

THE PHILANTHROPIC BEHAVIOR OF
NONPROFIT HOSPITALS

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ABSTRACT

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The Philanthropic Behavior of Nonprofit Hospitals

The study of the nonprofit sector has traditionally focused on nonprofit organizations as recipients of charity. A perspective that has been relatively neglected is that of nonprofit organizations as not only recipients but also as donors of charitable resources.

This dissertation explores the phenomenon of philanthropic behavior of nonprofit organizations, using studies of the contributions and community health programs of nonprofit hospitals in Indiana as an example. Philanthropic behavior is defined as actions and programs initiated by a nonprofit organization to meet additional community needs – beyond its primary mission or services. It presents the hypothesis that such activities are undertaken for reasons similar to for-profit organizations – and have comparable organizational benefits. The studies reported in the dissertation show a wide variation in reporting such activities as well as of the organizational structures in place to manage such behavior. This variation is seen even in seemingly similar hospitals such as religious hospitals within an identified system.

The dissertation discovers that while nonprofit organizations may engage in philanthropic behavior, these practices go largely unrecognized. Because the

actions are not systematically noted or recorded, some very significant residual benefits that nonprofits provide for their defined communities are also unrecognized. It also finds that when these activities are evident, they are driven more by the professional values and actions of individual employees than by organizational policies.

The dissertation concludes that drawing conclusions from this study of the data on Indiana hospitals – both from state reports and the IRS Form 990s – is difficult. There is an inconsistency between the two databases as well as within each of the datasets that makes any specific conclusions as to the relative values of different hospitals or to standards is suspect. It notes that while the revised Form 990 should help in overall transparency, the reporting of areas such as health education and donations will most probably continue to be inconsistent. This inconsistency makes the information difficult to use as either an evaluation tool or as policy to encourage community-serving behavior.

Richard Steinberg, PhD, Chair

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AN OVERVIEW OF THE DISSERTATION

This dissertation identifies and explores the phenomenon of philanthropic behavior of nonprofit organizations, using nonprofit hospitals in Indiana as an example. Philanthropic behavior is defined as actions and programs initiated by a nonprofit organization to meet additional community needs – beyond its primary mission or services.

The dissertation presents the overall hypothesis that while nonprofit organizations may engage in philanthropic behavior, these practices go largely unrecognized. Because the actions are not noted or recorded, some very significant residual benefits that nonprofits provide for their defined communities are also unrecognized. Since the existence and benefits of this behavior are not reported, governmental agencies fail to develop policies that might encourage an increase in this behavior in the future – and that may also yield an additional benefit for society. Recent changes in the Internal Revenue Service year-end report Form 990 could help improve the reporting and availability of such information, but stop short of requiring the types of information related to this type of behavior. Because information that could track these behaviors is not adequately sought or reported, the ability of the changes to encourage increased nonprofit philanthropy is limited.

Questions Addressed by the Dissertation

The overall question addressed by the dissertation is: “Does nonprofit philanthropy exist?” If it does exist, secondary questions are: “Why would a nonprofit organization engage in philanthropic behavior?” and “Do our current reporting systems have the ability to measure the extent of that behavior?” If we are able to measure philanthropic behavior it raises a final question: “How much philanthropy does a nonprofit organization provide?”

These questions are addressed in six chapters. Chapter One asks: “What is nonprofit philanthropic behavior?” and “Why would a nonprofit organization engage in such behavior?” It further addresses: “Why are nonprofit hospitals particularly appropriate to measure philanthropic behavior?” Chapter Two seeks to answer: “Do current reporting procedures allow us to reliably measure nonprofit hospital philanthropic behavior?” Chapter Three asks “How well does an existing voluntary state reporting system capture nonprofit philanthropic behavior?” Chapters Four and Five inquire: “What information about philanthropic behavior are we able to determine from investigating individual nonprofit hospitals?” Chapter Six summarizes the answers to these questions.

Background of the Dissertation

Giving USA (2007) is one source that reports annual contribution figures in the United States. These contributions represent private gifts from individuals as well as from foundations and corporations. Nonprofit organizations are the legal recipient of these tax-deductible financial donations. Some contributions from nonprofit organizations are included in these contribution figures: those either designated as grants from private foundations or identified as transfers of philanthropy by pass-through organizations such as United Way or the United Jewish Communities appeal. These are nonprofits that collect funds for distribution to other nonprofit public benefit organizations.

However nonprofit public benefit organizations do not only receive donations. They also make donations to other nonprofit organizations, even though national philanthropy figures do not report this source of contributions. This dissertation notes the existence of nonprofit philanthropy and explores the practice of such organizational behavior. It uses nonprofit hospitals as an example of this type of practice. One reason to focus on nonprofit hospitals is that hospital community benefit standard reports do acknowledge that nonprofit hospitals make financial contributions. They include “Donations,” as one measurement of nonprofit hospital community benefit.¹ However official reports generally do not highlight these donations of individual hospitals (such as reports they file with the Internal

¹ As categorized by criteria developed by the Catholic Health Association and Voluntary Hospitals of America (CHA/VHA 2006) – and endorsed by members of the United States Senate Finance Committee (Senate Committee on Finance 2006) as well as used as a model by the Internal Revenue Service in revising their own reporting criteria (Internal Revenue Service, “Schedule H: Hospitals,” n.d.).

Revenue Service or the American Hospital Association). General public relations reports to the hospital's community also rarely highlight these types of data, focusing instead on general programs rather than defining and explaining the financial value of the actual philanthropy provided.² These figures are subsequently not meaningfully aggregated into national hospital, nonprofit, or philanthropy reports.

The failure to capture this type of direct nonprofit financial philanthropy also raises the question whether other types of in-kind nonprofit philanthropic behavior are recognized as part of the total philanthropic effort in the United States. Additional expressions of nonprofit philanthropy include provisions of services to benefit broader community needs – activities that go beyond serving a nonprofit organization's primary constituency and purpose. In the case of nonprofit hospitals examples of this are health education programs that seek to improve the general wellness of the community. These programs serve a broader public and meet more expanded purposes than the primary mission of the hospital to treat the sick and injured. This paper determines that programs comprising philanthropic behavior are a subset of a broader concept of community benefit, which is the rationale for the tax-exemption of nonprofit hospitals as defined by the Internal Revenue Service (IRS, Revenue Ruling 69-545).

² It should be acknowledged that donations figures are included in the IRS Form 990, generally as supplementary materials or in the aggregate on Page 2 of the Form 990. They also may be referred to in some individual hospital community benefit reports or newsletters, at the discretion of the organization.

In July 2007 the office of Senator Charles Grassley (at that time, the ranking Republican on the Senate Finance Committee) issued a minority Staff Report proposing that the current community benefit standard for nonprofit hospitals should be replaced by a Charity Care requirement of 5% of operating expenses or revenue (whichever is greater). (Senate Committee on Finance – Minority 2007)

While it is debatable whether Congress would pass such standards, the Staff Report did prompt a flurry of response from the healthcare industry. The American Hospital Association replied in a particularly strong letter implying that political motivations rather than concern over healthcare was driving this type of congressional proposal:

“The real issue here is the lack of health insurance for 47 million Americans. In our May 1, 2006 letter to you, we described in some detail how hospitals across the nation do their very best to compensate in the absence of a national policy to address this crisis . . . Unfortunately the proposals in the minority draft do not address the problems of the uninsured. Instead, the draft singles out hospitals for unfair criticism and recommends punitive measures that are unwarranted.”³

The Association of American Medical Colleges (AAMC) also questioned the basic assumptions of the Senate Finance Committee’s Minority Report (as well as assumptions of other critics of nonprofit hospitals and the community benefit standards) that charity care was the proper benchmark for nonprofit hospital tax exemption:

“First and foremost, the AAMC strongly opposes . . . limiting the definition of `community benefit only to charity care . . .The AAMC

³ American Hospital Association letter (September 6, 2007).

believes it would be inappropriate and is unnecessary to propose legislation that would require special rules for hospitals that qualify under section 501(c)(3) of the tax code. Voluntary efforts have yielded outstanding community contributions by teaching and other non-profit hospitals. We believe that the challenge we collectively face is that all hospitals, including teaching hospitals, do not do an adequate job of describing the wide range of community benefit activities in which they are engaged . . . with the most common problem being underreporting of community benefit.” (AAMC 2007, emphasis in original)

A *Wall Street Journal* front-page article in April 2008 extended the other side of this argument with an opening sentence: “Nonprofit hospitals, originally set up to serve the poor, have transformed themselves into profit machines.” The article emphasized large nonprofit hospitals such as the Cleveland Clinic and Northwestern Memorial in Chicago had significant net income and noted many of these same profitable hospitals essentially made their surpluses through the tax-exemptions they enjoyed. In return, the article maintained, the hospitals provided limited charity care or other benefits to the communities that underwrote these tax advantages.

In a letter to the editor, the Association for Healthcare Philanthropy (AHP) took issue with many of the claims in the *Wall Street Journal* article, stating it:

“ . . . gives no coverage on the challenges facing the majority of nonprofit hospitals today . . . The reality is however that most nonprofits are meeting heir community and financial responsibilities . . . we must take into account that the majority of nonprofit hospitals are fulfilling their missions in providing community benefits and charity care.” (AHP 2007)

Conversely, alternative observations maintain that hospitals use the community benefit standard as a public relations tool more than as an objective standard.

These critics assert that community benefits are “what hospitals say they are” and merely identify elements that are common to all hospitals or any business employing members of the community (Noble et al 1998).

Critics that mislabel a nonprofit hospital’s net revenues as “profits” are missing the obvious point that these “profits” do not benefit any individual. Instead any “extra” funds that any nonprofit hospital generates – like any nonprofit organization – are reinvested into their community’s future needs. In the case of a nonprofit hospital these future investments are dedicated for an improved health system and a board of trustees, composed of community leaders and representatives, oversees this investment process. Ironically these critics of nonprofit hospitals could also be encouraging the very behavior they profess to be trying to prevent. A proposal to remove tax-exempt status because a hospital generates an “excess” of profits could actually prompt hospitals to spend current revenues rather than saving them for future equipment, program, and facility needs – particularly if they knew that government was going to penalize such savings through a “tax”. In extreme cases such a proposal could even encourage more hospitals to seek for-profit status (if there is less incentive to remain nonprofit).

Beyond the political and public relations rhetoric, the reality is that since 1968 nonprofit hospitals have undertaken numerous actions to define and meet the existing community benefit standards. The American Hospital Association,

Voluntary Hospitals of America, and the Catholic Health Association have defined national guidelines and encouraged their member organizations to meet those standards. Many states have implemented various reporting standards, both mandatory and voluntary. This dissertation maintains that these actions have yielded many benefits for their communities, benefits that can be identified. Some of these actions go beyond meeting limited interpretations of the community benefit standards and philanthropically contribute to the broader good of their community.

This dissertation uses databases of Indiana hospitals to investigate how well individual hospitals adhere to and report community benefit as well as to explore the existence, extent, and nature of nonprofit philanthropy. It includes in its exploration of Indiana nonprofit hospital philanthropy both contributions to other organizations and the costs of health education programs for the benefit of its general community. The former is specifically defined as cash contributions to other nonprofit organizations; the latter is designated as an in-kind contributions intended for the welfare of the general community rather than for the benefit of the primary stakeholders of the hospital – stakeholders that include patients as well as employees, board members, volunteers, and medical staff of the hospital.

The importance of identifying nonprofit philanthropic behavior has a greater impact than capturing additional giving information. It also expands our understanding of the strategic practices and ethical values of nonprofit

organizations. Exploring the underlying motivations and benefits of nonprofit philanthropic behavior identifies an additional aspect of nonprofit organizational strategy. Recognizing this can provide an example for other nonprofit organizations to incorporate such practices into their own community and resource strategies. It also has a broader benefit, as it expands our awareness of the role nonprofit organizations play within society.

The Structure of the Dissertation

The dissertation seeks to answer the general questions: “Does nonprofit philanthropy exist?” and “If it does exist, why?” To address these questions, the dissertation is organized into six chapters. Each chapter explores specific aspects related to investigating the existence, nature, and practice of nonprofit philanthropy – as practiced by nonprofit community hospitals.

Chapter One presents an overview of the concept of nonprofit philanthropy. It addresses the questions: “What is nonprofit philanthropic behavior?” and “Why might a nonprofit organization engage in philanthropic behavior?” The chapter outlines a general theoretical approach for exploring the practice of nonprofit philanthropic behavior. This exploration includes incorporating economic, sociological, and management theories that help illuminate these practices. It further hypothesizes that organizational motivations for this philanthropic behavior might be identified based on the location of philanthropic behavior within an organization’s structure. The chapter concludes by addressing the

question: “Why are nonprofit hospitals particularly appropriate to measure philanthropic behavior?” It positions nonprofit hospital philanthropy as a subset of the broader community benefit standard that currently serves as a basis for the federal tax-exemption of nonprofit hospitals.

Chapter Two seeks to answer: “Do current reporting procedures allow us to reliably measure nonprofit hospital philanthropic behavior?” To identify and measure nonprofit philanthropic behavior requires dependable sources for that information. Chapter Two summarizes the existing national and state databases on nonprofit hospitals and evaluates the validity of current reports and data that capture information related to nonprofit philanthropy. It specifically addresses the question: “How reliable are national and state data sources for determining nonprofit philanthropy?”

Chapter Three continues this investigation into the validity of current databases by asking: “How well does an existing voluntary state reporting system capture nonprofit philanthropic behavior?” It explores the publicly available information of one state (Indiana) that has required and collected detailed financial and community benefit reports from each hospital in the state for the past ten years. The chapter analyzes what such reports tell us about nonprofit hospitals in general and about their philanthropic behavior in particular. It further evaluates Indiana’s requirements to determine how well these processes might serve as national models and how similar national reporting requirements might affect the

level of philanthropy and community benefit these hospitals provide. Finally the chapter examines the Indiana information related to hospital ownership and system affiliation and determines how these different criteria may affect community benefit and philanthropic behavior as well as illuminate the validity of this reporting requirement.

Chapters Four and Five ask: “What information about philanthropic behavior can we determine from investigating individual nonprofit hospitals?” The chapters specifically summarize and evaluate the available information and organizational practices that Indiana hospitals use to determine and manage health education and donation programs. Chapter Four focuses on health education and asks: “How and why do Indiana nonprofit hospitals provide community health education programs?” The chapter begins by presenting a hypothetical framework for identifying the organizational level where the philanthropic behavior is located as a way of defining the organizational motive and values for undertaking such behavior. This hypothesis expands upon the general economic, sociological, and management theories presented in Chapter One by developing a four-part structural analysis that corresponds to different organizational theories that explain possible motivations for nonprofit philanthropic behavior. The chapter then builds on the ISDH data used in Chapter Three by adding and comparing information contained in the year-end Internal Revenue Service Form 990 reports. It then gives the results of written and personal surveys of selected Indiana hospitals to determine the extent, the decision processes, and the

organizational levels related to determining, presenting, and reporting health education programs. The results of these surveys are then placed within the theoretical framework to analyze the relationship of actual practices to the theories.

Chapter Five addresses donations and the question: “How and why do Indiana nonprofit hospitals make financial contributions?” It uses the same organizational framework as developed in Chapter Four, as well as a similar analysis of reports and surveys to explore how individual hospitals determine and disburse donations to their community. It also notes how these donations relate to efforts by nonprofit hospitals to attract contributions from their communities. As in Chapter Three, both Chapter Four and Chapter Five note how ownership and religious affiliations may affect the philanthropic behavior of these hospitals.

Chapter Six concludes with a summary of the findings of the theoretical and empirical exploration. The conclusion also identifies how understanding nonprofit philanthropic behavior can change our perception of the role of nonprofit organizations within our society. These perceptions may be positive as philanthropic behavior extends the impact of the values of the nonprofit sector on society. The perceptions also may be negative as such behavior can raise questions about continuing the tax-exempt status for organizations that seem to adopt behaviors traditionally associated with for-profit behavior. The conclusion also reemphasizes how an awareness of philanthropic behavior might enable

other nonprofit organizations to use such behavior to improve their own operational capabilities and strengthen their organizational sustainability. Finally, this conclusion outlines a potential research agenda for expanding our understanding of nonprofit philanthropic behavior.

