

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

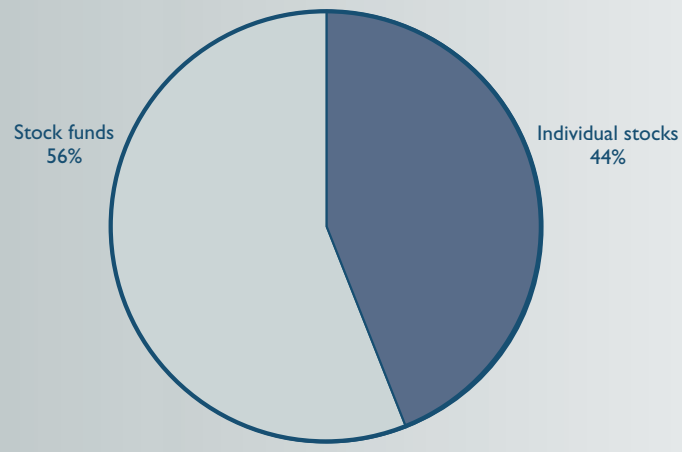
half) of foundations was between 24 percent and 35 percent, but some foundations put as little as 5 percent or as much as 95 percent of their portfolio in fixed income investments. It was not unusual for up to 10 percent of a foundation's portfolio to be in alternative investments and up to 5 percent to be held in cash. The largest reported investment in alternatives was 47 percent, while the highest percentage held in cash was 14 percent. Compared with information on foundation asset allocations that was recently published by the Commonfund Institute, data from GIH's survey showed foundations formed from health care conversions investing a slightly higher share of their assets in equity and fixed income investments, and considerably less in alternative investments than the foundations participating in the Commonfund survey (Commonfund Institute 2004).[7]

Equity Investments

Foundations take different approaches to their equity investments. Approximately 56 percent of foundations responding to GIH's survey invest primarily in stock funds, whereas 44 percent reported primarily investing in individual stocks (Exhibit 20).

About half of responding foundations report that they direct their equity investments equally among growth, value, and core stocks or funds (Exhibit 21). Among those that reported an emphasis on one particular type of equity investment, growth stocks or funds (defined as companies experiencing rapid growth in sales, revenue, or earnings typically with high price-to-earning ratios) were least likely to be the largest area of investment. Foundations showing a

Exhibit 20. *Primary Form of Equity Investments by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*

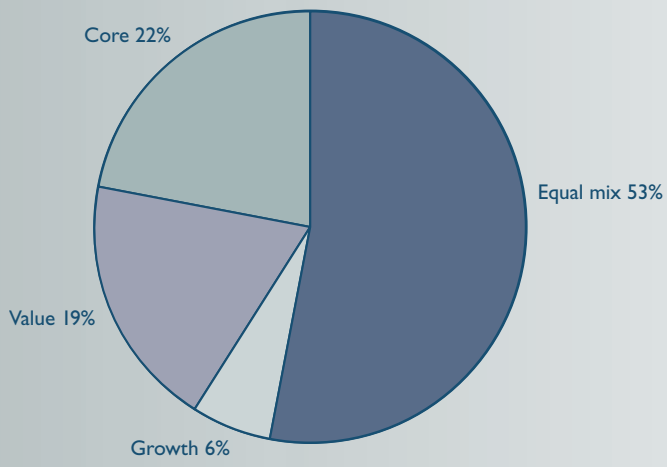


N=73

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

[7] The Commonfund Institute surveyed 272 community, private, and public foundations throughout the United States on a variety of topics, including investment returns, objectives, and benchmarks; asset allocation, rebalancing, and costs of managing investment programs; donor stock; spending, underwater funds, and gifts; foundation management resources; and foundation governance. The Commonfund study reported the following average asset allocations for fiscal year 2003: domestic equities, 48 percent; fixed income, 21 percent; alternative investments, 14 percent; international equities, 12 percent; and cash/short-term, 5 percent. The two surveys differed in that GIH's survey asked foundations to report whether they invested in international investments, but did not ask them to report the share of their assets allocated to international equities. For comparability, GIH dropped the international equities from the Commonfund benchmark allocation and recalculated the shares corresponding to the remaining types of investments. GIH's recalculation yielded the following figures for the foundations surveyed by the Commonfund Institute: domestic equities, 54 percent; fixed income, 24 percent; alternative investments, 16 percent; and cash/short-term, 6 percent.

Exhibit 21. *Emphasis on Particular Types of Investments by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=68

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

preference were slightly more likely to emphasize core investments (defined as companies with dominant positions in their industries with a strong history of revenue and earnings growth and less volatility) than value investments (defined as those with low price-to-earning ratios that are viewed as having bargain prices at the time of purchase).

Equity investments are typically divided into three groups: small-capitalization (cap) companies, mid-cap companies, and large-cap companies.[8] Nearly all surveyed foundations (95 percent) include large-cap equities in their portfolios, while most also include small-cap companies (78 percent) and mid-cap companies (64 percent) (Exhibit 22).

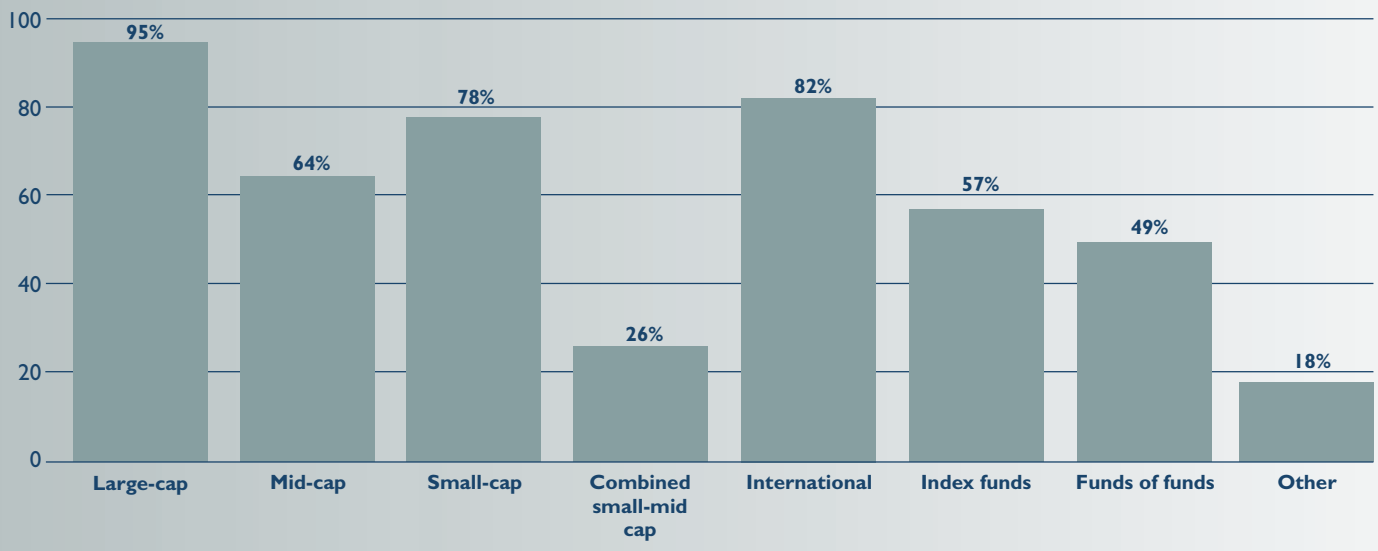
International investments were also common, being found in the portfolios of 82 percent of the surveyed foundations. A little over half of the foundations include index funds in their portfolios. Index funds are mutual funds that try to copy the performance of a stock market index such as the S&P 500 by purchasing all 500 stocks using the same percentages as the index. In addition, about half include funds of funds, which are defined as mutual funds that invest in other funds. About 18 percent of respondents indicated that their equity portfolios include some other type of investments as well.

Alternative Investments

Alternative investments are a relatively small part of most foundation portfolios. The most common types of alternative investments are hedge funds of funds (28 percent of respondents) and real estate investment trusts (REITs) (23 percent) (Exhibit 23). Hedge funds are allowed to use aggressive strategies unavailable to other mutual funds, including selling short, leverage, program trading, swaps, arbitrage, and derivatives. Normal rules governing mutual funds do not apply to these funds, and they are typically restricted to large investors. Hedge funds of funds

[8] Capitalization is the market value of a company's stock. Small-cap companies have a stock market value that is generally defined as under $2 billion, mid-cap companies have a stock market value between about $2 billion and $8 billion, and large-cap companies have a stock market value of over $10 billion.