CHAPTER ONE:

NONPROFIT ORGANIZATIONS AND PHILANTHROPIC BEHAVIOR

This chapter is an overview of the theories behind nonprofit philanthropy and how nonprofit hospitals demonstrate this type of behavior. It addresses the questions: “What is nonprofit philanthropy?” and “Why might nonprofit hospitals engage in philanthropic behavior?”

The first section outlines the concept of philanthropic behavior and how this concept can be used to explore a relatively neglected aspect of nonprofit behavior: i.e. nonprofit organizations making in-kind and monetary contributions to their communities. The section proposes a definition that is used in this paper to identify and evaluate that behavior. The second section is the most extensive part of Chapter One. It develops a theoretical approach that can be used to explore the practice of nonprofit philanthropic behavior. Section two outlines the economic, sociological, and management theories that illuminate these practices and applies these theories to propose a methodological structure that allows research into such behavior. The third section presents nonprofit hospitals as especially appropriate for investigating such behavior. It defines nonprofit hospital philanthropy as a subset of the broader community benefit standard that currently is the basis for the federal tax-exemption of nonprofit hospitals. The chapter evaluates the philanthropic nature of each element of community benefit. It then uses this definition to focus on two elements that have been relatively

under-studied and most directly reflect organizational philanthropic behavior: a hospital's expenditures for community health promotion programs and donations made to other community nonprofit organizations.

The chapter concludes with an outline of how the theoretical and community benefit analyses relate to the empirical investigations pursued later in the dissertation.

On Philanthropy and Nonprofit Organizations

The first section of the chapter addresses the question: "What is nonprofit philanthropic behavior?" The proposed definition used throughout this paper of nonprofit philanthropic behavior is based on three criteria. The first is that the behavior is not required by regulation or otherwise coerced. The second factor is that there should be some kind of demonstrated measurable action involved, beyond a theoretical intent or a generalized organizational purpose. This behavior is generally in the form of budgetary financial expenditures, but could also be defined in terms of in-kind provision of goods and/or services. The third element is that the services identified as "philanthropic" benefit a wider public than is typically assisted through the organization's primary activities.

It should be emphasized that this definition of philanthropic behavior is not intended to apply to all situations or all practices of nonprofit organizations, beyond this paper. The definition outlined above is used for two purposes within

this paper. The first is to relate the similarities of nonprofit behaviors to similar behaviors of for-profit companies. The second purpose is to explore an area of nonprofit behavior that has not been explored in previous studies.

Philanthropy may be either narrowly defined referring to transfers of funds (or sometimes also of volunteer time) or more broadly include any thought word or deed for the love of another human being (Steinberg and Powell 2006, p. 3). The definition used in this paper identifies philanthropic behavior based on the more narrow definition of the actual transfer of measurable time, property, or money. For the purposes of this paper, it further defines the transfer of such gifts as being not only from private individuals or businesses to a formal nonprofit or philanthropic organization but also includes gifts from that "philanthropic organization" to a broader community. Nonprofit organizations are commonly viewed as using gifts and other resources to meet defined public needs. This paper broadens this concept by identifying nonprofit organizational philanthropy: a "gift" made by the nonprofit that addresses a public need or provides a community service that goes beyond the nonprofit organization's defined purpose or traditional mission. In the words of Paul Schervish, this definition focuses on activities that "exceed market standards" (Schervish 1993, cited in Steinberg and Powell 2006, p. 4). One premise of this paper is that this "market standard" can apply to nonprofit as well as to for-profit organizations.

This dissertation begins with a general definition of philanthropy as: “voluntary private action for the public good”.¹ As applied to nonprofit organizations, it further defines “voluntary” as meaning non-regulatory or non-coerced; “private action” as organizational behavior initiated by the nonprofit entity; and “for the public good” as to the benefits for a broader community beyond the specific constituency and immediate purposes directly served by the nonprofit. Concepts that are opposed to or diverge from this definition include: taxes or laws imposed by government, as an alternative to “voluntary”; charitable purpose or intent instead of “action;” and the private good of the organizational entity in contrast to the “public good”. A further distinction is made between programs that directly benefit an individual or group and those that only indirectly benefit various publics. These distinctions are made to better separate the concepts studied in this paper from those more traditional clientele and programs of nonprofit organizations that have been extensively studied in the literature.

Developing a Philanthropic Standard:

Measuring “Voluntary Action for the Public Good”

The concept of philanthropy can be approached from two perspectives. The first is as a generalized set of broad standards and actions that characterize a wide range of human actions and motivations that benefit “others” within society – and may or may not also benefit the philanthropic actor. A second approach is

¹ This definition slightly modifies the definition developed by Robert Payton (1988), adding the term “private” to delineate the private actions of the nonprofit sector from the public actions of governmental entities. This is partially suggested by Merle Curti’s definition (“private and voluntary giving, individually and collectively, for public purposes;” 1973-74).

grounded in a more definitive treatment of philanthropy – one based on the definition presented by Robert Payton: *voluntary (private) action for the public good* (1988). This definitional approach potentially provides the basis for research criteria that provides qualitative criteria and leads to the development of a measurable basis for evaluating various human and organizational activities. This definition is especially useful for applying the concept of philanthropy beyond the limited connotations that focus on the large financial gifts of a few individual and institutional donors rather than the broader area of human endeavors (Katz 1999, Hall 1999).

The definition of philanthropy as “voluntary (private) action for the public good” carries with it three important implications for studying philanthropic behavior and its consequences. The first is the concept of *voluntary* which has three different but related meanings. The most common – and also the least helpful or accurate – is unpaid work or involvement. A second definition is action motivated by one’s own will or volition. The third definition expands upon the second and involves the ease of exit from a situation. The second and third definitions can be combined to understand voluntary action as internally motivated and executed achievements, as opposed to acts externally coerced or mandated by regulation.

“Voluntary action” as applied to an organization places the definition within an operational context (i.e. budgets and programs) rather than broader organizational philosophies (i.e. mission statement or organizational purpose).

Furthermore, because this budgetary or other resource allocation is defined as voluntary, it needs to be initiated by internal will of leadership or other agents within an organization (i.e. board, administration, and other staff or volunteers representing the entire constituency) rather than being defined by external constituents. To provide a non-regulatory example: if a church decides to make its facilities available to meetings of community organizations at no charge, expenses incurred as part of this program could be considered a philanthropic action; if the facilities are rented by an organization and then for whatever reason the renting organization ends up not paying for that rental, the expenses incurred are not initiated by the church but rather by the non-payment of that external organization. This latter situation would not be considered as voluntary, but as a bad debt. Because philanthropic action is generally budget-based, it can be used to develop a quantitative evaluation for “all kinds of noncoerced human behavior, collective or individual, that is engaged in because of a commitment to values other than direct, immediate remuneration” (ARNOVA, *Journal of Voluntary Action Research* 1985, inside front cover, cited in Steinberg and Powell 2006, p. 4).

A third element of philanthropic behavior is also implied by the concept of “the public good” – namely that it addresses a public beyond those that are the focus of an organization’s principal mission. This can be determined by looking at the services an organization provides falling into four areas – the final three all being considered as philanthropic or beyond an organization’s primary purpose. For

example, the primary mission of a particular community medical-surgical hospital might be to provide healthcare services to individuals who are sick or injured. Providing patient care is part of that primary mission, whether through the emergency room or other medical or surgical procedures – regardless of a person’s financial ability or insurance situation. If the hospital also offers health education or preventive medicine programs, services that benefit a wider public beyond those requiring direct patient care, these are examples of a service that goes beyond its primary mission. A contribution to an organization that does not provide direct patient care is another example of this type of service. These latter types of public benefit programs serve a broader public than is addressed in the organization’s primary mission and are considered as philanthropic behavior.

As applied to nonprofit organizations, philanthropic behavior is therefore broadly defined as: “non-regulated budgetary or other expenditure of resources that provides a value to a broader public beyond the primary mission and purposes of that private nonprofit.” This extra-ordinary behavior could include activities that may be typically considered as within the realm of governmental agencies rather than private nonprofit providers.

Organizational Theories and Nonprofit Philanthropic Behavior: An Overview

An essential question that arises in considering philanthropic behavior by nonprofit organizations is: “Why would a nonprofit make a contribution to others in its community?” Nonprofits are typically thought of as recipients of the generosity of individuals and businesses. What would encourage them to become a source of philanthropic support rather than the destination? This question becomes more complex when we consider that at the same time these nonprofits may also be receiving – and actively encouraging – contributions from their communities. As nonprofit hospitals are the focus of this dissertation, it is also important to incorporate how the particular challenges and considerations of the healthcare sector add to this question.

The area of nonprofit philanthropic behavior is one that has not been previously recognized or addressed, either by the theoretical literature on organizational behavior or through empirical examination of these types of practices. However once it is recognized that such behavior exists, related theoretical and empirical studies can provide insights into possible motivations for such behavior. Most applicable are theories attempting to explain the motivations of for-profit corporate philanthropy, especially as one expression of corporate social responsibility. Additional theoretical precedents can be found in the literature on the rationales for the nonprofit sector, the behavior of nonprofit organizations, and studies of hospitals as organizations. A further focus of this section is to

investigate how philanthropic behavior might intersect with, broaden, or differ from these theories.

This section also uses the applicable organizational theories to develop a proposed structure for researching the practice of nonprofit philanthropic behavior and motivation. This structure locates those practices associated with alternative philanthropic motivations at different levels of the organization. This exploration includes theories in organizational sociology as well as related work from economics and management theory.

This theoretical investigation is organized into five parts. The first part presents a proposed four-level research template from the corporate philanthropy management literature that identifies potential motivations for corporate philanthropy. This template is used throughout the remainder of the section to incorporate additional theoretical motivations drawn from a variety of related literature. A key objective of this compilation is to identify potential motivations as well as to relate these motivations to operational or structural practices.

Associating the location of organizational practices with underlying motivations allows the classification of identified philanthropic behavior. This classification provides a method to identify why a specific organization – including a nonprofit organization – might behave philanthropically

The exploration of the theoretical literature begins in Part B with examining corporate philanthropy and corporate social responsibility. While nonprofit philanthropic behavior has not been previously identified, it is hypothesized that nonprofit organizations engage in this behavior for reasons similar to for-profit corporations. This is especially true for nonprofit hospitals that are termed “commercial nonprofits” because of their reliance on income from fees and services (Hansmann 1980), and therefore can be similar to a for-profit company. There also may be important differences between nonprofit and for-profit philanthropic motivations – differences that can emerge by also incorporating theories related to nonprofit organizations and nonprofit hospitals.

The remainder of the section integrates the broader theoretical literature with the philanthropic research structure. Part C outlines the various institutional theories that apply to philanthropic behavior in the nonprofit sector. Part D explores how the economic and social theories of the nonprofit sector relate to nonprofit philanthropic behavior. Part E adds appropriate insights from social theories related to hospitals, emphasizing those that specifically relate to nonprofit hospitals. The section ends with part F, demonstrating how the various theoretical approaches might alter the proposed four-part philanthropic research template. It presents a revised structure that applies to nonprofit hospitals based upon that compilation. This final template is used to investigate the philanthropic behavior of Indiana nonprofit hospitals later in the dissertation.

A Structure for Investigating:

“Why a Nonprofit Organization Might Behave Philanthropically”

When nonprofit philanthropy does occur, a key question is: Is nonprofit philanthropic behavior a deliberate strategy of a nonprofit organization or something that happens as a personal expression of an individual involved with the organization? If it is the latter, that individual could be located at various points in the organization, depending upon the structures and policies of that organization. It could be that a chief executive officer decides to make a commitment from a nonprofit hospital to a community arts center, or a community health nurse chooses to offer a wellness class in a local community center, or a public relations staff member agrees to sponsor a local softball team.² Since nonprofit philanthropy is not an action that has been typically noted by those who track and evaluate nonprofit behavior, it is also possible that the action itself is not recognized as a deliberate and well-defined strategy by a nonprofit hospital's leadership team. Conversely it is also possible that nonprofit philanthropy is as strategically determined and placed in a nonprofit organization as corporate philanthropy has become for for-profit businesses.

Table 1A presents a proposed template for categorizing nonprofit giving motivations. This template is based on four models defining the motivations of corporate giving, defined by Young and Burlingame (1996, see also Burlingame and Smith 1999):

² Each of these examples represent actual cases drawn from the research of philanthropic behavior by Indiana hospitals, presented in Chapters Four and Five of this dissertation.

Table 1A: The Corporate Philanthropy Models

Young and Burlingame Model	Neoclassical/ Productivity Model	Ethical/ Altruistic Model	Political Model	Stakeholder Model
Organizational Motivation (from Young and Burlingame)	To ensure and/or increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Nonprofit Philanthropy Model	Management Function	Leadership Directed (CEO or Board)	Separate Organizational Function	Stakeholder Discretion
Organizational Structure	Embedded in Dep't and Manager Hierarchy	Practices at Leadership Level	Separate foundation or identified and publicly-visible department	Dispersed throughout organization

The following section shows that while there are potential differences between for-profit and nonprofit philanthropy that could require revisions in this model, motivational similarities validate the grounding of a nonprofit philanthropy template in for-profit philanthropy concepts.

The Corporate Philanthropy Model: Young and Burlingame outline four paradigms for corporate giving: the Neoclassical/Productivity Model (focused on firm profitability), the Ethical/Altruistic Model (emphasizing a society's social norms), the Political Model (stressing organizational power within a community), and the Stakeholder Model (satisfying multiple constituencies).

The Neoclassical/Productivity Model presents corporate giving as a strategy to increase the financial bottom-line of the organization. Under this model, giving by a firm or organization is treated as any other profit center or activity and must

yield a corresponding return on that investment, even though that return might be long-term, in the case of improved employee morale or public relations (Lewin and Sabater 1996), or indirect, as in cause-related marketing (Yankey 1996). In such scenarios, corporate giving programs can be viewed as not being truly philanthropic but rather a corporate strategy designed to benefit the firm itself. The Ethical/Altruistic Model is based on the concept that corporate giving is one aspect of *corporate social responsibility*, with intended outcomes based in social ethical motives rather than profitability. One key aspect of this model is that the philanthropic activity of the firm is seen as being “*beyond* the normal course of business operations,” which is “maximizing profits” (Buhl 1996, p. 129, emphasis in the original). Because individual moral standards generally influence organizational ethical actions, the motivation for this model is an expression of the personal behavior and values of the business leadership and staff as well as of the normative principles of the organization itself.

The Political Model presents corporate giving programs as a means to strengthen the societal influence of businesses. In this perspective, by creating networks and relationships with nonprofit partners and other corporate supporters, the business is simultaneously limiting the interference of government on matters relating to local economic development and community need (Himmelstein 1996, 1997). Young and Burlingame acknowledge the Stakeholder Model is both the most comprehensive theory of corporate giving as well as the most ambiguous. The Stakeholder Model maintains that corporate

philanthropy is an effort to balance the multiple demands on a corporation by the various entities that are its constituency, and to meet their varying needs and interests (Wood and Jones 1996). These multiple Stakeholders include internal groups (i.e. managers and workers) and corporate investors (i.e. owners and stockholders) as well as external publics with various relationships to the business (i.e. customers, suppliers, and other related community members).