Exhibit 22. *Types of Equity Investments by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=72

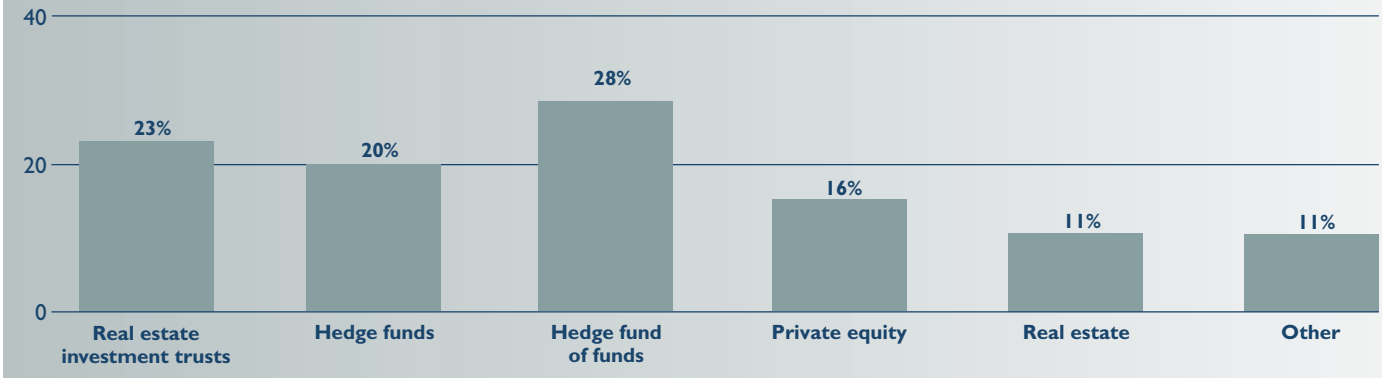
Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

invest in several hedge funds to dilute the risk found in these funds. Some also reported investing in hedge funds (20 percent), private equity (16 percent), or real estate (11 percent). Another 11 percent of respondents volunteered other types of alternative investments, including commodity funds, venture capital investments, and timber funds. According to the 2004 Commonfund report, hedge funds were reported to be the largest area of alternative investment for the foundations participating in that survey.

Management of Foundation Investments

Foundations, like other investors, must monitor the performance of their portfolios and make changes based on market conditions to reach their investment return goals. GIH's survey asked foundations to describe the methods and practices they use to manage their investments.

Exhibit 23. *Use of Alternative Investments by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



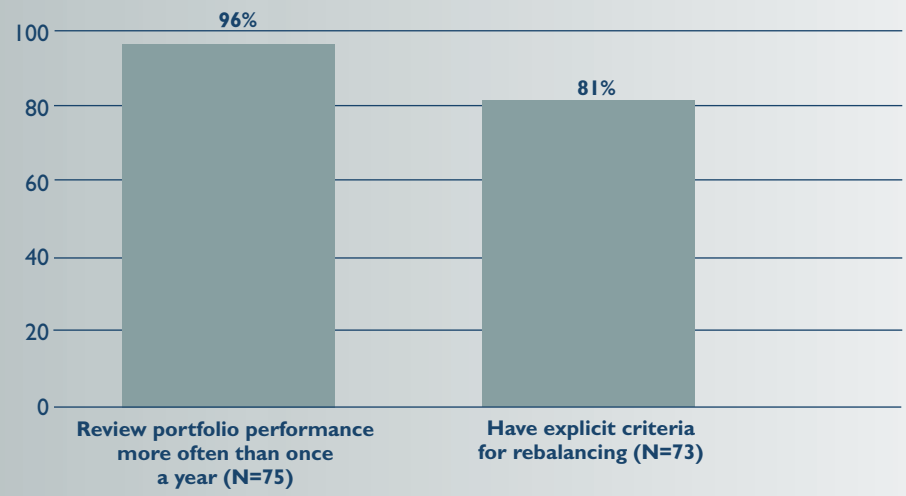
N=74

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Reviewing and Rebalancing Portfolios

Nearly all foundations review their portfolio performance more often than once a year (96 percent), and most also include explicit criteria for rebalancing their portfolios in their investment policies (81 percent) (Exhibit 24). That is consistent with statistics on rebalancing in the Commonfund Institute's 2004 benchmark report: portfolio rebalancing during the most recent year was reported by 84 percent of the 272 foundations surveyed by Commonfund.

Exhibit 24. *Policies Regarding Review of Portfolio Performance and Rebalancing in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*

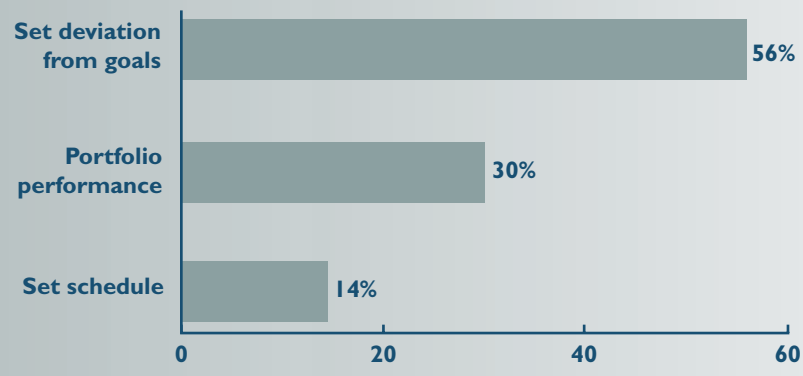


N=75

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

More than half of all foundations (56 percent) surveyed for this report stated that they rebalance or realign the proportions of assets in a portfolio based on a set deviation from their asset allocation goals (Exhibit 25). Of those remaining, 30 percent rebalance their portfolios based on portfolio performance, while 14 percent rebalance their portfolios on a set time schedule.

Exhibit 25. *Reasons for Rebalancing Portfolios of Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=70

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

The foundations that rebalance their portfolios based on a set deviation from asset allocation goals reported various asset allocation ranges (minimums and maximums) for each asset class (both broad classes such as equity versus alternative investments or more specific classes such as large-cap versus small-cap equities). If the allocations fall outside the specified range, the portfolio is rebalanced. Most of the foundations that elaborated on their rebalancing policies stated that rebalancing usually occurs when there is a 5 percent deviation above or below a specified target. Thus if the target is 70 percent equity and 30 percent fixed investments, the portfolio would be rebalanced if market returns caused the proportion in equities to drop below 65 percent or rise above 75 percent. In one case, the foundation reported waiting until a 10 percent deviation occurred before rebalancing the portfolio.

Foundations that reported rebalancing based on the performance of their portfolios assess the need to rebalance in different ways: they do so based on discussions with investment consultants or finance advisory committees, to adhere to foundation guidelines or investment policies, to return to a specific investment ratio, or if performance of investments falls below expectations. Those foundations that reported rebalancing on a set schedule specified that such rebalancing occurs either annually, quarterly, or monthly.

Most foundations reported in mid-2004 that they had rebalanced their portfolios within the previous 12 months. Only a handful had last done so in 2002 or earlier.

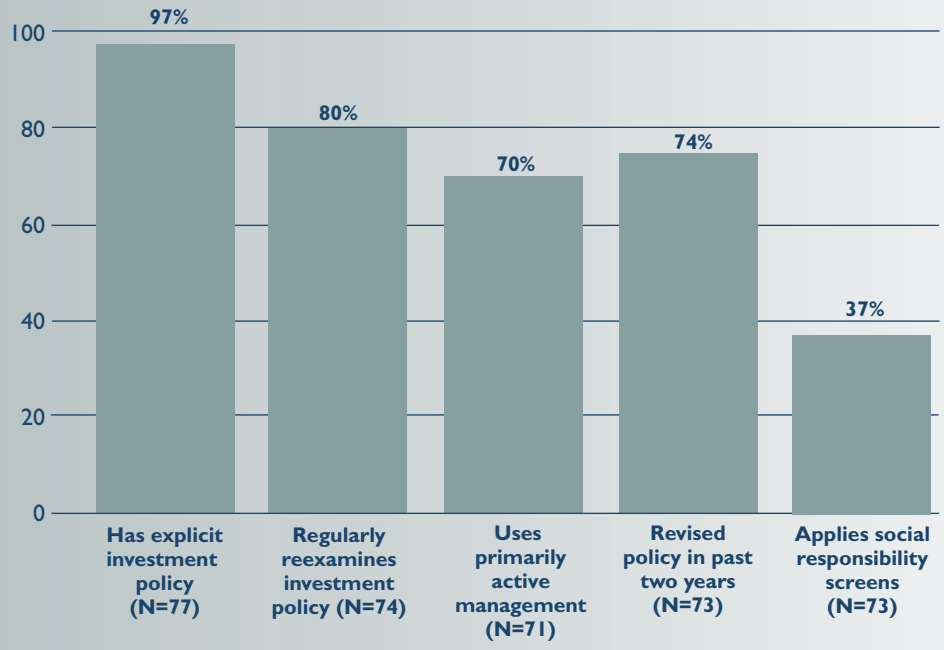
Guidelines for Removing Investments from Portfolios

About 60 percent of foundations indicated that they have guidelines or rules of thumb that trigger a decision to eliminate a particular investment from their portfolio. In open-ended responses, about two-thirds of foundations with guidelines reported that they look at the performance of a fund over time. Some noted that they compare a fund's performance to specific benchmarks for the fund's peer group over a period ranging from two quarters to three years. One-third of foundations with guidelines look to the advice of advisors or board members in making decisions to remove investments from portfolios, while a smaller number regard a significant change in fund personnel as a signal to make a change.

Foundation Investment Policies

Nearly all the surveyed foundations (97 percent) have adopted an explicit investment policy (Exhibit 26). About 80 percent report that they reexamine their policies regularly, while most of the rest reexamine their policies as issues arise. Most (70 percent) characterize their investment management as primarily active, meaning that the foundation has a strategy for changing the allocation of its assets into particular investment classes based on market conditions, as well as criteria for choosing individual stocks (whereas passive management focuses on diversification and long-term investments to achieve investment goals).

Exhibit 26. *Adoption of Specific Investment Policies by Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*



N=77

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Foundation investment policies are not static, with about 74 percent of foundations reporting that they have revised their policies within the last two years. Those that did so were most likely to change allocation targets for different types of investments or to add new types of investments. The reason most often cited for such changes was to achieve further diversification (63 percent of those making revisions) or to take advantage of new opportunities (37 percent). Poor rate of return was the reason least often cited (about one-fifth of foundations).

About one-third of the surveyed foundations volunteered other reasons for changing investment policies. For example, one foundation indicated that as its board members gained experience, they were more confident about taking some risks to enhance returns. Other foundations reported changing their policies to update or fine-tune them, most commonly after conducting reviews of current spending policies. Others mentioned a desire to incorporate social responsibility screens, to revise investment strategies to put them more in line with a private grantmaking organization, or to improve compliance with fund-specific investment restrictions. Some also indicated that hiring new investment managers led to a change in allocation formulas.

About 37 percent of all foundations reported applying social responsibility screens to their investments (Exhibit 27). Screening describes the inclusion or exclusion of corporate securities in investment portfolios based on social or environmental criteria such as employee relations records, levels of community involvement, environmental impact policies and practices, human rights policies, and the safety of products. The screens most commonly used by survey respondents were avoidance of investments in companies connected to tobacco products and

alcohol. Other screens that were cited included firearms, environmental concerns, gambling, production of pornographic publications and products, production of indiscriminant weapons of mass destruction, and process-oriented criteria such as companies with gross violations of consumer fraud or occupational safety standards.

Exhibit 27. *Use of Social Responsibility Screens in Investment Decisions by Foundations Formed from Health Care Conversions, 2004 (number and percentage of foundations)*

Type of Screen	Number of Foundations	Percentage of Foundations
Any type of social responsibility screen	27	37
No social responsibility screen	46	63
No tobacco-related investments	17	23
No alcohol-related investments	8	11
No firearms-related investments	3	4
Environmental concerns	2	3
No gambling-related investments	2	3
Other types of screens	7	10

N=73

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Target Rate of Return on Investments

As part of their reporting on investment policies, foundations reported a median target rate of return of 8.0 percent (the average was 7.6 percent), with half the responding foundations falling between 7.0 percent and 8.7 percent. The highest target rate reported was 12 percent.

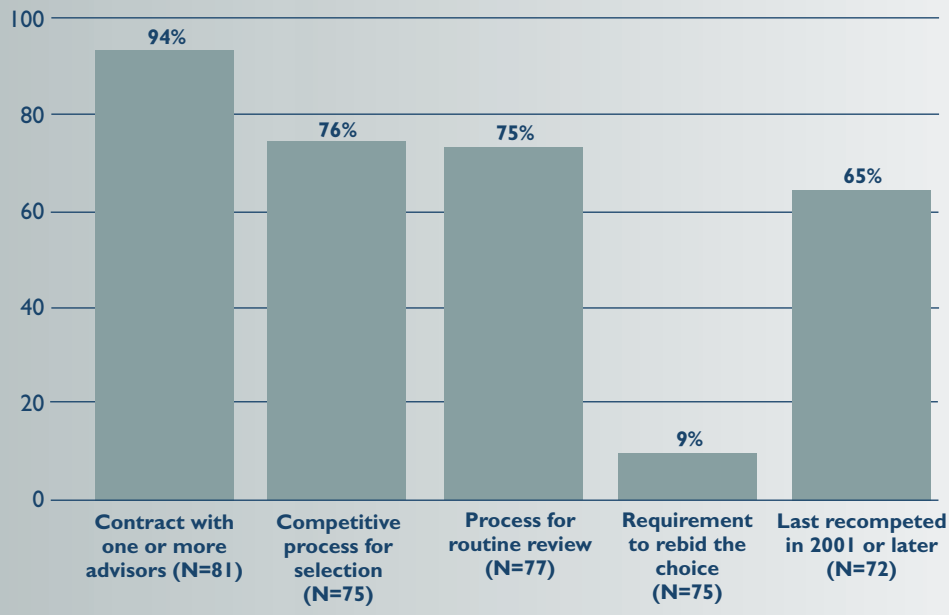
Actual rates of return for the most recently completed fiscal year averaged 16.4 percent (the median was 17.9 percent), with a range between 7.8 percent and 25.1 percent return on investments. Returns for foundations formed from health care conversions were quite similar to a reported average annual return of 17 percent for 272 community, private, and public foundations recently surveyed by the Commonfund Institute.

Use of Investment Advisors

Nearly all of the responding foundations (94 percent) currently use an investment advisor to help them manage their investments (Exhibit 28). About three-fourths (76 percent) select their investment advisor competitively, and 75 percent have a process for routine review of the advisor's performance.

It is unusual for foundations to require a regular competitive rebidding for an investment advisor: only 9 percent of foundations have this requirement. Even though most do not require it, about two-thirds completed a competitive rebidding process within the past four years (one-third within the last two years). Foundations may choose to recompete their choice of investment advisor in order to gain better quality or price for financial services. About 5 percent have not held a rebidding process for ten years. For nearly half the foundations, their investment

Exhibit 28. *Practices Related to Use of Investment Advisors in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*

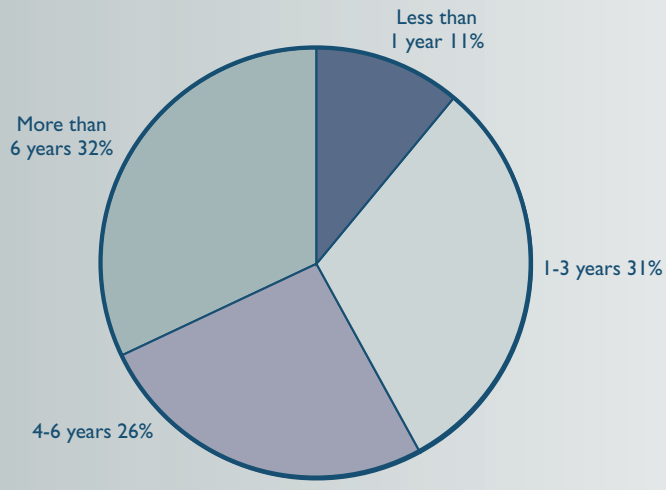


N=81

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

advisor has been in place for three years or fewer, but for a third of the foundations, the current investment advisor has been in place for more than six years (Exhibit 29). Those with short tenures, however, were disproportionately drawn from the newer foundations.

Exhibit 29. *Tenure of Investment Advisors in Foundations Formed from Health Care Conversions, 2004 (percentage of foundations)*

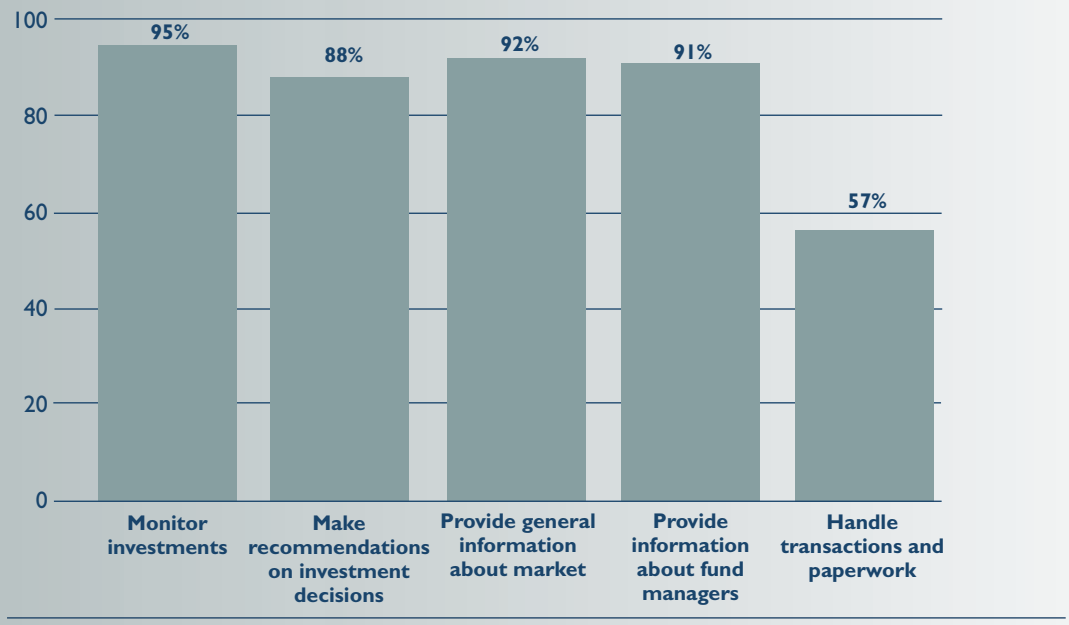


N=74

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

According to the survey, nearly all foundations that use investment advisors use them to monitor the foundation's investments (95 percent) (Exhibit 30). Other common functions include making recommendations regarding investment decisions (88 percent), providing general information about the market (92 percent), and providing information on specific fund managers (91 percent). It is less common for advisors to handle transactions and paperwork (57 percent).