Table 1B outlines these four models and identifies the different organizational motivations associated with each model:

Table 1B: The Young/Burlingame Models of Corporate Giving Motivation

Young and Burlingame Models	Neoclassical/ Productivity	Ethical/ Altruistic	Political	Stakeholder
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies

Developing the Organizational Giving Template: The Young/Burlingame models provide a template within which additional theories related to organizational philanthropy, nonprofit behavior, and hospital structures might be incorporated into a final research structure. To provide an initial example: in his 1961 work on organizational prestige, Charles Perrow differentiated the intrinsic characteristics of an organization as being distinct from its extrinsic characteristics. He defined

intrinsic characteristics as goods or services “fundamental to (the) official purpose of the organization,” while “extrinsic characteristics are not essential to maintaining production standards though they may be vital in insuring acceptance and resources” (p. 336). Perrow emphasizes that extrinsic and intrinsic distinctions will vary depending upon the organization’s goals and the “target group” that the organization intends to influence by the image. He further notes that an analytical typology may be derived from these kinds of considerations, and that defining organizational activities as intrinsic or extrinsic is an initial but *crude* (sic) step in developing such a typology. Under this perspective, philanthropic behavior generally would be considered to be an extrinsic organizational characteristic rather than an intrinsic one.³ This leads to an approach for further understanding the nature of philanthropic behavior in a nonprofit organization. When activities are identified as being “philanthropic”, they can then be further investigated as to whether those behaviors are treated intrinsically by the organization (i.e. operated by staff and departments that directly serve the organization’s primary purpose of providing goods or services) or are treated extrinsically (i.e. operated by individuals or departments that have administrative or external responsibilities). The extrinsic/intrinsic example is one possible categorization that could more specifically identify organizational positions of nonprofit philanthropic behavior and potentially lead to better understanding the motivations behind such behaviors. As such they can be incorporated into the Young/Burlingame models to expand their application to a

³ In the article Perrow refers specifically to charitable donations by organizations as an example of an extrinsic, value-laden characteristic that helps build organizational prestige (1961, p. 336).

theoretical framework. Under this distinction, the Neoclassical/Productivity Model can be identified as an intrinsic use of prestige while the other three models fit more logically into the extrinsic category. When examining the organizational location of philanthropic behavior, the more closely that function is linked to staff and departments serving the business operations of producing and delivering products and services, the more such behavior could be categorized as being motivated by financial profitability rationales. This intrinsic/extrinsic distinction is noted in Table 1C, with a cell added to the previous table that includes the locale of philanthropic behavior related to Perrow's concept of prestige.

Table 1C: Intrinsic/Extrinsic Characteristics of Corporate Giving Models

Young and Burlingame Models	<i>Neoclassical/ Productivity</i>	<i>Ethical/ Altruistic</i>	<i>Political</i>	<i>Stakeholder</i>
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
General Locale of Philanthropic Behavior: Prestige (Perrow 1961)	Intrinsic	Extrinsic	Extrinsic	Extrinsic

The Organizational Location of a Corporate Function: The function of corporate philanthropy involves three actions. The actions are: 1) the decision to make

contributions, 2) the philanthropic action itself, and 3) communicating, reporting, or promoting of that action to the desired constituency. Each of these actions could be located either at different organizational levels or within a single entity of the organization. Identifying where in the organizational structural location the first action is located, (i.e. the decision to make contributions) is potentially the most difficult part of the contribution process to identify. The literature on corporate structure and decision-making does not identify this type of distinction, particularly related to external functions of the business.

Most commentators in the business literature assume that decisions are made in the context of profit-making activities.⁴ The literature on ethical decision-making does include a handful of studies trying to link organizational level with ethical behavior, but it is observed that these limited studies yield mixed and inconclusive results (Bartlett 2003, p. 217, see also Lowe et al 2000, Lozano 1996, Ford and Richardson 1994, and Boatright 1988). Boatright (1988) concludes that business ethical values and decisions are based on the individual values of managers, generally of the chief executive officer. He differentiates between the rational model approach to business ethics (in which all decisions are made to further corporate profitability) and the political model (in which stakeholder interests are incorporated). However, while he notes the limitations of the rational model related to ethical decisions he also acknowledges that the political model has not been fully explored or worked through. Boatright does

⁴ See James March, *Decisions and Organizations*, Cambridge MA: Basil Blackwell (1988) for one compilation of work on organizational decisions.

identify that organizational legitimacy is a primary motivation for undertaking ethical behavior, which raises a key attribute of organizational philanthropy that is more fully explored later in this section. However, his final conclusion is to link business ethical values as an expression of the individual values of business leaders. This link of business values with the personal ethics of managers is also echoed in Bartlett (2003) and Geva (2006) among others. Ferrell and Skinner (1988) do attempt to construct a formal model in applying ethical behavior in market research organizations but limit it to either a centralized or a de-centralized designation. Their assumption is that “highly centralized organizations would have more opportunity to control ethical decisions” (p. 104) – leading to the supposition that organizations that have more managerial control will also be more ethical.

There has been some work on the organizational structure of external organizational practices. However this literature only gives limited attention to how variable structures might indicate different organizational motives. Miles (1987), while noting that little research (at that time) had been done on the process and placement of external affairs activity, identifies two basic approaches to this activity. The first approach is to concentrate the tasks within a unit whose primary function is external affairs. The second approach is that external affairs responsibilities are placed in individuals whose primary responsibilities lie in other areas. He further identifies four internal design dimensions of this strategy. The first dimension is breadth, indicating the number

of different units within a company that manage external affairs components. The second is depth, involving the intensity that external affairs units may research and develop programs. The third is influence and integration, addressing the internal relationships of external affairs with other internal units. And the fourth is line-manager involvement, which emphasizes the internal relationships with senior management. Miles then conducts three case studies of insurance companies to further develop a classification of the different treatments accorded external affairs based on these companies. He concludes by identifying four core concepts governing external affairs: business exposure or strategy (external affairs are linked to business goals), top management philosophy (external affairs are a reflection of leadership ethics), external affairs strategy (that links the business with others in their environment through collaboration and/or legitimizing behavior) and external affairs design (relating to internal stakeholders). These core concepts relate to the four models of corporate philanthropy previously outlined (see Table 1D). Recent literature hasn't greatly expanded Miles' work. Several commentators have addressed categorizing the outcomes or actions relative to corporate social responsibilities (for example Mattingly and Bermann 2006, Black and Hartel 2004, Agle and Caldwell 1999), but not the internal structures and locations of activity as an indicator of corporate motivations.

While Miles' application of his structure is limited to three case studies of insurance companies, it does provide a potential organizational structural

framework within which corporate philanthropy (and nonprofit philanthropy) can be classified. His theoretical conclusions do not make specific distinctions of specifically where within an organization external affairs might be located based on the core approach that is primarily adopted by the organization, but it requires a relatively small logical step to link his explanations of the core concepts, design dimensions, and basic components to desirable corporate structural approaches. The business exposure model emphasizes that external affairs needs to be tightly linked to support the primary products, services, and customers of the firm. It can be expected that businesses that have this motivation would locate external affairs either within those departments or are closely linked to that primary activity through a direct departmental manager reporting structure. The top-management philosophy is based on the ethical values of leadership and external activities and it is expected that businesses with this motivation would have external affairs coordinated, if not directly managed, at the highest levels of the business hierarchy. A business that adheres to the external affairs strategy would seek to have maximum awareness and potential linkages with other businesses, government, or agencies in their environment. This is most effectively accomplished through a well-defined external affairs effort, possibly in a completely separate department or even an organizational division, such as a corporate foundation. The external affairs design concentrates on establishing internal linkages with existing organization stakeholders. With this motivation, these stakeholder connections would be differentiated, dispersed, and integrated throughout the organization, and the external affairs activities would also be

dispersed. The relationship of the four model corporate philanthropy template, the core concepts presented by Miles and the extrapolated locations of these actions within the corporate structure are added to the previous tables in Table 1D.

Table 1D: Corporate Giving Models and External Affairs Structures

Young and Burlingame Models	<i>Neoclassical/ Productivity</i>	<i>Ethical/ Altruistic</i>	<i>Political</i>	<i>Stakeholder</i>
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
General Locale of Philanthropic Behavior: Prestige (Perrow 1961)	Intrinsic	Extrinsic	Extrinsic	Extrinsic
Core Concepts of External Affairs (Miles 1987)	Business exposure or strategy - Linked to business goals	Top management philosophy - Reflection of leadership ethics	External affairs strategy - Relate to environment through collaboration and/or legitimizing behavior	External affairs design elements - Relate to internal stakeholders
Expected Organizational Location of External Affairs, Based on Core Concepts	Linked to internal financial and marketing activities	Directed by leadership	A defined division, providing linkage opportunities with key external organizations	Dispersed within the organization

It is the contention of this thesis that this type of classification related to identifying motivations for corporate philanthropy and external affairs has direct applicability to nonprofit philanthropic behavior. A variety of applicable organizational and management theories are used to justify this contention. Following is a further examination of how existing theories relate to these four models of corporate philanthropy – and how ultimately nonprofit philanthropic

behavior also reflects and incorporates these distinctions. As a next step in this theoretical exploration, the literature on corporate giving and corporate responsibility is investigated, outlining how alternative perspectives add to or alter the corporate giving models.

The Theoretical Foundations of Corporate Philanthropy and Corporate Social Responsibility

While nonprofit organizational philanthropy has not been previously investigated, philanthropy as practiced by for-profit corporations has received extensive academic attention. Although the ownership structures of nonprofit and for-profit organizations may differ, the underlying organizational motivations to acquire resources, to provide goods and services for a defined public or market, and to strengthen their ability to survive as an organization are held in common. Identifying how for-profit organizational philanthropy is currently understood becomes an important first step in expanding this understanding to nonprofit philanthropy.

Corporate Philanthropy Defined: Nonprofit philanthropic behavior is defined previously in this paper as: “non-regulated budgetary or other expenditure of resources that provides a value to a broader public and operates beyond the primary mission and purposes of that private nonprofit.” This is more precise than typical definitions of corporate philanthropy that are found within the corporate philanthropy literature. In most of the sources is assumed that either

the reader “knows” what corporate philanthropy is or it is explicitly identified as a gift of money to a nonprofit organization, regardless of the purposes of the donations or the motivations involved (for examples, see: Useem 1987, p. 340, Johnson 1966, p. 489). One such definition of corporate philanthropy is “. . . a transfer, of a charitable nature,⁵ of corporate resources to recipients at below market prices” (Ireland and Johnson 1970 as cited in Fry et al 1982). However, corporate philanthropy is also seen by several commentators as part of the broader term of corporate social responsibility, including as being “the top of the ‘pyramid of corporate social responsibility’” (Carroll 1991, p. 42, cited in Saiia et al 2003, p. 169), “the oldest form of corporate social behavior” (Mescon and Tilson 1987, p.49), or “a narrower term (than corporate social responsibility or corporate citizenship), restricted to the charitable giving that a company may do to meet part of its felt citizenship responsibilities” (Burlingame and Smith 1999, p. 60).

The treatment of corporate philanthropy has also evolved into merging business and social interests, either through concepts such as “strategic philanthropy” (Porter and Kramer 2002, Marx 1999, Mescon and Tilson 1987) or philanthropy as a means to increase corporate power or influence (Himmelstein 1977). For the purpose of this paper, corporate philanthropy is termed as expenditures and actions that reach beyond a corporation’s primary business purpose, operation, and customers to serve a wider public mission and constituency. This definition

⁵ The phrase “of a charitable nature” can be particularly ambiguous, as will be shown in the discussion (below) related to hospital tax exemption and the legal considerations of community benefit.

focuses on the recipient and use of corporate donations, and does not limit the residual values that may accrue to a corporation, such as the recognition of being a business donor or sponsor. This definition is related to Buhl's concept of corporate social responsibility as being "*beyond* the normal course of business operations," (Buhl 1996, p. 129, emphasis in the original). This distinction is similar to what was previously noted for defining nonprofit philanthropy.

Much of the current business and management literature tend to stress the strategic aspects of corporate philanthropy: that the primary role of making contributions by businesses is to advance the long and short-term interests of the corporation and its stakeholders. This is true even when giving seems to benefit the greater public. While a strengthened environmental and community context may benefit the larger society, it will also aid the human resources, image, and competitive advantages available to the business (Porter and Kramer 2002). This view of strategic philanthropy is but one factor that complicates efforts to assign single motivations to a multi-faceted practice such as philanthropy. Nevertheless there is value to using different manifestations of this practice to determine a prominent motivation – while also acknowledging the potential existence of additional considerations.

The Literature on Corporate Philanthropy: The concept of strategic philanthropy is one example of how our understanding of corporate philanthropy has evolved over the past three or four decades. The literature on corporate philanthropy has

three primary branches: the historical documentation of business giving, the identification of various business philanthropic practices in the management literature, and the efforts of organizational theorists to develop a conceptual understanding of why this type of behavior might be undertaken by a business. To reach an understanding of nonprofit philanthropic behavior, the branch that incorporates the organizational theory literature is especially appropriate to investigate for two reasons. The first is that these theories seek not merely to record various actions but also provide insights into possible organizational motivations behind various actions and structures. Second, and perhaps more importantly, these theories have been applied to varying types of organizations as well as to various organizational actions. Tracing the references to similar theories can provide possible linkages between otherwise unrelated practices. For example, the theory of organizational prestige is used as an underlying rationale for both for-profit corporate giving (Kamens 1985) and for nonprofit behavior (Perrow 1961). This provides a motivational link that could help identify a key attribute for nonprofit philanthropy, linking two seemingly disparate elements of corporate giving and nonprofit behavior.

Although the organizational theory literature is the primary focus of this thesis, a brief summary of the literature related to the historical evolution of corporate giving and the management perspective on for-profit philanthropy provides a context for viewing the extent and evolution of scholarly attention to corporate philanthropy. In terms of the historical documentation, the Russell Sage

Foundation executive F. Emerson Andrews first attempted to trace the history of corporate giving in the United States in 1952. Since that time historians of business and of the nonprofit sector have richly explored the historical evolution of corporate giving, including Peter Dobkin Hall (1997, 1989), Karl (1991), Useem (1987), Hayden W. Smith (1983), Nelson (1970), and Heald (1970). Marinetto (1999) has done a similar historical view of business philanthropy in Britain. Several studies of corporate philanthropy have looked at factual trends, including equating varying levels of philanthropy with firm size and type (Brown, Helland, and Smith 2006, Johnson 1966) or with advertising expense (Fry, Keim, and Meiners 1982). While some of the historical and factual sources do attempt a theoretical explanation for noting certain trends, such explorations are limited and that one particularly useful application of the works is more descriptive than analytical. However, Young and Burlingame note the value of the historical documentation as it indicates shifts in corporate giving behavior that link the historical literature to different stages of their four-part model: “The neoclassical model grows out of an era of American business domination of the economy through the 1950s. The ethical/altruistic model offers a 1960s flavor of social responsibility . . . The political model reflects a growing sense of societal participation by corporations in the world of the 1970s and 1980s . . . And stakeholder theory integrates the notion of empowerment, a growing societal force since the 1960s . . .” (Young and Burlingame 1996, p. 162).

The management literature primarily focuses on documenting corporate philanthropy practices and presenting analyses that can be applied to either assisting corporate decisions or better understanding corporate philanthropy as a social resource. This literature is differentiated from that of organizational theory as works within this framework have limited references to the works of organizational theory, particularly those themes most closely associated with nonprofit behavior. However they do add valuable insights into characteristics of business behavior related to motivations for corporate philanthropy and as such are important to investigate in a little more depth.

Key works in the management literature that address corporate philanthropy are the previously mentioned works of Young and Burlingame (1996) and Burlingame and Smith (1987), which help to synthesize the various explanations into a more cohesive framework. Other sources provide confirmation of one or more of these four corporate giving models. This particularly includes the role of community power explored in the work of Himmelstein (1997) and Mitchell (1989). Himmelstein's work is especially significant in advancing our understanding of how corporate philanthropy helps an individual business become more influential in its community while also strengthening the overall autonomy of a community's private business sector. The studies of Galaskiewicz (2006, 1991, and 1989) and his explorations of corporate philanthropy in the Minneapolis area and resulting depictions of this philanthropy as collaborative partnerships reinforce this perspective. The works of Galaskiewicz and

Himmelstein strengthen the rationales for the Political Model of philanthropy as a means to increase community power and influence. Under this model, corporate philanthropy is a means for the private sector in a community to join resources to address community needs while simultaneously limiting the need for influence and intervention of the public sector through government action. This has a potential parallel application to motivations for nonprofit philanthropy as a means for the private, nonprofit sector to expand its own influence while minimizing governmental involvement and resulting oversight.

The management literature also helps support the Stakeholder Model for corporate giving. Brudney and Farrell (2002) explore the legal considerations of corporate philanthropy as a means for meeting shareholder interests in relation to social needs (treating shareholder as a narrow but relevant definition of stakeholder). They determine that stockholders have not only economic interests but also concerns about community and social issues. Brudney and Ferrell maintain that management needs to consider identifying and incorporating these stakeholder/stockholder interests in their philanthropic decisions, as well as addressing the interests of the business itself. Brammer and Millington (2005) also emphasize the role that corporate philanthropy plays in shaping stakeholder perceptions of a corporation's reputation. Their work reinforces the function of philanthropic actions as a way to develop corporate reputation. They indicate that corporate reputation among various stakeholders is an image that is created

over time and is an asset that has explicit residual benefits for the business.⁶ As an asset, reputation can be developed through deliberate strategies such as philanthropy. The relationship of corporate philanthropy and reputation with the theoretical concepts of prestige and legitimacy is especially notable and helps to link the for-profit and nonprofit characteristics, as will be shown in the next section.

The two other models (Productivity and Ethical) are even more extensively addressed in the management literature on corporate social responsibility. As mentioned, the *strategic philanthropy* approach to corporate giving advocated by Porter and Kramer (2002) and others relates directly to the Productivity Model. Strategic philanthropy can also be considered as an attempt to at least partially unify the various models. However the strategic philanthropy approach emphasizes that increased business benefit is always one of the evaluative criteria for corporate philanthropy, regardless of what the other criteria may be. Therefore it is considered as rooted primarily in the Productivity Model. Conversely, the linkage that strategic philanthropy establishes between increased productivity and other motivations does illustrate the difficulty in assigning a single motive to increasingly complex behavior. For instance, the observation has been made that corporate giving has seen a relative decline in the past few years (Burlingame 2003, pp. 178-179) although this does fluctuate

⁶ Corporate reputation is an area that has seen increased interest over the past twenty years, particularly as a strategy. Mahon (2002) and Fombrun and Shanley (1990) are two sources relating to this area. The relationship of reputation and corporate social responsibility (CSR) is less explored, but is especially evident in the use of visible CSR as a method to combat negative public perceptions (such as Williams and Barrett 2000).

year-to-year (Giving USA 2007, p. 79). But this decline has been balanced by what is termed *corporate-nonprofit partnerships*, business practices that are beyond simple charity but have dual benefits as their expressed purposes (ibid, pp. 81-82, Galaskiewicz 2006, Sagawa and Segal 2000). Examples of this partnership are corporate sponsorships, funding for specific nonprofit programs from corporate research or human resources budgets, or true collaborative programs with business and nonprofits working together to jointly achieve community initiatives and meet social needs (Galaskiewicz and Colman 2006, Burlingame and Smith 1989). It could be notable that the second edition of *The Nonprofit Handbook* (2006) replaced the chapter from the first edition on “Corporate Philanthropy” (Useem 1987) with “Collaboration between Corporations and Nonprofit Organizations” (Galaskiewicz and Colman 2006), perhaps signaling this shift in the priorities of business philanthropy.

Galaskiewicz and Colman emphasize “that since Useem’s (1987) review (i.e. in the first edition), there has been a blurring of the boundaries across sectors and an expansion of the interface between nonprofits and business” (2006, p. 196). This shift toward partnerships and collaborations potentially supports the Political Model, as these represent private efforts to address community needs without the explicit role of government. This also suggests that corporate programs for social benefit have a broader strategic role: to satisfy social, political, and stakeholder needs as well as benefit business interests – a new paradigm for corporate philanthropy as termed by Burlingame and Smith (1996).

These partnerships also potentially provide another unifying mechanism for corporate philanthropy, bridging political, stakeholder, and ethical perspectives in ways that could provide financial benefits.

The Ethical Model is well represented in the broad management literature on business ethics and particularly on corporate social responsibility. To completely examine that extensive literature is beyond the scope of this paper. However several observations are helpful for the theme of the paper. The broader definition of corporate social responsibility or corporate social action contains additional concepts that differentiate it from self-serving business strategies: “behaviors and practices that extend beyond immediate profit maximization goals” (Marquis, Glynn and Davis 2007, p. 926). In his explorations of the evolving definitions of corporate philanthropy and corporate social responsibility, Carroll emphasizes that although the specific measurements and uses of the term corporate social responsibility are continually changing, its basic foundations, dating back over fifty years, relate to enduring public expectations of the social role of businesses (Carroll 1999, pp. 291-292). Carroll also notes that some commentators have defined social responsibility as involving not only behavior that goes “beyond economic and legal considerations” but that are purely voluntary. He specifically cites Manne and Wallich (1972, p. 5), “Another aspect of any workable definition of corporate social responsibility is that the behavior of the firms must be voluntary” (Carroll 1979, p. 498). Whether this “voluntary” behavior differentiates at all from “voluntary” business efforts to

increase profits is debatable. But the fact that social responsibility is not something that is forced by an external mandate – such as by government – does link the concept not only to the “voluntary private action for the public good” philanthropy definition but also provides a “softer” context for connecting the concept with the more combative-sounding model of *power*. The emphasis of social responsibility on being voluntary provides a sense that efforts to achieve what is termed political and economic power might actually more properly be termed as independence or autonomy of the private sector. This provides an additional attribute that has potential application to explaining nonprofit philanthropy.

Corporate social responsibility and corporate philanthropy can be characterized as an effort by a company to advance its own worth and concern for a community in the eyes of its customers and the greater public. This may also reflect a need to emulate similar actions of other businesses. Both of these motivations are explored through the organizational theory literature related to legitimacy and isomorphism.

Nonprofit Organizational Theories and Neo-Institutionalism – On Organizational Legitimacy, Institutional Isomorphism, and Nonprofit Philanthropy

Legitimacy is one of the two broad theories that this paper maintains provide the motivational foundations of organizational philanthropy. The other theory is institutional isomorphism. Both of these concepts connect to the nonprofit sector

within the general designation of neo-institutional theory. Legitimacy includes related concepts such as corporate reputation and prestige and can be closely related to and is an outcome of isomorphism. Isomorphism, as developed by DiMaggio and Powell (1983) refers to the homogenization of organizations that occurs as environmental constraints encourage one organization to resemble other organizations occupying similar institutional or other organizational population contexts. Their approach sought a different theoretical approach to organizational theory that stressed a “homogeneity of organizational forms and practices” (ibid, p.148) that contrasted with theories that focused on explaining organizational variations within a population (such as ecology theory as expressed by Hannan and Freeman 1977). One consequence of adapting similar structures and practices can be to increase the legitimacy of the organization (DiMaggio and Powell 1983, pp. 149-150). Legitimacy and isomorphism can both be segmented into sub-categories that correspond to the four models of corporate giving and provide further insights into nonprofit philanthropy.⁷

The general concept of neo-institutionalism, as presented by Meyer and Rowan (1975) and expanded by DiMaggio and Powell (1983) forms the basis for these comparative theories. This includes work grounded in the concepts of Meyer and Rowan (1977) on myth and ceremony, of Orton and Weick (1990, and Weick

⁷ As will be explored further below, DiMaggio and Powell (1983) differentiate between coercive, normative, and mimetic isomorphism in their work on how institutional system seek rationality. Dacin, Oliver and Roy identified a framework of five legitimating functions for corporate strategic alliances (of which philanthropy is one expression): market, relational, social, investment, and alliance legitimacy.

1976) on loose coupling, and of Perrow (1961) and Dowling and Pfeffer (1975) as well as Suchman (1995) on organizational prestige and legitimacy. Other theoretical work that relates to organizational philanthropy – and are included in this summary of theoretical connections with the neo-institutional theories – are Hannan and Freeman (1977) on organizational ecology and of Pfeffer and Salancik (1978) on resource dependency.

The following exploration of these theories first looks at the general concept of neo-institutionalism and the various theories related to neo-institutionalism. It next explores specifically how organizational legitimacy relates to these concepts and then outlines the concept of institutional isomorphism and its relationship to nonprofit organization. This part concludes by summarizing how these concepts relate to the model of corporate philanthropy.

Neo-institutionalism: Scott (1998) classifies the various organizational theories into three broad categories of what he terms perspectives: *rational systems*, formally imposed internally oriented structures; *natural systems*, focused on the informal internal behavioral structures; and a third classification, *open systems*, includes the effects of environmental factors on the function and structure of organizations as opposed to *closed system* perspectives that focus on internal organizational mechanisms. The concept of *institutionalism* arises within the *open system* perspective.

Scott (1987) shared one of the classic definitions of institutionalism: “. . . organizational structure as an adaptive vehicle shaped in reaction to the characteristics and commitments of participants as well as to influences and constraints from the external environment. Institutionalization refers to this adaptive process: ‘in what is perhaps its most significant meaning, “to institutionalize” is to infuse with value beyond the technical requirements of the task at hand’” (Selznick 1957, p. 17, cited in Scott 1987, p. 494). Jepperson echoes this definition in a simpler form in defining an institution as “a social order or pattern that has attained a certain state or property” and goes on to clarify that these properties refer to particular contexts and external relationships that affect organizational structures and functions (1991, pp. 145-146). Scott (1991) further identified the variety and complexity of environmental influences affecting institutional theories as including cultural elements such as myth and ceremony, concerns over legitimacy, and other relationships connecting the organization to its wider society. This environmental approach to corporate behavior is particularly applicable to external and relational actions such as corporate social responsibility and its more specific expression of corporate – and nonprofit – philanthropic behavior.

Neo-institutional theories are grounded in *open system* approaches to organizational structure and function (Powell and Di Maggio 1991). The *institutionalism* theories of the 1950s focused on the non-rational institutionalized behavior within organizations, separate from their environment. Neo-

*institutionalism*⁸ generally refers to a group of theories developed in the 1970s and is similar to institutionalism but considers the pressures of the organizational environment affecting organizational behavior. This group of theories includes organizational legitimacy and isomorphism as well as the related concepts of myth and ceremony (Meyer and Rowan 1977) and on tight and loose coupling (Orton and Weick 1990, and Weick 1976). Open system theory also incorporates institutional concepts such as population ecology (Hannan and Freeman 1977) and resource dependency theory (Pfeffer and Salancik 1978). These concepts are helpful for expanding the exploration of nonprofit philanthropic behavior, but legitimacy and isomorphism have the strongest direct application.

Organizational Legitimacy: As stated earlier, Perrow (1961) explored the importance of the concept of organizational prestige, a concept related to legitimacy, and in some sources used interchangeably. He based his examination on observations of a hospital (generically identified by Perrow as

⁸ This thesis tends to focus on concepts typically included under “new” institutionalism, focusing on cultural concepts such as legitimacy. The concept of *new institutionalism* or *neo-institutionalism* is sometimes contrasted to that of *institutionalism*, to distinguish the advancements to theory in the research and writings of sociologists in the 1970s and 1980s from older traditions of linking organizational behavior with social, political, and economic environmental influences. The original institutional approaches were developed in the nineteenth and early twentieth centuries by theorists such as Veblen, Parsons, and Coase, and further advanced in the mid-twentieth century by Selznick. The “new institutionalism” of the later twentieth century further explored and defined the various environmental influences on organizational behavior and is expressed in fields such as economics, social psychology, and political science as well as sociology (DiMaggio and Powell 1991, pp. 1-3). Selznick (1996) explores the differences in new and old institutionalism, especially the tendency of the new institutional theories to emphasize the theme of incoherence in complex organizations. In this paper, *institutionalism* and *new* or *neo-institutionalism* may occasionally be used interchangeably, but unless otherwise indicated either term refers primarily to the work of the more recent theorists.

“Valley Hospital”) and its attempts to construct its public image in a way that corresponded to social norms. He observed that in such situations the quality of extrinsic actions (i.e. those outside of an organization’s “official purposes”) become as important as those intrinsic approaches that emphasize the quality of an organization’s primary purposes. This may be especially true of organizations that have purposes that may be difficult for the typical consumer to judge their quality, such as healthcare provided by a hospital.⁹ In these cases, the style of facilities, presence of personal amenities, and public actions such as making contributions may be used to convey to a community an image of organizational quality. Prestige also relates to theories such as organizational image¹⁰ and the related concept of reputation.¹¹ The perspective of image is particularly relevant to the enhancement of organizational prestige. Image has been depicted in the management literature as related to external perceptions of an organization, whether through manipulation of that image by internal processes (i.e. “public relations”) or through normative perceptions rooted through experience of external constituencies (e.g. customer experience). The concept of image is generally opposed to more objectively measurable substance (Gioia and Thomas 1996, p. 370) and is separated from organizational identity (representing the perceptions of insiders) as being externally held appraisals (Scott and Lane

⁹ This also relates to the economic theories of the nonprofit sector regarding contract failure – addressed later in this chapter.

¹⁰ Especially work by Avesson (1990) and Dutton and Dukerich (1991), as cited in Scott and Lane (2000) and Gioia and Thomas (1996).

¹¹ Corporate reputation has had various explorations in the management literature, particularly related to strategy and marketing. For a fairly extensive identification of the literature, see Mahon (2002).

2000, p. 43). Perrow (1961) and the management literature provide a connection of these theories with the broader central concept of organizational legitimacy. Dowling and Pfeffer (1975) helped expand organizational legitimacy as a factor in both organizational and institutional analysis. They defined organizational legitimacy as the “congruence between the social values associated with or implied by their activities and the norms of acceptable behavior in the larger social system” (p. 122). Building on the definitions put forth by Parsons (“the appraisal of action in terms of shared or common values in the context of the action in the social system”)¹² and Maurer (“the process whereby an organization justifies to a peer or subordinate system its right to exist”),¹³ Dowling and Pfeffer identify legitimacy as one of three sets of organizational behavior – with economic viability and legal viability being the other two (p. 124). In their definition, legitimacy is seen as strongly linked to societal values and norms – and is evident in communications among societal entities as well as an influence for organizational change (i.e. to conform to changing societal norms and values). This behavior is especially seen as an important concept for analyzing linkages and relationships between an organization and others in their external environment. Dowling and Pfeffer also specifically identify contributions to charity as an example of legitimating behavior. They present three perspectives that can be used for analysis of such corporate generosity: economic benefits, truly altruistic behavior, and legitimating behavior.

¹² Talcott Parsons, *Structure and Process in Modern Societies*, New York: Free Press (1960): 175.

¹³ J.G. Maurer, *Readings in Organization Theory: Open-System Approaches*, New York: Random House, (1971): 136.

Suchman (1995) further delineates three broad types of legitimacy: pragmatic, moral, and cognitive. Within Suchman's definition of legitimacy ("a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions." p. 574), *pragmatic legitimacy* is the first type identified. It refers to organizational actions that are self-interested, using political, economic, or social conformity to the systems of societal norms for organizational benefit. He demarcates within this category exchange legitimacy (related to economic profitability as well as power-dependency), influence legitimacy (attracting support because of the perception the organization is responsive to larger interests), and dispositional legitimacy (the organization is personified in the minds of external constituents, as being trustworthy and mindful of their interests). Each of these is presented as an organizational attempt to manipulate the public perception of the quality of the organization for internal benefit.

The second type of legitimacy presented by Suchman is *moral legitimacy*. Related to altruism, *moral legitimacy* involves various behaviors of the organization as being primarily in the interest of external actors rather than of the internal organization. Identifying moral legitimacy involves various levels of evaluation, including consequences of the actions, procedures involved with the behavior, structures of the activity, or the motivations and subsequent actions of an organization's leaders. *Cognitive legitimacy* relates to an organization's actions being culturally accepted as deserving existence and support due to it

being perceived as socially necessary or inevitable, based on taken-for-granted cultural accounts. An example of *cognitive legitimacy* might be a church being assumed to be primarily interested in the spiritual benefit of its community (rather than the personal enrichment of the churches leaders) or a police car representing the legal enforcement of socially developed regulations (rather than the personal beliefs of the police officers). *Cognitive legitimacy* is especially vulnerable to cases of organizational scandal or transgressions. When an organization violates the conditions underlying the societal assumption, it can cast doubt on the entire organizational field or institution that represents that specific set of values.