Exhibit 30. *Functions of Investment Advisors in Foundations Formed from Health Care Conversions that Use Investment Advisors, 2004 (percentage of foundations)*



N=76

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004.*

Half of the foundations (50 percent) that use investment advisors compensate them based on a percentage of the value of the foundation's portfolio. Approximately 41 percent of the remaining foundations compensate on a flat-fee basis. Some foundations also pay other fees related to asset management: transaction fees (42 percent), broker's fees (23 percent), and other fees for consultants or advisors (20 percent).

Foundation boards work closely with their investment advisors. Investment committees meet often with the investment advisors, with more than two-thirds meeting at least every three months. Only one foundation responded that meetings with investment advisors were less frequent than once a year.

Staff Authority to Make Investment Decisions

In about two-thirds of foundations (66 percent), the staff has no authority to make investment decisions. Where they do have such authority, the most common is to rebalance the portfolio (23 percent). Another 8 percent of staffs have authority to switch funds, and other situations mentioned included the authority to turn over fixed income investments and withdrawing funds to meet operating requirements or grant obligations.

SUMMARY AND CONCLUSIONS

The trend toward conversion of nonprofit health care organizations to for-profit status is continuing. The current pattern of conversions may be slightly altered from the 1990s – health plan conversions, for example, are facing more opposition in many localities and have therefore become less common – but the country is likely to continue to see the formation of new foundations. In particular, the pace of hospital conversions is likely to persist due to the competitive hospital market and the desire of many to obtain capital for modernization and other advantages of for-profit status.

While the debate about the desirability of for-profit health care continues, the foundations that result from many of these transactions make important contributions to the communities they serve. With grantmaking interests that encompass many aspects of health and health care, foundations formed from health care conversions are part of the solution to the problems facing individuals, families, and localities across the country. In addition, many of these foundations are operating their own programs to address the needs they see in their communities.

At the same time that new foundations are being created, many foundations formed from health care conversions have now been operating for a decade or more. The maturation of this sector of health philanthropy is evident from the strong governance and investment policies they have put in place, as well as the improvement – albeit a modest one – in the diversity of their boards. There is room for improvement in some areas, notably the availability of annual reports with audited financial statements, gender diversity on foundation boards, and the processes used to select investment advisors and auditors. In general, however, foundations formed from health care conversions have solid governance policies and practices in place.

When it comes to investment policies and strategies, the practices of foundations formed from health care conversions look very similar to those of foundations formed in other ways. As with other foundations, the leadership and staff of foundations formed from health care conversions seek to be good stewards of the resources entrusted to them. The early years of this decade were challenging ones financially for foundations formed from health care conversions, as they were for all foundations. Generally, however, this group of foundations weathered the storm well, protecting their assets and their ability to make grants. Going forward, they will continue to make an important difference in the health and well-being of the communities they serve.

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Grantmakers In Health, *A Profile of New Health Foundations* (Washington, DC: 2003).

Grantmakers In Health, *Assets for Health: Findings from the 2001 Survey of New Health Foundations* (Washington, DC: 2002).

APPENDIX 1

Operational Characteristics, Governance, and Expenses of Foundations Formed from Health Care Conversions, by Value of Assets, 2004

	Value of Assets[a]				
	Below $10 million	**$10-$20 million**	**$20-$50 million**	**$50-$100 million**	**Over $100 million**
Foundation Operations					
Focus primarily on grantmaking (percentage of foundations)	11% N=9	20% N=10	6% N=17	5% N=22	0% N=27
Operate programs directly, in addition to grantmaking (percentage of foundations)	22% N=9	10% N=10	12% N=17	18% N=22	44% N=27
Focus primarily on operating programs directly (percentage of foundations)	67% N=9	70% N=10	82% N=17	77% N=22	56% N=27
Number of staff (mean, in FTEs)[b]	1.3 N=6	4.7 N=9	2.6 N=15	7.1 N=21	23.4 N=26
Number of staff (median, in FTEs)[b]	1.5 N=6	2.25 N=9	2.9 N=15	4.5 N=21	12.1 N=26
Governance					
Board size (median)[c]	12.5 N=18	11.5 N=16	12.5 N=38	13 N=24	13 N=35
Board member discretionary grants permitted (percentage of foundations)	0% N=6	0% N=11	18% N=17	5% N=22	29% N=21
Compensation for service on board provided (percentage of foundations)	0% N=6	5% N=11	11% N=18	14% N=22	36% N=22
Has a finance committee (percentage of foundations)	100% N=6	83% N=12	88% N=17	100% N=22	95% N=22
Has an investment committee (percentage of foundations)	86% N=7	91% N=12	82% N=17	95% N=22	95% N=22
Has an audit committee (percentage of foundations)	66% N=6	66% N=12	59% N=17	82% N=22	90% N=21

	Value of Assets[a]				
	Below $10 million	**$10-$20 million**	**$20-$50 million**	**$50-$100 million**	**Over $100 million**
Expenses					
Administrative expenses (mean as a percentage of value of assets)	1% N=17	2% N=17	2% N=38	1% N=30	1% N=33
Has an explicit spending policy (percentage of foundations)	29% N=7	44% N=9	39% N=18	56% N=18	54% N=24
Availability of annual report with audited financial statement (percentage of foundations)	33% N=6	58 % N=12	74% N=19	73% N=22	67% N=21

[a] Asset values were not available for two foundations.

[b] FTE refers to full-time equivalent, a measure of staff hours equal to those of a full-time employee. Two people working half time equal one FTE.

[c] Includes foundations that responded to GIH's survey, as well as foundations for which information was gathered from public sources.

Note: The sample sizes for some of the columns in the table are small. Caution should be used in interpreting percentages, means, and medians, especially where the total number of cases is below 10.

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004*.

APPENDIX II

Year of Conversion, Type of Entity Converted, and Tax Status of Foundations Formed from Health Care Conversions, by Value of Assets, 2004

	Value of Assets[a]				
	Below $10 million N=26	**$10-$20 million N=18**	**$20-$50 million N=41**	**$50-$100 million N=41**	**Over $100 million N=46**
Year of Conversion					
Before 1984 (percentage of foundations) (N=6)	8% N=2	6% N=1	5% N=2	2% N=1	—
1984-1993 (percentage of foundations) (N=37)	31% N=8	28% N=5	22% N=9	17% N=7	17% N=8
1994-1998 (percentage of foundations) (N=92)	42% N=11	56% N=10	51% N=21	51% N=21	63% N=29
1999-2001 (percentage of foundations) (N=29)	15% N=4	11% N=2	20% N=8	22% N=9	13% N=6
2002 or later (percentage of foundations) (N=8)	4% N=1	—	2% N=1	7% N=3	7% N=3
Type of Entity Converted					
Hospital (percentage of foundations) (N=113)	69% N=18	94% N=17	76% N=31	63% N=26	46% N=21
Health system (percentage of foundations) (N=18)	—	6% N=1	2% N=1	12% N=5	24% N=11
Hospital and health system (percentage of foundations) (N=8)	4% N=1	—	7% N=3	2% N=1	7% N=3
Health plan (percentage of foundations) (N=30)	19% N=5	—	12% N=5	22% N=9	24% N=11
Other (percentage of foundations) (N=3)	8% N=2	—	2% N=1	—	—

	Value of Assets[a]				
	Below $10 million N=26	**$10-$20 million N=18**	**$20-$50 million N=41**	**$50-$100 million N=41**	**Over $100 million N=46**
Tax Status[b]					
Private foundation (percentage of foundations) (N=77)	38% N=10	56% N=10	39% N=16	50% N=20	47% N=21
Public charity – 509(a)(1) traditional (percentage of foundations) (N=42)	42% N=11	33% N=6	24% N=10	23% N=9	14% N=6
Public charity – 509(a)(2) gross receipts (percentage of foundations) (N=6)	4% N=1	—	7% N=3	—	5% N=2
Public charity – 509(a)(3) supporting organization (percentage of foundations) (N=36)	15% N=4	11% N=2	27% N=11	23% N=9	23% N=10
Social welfare organization (N=6)	—	—	—	5% N=2	9% N=4
Other (N=2)	—	—	2% N=1	—	2% N=1

[a] Asset values were not available for two foundations.

[b] Tax status was not available for three foundations with asset values.

Note: Percentages may not sum to 100 due to rounding. The sample sizes for some columns are small. Caution should be used in interpreting data, especially where the total number of cases is below 10.

Source: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004*.