Dacin, Oliver, and Roy (2007) have strengthened the motivations for corporate alliances to increasing legitimacy. They have further identified five legitimating roles for strategic alliances: market, relational, social, investment, and alliance. These roles correspond to three of the four models of corporate philanthropy (market and investment = Productivity, social = Ethical, and relational and alliance = Political), with even the Stakeholder Model potentially being addressed through the relational classification.

Legitimacy and myth and ceremony: The theory of legitimation and the process by which organizations acquire and use it to interact with the environment are expanded through the concept of organizational myth and ceremony as put forth by Meyer and Rowan (1977). Meyer and Rowan's paper is especially significant

as it unifies several theories into a broader institutional theory, creating a context for later theorists such as Powell and DiMaggio (1991) and Haley (1991) who conceptualized the entire philanthropic process as a *masque*, with the purpose of strengthening the image of the organization as one of prestige and legitimacy. How myth and ceremony supplement the concept of legitimacy also led Chen, Patten, and Roberts (2008) to explain the connection between corporate philanthropy and employee relations, environmental policies, or product safety. Meyer and Rowan not only emphasized that rationalized myths help support organizational legitimacy but also link professional and other institutionalized norms with organizational policies. These institutionalized myths help encourage organizational isomorphism as conformity to ceremony leads to organizations developing similar policies, procedures, and rules based on those institutionalized standards. These institutionalized myths and ceremonies help link the theoretical concept of the desire of an organization to attain external legitimacy with isomorphism and its corresponding need to emulate other organizations that have that desired legitimacy.¹⁴ Meyer and Rowan also show how the potential conflict between organizational efficiency and ceremonial rules (which they note may be costly for an organization to satisfy, without a corresponding direct financial benefit) may be addressed through a process of organizational decoupling of the ritualized elements related to legitimacy from the units of financial production of goods and services. This helps preserve the

¹⁴ Institutionalized isomorphism is explored more fully by DiMaggio and Powell (1983).

ceremonial aspects valued by society from the goods and service outputs related to the economic viability of the organization.

However, decoupling certain activities from the rest of the organization can also lead to organizational anarchy. Meyer and Rowan present a further concept they title *the logic of confidence and good faith*, as a mechanism whereby organizational ceremony broadly applies to an entire organization by reinforcing the myth of legitimacy both internally and externally for standardized, institutionalized aspects of an organization while the actual practices related to production of goods and services may have relative diversity. It is the combination of the decoupled institutionalized activity with the legitimating ceremonial behavior that allows organizations to incorporate regulated or other requirements related to professionalism and other inter-organizational standards while also allowing the productive aspects of the organization to develop more individualized, competitive – and presumably profitable – strategies.

Legitimacy and loose coupling: The concept of decoupling advanced by Meyer and Rowan relates to loose coupling as presented by Weick (1976) and subsequently expanded by Orton and Weick (1990). Decoupling or loose coupling¹⁵ is presented as a way for organizations to deal with problems brought

¹⁵ Orton and Weick (1990) make a distinction between decoupled and loosely coupled organizations. The distinction depends upon the extent the organizational structure allows for the individual elements to be distinct, while the organizational function allows them to be responsive to each other. According to Orton and Weick, if the organizational elements are distinct and non-responsive, they are decoupled. If they are distinct but responsive, they are loosely coupled (p. 205). The other two possibilities are non-coupled (not distinct or responsive – and therefore not a system) and lightly coupled (not distinct but responsive). One of the concerns they express in the

about through information asymmetry, a particular need in organizational fields that provide goods and services that cannot be easily evaluated by consumers – such as healthcare and hospitals. This parallels the concept of decoupling with an economic rationale for the nonprofit sector as one mechanism to address *contract failure* and establish trustworthiness (Hansman 1980). In this case the nonprofit designation could be said to act as the legitimating myth to address this product uncertainty. Weick (1976) and others have helped define and clarify the role decoupling or loose coupling plays in helping to mediate processes related to institutional legitimacy. They stress that loose coupling of disparate organizational elements helps the organization maintain its stability and viability through the simultaneous existence of both rationality and indeterminacy. This simultaneous functioning allows the technical level of the organization to function as a closed, rational system while the institutionalized level can operate as an open system with more subjective linkages to external influences (Orton and Weick 2004).¹⁶ Evaluating the degree that the philanthropic function of an organization is either tightly or loosely coupled to other organizational functions allows us to potentially understand the primary motivation for an organization to act philanthropically. If philanthropy is closely aligned with the organization's primary purpose – through strong departmental and managerial lines of reporting and authority – it can be hypothesized that the motivations behind that activity

article is that researchers and theoreticians have tended to use the terms decoupled and loosely coupled either interchangeably or in very imprecise ways, weakening the explanatory value of the concept.

¹⁶ Orton and Weick cite Thompson (1967) as their source for this concept of technical and institutionalized simultaneity. J.D. Thompson, *Organizations in Action: Social Science Bases of Administrative Theory*, New York: McGraw-Hill (1967).

are also closely tied to improved financial outcomes. If the activity is tightly related to the top leadership, ethical motivations may be presumed.¹⁷

Conversely, when the actions are loosely coupled in relation to the organization's primary services they may be found dispersed throughout the organization. In this case of loose-coupling, stakeholder motivations can be a primary motivation for philanthropic behavior. Philanthropy that is well-defined but loosely-coupled from other organizational activities could also be seeking the political visibility and influence that goes along with the Political Model. These designations are noted in Table 1E.

The development of the concept of legitimacy over the past fifty years has increasingly identified specific programs and actions that serve to connect the organization with external factors and mores. These externally connecting programs (such as organizational philanthropy) are also increasingly understood as potentially being separate from – or at least loosely-coupled to – the internal operations and the primary services of the organization. A complete de-coupling of these activities from the core operations of the organization is at the extreme end of this development process, but there can be some very real advantages to this type of separation. By separating the activities that primarily link the organization with social expectations (such as philanthropic behavior) from

¹⁷ The intrusion of chief executive desires can serve as a signal that the activities are tightly coupled to the ethical model, even if the structure appears to be loosely coupled through a separate organizational function or stakeholder model. The distinction is how much power the executive has to alter the desires of the seemingly separate operations, as opposed to the stakeholder autonomy.

operational activities, an organization can potentially satisfy both social norms and internal organizational objectives.

Institutional isomorphism: A second overall theory that has significant application to organizational philanthropy is institutional isomorphism – a theory that explores the organizational actions that are consequences of their efforts to achieve legitimacy. This theory maintains that organizations within a given field (or community environment) evolve to resemble each other as well as to emulate those organizations they wish to be seen like. DiMaggio and Powell (1983) developed earlier treatments of institutional isomorphism into a coherent theory. Based on the structuration theories of Giddens (1979) related to the institutionalized coherencies of organizational fields, DiMaggio and Powell maintained that it wasn't competition or efficiency that drove structural change but rather environmental forces that encouraged homogeneity. They especially identified the state and the professions as "the great rationalizers of the second half of the twentieth century" (p. 147). They state that the process of this "institutional definition or 'structuration'" has four parts: increased interactions among organizations in a given field; interorganizational structures, reflecting domination and coalitions; an increase in inter-agency information; and a rise in the mutual awareness of organizations involved in common efforts (p. 148). As organizations begin to coalesce into a common field, they also come to resemble each other in terms of structure and function. In such a scenario, isomorphism brings not only institutionalized legitimacy that generally carries increased cost

requirements, but also a strategic asset that can provide direct benefit to the organization, including possible financial resources.

DiMaggio and Powell differentiate three types of isomorphism: coercive, mimetic, and normative (p. 150). *Coercive isomorphism* stems from political pressures, influences of other organizations, rules legitimated by institutions, and legal and regulatory requirements of the state. As such it is related to at least one type of legitimacy, that which is associated with standardized accountability of various kinds. It could be linked to Suchman's (1995) concept of *pragmatic legitimacy*, being sought for self-interested reasons. As is outlined more extensively later in this section, *coercive isomorphism* identifies a potential fifth model or motivation for nonprofit organizational behavior that may be more prominent for nonprofit organizations than for-profit organizations, but that may also be an over-looked motivation for corporate philanthropy. This fifth motivation is termed the External Mandate Model and refers to structures or practices imposed by regulation or accreditation – or also because an organization is part of a larger system that has determined certain standardized forms will be adopted by their subsidiaries. *Mimetic isomorphism* develops as a response to problems of uncertainties. DiMaggio and Powell link this specifically to the concept of modeling, or copying other organizations that are considered “modern” or “progressive” or some other desirable characteristic. This also is a manifestation of the type of legitimacy characterized by Suchman (1995) as *cognitive legitimacy*, reflecting assumed values by society. *Normative isomorphism* is associated with professionalism,

both of workers within an organization as well as of the managers. The professionalization of workers within an organization means they are increasingly likely to belong to professional associations that bridge organizational boundaries and encourage similar ethical practices. The professionalization of the managers generally includes formal and professional education that enables them to learn increasingly standardized organizational approaches to specific situations within identified organizational fields. While the DiMaggio and Powell focus their definition of *normative isomorphism* on professional criteria, it can also relate to broader social concepts expressing general ethical values, which links it to Suchman's concept of moral legitimacy. The degree that an organization's philanthropic actions and structure mirror other organizations within their community is a potential indication of their motivations behind those actions.

Other Organizational Theories - Organizational Ecology and Resource

Dependency: Two other theories based in open systems approaches have a relationship with organizational philanthropy: organizational population ecology and resource dependency. Hannan and Freeman (1977) apply to organizational theory the social Darwinian concept of populations occupying unique niches within a larger ecological environment. To be competitive, individual organizations within each niche must adapt to the environmental factors within the niche as well as to meet the demands of the broader ecology. To adapt to multi-level environmental constraints, organizations will assume similar structural forms. Hannan and Freeman term this tendency structural inertia.

These constraints are both internal and external, and one major external constraint they identify is legitimacy. They point out that any organizational adaptation that violates this institutional legitimacy incurs a significant competitive cost and jeopardizes the organization's fitness to thrive or even exist within that ecology.¹⁸ This theory further links legitimacy with organizational isomorphism, similar to that provided by Meyer and Rowan (1977) above.

Hannan and Freeman identify several concepts that relate how ecology encourages the development of isomorphic structures and behavior. One concept is that organizations face multiple environments and therefore must develop alternative (and in many cases similar) structures to address this variety of constraints (p. 939).¹⁹ A second concept is the effect the expansion of political and economic centers, as well as government regulations, have on replacing local adaptations with broader institutional standards (p. 944). A third concept is that organizations of different size occupy different niches and therefore even though organizations may be in similar fields, larger organizations may reflect different organizational structures than small organizations (p. 945). The overriding theory behind their analysis is that competition will tend to produce similar organizations occupying the same ecological niche. This competitive drive within the organizational ecology connects to the Political Model of philanthropic behavior.

¹⁸ An example Hannan and Freeman give of adaptation that would violate legitimacy is a university eliminating undergraduate education (p. 932).

¹⁹ This need for alternative structures within a single organization could be further examined using the concept of decoupling, although this is not a concept Hannan and Freeman include in their analysis.

The emphasis Hannan and Freeman place upon competition as a factor in shaping an isomorphic organizational structure has a corollary in resource dependency theory. Resource dependency theory (developed most thoroughly by Pfeffer and Salancik 1978) emphasizes that organizations not only adapt to the environment but also are particularly influenced by environmental considerations of political as well as economic factors (Scott 2004). Resource dependency theory holds that environmental constraints force organizations to adapt to the changing environmental conditions and seek relationships that provide access to needed resources. As an organization acknowledges their dependence on other organizations it also searches for methods to manage those dependencies and to minimize the power it must sacrifice to the source of the desired resource. Growing out of theories of power-dependence relations (Emerson 1962), this theory holds that power rather than efficiency best explains the actions and results of those actions (Pfeffer and Salancik 1978). This link to financial and other resources also relates actions like philanthropic behavior to resource dependency and the Productivity Model of organizational philanthropy.

Neo-institutionalism and Nonprofit Theories: Organizational social theory that is specifically related to identifying the origins and operations of the nonprofit sector as distinct from the for-profit or governmental sectors, is more indefinite than that found in economic theory (outlined later in this section). Much of that undefined quality is due to the heterogeneity found in the sector. Sociological theory has

generally been found to be more valuable through analysis at the industry-level rather than the sector-level (DiMaggio and Anheier 1990, p. 137). Nevertheless several theories related to the nonprofit sector have provided perspectives on the nonprofit sector. These are primarily found within neo-institutional theory, defined as effects on organizations due to their membership in various socially constituted and normative structures.

Sociological approaches to understanding the behavior of nonprofit organizations were generically outlined in the general perspective of sociology and the nonprofit sector by DiMaggio and Anheier (1990). They concluded that the behavior of nonprofit organizations reflected state and institutional factors and influences as well as internal choices. These factors are influenced by the organizational ecology at an industry level, an element they claim economic theories don't fully account for. They further emphasize that status groups, professionals, and state policies have provided important influences for the development and operations of nonprofit organizations. These influences reflect theories related to organizational prestige and legitimacy as well as to factors of ecology and resource dependency. DiMaggio and Anheier's work is also particularly relevant to the topic of nonprofit hospitals as they emphasize that up to that time hospitals, along with schools, had seen the most attention by researchers (p. 147).

DiMaggio and Anheier incorporated and applied to the nonprofit sector theories on organizational prestige developed by Perrow (1961) and of organizational legitimacy by Dowling and Pfeffer (1975), as well as the related concepts of myth and ceremony of Meyer and Rowan (1977). They also acknowledged the importance of institutional isomorphism presented by DiMaggio and Powell (1983) as well as incorporated the related theories of organizational ecology by Hannan and Freeman (1977) and resource dependency of Pfeffer and Salancik (1978).

The work exploring the role of organizational legitimacy and institutional isomorphism in the nonprofit sector emphasize a need for nonprofit organizations not only to consider how well they provide a given service but also how the external society perceives the relative value of their services. It is important not only that a nonprofit “does good,” but that its community is aware that it does good. In many cases, these dual expectations can be most advantageously approached as two separate processes requiring two different organizational strategies. By decoupling the activities designed to improve an organization’s external perceptions (such as philanthropic behavior) from operational activities, a nonprofit can most effectively meet their external goals while supporting – but not adversely affecting – the operations fulfilling their primary mission.

Institutional Theories and Organizational Philanthropy – A Summary: Various organizational theories, linked with the generic concept of neo-institutionalism,

have potential application to explaining not only corporate philanthropy but also why a nonprofit organization might also practice such behavior. Seeking to emulate other organizations – both other nonprofits as well as for-profits – can also provide legitimacy for their commitment to larger community actions or as a key player in their community's political structure. Philanthropy can also be a way nonprofit organizations – for reasons similar to a for-profit organization – may meet the interests of various stakeholders or the ethical values of their leadership while being separated or de-coupled from the organization's primary activity or mission. The theories link at various places in their relationship to the four part corporate model of giving and provide a potential for hypothetically locating the different motivational sources within different levels of the nonprofit organization. Table 1E pulls together the various perspectives from the organizational theory literature and shows their role within the respective four models of corporate giving (as was initially presented in Table 1A).