APPENDIX III

A Profile of Foundations Formed From Health Care Conversions

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Allegany Franciscan Foundation *Clearwater, FL* http://franciscanfdn.org	1998	$114,160,025	Public Charity[3]	Hospital	Physical, mental, and spiritual health; wellness and disease prevention awareness; healthy living promotion and screening; development of neighborhood health advocates; the full spectrum of family competency, including childhood and youth development; and family skill building for parent/adult engagement with children
The Alleghany Foundation *Covington, VA*	1995	$45,445,859	Private Foundation	Hospital	Quality of life; nurses; school and dental services; and education
Alliance Healthcare Foundation *San Diego, CA* www.alliancehf.org	1994	$70,607,952	Private Foundation	Health Plan	Substance abuse; communicable disease; mental health; access to care; and violence prevention
Andalusia Health Services, Inc. *Andalusia, AL*	1981	$2,478,976	Private Foundation	Hospital	Medical scholarships
Anthem Foundation of Ohio *Cincinnati, OH* www.greatercincinnatifdn.org/page494.cfm	1995	$25,987,152	Public Charity[3]	Health Plan	Preventive oral health care and family violence prevention programs for indigent populations.
Archstone Foundation *Long Beach, CA* www.archstone.org	1985	$102,889,229	Private Foundation	Health Plan	Elder abuse prevention; fall prevention; end-of-life issues; and responsive grantmaking
Asbury Foundation of Hattiesburg, Inc. Hattiesburg, MS	1997	$35,371,446	Private Foundation	Hospital and Health System	General health
The Assisi Foundation of Memphis, Inc. *Memphis, TN* www.assisifoundation.org	1994	$178,000,000	Private Foundation	Hospital and Health System	Delivery of preventive and primary care and related services; health promotion and education; support and enhancement of health and human services systems; and healthy communities
Austin-Bailey Health & Wellness Foundation *Canton, OH* www.foundationcenter.org/grantmaker/austinbailey	1996	$8,700,000	Private Foundation	Hospital	Health care affordability for the uninsured and underinsured, the poor, children, single parents, and the aging; mental health needs of individuals and families; and domestic violence
Baptist Community Ministries *New Orleans, LA* www.bcm.org	1995	$230,000,000	Private Foundation	Health System	Physical, mental, spiritual health; social/risk factor reduction and protective factors; access to care; care coordination; education; public safety; and governmental oversight
Baptist Healing Trust *Nashville, TN* www.healingtrust.org	2001	$130,000,000	Public Charity[1]	Health System	Access to appropriate and affordable health care and capacity building of nonprofit organizations
Barberton Community Foundation *Barberton, OH* www.bcfcharity.org	1996	$94,391,950	Public Charity[3]	Hospital	Public health; human services; education; recreation; and community development

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Bedford Community Health Foundation *Bedford, VA* www.bchf.org	1984	$4,247,291	Public Charity[1]	Hospital	Emergency medical services; senior care; nursing scholarships; and charity care
Bernardine Franciscan Sisters Foundation *Newport News, VA* www.bfranfound.org/	1996	$12,674,520	Public Charity[3]	Hospital	Charitable, scientific and/or educational activities related to the health care and charitable works of the Bernardine Sisters of the Third Order of Saint Francis; services to the sick and injured; human services; and education
Berwick Health and Wellness Fund *Berwick, PA* www.csgiving.org	1999	$23,570,000	Public Charity[1]	Hospital	Oral health; school readiness; mental health; healthy lifestyles, prevention, and community health; and cardiovascular health
BHHS Legacy Foundation *Phoenix, AZ*	2000	$110,687,000	Public Charity[3]	Health System	Children; families; and seniors
Birmingham Foundation *Pittsburgh, PA* www.birminghamfoundation.org	1996	$18,303,016	Private Foundation	Hospital	Children's well-being; senior safety; health access and promotion; capacity building; community life; health disparities; and vulnerable populations
Mary Black Foundation, Inc. *Spartanburg, SC* www.maryblackfoundation.org	1996	$74,000,000	Private Foundation	Hospital and Health System	Health and wellness; early childhood development; and physical activity
The Blowitz-Ridgeway Foundation *Schaumburg, IL* www.blowitzridgeway.org	1984	$22,321,977	Private Foundation	Hospital	Health care and human services for the economically disadvantaged
Brandywine Health & Wellness Foundation *Coatesville, PA* www.brandywinefoundation.org	2001	$22,000,000	Public Charity[1]	Hospital	Increasing access to medical, dental, and mental health services; removing insurance and language barriers; improving community health status by reducing health disparities; afterschool programs; domestic violence; and drug and alcohol prevention
The Brentwood Foundation *Medina, OH* www.southpointegme.com/brentwood/foundation.cfm	1994	$18,843,731	Private Foundation	Hospital	Medical education; research; and community health
Drs. Bruce and Lee Foundation *Florence, SC*	1995	$127,562,044	Private Foundation	Hospital	Health; human services; and youth education
Byerly Foundation *Hartsville, SC* www.byerlyfoundation.org	1995	$24,426,404	Private Foundation	Hospital	Education; economic development; and community life
Calhoun County Community Foundation *Anniston, AL* www.cccfoundation.org	1997	$14,229,669	Private Foundation	Hospital	Substance abuse; and child abuse and neglect intervention and prevention
The California Endowment *Woodland Hills, CA* www.calendow.org	1996	$2,762,621,100	Private Foundation	Health Plan	Access to affordable, quality health care; workforce diversity; cultural competence; and health disparities

NAME, LOCATION, AND WEB ADDRESS	YEAR OF CONVERSION	ASSETS	IRS TAX-EXEMPT STATUS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
California HealthCare Foundation *Oakland, CA* www.chcf.org	1996	$750,000,000	Social Welfare Organization	Health Plan	Chronic disease; hospitals and nursing homes; health insurance; and public financing and policy
The California Wellness Foundation *Woodland Hills, CA* www.tcwf.org	1992	$968,000,000	Private Foundation	Health Plan	Diversity in health professions; environmental health; healthy aging; women's health; mental health; teen pregnancy prevention; violence prevention; and work and health
The Cameron Foundation *Petersburg, VA* www.thecameronfoundation.org	2003	$89,883,474	Public Charity[1]	Hospital	Health care; human services; civic affairs; community and economic development; education; conservation and historic preservation; and cultural enrichment
Cape Fear Memorial Foundation *Wilmington, NC*	1996	$54,400,000	Private Foundation	Hospital	Health, medical, and human services
Caring for Colorado Foundation *Denver, CO* www.caringforcolorado.org	1999	$138,831,460	Social Welfare Organization	Health Plan	Health infrastructure; emerging and community-specific issues; and informed health decisionmaking
Carlisle Area Health & Wellness Foundation *Carlisle, PA* www.carlislehealthfoundation.org	2001	$39,901,768	Public Charity[1]	Hospital	Behavioral health, including substance abuse and mental health; oral health; and chronic disease, including diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, and cancer
Central Florida Healthcare Development Foundation *Leesburg, FL*	1997	$126,750,308	Public Charity[3]	Hospital and Health System	Access to care; education; and direct service
Christy-Houston Foundation *Murfreesboro, TN*	1986	$71,367,397	Private Foundation	Hospital	Health care; education; charitable activities; nursing homes; nursing education
Colorado Springs Osteopathic Foundation *Colorado Springs, CO* www.csof.org	1984	$11,497,701	Public Charity[1]	Hospital	Medical education and medical care to meet community needs
The Colorado Trust *Denver, CO* www.coloradotrust.org	1985	$403,714,627	Private Foundation	Health System	Accessible and affordable health care; and strengthening families
Columbus Medical Association Foundation *Columbus, OH* www.goodhealthcolumbus.org	1992	$70,000,000	Public Charity[3]	Health Plan	Access to health care; health education; and health promotion
Community Health Endowment of Lincoln *Lincoln, NE* www.chelincoln.org/	1997	$43,998,549	Other[4]	Hospital	Improving community health
Community Health Foundation *Massillon, OH* http://chfoundation.org	1999	$5,896,965	Private Foundation	Hospital and Health System	Promoting physical, mental, and emotional health of community residents
Community Health Foundation of Western and Central New York *Buffalo, NY* www.chfwcny.org	2001	$60,000,000	Private Foundation	Health Plan	Improved health and health care, primarily for frail elders and children in poverty