Table 1E:
Relationship of Organizational Theories to Corporate Giving Models

Young and Burlingame Models	Neoclassical/Productivity	Ethical/Altruistic	Political	Stakeholder
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
3 Perspectives of Legitimacy – (Suchman) – (Dowling and Pfeffer) (Dacin, Oliver, and Roy)	Pragmatic – self-interested Economic benefits Market and Investment legitimacy	Moral Altruistic behavior Social legitimacy	Cognitive: Political legitimacy (Prestige) – Legitimizing behavior Relational and Alliance legitimacy	Legitimizing behavior (Partially) Relational legitimacy
Level of Coupling	Tightly coupled	Tightly coupled to leadership, but loosely coupled or de-coupled from other organizational activities	Loosely coupled or de-coupled from the organization – Linked with other external organizations	Loosely coupled
Isomorphism (DiMaggio and Powell)	Coercive	Normative	Mimetic	Normative
Other Theories	Resource Dependency	Normative theories	Population Ecology	Population Ecology
Expected Organizational Location of Philanthropic Function	Linked with primary mission or operation	Board or CEO leadership	Separate foundation or identified and publicly-visible department	Dispersed throughout organization

Corporate Philanthropy and Organizational Theory: The next step is to look at the key institutional and organizational literature that has been incorporated into analyses of corporate philanthropy. The relation of these neo-institutional

theories to the nonprofit sector provide a link to the models of corporate philanthropy as well as a mechanism for expanding those models to include nonprofit philanthropic behavior.

The historical evolution of the concept of corporate social responsibility and corporate philanthropy in the management literature is well documented (see particularly Lee 2008, Frederick 2006, Carroll 1999). The theoretical literature is of more concern to this thesis and has related roots in the organizational sociology literature. Particular attention is paid to related theoretical work that has direct application and use both to organizational philanthropy (as it is practiced by corporations) and to the behavior of nonprofit organizations – found predominantly in the organizational theories of institutionalism and new institutionalism as expressed by DiMaggio with Powell (1983) and Anheier (1990). How and where these two groups of theories intersect can provide insight into nonprofit philanthropic behavior.

There has been considerable attention to documenting corporate philanthropy and to exploring ramifications of corporate philanthropic practices from both the perspective of the business sector as well as the nonprofit literature. However, there have been only a handful of social theorists who have attempted to explore the theoretical motivations that might underlie corporate philanthropy or have been used as foundations for further examination. Those that have looked at corporate philanthropy in terms of institutional theory primarily focus on the

broader topic of corporate social responsibility rather than the narrower element of corporate philanthropy per se. However, as Campbell notes in a recent article, “little theoretical attention has been paid to understanding why or why not corporations act in socially responsible ways.” (Campbell 2007, p. 946)

One of the first works to address corporate giving from an institutional theory perspective was Kamens (1985) looking at corporate giving as a strategy to develop organizational legitimacy. Kamens explores the theory of how organizational legitimacy is drawn from the interactions of the organization with its environment, with corporate giving being a primary example of that interaction. He draws his work from the normative perspectives of Meyer and Rowan (1977) and DiMaggio and Powell (1983) relating to ethical legitimacy and the concept of political legitimacy of Perrow (1961). He also notes that legitimacy and corporate philanthropy could tie-in with other theories such as resource dependency (Pfeffer and Sancik 1978) and population ecology (Hannan and Freeman 1977), which places legitimacy as an overall concept that could bridge the four models of corporate philanthropy. Kamens goes on to investigate how differing environments may affect different giving strategies, suggesting these different situations might prompt different giving responses by corporations by using giving as one way to bridge the boundary between the organization and its environment.

Useem (1987) does address institutional theory in passing with mention of DiMaggio and Powell's (1983) work on organizational isomorphism but doesn't expand much upon it except to note that nonprofit organizations will attempt to resemble their sponsors, i.e. corporations. While the implication by Useem is that it is the general business-like values and structures that nonprofits will try to emulate, it is not difficult to extend these isomorphic practices to specific business practices including philanthropic actions. David Campbell (2000), while looking at decisions by corporations to voluntarily report on corporate social behavior (CSR) rather than corporate philanthropy, advances legitimacy theory as a key motivating factor for voluntary social disclosure. Echoing Kamens (1985), Campbell identifies CSR as a strategy that can be used to gain societal support and shape the corporate image in the community, drawing upon the legitimacy theories of Dowling and Pfeffer (1975) and Suchman (1995).

Saia et al (2003) develop the argument that increased institutionalization will shift the locus of control of the giving function from the top of a bureaucratic structure to more decentralized professional control. They base this on the theories of DiMaggio and Powell (1983) that as goals become more ambiguous firms will engage in isomorphic behavior of firms that they perceive to be successful – e.g. those with visible philanthropic divisions. This relates to one rationale behind the Political Model of corporate giving, as previously defined. A similar theory can be applied to nonprofit organizations that seek to emulate for-

profit firm behavior. This could be especially true for commercial nonprofits (such as hospitals) that have debatable differences with their for-profit counterparts.

Marquis et al (2007) also focus on isomorphism as a primary force for corporations to act with social motivations in their communities. They specifically cite the work of Galaskiewicz (1989, 1991) as providing evidence that local geographic community expectations of corporate behavior give rise to isomorphic business giving patterns by other businesses that seek influence in their community. John Campbell (2007) develops an institutional-level theory of corporate social responsibility based on several societal conditions. While he doesn't apply these to the organizational level, his approaches emphasize connections to the institutional environment that could explain organizational level behavior in terms of being a response to governmental pressures, institutionalized norms, and collaborative strategies.

According to the corporate management literature, corporate giving has two essential motivations beyond financial benefit to the company: enhanced reputation (or prestige – or legitimacy) and the opportunity to limit governmental intervention in meeting community needs, thus strengthening the political influence of the organization. The relationship of the latter motivations to the Political Model has been fairly well defined. But where enhanced reputation or legitimacy might be specifically placed in relation to the four models is a little more subjective. Enhanced legitimacy could apply to any of the four models,

depending upon the specific constituency that a corporation wishes to enhance its legitimacy for. Any actions designed to enhance legitimacy actually involve four steps: first to identify the constituency of interest; second to determine the appropriate action to meet the interests of that constituency; third to take the action; and fourth to communicate that action back to the constituency.

The fourth action, communication – also termed variously as public relations, marketing, and/or advertising – is critical in the corporate philanthropy process. If enhanced legitimacy (in the view of some targeted or defined constituency) is an important rationale for corporate giving (as the management literature seems to suggest), then it is imperative that both the action and results of that action are communicated to the desired constituency. If this final communication step is not taken, then it will be left to chance whether the philanthropic action will achieve the desired effect of enhanced legitimacy. In the subsequent examples communications is seen as a “follow-up corporate action” (to the initial corporate action of the giving itself).

One hypothesis of this thesis is that this process of constituency identification, philanthropic activities, and reporting back to that constituency will be located in different levels in a corporation based on how they give philanthropic activities visibility with different constituencies. Identifying the corporate location of the giving function – as well as the method of communicating that giving – can provide a way to potentially identify the underlying motivation for the specific

behavior. The next section uses this hypothesis to further define underlying corporate motivations suggested by the broader concept of enhanced legitimacy.

The Legitimacy Process and Corporate Philanthropy: A quest for legitimacy can apply to any of the four models of corporate philanthropy. How and where the philanthropic activities occur can help to further determine which model is most appropriate. According to the Neoclassical/Productivity Model as defined by Young and Burlingame, the purpose of giving is to increase firm profitability. This relates to the primary theoretical motivation (identified by the management literature), which is to increase profit. If profit were the primary motivation, the targeted constituency the company would most seek to enhance legitimacy with would be the beneficiaries of that profit – i.e. the owners, stockholders, and potential future investors in the company. A constituency that would also be important would be customers and potential customers – i.e. those who have potential interests in the product and would be more inclined to purchase the goods or services because of this enhanced legitimacy. A third constituency could be an organization's employees and programs that strengthen the human relations function of the organization. A matching gifts program that supports organizations that an employee contributes to could be an example of this type of human relations emphasis. Because the desired outcome of corporate philanthropy is improved financial profit, the corporate strategic actions would be expected to support causes with images and interests directly related to the services produced and sold by the company. This would also mean that once

the philanthropy occurred, follow-up corporate actions would involve integrated marketing activities designed to develop and carry out philanthropic strategies that strengthen the financial return of the company and to subsequently communicate those actions and the consequences of those actions to current and potential investors and customers. Communication would focus on prominence in corporate annual reports distributed to stockholders and potential investors. Marketing strategies would be designed to interact with targeted customer populations, such as on product labels or other direct marketing methods. If employees were one of the constituencies targeted by a human relations-oriented contribution program, such as a matching gifts program, then communication through internal media would also be important. These strategies would be directly tied to the product or service. Under the Neoclassical/Productivity model, corporate giving is just one strategy that is part of the normal development and promotion of the goods and services. As such its operation could be expected to be located within that same existing corporate structure, within an integrated marketing effort involving closely linked departments, coordinated at a departmental managerial level.

Corporations that might be motivated by the Ethical/Altruistic Model would seek to meet broad community and social responsibility and to convey a general image of ethical corporate behavior. Under this model it is the entire community that the corporation would seek to communicate with, to broadly enhance their public image of reputation or legitimacy. The desired outcome of corporate

philanthropy would be to use giving as a means to express the social values of the overall corporation and/or of the individual corporate leaders. The corporate strategic actions would support causes based on social values rather than tied to specific products or services. Follow-up corporate actions would be to communicate the philanthropic actions and their consequences to a larger community, beyond the primary owners or customers. Under the Ethical/Altruism Model corporate giving decisions would expect to be separated from the location and process of philanthropic activity and communication. Giving decisions and possibly activities would be located in top management while the communication of the benefits of that philanthropic action would be an effort of a separate public relations department, distinct from its efforts to promote products and services to customers.

Beyond programs matching employee gifts, the human relations aspect of and uses of corporate philanthropy has potentially broader application to both the Neoclassical/Productivity model and to the Ethical/Altruistic model, linking their motivations and practice. Fostering an image of ethical behavior can help reduce the cost of recruiting personnel as well as help retain personnel, reducing the training costs of new employees. An organization that has a strong image of being ethical might also be able to pay less in salaries to their employees, as sharing in the image of being part of an ethical organization may be perceived as one "benefit" an employee receives by working at such an organization. From an external constituency perspective, being considered as an ethical organization

may justify customers paying a higher price for a product. Finally it may serve as a signal to regulatory agencies that the organizational field is proactively meeting community needs and help to forestall additional regulatory provisions that could increase expenses and limit profits.

Under the Political Model the motivation for corporate giving is to strengthen the economic and community power of the private business community in general and of the company in particular. That enhanced power involves improving the reputation of the company with other community leaders in order to achieve the desired outcome of limiting government intervention and increasing the company's influence in the community. Corporate strategic philanthropic actions could involve programs that improve the community's infrastructure through private support. Collaborative projects with other businesses, nonprofits, and community agencies would also help achieve those outcomes. Such community improvement activities may also have direct benefits for the corporation, such as neighborhood improvement or redevelopment programs. Follow-up corporate communications activities would focus on communicating the philanthropic actions and their consequences to others in positions of influence in a way that would strengthen that political influence. Locating the action (and promotion) within a separate giving entity or department helps give maximum exposure to the ongoing commitment of the company to this mission. This separation of community giving from the primary corporate operation is important even if one strategy is to get the corporate leadership involved with these community-

building activities. Separating the chief executive's involvement from the ongoing business operations can enhance the image and political position of the activity as well as the corporation. It positions the activity as focused on the good of the community rather than the advantage of the corporation – even though the residual benefits of increased political power can be a very real asset for the company. Under the Political Model, being able to internally unify and coordinate a strong external image through a separate foundation or defined department for that specific purpose would help ensure the permanence of the company's commitment and strengthen that internal power.

Under the Stakeholder Model, corporate philanthropy is undertaken to satisfy multiple constituencies, to enhance the business's reputation among various stakeholder constituencies. These constituencies might include some of the fore-mentioned constituencies (such as owners, customers, or corporate leaders) but also could involve such seemingly secondary groups such as neighbors, vendors, or competitors. In order to support the interests of a variety of stakeholders, corporate philanthropic actions could be expected to support various potentially individualized causes based on specific stakeholder interests. As the company undertakes those activities it would want to communicate those actions and their consequences directly to those different stakeholders. Because of this need to differentiate and directly communicate actions to groups with different linkages to the company, it could be expected that giving decisions as well as the communication of those decisions would be scattered throughout the

organization, involving those departments or individuals that would have the best connections with disparate groups. Under the Stakeholder Model, corporate philanthropy can be seen as an ethical value of the business that permeates the entire organization, rather than being focused at a single point in the organizational chart.

Both the Political and Stakeholder Models provide examples of how decoupling philanthropic behavior from the primary activities of the business can provide legitimacy within different organizational ecologies. This enables the legitimizing behavior to become isomorphic with the broader ethical values of that particular ecology while preserving the competitive autonomy of their primary operations. Under the Political Model the organization seeks legitimacy within their broader community, being able to mirror behavior of other corporate players within that population, regardless of their professional or industrial sector. Conversely, under the Stakeholder Model the isomorphic behavior allows the organizational actors to reflect the values and actions of a broader professional institution while also meeting the immediate operational needs of the organization. How these motivations and locations of the giving and communication structure relate are outlined in Table 1F (adding to the initial corporate model outlined in Table 1A).

Table 1F: Motivational Characteristics of Corporate Giving Models

Young and Burlingame Models	Neoclassical/ Productivity	Ethical/ Altruistic	Political	Stakeholder
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Theoretical motivation (from the Management Literature)	[Enhanced reputation] Increased profit	Enhanced Reputation	Enhanced Reputation Enhanced Power	Enhanced Reputation
Targeted Constituency	Owners/ stockholders and Future Investors	Community	Community Leaders	Various Stakeholders
Desired Outcome of Corporate Philanthropy	Improve Financial Profit	Express corporate social values (or values of the individual leaders?)	Limit government intervention Increase company's influence (Himmelstein)	Support interests of stakeholders
Corporate Strategic Actions	Support causes related to primary services produced and sold	Support causes based on broad social values	Improve community infrastructure Collaboration (Galaskiewicz)	Support targeted causes based on stakeholder interests
Follow-up Corporate Actions – Communications	Communicate actions and consequences to current and potential investors	Communicate actions and consequences to the broad Community	Communicate actions and consequences to others in positions of influence	Communicate actions and consequences to the different stakeholders
Potential Location of Corporate Giving within the Structure	Formal Giving Structure, tied-in with primary service departments	Located in Top Management	Internally Unified and Externally Presented: A separate giving entity or department for maximum exposure	Internally Scattered

What does the Corporate Giving Literature tell us? The corporate giving literature related to organizational theory reinforces the four models of corporate giving previously presented. They identify multi-faceted motivations for corporate giving behavior based primarily in the broad concept of legitimacy, but expressed in different motivational forms. These motivations help to strengthen the four-model approach while providing grounds for potential hypothetical linkages to different organizational levels or approaches.

Table 1G compiles all the various theories previously covered into a single template showing the relationships and applications of the various approaches to the corporate giving model.

Table 1G: Corporate Structure Elements of Philanthropic Behavior

Young and Burlingame Models	<i>Neoclassical/ Productivity</i>	<i>Ethical/ Altruistic</i>	<i>Political</i>	<i>Stakeholder</i>
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
General Locale of Prestige (Perrow 1961)	Intrinsic	Extrinsic	Extrinsic	Extrinsic
Expected Organizational Location of External Affairs, Based on Core Concepts	Linked to internal financial and marketing activities	Directed by leadership	A defined division, visible to key external organizations	Dispersed within the organization
Targeted Constituency	Owners/stockholders and Future Investors	Community	Community Leaders	Various Stakeholders
Corporate Strategic Actions	Support causes related to primary services produced and sold	Support causes based on broad social values	Improve community infrastructure Collaboration (Galskiewicz)	Support targeted causes based on stakeholder interests
Follow-up Corporate Actions – Communications	Communicate actions and consequences to current and potential investors	Communicate actions and consequences to the broad Community	Communicate actions and consequences to others in positions of influence	Communicate actions and consequences to the different stakeholders
Potential Location of Corporate Giving within the Structure	Formal Giving Structure, tied-in with primary service departments	Located in Top Management	Internally Unified and Externally Presented: A separate giving entity or department for maximum exposure	Internally Scattered
Expected Organizational Location of Philanthropic Function	Linked with primary mission or operation	Board or CEO leadership	Separate foundation or identified and publicly-visible department	Dispersed throughout organization

To fully incorporate the theories of the nonprofit sector into our understanding of nonprofit philanthropy also requires looking at the economic theories of the nonprofit sector. The next section outlines those theories and how they help us more fully understand the motivations involved with nonprofit philanthropy.