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Community Health Partnership *Portland, OR*	1997	$54,832	Public Charity[1]	Health Plan	Public health; graduate scholarships; public health workforce development; and urgent needs in public health system
Community Memorial Foundation *Hinsdale, IL* www.cmfdn.org	1995	$82,048,529	Private Foundation	Hospital	Positive youth development; primary health care for the uninsured and underinsured; strengthening families; community cohesiveness; and healthy aging
CommunityCare Foundation, Inc. *Springdale, AR* www.ccfound.org	1998	$134,500,000	Public Charity[3]	Health System	Health; human services; and education
Con Alma Health Foundation *Santa Fe, NM* www.conalma.org	2001	$25,000,000	Private Foundation	Health Plan	Improved health status and access to health care services
Moses Cone-Wesley Long Community Health Foundation *Greensboro, NC* www.mcwlhealthfoundation.org	1997	$104,652,000	Public Charity[3]	Hospital	Access and wellness, with particular attention to physical activity, nutrition, obesity, substance abuse, responsible sexual behavior, mental health, and injury prevention
Connecticut Health Foundation *Farmington, CT* www.cthealth.org	2001	$125,661,813	Private Foundation	Health Plan	Access; dental care; health promotion; healthy communities; mental health; and cultural competence
Consumer Health Foundation *Washington, DC* www.consumerhealthfdn.org	1994	$28,350,000	Private Foundation	Health Plan	Reducing health disparities through support for consumer voice and advocacy; equitable access to quality health care; prevention and wellness; and organizational infrastructure and capacity building
Dakota Medical Foundation *Fargo, ND* www.dakmed.org	1998	$23,287,000	Public Charity[1]	Hospital	Improving health and access to health care services, with an emphasis on children's health
Daughters of Charity Foundation *St. Louis, MO* www.daughtersofcharityfdn.org	1996	$192,000,000	Public Charity[3]	Hospital	Improving the health of low-income persons; quality of life for the elderly; stronger families; and healthier lifestyles
Daughters of Charity Healthcare Foundation of St. Louis *St. Louis, MO* http://daughtersofcharityfdn.org	1995	$1,118,024	Public Charity[3]	Hospital	Health and wellness education; primary and preventive medical services; and social services
Deaconess Community Foundation *Cleveland, OH* www.fdncenter.org/grantmaker/deaconess	1994	$35,037,975	Public Charity[3]	Hospital and Health System	Resources that help organizations empower people to become self-sufficient
Deaconess Foundation *St. Louis, MO* www.deaconess.org	1997	$71,000,000	Public Charity[3]	Health System	Innovative, results-oriented initiatives that address public health challenges, especially community-based health programs related to prevention and wellness for children
Desert Healthcare Foundation *Palm Springs, CA* www.dhcd.org/grant-program	1997	$6,027,976	Public Charity[1]	Hospital	Enhancing community health and wellness

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Eden Township HealthCare District *Castro Valley, CA* www.ethd.org	1998	$32,663,000	Other[5]	Hospital	Health care access and affordability; delivery of health-related services to high-risk or special needs populations; and collaboration with other organizations
Endowment for Health *Concord, NH* www.endowmentforhealth.org	1999	$77,844,748	Private Foundation	Health Plan	Oral health; and economic, geographic, and social/cultural barriers to accessing health care services
FISA Foundation *Pittsburgh, PA* www.fisafoundation.org	1996	$35,016,260	Private Foundation	Rehabilitation Hospital	Access for individuals with disabilities; and health programs for women and girls relating to domestic and sexual violence, prenatal care, teen pregnancy, wellness, and diseases that primarily affect women
Foundation for a Healthy Kentucky *Louisville, KY* www.healthyky.org	2001	$51,940,959	Public Charity[1]	Health Plan	Access to health and mental health care; and health education and prevention programs focused on nutrition and fitness, tobacco, and substance abuse
Foundation for Community Health *Salisbury, CT* www.fchealth.org	2001	$13,100,000	Public Charity[3]	Hospital	Physical and mental health maintenance and improvement
Foundation for Seacoast Health *Portsmouth, NH* www.ffsh.org	1984	$66,238,876	Private Foundation	Hospital	Health care expenses for the medically indigent; healthy lifestyles and health promotion; access to health information and preventive care for women and girls; and health professions scholarships
Four County Community Foundation *Almont, MI* www.4ccf.org	1987	$5,693,254	Public Charity[1]	Hospital	Healthy seniors; healthy youth; and public safety
Franklin Benevolent Corporation *Corte Madera, CA* www.frankben.org	1998	$32,025,536	Public Charity[1]	Hospital	Health-related issues
The Georgia Health Foundation *Atlanta, GA* www.gahealthfdn.org	1985	$9,045,498	Private Foundation	Health Plan	Personal and community health, including access, delivery, maintenance, public awareness, education, quality evaluation, clinical research, and preventive care
Georgia Osteopathic Institute of the South *Grayson, GA* www.goi.org	1986	$3,269,291	Public Charity[1]	Hospital	Osteopathic education and clinical services
Good Samaritan Foundation, Inc. *Lexington, KY* www.gsfky.org	1995	$1,794,408	Private Foundation	Hospital	Charitable and educational activities related to health care, health education, and research
Greater St. Louis Health Foundation *Kirkwood, MO*	1985	$3,890,000	Public Charity[1]	Health Plan	Health care providers; health promotion; and illness prevention
Grotta Fund for Senior Care *South Orange, NJ*	1993	$6,394,642	Private Foundation	Nursing Home	Aging; mental and physical health of the elderly; family caregivers; and nonclinical in-home services
Gulf Coast Community Foundation of Venice *Venice, FL* www.gulfcoastcf.org	1995	$150,000,000	Public Charity[1]	Hospital and Health System	Health; human services; education; civic affairs; and arts and culture

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Gulf Coast Medical Foundation *Wharton, TX*	1983	$13,912,889	Private Foundation	Hospital	Medically related services; local emergency medical services; and primary care
The Harvest Foundation *Martinsville, VA* www.theharvestfoundation.org	2002	$191,000,000	Private Foundation	Hospital	Health; education; and welfare
Health Care Foundation of Greater Kansas City *Kansas City, MO* www.healthcare4kc.org	2003	$425,000,000	N/A	Health System	Access to quality health care services, focusing on the medically indigent
The Health Foundation of Central Massachusetts, Inc. *Worcester, MA* www.hfcm.org	1995	$54,000,000	Social Welfare Organization	Health Plan	Health improvement, with emphasis on vulnerable populations and unmet needs; health promotion; and health disparities
The Health Foundation of Greater Cincinnati *Cincinnati, OH* www.healthfoundation.org	1997	$241,000,000	Social Welfare Organization	Health Plan	Strengthening primary care providers for the poor; school-based child health interventions; substance abuse; and severe mental illness
The Health Foundation of Greater Indianapolis, Inc. *Indianapolis, IN* www.thfgi.org	1984	$31,660,290	Private Foundation	Health Plan	HIV/AIDS advocacy and prevention; adolescent/child health (access to primary care and school-based health); and elder health advocacy
Health Foundation of South Florida *Miami, FL* www.hfsf.org	1993	$127,000,000	Public Charity[1]	Hospital	Access to quality health care; and health status improvement
Health Future Foundation *Omaha , NE*	1984	$67,999,322	Public Charity[1]	Hospital	Indigent care; research; and health-related projects at Creighton University
The Health Trust *San Jose, CA* www.healthtrust.org	1996	$118,053,000	Public Charity[2]	Health System	Community-based health, disease prevention, and wellness education especially for medically indigent children, frail elderly, and vulnerable adults
The HealthCare Foundation for Orange County *Santa Ana, CA* www.hfoc.org	1997	$15,382,233	Private Foundation	Health System	Health promotion; prevention; cultural competency; access; community health; and health needs of children, adolescents, and pregnant women
The Healthcare Foundation of New Jersey *Livingston, NJ* http://hfnj.org	1996	$132,198,980	Private Foundation	Hospital	Health care needs of vulnerable populations
Healthcare Georgia Foundation, Inc. *Atlanta, GA* www.healthcaregeorgia.org/	1999	$116,599,324	Private Foundation	Health Plan	Health disparities; strengthening nonprofit health organizations; and expanding access to primary health care
HealthONE Alliance *Denver, CO* www.health1.org	1995	$178,482,000	Public Charity[1]	Health System	Unmet health needs
Helena Health Foundation Fund *Helena, AR*	2002	$9,860,000	Private Foundation	Hospital	Access to health care for poor and elderly; and health education
Hill Crest Foundation *Mountainbrook, AL*	1984	$32,310,940	Private Foundation	Hospital	Mental health; arts; and education

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Hilton Head Island Foundation, Inc. *Hilton Head Island, SC* www.cf-lowcountry.org	1994	$20,362,672	Public Charity[1]	Hospital	Community development; health; and human services
HNHfoundation (formerly Healthy New Hampshire Foundation) *Concord, NH* www.hnhfoundation.org	1997	$1,800,000	Private Foundation	Health Plan	Health promotion
The Horizon Foundation *Columbia, MD* www.thehorizonfoundation.org	1998	$76,000,000	Public Charity[1]	Hospital	Health system improvement; community health and wellness; older adult health; adolescent health; and information technology and health
Incarnate Word Foundation *St. Louis, MO* www.incarnatewordfund.com	1997	$25,701,373	Public Charity[3]	Hospital	Promotion of community health and well-being; addressing the root causes of problems; and supporting collaboration among various organizations, with a special interest in the poor, women, children, and the elderly
Institute for Health Care Advancement *La Habra, CA* www.iha4health.org	1995	$27,878,218	Private Foundation	Health System	Demonstrating innovative health care practices; and educating health care providers and consumers
Irvine Health Foundation *Irvine, CA* www.ihf.org	1986	$23,500,000	Private Foundation	Hospital	Quality health and dental care; research and policy; and capacity building of safety net providers and the community
The Jackson Foundation, Inc. *Dickson, TN* www.jacksonfoundation.org	1995	$76,609,673	Public Charity[1]	Hospital	Motivating and educating children and adults through the use of technology in the areas of the arts, science, and humanities
Jenkins Foundation *Richmond, VA* www.tcfrichmond.org	1995	$36,500,000	Public Charity[3]	Hospital	Prevention of teen pregnancy, violence, and substance abuse; and access to health care services for the uninsured and underinsured
The Jewish Foundation of Cincinnati *Cincinnati, OH*	1996	$76,415,894	Private Foundation	Hospital	Capital improvement projects
Jewish Healthcare Foundation *Pittsburgh, PA* www.jhf.org	1990	$102,062,728	Private Foundation	Hospital	Financing and delivering health services; strengthening health systems and expanding coverage; advancing health, biomedical, technological, and informatics discovery; and integrating physical, behavioral, and environmental health
Kansas Health Foundation *Wichita, KS* www.kansashealth.org	1985	$441,548,650	Private Foundation	Hospital	Public health; children's health; and leadership
Lancaster Osteopathic Health Foundation *Lancaster, PA*	1999	$12,000,000	Public Charity[1]	Hospital	Community health and wellness, with an emphasis on children and their families; and scholarship support for osteopathic medical school and nursing school students
Logan Healthcare Foundation *Logan, WV*	2004	N/A	N/A	Hospital	N/A

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Lower Pearl River Valley Foundation *Picayune, MS*	1998	$12,899,287	Private Foundation	Hospital	Improving physical, mental, emotional, spiritual, and social health
Lutheran Foundation of St. Louis *St. Louis, MO* www.lutheranfoundation.org	1984	$70,136,007	Public Charity[3]	Hospital	Physical and development disability; children; elderly; substance abuse; parish nursing; and congregation services in the community
Dr. John T. Macdonald Foundation, Inc. *Coral Gables, FL* www.jtmacdonaldfdn.org/	1992	$34,639,461	Private Foundation	Hospital	Health education; prevention and early detection of disease; children and the economically disadvantaged; medical rehabilitation; and direct medical and dental care
MacNeal Health Foundation *Berwyn, IL* www.macnealhf.org	2000	$85,000,000	Private Foundation	Hospital	Health care agencies; medical research; and education
Maine Health Access Foundation *Augusta, ME* www.mehaf.org	2000	$99,000,000	Private Foundation	Health Plan	Affordable and timely access to comprehensive quality health care; and strategic solutions to improving access to health care, particularly for the medically uninsured and underserved
The Memorial Foundation *Hendersonville, TN* www.memfoundation.org	1994	$134,638,670	Public Charity[1]	Hospital	Nonprofit organizations offering health programs
Methodist Healthcare Ministries of South Texas, Inc. *San Antonio, TX* www.mhm.org	1995	$291,000,000	Public Charity[3]	Hospital	Primary care clinics providing medical, dental, and support/counseling services for uninsured clients; parenting programs; church-based nursing program; community clinics serving uninsured clients; and clinical pastoral edeucation
MetroWest Community Health Care Foundation *Framingham, MA* www.mchcf.org	1996	$93,000,000	Private Foundation	Health System	Health programs for children, elders, and the disabled; and community health initiatives
Mid-Iowa Health Foundation *Des Moines, IA* www.midiowahealth.org	1984	$16,071,633	Private Foundation	Hospital	Preventive health services for vulnerable populations
Missouri Foundation for Health *St. Louis, MO* www.mffh.org	2000	$1,080,000,000	Social Welfare Organization	Health Plan	Reducing disparities; improving access; strengthening the safety net; health promotion and disease prevention; improving the health of children; community capacity building; and public policy activities
Mount Zion Health Fund, Inc. *San Francisco, CA* www.mzhf.org	1990	$45,750,000	Public Charity[1]	Hospital	Vulnerable populations; filling funding gaps; and providing responsive and creative solutions to health-related needs
The Mt. Sinai Health Care Foundation *Cleveland, OH* www.mtsinaifoundation.org	1996	$126,000,000	Public Charity[3]	Health System	Child development; brain development; services for the elderly; building the capacity of community organizations; health policy; and community health
New York Charitable Asset Foundation *New York, NY*	2002	$110,000,000	N/A	Health Plan	N/A

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North Dade Medical Foundation, Inc. *North Miami, FL*	1997	$25,941,211	Public Charity[2]	Hospital	Community health services and educational opportunities
North Penn Community Health Foundation *Lansdale, PA* www.npchf.org	2001	$38,527,315	Public Charity[3]	Hospital	Access to health and human services for at-risk populations; helping people with chronic diseases remain in their homes and communities; volunteerism; prevention and education; and strengthening organizational effectiveness and partnerships
Northwest Health Foundation *Portland, OR* www.nwhf.org	1997	$60,000,000	Social Welfare Organization	Health Plan	Access; youth mental health; nursing workforce; arthritis-related research; children's health; rural health; and health care delivery to culturally diverse communities, impoverished families, and people with chronic conditions
Northwest Osteopathic Medical Foundation *Portland, ,OR* www.nwosteo.org	1984	$6,989,131	Public Charity[1]	Hospital	Families and children; scholarships to osteopathic medical students; and training clinics for osteopathic residency programs
Osteopathic Founders Foundation *Tulsa, OK* www.osteopathicfounders.org	1996	$18,908,900	Public Charity[1]	Hospital	Osteopathic medical education; and community health
Osteopathic Heritage Foundations *Columbus, OH* www.osteopathicheritage.org	1998	$252,000,000	Private Foundation	Hospital	Health; quality of life; osteopathic medical education; and medical research
Pajaro Valley Community Health Trust *Watsonville, CA* www.pvhealthtrust.org	1998	$10,068,755	Public Charity[1]	Hospital	Diabetes; oral health; healthy lifestyle choices for youth ages 6-21; and health for farm workers and their families
Palm Healthcare Foundation *West Palm Beach, FL* www.palmhealthcarefoundation.org	2001	$68,414,536	Public Charity[1]	Hospital	Access; health professions education; nursing; and primary care
Paso del Norte Health Foundation *El Paso, TX* www.pdnhf.org	1995	$182,000,000	Private Foundation	Hospital	Health status improvement through education and prevention; healthy communities; physical fitness; youth alcohol and tobacco use; teen pregnancy prevention; preventive health screening promotion; and health services research
Annie Penn Community Trust *Reidsville, NC*	2001	$30,000,000	Private Foundation	Hospital	Health and quality of life improvement
Philadelphia Health Care Trust *Philadelphia, PA*	1996	$76,804,341	Private Foundation	Health System	N/A
Phoenixville Community Health Foundation *Phoenixville, PA* www.pchf1.org	1997	$27,506,330	Public Charity[3]	Hospital	Wellness and prevention; physical and behavioral health; public health and safety; community-based health supports; environmental health; community health; and educational opportunities for health-related fields

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Portsmouth General Hospital Foundation *Portsmouth, VA* www.pghfoundation.org	1988	$13,630,410	Private Foundation	Hospital	Health and quality of life improvement; substance abuse; teen pregnancy prevention; health education and preventive health; indigent care; healthy families; education; environment; and arts
Pottstown Area Health and Wellness Foundation *Pottstown, PA* www.pottstownfoundation.org	2003	$65,000,000	Private Foundation	Hospital	Increased access to health and wellness education and services
Presbyterian Health Foundation *Oklahoma City, OK*	1985	$180,413,301	Private Foundation	Hospital	Medical research to save and enhance human life
Prime Health Foundation *Kansas City, MO* www.primehealthfoundation.org	1989	$6,191,675	Public Charity[3]	Health Plan	Managed care; health care education; and disease management
Quad City Osteopathic Foundation *Bettendorf, IA*	1984	$39,298,810	Private Foundation	Hospital	Scholarships and grants for medical education
Quantum Foundation, Inc. *West Palm Beach, FL* www.quantumfnd.org	1995	$148,000,000	Private Foundation	Hospital	Health access; health status; children's mental health; school-based community wellness programs; independent living and pharmacy support for the elderly; common eligibility; and federally qualified health centers
QueensCare *Los Angeles, CA* www.queenscare.org	1998	$332,878,000	Public Charity[1]	Hospital	Health care services; and nonprofit health care agencies
John Randolph Foundation *Hopewell, VA*	1995	$34,600,000	Public Charity[2]	Hospital	Primary care; access to care; meeting the needs of children; and quality of life
The Rapides Foundation *Alexandria, LA* www.rapidesfoundation.org	1994	$202,768,940	Public Charity[2]	Hospital	Prevention, wellness, and health care; healthy communities; K-12 education; community and economic development; and arts and culture
REACH (Research, Education, and Access to Charitable Health Care) Foundation *Kansas City, KS*	2003	$99,000,000	N/A	Health System	N/A
REACH Community Health Foundation, Inc. *North Adams, MA* www.nbhealth.org/default.asp?id=16&mnu=16		N/A	N/A	Health System	Improving the health of women, children, families, and elders; health promotion and disease prevention; health care and disease management initiatives; access to health care; and health communications
Michael Reese Health Trust *Chicago, IL* www.fdncenter.org/grantmaker/health	1991	$95,931,818	Private Foundation	Hospital	Community-based health services to vulnerable populations, including the medically indigent and underserved, immigrants and refugees, the elderly, the mentally and physically disabled, and children and youth
John Rex Endowment *Raleigh, NC* www.rexendowment.org	2000	$74,000,000	Public Charity[1]	Hospital	Access to health services for low-income people