Economic Theories of the Nonprofit Sector²⁰

The economic theories of the nonprofit sector don't specifically address the question of the location of an organization's motivation to engage in philanthropic behavior. But they do help define the rationales for the existence and operation of nonprofit organizations and their tax-exempt purpose and mission. Because of this relationship to an organization's mission, a brief overview of these economic theories is included.

Perhaps the most influential rationales for the existence of the nonprofit sector revolve around the three-failure theories first developed by the economists Burton Weisbrod (1975) and Henry Hansmann (1980) and expanded upon by Salamon (1987).²¹ The three failure theory maintains that each of the three sectors of our economy (i.e. the government, business, and nonprofit sectors) is able to only partially fulfill the needs and desires of society for private and public goods and services. The limitations of each sector to fully meet society's needs are defined by their "failures," inherent in each sector's respective parameters.

²⁰ This outline of the economic theories of the nonprofit sector is based in part on the overview by Steinberg (2006).

²¹ Salamon (1987) is primarily credited with defining the third part of the three-failure theory: *voluntary failure*, addressed in a later part of this chapter.

For-profit firms are limited by *market failure* and *contract failure*. *Market failure* occurs primarily with public or collective goods where consumers may utilize the goods and services produced without paying for them.²² This leads to a free-rider problem – that consumers cannot be prevented from benefiting from a good or service despite not paying for it. This problem cannot be solved by the profit motive of the for-profit sector, so the government sector is needed to collect funds for these services through taxation and then provide them for their public constituency. *Contract failure* refers to the consequence of the inability of consumers to judge the quality of a good or service (such as quality healthcare) and therefore to make an informed decision in the marketplace, termed “information asymmetry”. Hansmann (1980) proposed that the nonprofit sector helped address this failure because its nondistribution constraint prohibited nonprofit leaders from directly profiting from consumer decisions. According to the *contract failure theory*, government agencies and nonprofit organizations are more trustworthy providers of these types of goods or services due to their limited profit motives, termed as the nondistribution constraint.

Government may be able to help meet public good needs underprovided by the market through taxation and public provision of needed public goods and services. However government failure may occur, primarily because of its need to respond to the majority of a given constituency – termed as the median-

²² Samuelson (1954) defined “pure public goods” as those that are non-excludable (unable to prevent some individuals from consuming them, regardless of whether they paid for them) and non-rival (they are not used up by another consumption). Popular examples of public goods are clean air, national defense, and public radio.

preference voter. In this scenario, the wishes of a minority for a particular good or service may not be met. This encourages for the provision of that particular collective good by a private, nonprofit provider.²³

Several aspects of the failures of government and for-profit sectors help define the motivations of nonprofit organizations that engage in philanthropic behavior.

Philanthropic behavior allows the nonprofit organization to utilize a portion of the net revenue it generates to help support other community needs, beyond its own primary purpose or mission. The motivations of a nonprofit organization to engage in this type of behavior can be partially understood through these economic theories of the failures of the for-profit and governmental sectors. This is especially true for a commercial nonprofit (such as a hospital) that because of its market-orientation may have the financial and professional resources to meet community needs beyond those they primarily address.

The primary societal attribute a nonprofit organization brings to philanthropic behavior relates to its trustworthiness due to the nondistribution constraint, and as identified within the contract failure of the for-profit sector. The nondistribution constraint brings two advantages to nonprofit philanthropy not shared by for-profit corporate giving. The first is there is less incentive for the nonprofit organization to use contributions as a means for profit enhancement. This can help provide a

²³ Other identified sources of government failure include the involuntary nature of taxation, the inability of government to identify or detect certain needs, and constitutional restrictions on governmental actions (such as noninvolvement with religious provisions). (Steinberg 2006, 122-123).

level of trust that a nonprofit organization will support causes for other motivations, such as those of greatest community need or of primary interest to their stakeholders.

The second advantage of the nondistribution constraint is because the nonprofit organization is “owned” by the community and is not responsible for supplementing the income of shareholders and/or owners, it is appropriate that any net revenue is utilized for additional public needs. In many cases those additional public needs may involve expanding the services provided through the organization’s primary mission (such as for a hospital buying new health diagnostic equipment). But those community needs may also lie with other related or even unrelated organizations. A nonprofit organization that is led by a community board and is primarily serving under-served populations, is well situated to be aware of and to respond to such needs through the dispersal of a part of their net revenues. This rationale also relates to the role of nonprofit organizations addressing the problem of market failure. Nonprofit organizations are positioned in a community to be aware of additional unmet public good needs, as they deal with underserved populations through their primary mission. While for-profit organizations may be primarily aware of the needs, wants, and desires of their owners, customers and potential customers, nonprofit organizations have the potential to be aware of populations underserved by these for-profit firms.

A second societal attribute of a nonprofit organization involves its ability fill in the gaps from *market failure* to also attract philanthropic contributions to help meet underprovided goods or services – a societal alternative to taxation as a means to address free-rider problem related to funding public goods. This role is already an important part of the nonprofit sector through private foundations, community foundations, and societal benefit organizations such as United Way. For commercial nonprofit organizations to also assume this broader role of addressing other community needs provides an additional philanthropic resource for the community. Many of these organizations are already organized to seek and accept private contributions for their primary mission; to expand that activity to include other community needs requires an adjustment to its existing fundraising operation and strategy.

Government failure theories also provide a strong societal rationale for nonprofit philanthropy. Nonprofit organizations are able to more readily respond to the needs of specific populations. This potentially includes those groups that are not able to mobilize political consensus or as a percentage of the political constituency make up less than the median-preference voter threshold that may command the government's primary attention. In many cases nonprofit organizations are directly working with these populations and are in a position to know first-hand what services are being provided and what others might be most needed. This is especially true when identifying public needs that are not sufficiently addressed through public and governmental resources. For society

this provides a clear private alternative to public provision. Additionally, private nonprofits acting as philanthropic agents face fewer constraints than government agencies to shift priorities to meet changing needs or to convince “others” such as stockholders, how public actions are also of private benefit.

The third failure theory relates to the weaknesses of the nonprofit sector.

Salamon (1987) is primarily credited with defining the third part of the three-failure theory: *voluntary failure*. *Voluntary failure* is defined as the limitations of the nonprofit sector to solely provide goods and services to society. These limitations include: philanthropic insufficiency (due to the deficiencies of voluntary funding), paternalism (by those who work for or fund an organization to address problems in ways as they see fit, rather than necessarily in ways as the client sees them), particularism (the tendency of nonprofits to focus on a specific group or issue), and amateurism (meaning under-qualified volunteers or staff may provide services as opposed to credentialed or more qualified professionals, potentially related to philanthropic insufficiency or paternalism).

In some cases, these voluntary failures represent organizational characteristics that nonprofit leadership might seek to directly address and surmount. In other cases, these failures may identify accepted parameters of a nonprofit's operation and their limitations may be accommodated within that structure. Put simply, an organization may want to preserve the particularism or amateurism that an outside perspective might label as a “failure”. Philanthropic insufficiency is one

aspect that generally (but not always) a nonprofit seeks to redress rather than accept. On the other hand, philanthropic paternalism may be an organizational trait that leadership seeks to extend, as it becomes an expression of their individual views and influence. It is proposed that some of the reasons a nonprofit organization might engage in philanthropic behavior are related to the organization trying to either extend the characteristic of voluntary failure theory or to overcome organizational limitations identified by the theory.

Before assembling all of the previously categorized theoretical and organizational criteria, there remains one other literature to investigate: the organizational theories relating specifically to hospitals. Since nonprofit hospitals are the subject of the research portion of this thesis, particular considerations involving hospitals has relevance for advancing our understanding of their actions and motivations.

Economic and Sociological Theories – and Nonprofit Hospitals

Henry Hansmann (1980) coined the term *commercial nonprofits* to identify nonprofit organizations that received fees as their primary source of financial income. These types of nonprofit organizations are differentiated from *donative nonprofits* that rely on contributions and grants as their principle source of revenue. Nonprofit hospitals, which are used as an example in this thesis, are a principal example of *commercial nonprofits*. As noted by Hall and Colombo (1991a), precise statistics on the percentage of total nonprofit hospital revenue

that comes from donations are limited and uncertain.²⁴ But various sources confirm that it is less than 1% (ibid, p. 406, n. 350). The remaining 99% of hospital revenue comes from fees-for-service either from private patients, private insurance, or reimbursement from government programs such as Medicare and Medicaid.²⁵ Mark Hall and John Colombo observe, “. . . nonprofit hospitals have increasingly taken on the appearance of business enterprises by serving mostly paying patients, decreasing their reliance on donations or volunteer labor, and striving to generate as much surplus revenue as possible through commercial transactions” (ibid, p. 319). In other words, nonprofit hospitals seem to adopt similar commercial strategies as for-profit businesses. Examining the theoretical literature related to hospitals can help to further define the motivations for nonprofit hospitals to engage in philanthropic behavior.

²⁴ The American Hospital Association annually gathers statistics from its members but contributions are not a separate line item. Instead they are included within the more generic “Non-operating Revenue” (American Hospital Association, *AHA Hospital Statistics, 2008 Edition*, Chicago IL: Health Forum, 2008, p. 221). Comparative statistics on hospital giving as a percentage of hospital revenues is not a figure that is currently compiled by the Internal Revenue Service (IRS) or typically gathered by annual member surveys of the Association for Healthcare Philanthropy. The revised IRS Form 990 and its accompanying Schedule H may help address this shortcoming in the future, although additional complications exist.

Part of the difficulty in identifying contributions as a percentage of revenue is that much of the philanthropic activity related to hospitals may occur in separate hospital foundations. These foundations file separate Form 990s, act as separate nonprofit corporations, and may transfer contributions directly to their member hospitals, or may hold them for investment or for transfer in future years. In some cases hospital foundations may disperse funding to organizations other than the hospital – or there may be a transfer of funds from the hospital to the foundation that is recorded by the foundation as a contribution (either as indirect or direct public support). In many hospital systems, a single foundation may collect and record contributions for multiple hospital facilities. The designation of contributions for special capital or endowment purposes, rather than operational expense, also complicates precise recording and comparisons – as some reporting criteria exclude “designated gifts” from total contributions.

²⁵ It should be noted that some portion of annual hospital revenue may also come from income from previous investments or income from other business interests.

Organizational Theories – The Elements and How Hospitals Relate to These Elements: As was previously stated, sociological theory has generally been found to be more valuable through analysis at the industry-level rather than the sector-level (DiMaggio and Anheier 1990, p. 137). This seems to hold true for nonprofit hospitals: nonprofit hospitals appear to have more in common with for-profit and public hospitals than they do with other nonprofits in different organizational fields. All hospitals are influenced by many of the theories that affect institutional and professional norms and standards and therefore fit many of the concepts outlined earlier in the neo-institutional theories.

Neo-institutionalism theories have particular application to the hospital field in their emphasis on the environment and ecology within which organizations function. The neo-institutional incorporation of myths and culture into organizational decisions includes medical ethics and community benefits as important hospital considerations. The need for institutionalized expressions of professional ethics emphasizes organizational legitimacy as well as encourages institutional isomorphism, two unifying concepts related to nonprofit philanthropy. The de-coupling process of formal administrative structures from the daily medical activities helps preserve the organizational culture and myths that are furthered through ceremonial displays revolving around evaluation (such as through the accreditation process or being selected as “one of the 100 best hospitals in the U.S.” or support of broad community benefits). These myths play

a prominent role in hospital marketing processes and materials – as well as in philanthropic behavior.

Institutional isomorphism as an outcome of *organizational ecology* is critical if a hospital is to be seen as “up-to-date” as well as legitimate in the eyes of its community. Standardization – and rewards for being standardized – prompted by regulatory and accrediting agencies further this isomorphism process. And the role of medical *professionalism* in both legitimizing the individual organization and connecting it to the broader profession is in potential conflict with the organization itself. This forms a source of continual negotiation and organizational compromise between medical professionals and hospital administration that can be addressed through legitimating activities such as philanthropy as well as de-coupled situations separating the financial activities of the hospital from the medical services.

Hospital Organizational Theories: Beyond some general descriptions of hospital structures and practices by The Commonwealth Fund (Bachmeyer and Hartman 1943), it wasn't until the 1960s that organizational theorists began to address the particular organizational characteristics of hospitals (Perrow 1961, Friedson 1963, Scott 1966, in Zola and McKinley 1974). Much of this was related to the perception that hospitals were either public utilities governed by public policy or charitable facilities operated by the philanthropic structure. In this perception hospitals were either subject to similar governmental controls as other public

services or to local charitable impulses similar to churches. For-profit facilities, generally operated and owned by physicians, were an additional but minor part of this medical organizational landscape.

An early observation by Perrow (1961) on the importance of *prestige* in shaping hospital organizational goals and decisions was one of the first acknowledgements that hospitals might have some unique theoretical characteristics. Perrow demonstrates that prestige could address the difficulties of patients in determining quality and the role of the intermediating professional (i.e. the physician) in directing organizational resources. Through the 1970s and 1980s empirical studies of individual hospitals predominated the literature. These include mention of the dominant factors of environmental, ethical, and professional influences being important theoretical concepts. They also re-emphasized the role of status or prestige as an organizational motivation for hospitals (Lindsay 1969, Newhouse 1970, Lee 1971, Shortell and Brown 1974), providing additional justification for the role of legitimacy theories in defining hospital behavior.

One key perspective of hospital organizational values relates specifically to the organizational structure: the image of the hospital as a public service organization rather than a business concern. Since a 1963 article by Kenneth Arrow, the special economic problems faced by hospitals and healthcare providers have been acknowledged. This particularly focuses on traditional

market uncertainties of when the “product” being delivered needs to maintain continual availability and be conducted within standards of expected behavior of physicians. This gives hospitals an image of being more a welfare and public service organization than a business-oriented entity (Arrow 1963). Yet financial issues are significant elements for management. The issue of for-profit vs. nonprofit governance – as well as private vs. public ownership - reflects a concern over an increased business-orientation of hospital leadership. However, the ethical concerns of healthcare professionals can also outweigh ownership form. Physicians and health care professionals may emphasize the mission of their professional calling rather than the business concerns of the organization. Many patients may prefer to believe (and to have demonstrated in practice) that medical decisions regarding healthcare are motivated by altruistic concern for the patient’s welfare, not by bottom-line profit motives. But as financial pressures become more complex and more visible to the community, it becomes an increasing challenge for hospital administration to assure the public that decisions are being made for the benefit of the community’s healthcare rather than for personal or organizational profit (Cuellar and Gertler 2003). This concern also extends to the employees – particularly the nursing staff who have the most direct contact with patients – who may be torn between a personal pride in serving the community and the realities of bureaucratic and financial power structures and compromises (Chambliss 1996). Nurturing the “myth” of being a health service organization through ceremony and other techniques forms an important element for any healthcare organization, regardless of ownership or

ultimate organizational ends. The actions of reaching out to the community through philanthropic behavior provide a critical expression of that myth and image of legitimacy.

A 1980 article by Fennell and a more in-depth analysis by Colle (1986) take a broader theoretical treatment. Fennell tested organizational ecology theory by studying the effects of the entry of new healthcare providers into a given market. However, her findings contradicted the expected theoretical condition of increased isomorphism as the population of healthcare providers expanded within a defined service area. Instead she found that individual organizations tended to move into specific ecological niches within larger clusters of other related healthcare providers. The needs and composition of these larger clusters influenced the size and form of the organizations, rather than the organizations imitating other similar providers in different niches. She conjectured that healthcare provision might be more properly looked at as clusters of providers rather than as individual entities, paving the way for understanding the future growth of formal health networks and systems. Fennell also confirmed Perrow's earlier emphasis on prestige as a key factor in organizational success and growth (Fennell 1980). In his book on the future changes in health care, Colle emphasized the environmental pressures on hospitals of shifting financial resources (private and public) and medical practices (especially from in-patient to out-patient), escalating technology (equipment, communication, and intellectual),

the increased role of the consumer in the decision process, and the increasingly complex ethical considerations (Colle 1986).