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Riverside Community Health Foundation *Riverside, CA* www.rchf.org	1997	$71,227,129	Public Charity[1]	Hospital	Access; health education and prevention; and health and safety
Roanoke-Chowan Foundation, Inc. *Ahoskie, NC*	1997	$14,187,530	Public Charity[1]	Hospital	Wellness; health; and well-being
Rose Community Foundation *Denver, CO* www.rcfdenver.org	1995	$238,035,000	Public Charity[3]	Hospital	Prevention; access; health policy leadership; aging; child and family development; education; and Jewish life
Saint Ann Foundation *Cleveland, OH* www.socstannfdn.org	1973	$29,037,686	Public Charity[3]	Hospital	Quality of life improvement for the underserved, particularly women, children, and youth
St. David's Foundation *Austin, TX* www.stdavidsfoundation.org	1996	$7,937,000	Public Charity[1]	Hospital	Access to health care; and improving community health by addressing the root causes of community health problems
St. Joseph Community Health Foundation *Fort Wayne, IN* www.stjosephhealthfdn.org	2000	$27,996,973	Public Charity[1]	Hospital	Health and wellness; and access for the poor and underserved
St. Joseph's Community Health Foundation *Minot, ND*	1998	$2,063,539	Public Charity[1]	Hospital	Mental, physical, and spiritual well-being
St. Joseph's Health Ministries Foundation *Lancaster, PA*	2000	$6,231,575	Public Charity[3]	Hospital	Children's health; and faith-based health initiatives, focusing on services to poor, disadvantaged, and underserved populations
St. Luke's Foundation *Bellingham, WA* www.stlukesfoundation.org/	1983	$9,040,101	Public Charity[2]	Hospital	Health care
Saint Luke's Foundation of Cleveland, Ohio *Cleveland, OH* www.saintlukesfoundation.org	1987	$84,000,000	Private Foundation	Hospital	Improvement and transformation of the health and well-being of individuals, families, and communities
St. Luke's Health Initiatives *Phoenix, AZ* www.slhi.org	1995	$90,289,178	Public Charity[3]	Health System	Access; mental health; advocacy and policy; and healthy communities
Salem Health and Wellness Foundation *Salem, NJ* http://fdncenter.org/grantmaker/salem/	2002	$41,328,152	Public Charity[1]	Hospital	Access to health care; preventive services; and recruitment, education, and retention of skilled health care professionals
San Angelo Health Foundation *San Angelo, TX* www.sahfoundation.org	1995	$46,384,574	Private Foundation	Hospital	Community health and wellness
SHARE Foundation *El Dorado, AR*	1996	$76,507,141	Public Charity[1]	Hospital	Wellness and prevention; hospice care; and indigent care
Sierra Health Foundation *Sacramento, CA* www.sierrahealth.org	1984	$118,459,477	Private Foundation	Health Plan	Local and regional health-related activities affecting underserved populations; conferencing and convening; capacity building; and leadership development
J. Marion Sims Foundation, Inc. *Lancaster, SC* www.jmsims.org	1994	$67,973,076	Private Foundation	Hospital	Health; human services; and economic and community development

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Sisters of Charity Foundation of Canton *Canton, OH* www.csahealthsystem.org/fd_min_soccan.asp	1995	$61,563,488	Public Charity[3]	Hospital	Health care access and affordability for the poor and underserved; disparities in care for racial and ethnic minorities; prescription assistance; and oral health
Sisters of Charity Foundation of Cleveland *Cleveland, OH* www.socstannfdn.org	1995	$39,487,338	Public Charity[3]	Hospital and Health System	Access to affordable health care for the uninsured and underinsured
Sisters of Charity Foundation of South Carolina *Columbia, SC* www.sistersofcharitysc.com	1995	$85,000,000	Public Charity[3]	Hospital	Economic and community development addressing the root causes of poverty; strengthening families; and promoting educational success
Sisters of Mercy of North Carolina Foundation, Inc. *Charlotte, NC* www.somncfdn.org	1995	$239,106,484	Public Charity[3]	Health System	Programs and services for disadvantaged populations, especially those serving women, children, the elderly, and the economically poor
The Sisters of St. Joseph Charitable Fund *Parkersburg, WV* www.ssjcharitablefund.org	1996	$20,265,000	Public Charity[3]	Hospital	Health and wellness, with a particular focus on healthy communities, healthy families, and healthy senior citizens
Community Foundation of South Lake County *Clermont, FL* www.cfslc.org	1995	$9,128,910	Public Charity[1]	Hospital	General health and wellness
Spalding Health Care Trust *Griffin, GA*	1984	$28,271,546	Public Charity[3]	Hospital	Free health clinics; emergency equipment for fire departments; capital projects; education; and social and human services
Sunflower Foundation: Health Care for Kansans *Topeka, KS* www.sunflowerfoundation.org	2000	$93,550,801	Public Charity[3]	Health Plan	Improving access to health care; building capacity within the health care safety net; and reducing the prevalence of overweight and obesity
Taylor Community Foundation *Ridley Park, PA* www.taylorcommfdn.org	1997	$10,939,685	Public Charity[1]	Hospital	Scholarships; community support; and support for Taylor Hospital
Truman Heartland Community Foundation *Independence, MO* www.thcf.org	1994	$20,140,000	Public Charity[1]	Hospital	Arts, culture, and historic preservation; strong neighborhoods; education; community spirit; health needs; leadership development; senior services; positive youth development; transportation; and violence prevention
Tucson Osteopathic Medical Foundation *Tucson, AZ* www.tomf.org	1986	$10,639,518	Private Foundation	Hospital	Osteopathic medical education; public understanding of osteopathic medicine; community health and well-being; higher education; arts and humanities; community service organizations; and public policy
Tuscora Park Health and Wellness Foundation *Barberton, OH*	1996	$3,246,754	Private Foundation	Hospital	Health and wellness
Two Rivers Health & Wellness Foundation *Easton, PA*	2001	$2,448,503	Private Foundation	Hospital	Prevention through education and access

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UniHealth Foundation *Woodland Hills, CA* www.unihealthfoundation.org	1998	$279,595,078	Private Foundation	Health System	Improving health and well-being
Union Labor Health Foundation *Bayside, CA* www.hafoundation.org/ulhf.html	1997	$4,442,000	Public Charity[3]	Hospital	Physical, mental, and moral well-being of individuals
United Methodist Health Ministry Fund *Hutchinson, KS* www.healthfund.org	1984	$60,434,000	Public Charity[3]	Hospital	Oral health; access to health care; and healthy lifestyles
Universal Health Care Foundation of Connecticut, Inc. *New Haven, CT* www.universalhealthct.org	1999	$45,419,821	Public Charity[3]	Health Plan	Compliance and quality of care; and community empowerment
Valley Care Association *Sewickley, PA* www.valley-care.org	1999	$7,928,073	Public Charity[1]	Nursing Home	Aging
The Valley Foundation *Los Gatos, CA* www.valley.org	1984	$55,342,624	Private Foundation	Hospital	Research; education and social service agencies dealing with health issues; arts; education; and social services
Washington Square Health Foundation, Inc. *Chicago, IL* www.wshf.org	1985	$23,200,000	Private Foundation	Hospital	Access; medical and nursing education; medical research; and direct health care services
Welborn Foundation *Evansville, IN* www.welbornfdn.org	1999	$92,000,000	Private Foundation	Hospital	School-based health and social services; early childhood development; healthy adolescent development; healthy lifestyles; and community health
Westlake Health Foundation *Oakbrook Terrace, IL* www.westlakehf.com	1998	$78,860,089	Private Foundation	Hospital	Improvements in community health
Williamsburg Community Health Foundation *Williamsburg, VA* www.wchf.com	1996	$110,000,000	Private Foundation	Hospital	Illness and disease prevention; primary health care services; health and well-being of seniors; and healthy communities
Winter Park Health Foundation *Winter Park, FL* www.wphf.org	1994	$119,427,255	Private Foundation	Hospital	Healthy communities; youth; older adults; access; and community education
Woodruff Foundation *Cleveland, OH* www.fmscleveland.com/woodruff/	1986	$11,530,000	Private Foundation	Hospital	Mental health; and addiction services
Wyandotte Health Foundation *Kansas City, KS*	1977	$44,705,978	Public Charity[2]	Hospital	Primary health care; prevention; intervention; and education

[1] Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(1) traditional.
[2] Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(2) gross receipts.
[3] Foundation is classified under the Internal Revenue Code as a public charity with the designation 509(a)(3) supporting organization.
[4] Community Health Endowment of Lincoln is a municipal fund.
[5] Eden Township Healthcare District is a local government agency.

Note: N/A means the information was not available to GIH from survey data or other sources.
Sources: Grantmakers In Health, *Survey of Foundations Formed from Health Care Conversions, 2004* and Grantmakers In Health Resource Center on Health Philanthropy Database.

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