Recently more extensive work has focused on hospitals and healthcare as unique theoretical studies, with combinations of characteristics and responses peculiar to the industry. Examples of this include the organizational effects of professionalization (Robinson 1999), ethical conflicts coupled with power, political interest groups, and bureaucratic routines (Chambliss 1996), the effects of health systems on local markets (Mobley 1997), and the position of individual hospital structures within the broader public health environment (Weiss 1997). Many theorists have acknowledged the broad complexity of factors affecting hospital decisions, with an emphasis on the conflicting roles of professionalism with other organizational requirements and the effect of the environment on individual organizational decisions (Scott 2000, Mick et al 1990, Shortell and Kaluzny 2000). W. Richard Scott (2000, and introductory chapters in Zola and McKinley 1974, Scott and Backman in Mick et al 1990) has particularly shaped the direction of hospital organizational theory through an emphasis on hospitals as a collection of related networks of professionals, health specialists, administrators, and employee segments, building directly on the more informal approaches of *neo-institutional* theory. He particularly notes how theoretical attention has shifted over the years. An initial focus was on the conflicts between the medical profession and the hospital organization. Subsequent attention was given to environmental issues. More current awareness incorporates the role of

medical ethics (Mick et al 1990). This attention to *organizational ethics* emphasizes maintaining organizational legitimacy amidst shifts in increased ownership of hospitals by for-profit entities and involvement with multi-hospital systems. Balancing the locus of decision-making power (both professional and management), access to financial resources (both capital and insurance), and maintaining ethical standards and image lies at the heart of understanding contemporary hospital structures and actions. Growing financial power and concern coupled with increased competition, means a business orientation needs to be balanced in a hospital's public service mission. This dual mission leads to questioning whether nonprofit hospitals truly deserve their tax-exempt status, as they seem to operate in a manner similar to for-profit organizations. A thorough exploration of the extensive literature involving hospital ownership issues is beyond the scope of this section, but the work of Schlesinger and Gray (2006a) particularly note the role of social theories related to isomorphism (especially mimetic isomorphism) in understanding the factors influencing hospital ownership and similarities of behavior among different ownership types. The final section of this chapter addresses part of this consideration through the community benefit debate. However, it should be noted that whether either ownership form produces improved healthcare and outcomes is contested,²⁶ and the influences on both nonprofit and for-profit hospitals, as on all organizations, are multi-faceted. As commercial nonprofits, hospitals are reliant on market-based income for their existence. This focuses attention on income-generating activities and

²⁶ See Schlesinger and Gray (2006a and 2006b) for a compilation of the differing studies and viewpoints.

motivations as depicted through resource dependency theory. However, other organizational theories beyond resource dependence also play a part in understanding hospital organizational changes including the role of the professional, the ethics and organizational culture involved with an organization that has a tradition of care for others before financial concerns, and responses to environmental and organizational ecology influences. These include efforts to increase organizational legitimacy and to adopt policies and structures prompted by institutional isomorphic forces.

The key theories referred to in relation to hospitals echo those that explain nonprofit theories as well as corporate philanthropy theories. They also have a strong correlation to the four corporate giving models presented by Burlingame and Young. The relationship of *resource dependency* theory to the Productivity model has already been well noted. The role of *ethics* and *organizational culture* in demonstrating that the hospital has a tradition of care for others that it places before its own financial concerns relates strongly to the Ethical/Altruism Model. The Political Model, as associated with *environmental and organizational ecology* theory, addresses the role of the hospital within its broader community. In addition, the *decision-making power* of nonprofit hospital philanthropic actions can reinforce the image of philanthropic decisions – and by extension, healthcare decisions – as being within local control. The importance of the *role of the professional* in a hospital necessitates that a hospital can respond to the various professional stakeholders that are an integral part of its institutional family, as

well as the external stakeholders. Philanthropic support allows for a decentralized and individualized response to varying motivations.

Table 1H shows how the various theoretical considerations related to nonprofit hospitals relates to the four corporate giving models.

Table 1H: Hospital Organizational Theories and Corporate Giving Models

<u>Young and Burlingame Models</u>	<u>Neoclassical/ Productivity</u>	<u>Ethical/ Altruistic</u>	<u>Political</u>	<u>Stakeholder</u>
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Hospital Organizational Theories	Resource dependency	Ethics and organizational culture	Decision-making power; Organizational Environment	Role of the professional

A Research Template for Nonprofit Organizational Philanthropy. Table 11 compiles all of the previously noted theoretical perspectives and shows how these perspectives relate to the four corporate giving models as well as to each other. The comparison shows first that the four model structure seems to be able to contain the perspectives from the various structures. There emerges a pattern to the types of theories that help explain and bridge – the various perspectives.

This thesis maintains that the intersection of these theories provides a structural basis for identifying the motivations and behaviors of nonprofit organizations acting philanthropically. Specifically it presents four different organizational structures that correspond to the underlying primary motivations the organizational theory indicates as a rationale for this behavior. These structural categories are subsequently used in the research portion of this paper investigating the philanthropic behavior of Indiana hospitals. Table 1A identifies the key categorizations from the compilation in Table 1I that relate directly to corporate structure.

**Table 11:
Compilation of Theoretical Perspectives to Corporate Giving Models**

Young and Burlingame Models	Neoclassical/ Productivity	Ethical/ Altruistic	Political	Stakeholder
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
General Locale of Prestige (Perrow 1961)	Intrinsic	Extrinsic	Extrinsic	Extrinsic
Core Concepts of External Affairs (Miles 1987)	Business exposure or strategy - Linked to business goals	Top management philosophy - Reflection of leadership ethics	External affairs strategy - Relate to environment through collaboration and/or legitimizing behavior	External affairs design elements - Relate to internal stakeholders
Expected Organizational Location of External Affairs, Based on Core Concepts	Linked to internal financial and marketing activities	Directed by leadership	A defined division, visible to key external organizations	Dispersed within the organization
Theoretical motivation (from the Management Literature)	[Enhanced reputation]; Increased profit	Enhanced Reputation	Enhanced Reputation; Enhanced Power	Enhanced Reputation
Targeted Constituency	Owners/ stockholders and Future Investors	Community	Community Leaders	Various Stakeholders
Desired Outcome of Corporate Philanthropy	Improve Financial Profit	Express corporate social values (or values of the individual leaders?)	Limit government intervention; Increase company's influence (Himmelstein)	Support interests of stakeholders
Corporate Strategic Actions	Support causes related to primary services produced and sold	Support causes based on broad social values	Improve community infrastructure; Collaboration (Galskiewicz)	Support targeted causes based on stakeholder interests
Follow-up Corporate Actions – Communications	Communicate actions and consequences to current and potential investors	Communicate actions and consequences to the broad Community	Communicate actions and consequences to others in positions of influence	Communicate actions and consequences to the different stakeholders

Table 11: Compilation of Theoretical Perspectives to Corporate Giving Models (cont.)				
Young and Burlingame Models	Neoclassical/Productivity	Ethical/Altruistic	Political	Stakeholder
Corporate Motivation	To increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Potential Location of Corporate Giving within the Structure	Formal Giving Structure, tied-in with primary service departments	Located in Top Management	Internally Unified and Externally Presented: A separate giving entity or department for maximum exposure	Internally Scattered
3 Perspectives of Legitimacy – (Suchman) – (Dowling and Pfeffer)	Pragmatic – self-interested Economic benefits	Moral Altruistic behavior	Cognitive: Political legitimacy (Prestige) – Legitimizing behavior	Legitimizing behavior
Level of Coupling	Tightly coupled	Tightly coupled to leadership, but loosely coupled or de-coupled from other organizational activities	Loosely coupled or de-coupled from the organization – Linked with other external organizations	Loosely coupled
Isomorphism (DiMaggio and Powell)	Coercive	Normative	Mimetic	Normative
Other Theories	Resource Dependency	Normative theories	Population Ecology	Population Ecology
Expected Organizational Location of Philanthropic Function	Linked with primary mission or operation	Board or CEO leadership	Separate foundation or identified and publicly-visible department	Dispersed throughout organization
Hospital Organizational Theories	Resource dependency	Ethics and organizational culture	Decision- making power; Organizational Environment	Role of the professional

The Proposed Nonprofit Philanthropy Model: As Table 1G (above) and Table 1I show, it is hypothesized that there are four potential organizational levels where nonprofit philanthropic behavior may occur. This thesis offers that there is a fifth model related to nonprofit organizations that is not directly identified in the existing literature of for-profit organizations. This fifth level of motivation relates to the concept of *coercive isomorphism* and is termed External Mandate, and is included in the template in Table 1J (and Table 1A).

Table 1J: The Nonprofit Philanthropy Models

Nonprofit Philanthropy Model	External Mandate	Management Function	Leadership Directed (CEO or Board)	Separate Organizational Function	Stakeholder Discretion
<u>Organizational Motivation</u> (from Young and Burlingame)	To comply with External Criteria	To ensure and/or increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Organizational Structure	Imitative of Mandates	Embedded in Dep't and Manager Hierarchy	Practices at Leadership Level	Separate foundation or identified and publicly-visible department	Dispersed throughout organization
Expected Organizational Location of Philanthropic Function	(Similar to regulatory mandates or system structures)	Linked with primary mission or operation: <i>DEPARTMENT</i>	Board or CEO leadership: <i>ADMINISTRATIVE</i>	Separate foundation or identified and publicly-visible department: <i>FOUNDATION</i>	Dispersed throughout organization <i>STAFF</i>

This model refers to practices and structures imposed from outside the organization, which could include governmental regulations or criteria dictated by an organizational system, such as a hospital system. In the case of nonprofit

organizations – and particularly nonprofit hospitals – while financial gain may be part of their motivation, this is seen as only one potential external “mandate” that may affect its actions. Governmental regulation or even systemized structures and practices that are required by the overall health system may also govern these decisions. Organizations that conform to this motivation are expected to have philanthropic structures that conform to the structures outlined by those outside regulatory criteria or that have a similar structure as other organizations within their systems. The External Mandate Model is strongly related to the Productivity Model and shares many similar characteristics of operation but may have very different evaluative and practical outcomes. To accommodate these additional criteria, the Nonprofit Philanthropy Template, divides the Productivity Model into the External Mandate Model and the Management Function Model.

Both structures are hypothesized to have tightly coupled departmental and managerial hierarchical connections within the management structure of the organization – either reflecting profit concerns or conformity to the mandates. The primary difference between the two models is that organizations motivated by External Mandates will have structures similar to those mandates and the communication function of the process may also be expected to be uncoupled from the philanthropic activities, as the philanthropic activity comes from external forces rather than as an integrated approach embedded in the organization’s mission.

The other Nonprofit Philanthropic Models relate to the corporate models used throughout this classification process. The Management Function Model identifies practices institutionalized into the formal mid-management levels of the organization and are closely tied to profit motivations. Organizations that engage in philanthropic behavior primarily due to this profit motivation would be expected to have the function and its subsequent communication embedded within the normal or existing organizational structures of the organization. The Leadership Directed Model includes practices controlled by the personal actions of organizational leadership, particularly of the board and/or Chief Executive Officer. A Separate Organizational Model identifies practices centralized into a discreet entity to gain maximum exposure for the behavior, yet separate from its primary mission. The Stakeholder Discretion Model refers to practices that arise at different levels in the organization as responses by various internal stakeholders to diverse external requests and situations. Table 1J outlines the five Models of Nonprofit Philanthropy.

These five models can be used to further identify decisions located within different levels of the corporation. As was previously stated, organizations that are motivated by financial return and exemplify the Productivity approach will probably have the philanthropic activity well integrated into the corporate structure and strategies, with well-defined departmental processes and reporting criteria closely linked to product and service production and delivery. Conversely, it could be expected that philanthropic behaviors under the Ethical

model would be determined and managed through the organizational board and executive leadership as expressions of a generic corporate standard or ethic. Such normative motivations may have institutional or professional influences, they may be definitive policies passed by present or past leadership, or may be controlled by the individual views of the organization's current leadership. Such a scenario relies on individual adherence to and expression of ethical standards and therefore would be considered as something that pervades the company structure rather than is isolated within a defined department or activity.

A philanthropy program with the Political motivation might be expected to organize its philanthropic programs in a manner visible to the greater community with numerous community linkages and connections. Corporate structural responses could include unifying philanthropic activities and reports to provide the maximum community impact, or even possibly placing those activities in a separate corporate entity to provide for increased identity. Organizations adhering to the Stakeholder rationale will face the problem of identifying and communicating with multiple constituencies and therefore face a communications challenge. A firm with such motivations might locate philanthropic programs within a public relations or other communications department that has the expertise and resources to respond most directly and continuously with the various constituents.

Nonprofit Hospitals, Public Policy, and Community Benefit

The third section of the chapter outlines why nonprofit hospitals are particularly appropriate for investigating nonprofit philanthropic behavior. As outlined earlier in this chapter, for the purposes of this paper nonprofit hospital philanthropy is considered as a subset of the broader community benefit standard that currently serves as a basis for the federal tax-exemption of nonprofit hospitals. It addresses the question: “What is the relationship of nonprofit hospital philanthropic behavior to community benefit?”

The section first introduces the current debate over nonprofit hospitals and community benefit. It then provides a brief overview of the community benefit standards, including a definition of the concept as currently determined by the Internal Revenue Service. The next part of the section outlines the origins and evolution of the concept of community benefit and its relationship to tax exempt organizations. The fourth part of the section looks at the general structure of the community benefit standard and part five evaluates the specific elements of community benefit to determine which of these elements fit within the definition of nonprofit philanthropic behavior. The chapter concludes by outlining the next step in the paper, to verify the validity of the databases for potentially evaluating hospital community benefit and nonprofit philanthropic behavior.

Part five of this section is of particular interest for identifying nonprofit philanthropic behavior. Each of the elements of these community benefit

standards are evaluated separately to determine their applicability to nonprofit philanthropic behavior, focusing on those benefits that are voluntary and of benefit to a wider public beyond the primary mission of the nonprofit hospital. The analysis ultimately identifies two elements that most directly reflect organizational philanthropic behavior and can potentially be evaluated and compared among community hospitals: i.e. a hospital's expenditures for community health promotion programs and donations made to other community nonprofit organizations. Community health promotion programs are defined as those education and wellness programs that improve the general health of the community. These are considered services that are beyond the primary health care activities and mission that provide direct patient care. The other category is "donations." This refers to the cash donations made by a nonprofit community hospital to another community organization. This section first outlines the scope and criteria of community benefit and how this relates to nonprofit hospitals.

The Current Debate over Community Benefits and Nonprofit Hospitals

Perhaps the most visible and debated example of nonprofit philanthropic behavior revolves around the community benefit standards of nonprofit hospitals. Since 1969 the Internal Revenue Service has determined that nonprofit hospitals incorporated under section 501(c)(3) of the Internal Revenue Service tax code enjoy certain tax advantages because they exist primarily for *community benefit*. Specifically the IRS Revenue Ruling 69-545 states:

"To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and

operated exclusively in furtherance of some purpose considered 'charitable' in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose (Restatement (Second), Trusts, sec. 368 and sec. 372; IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372).

. . . The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community . . ."

(Internal Revenue Service, Revenue Ruling 69-545, 1969-2 C.B. 117)

The debate arises because the 1969 IRS ruling does not define what precisely those services that provide "promotion of health" and are "beneficial to the community" (i.e. community benefits) should be, how they should be measured, or what constitutes an acceptable level of community benefit.

Critics of community benefit maintain that tax exemption should primarily be based on providing services to the poor. These critics, notably including Senator Charles Grassley (as mentioned in the introduction to this thesis) and the legal scholar John Colombo ("I come to bury the community benefit test, not to praise it." Colombo, 2005, p. 29). Colombo maintains that among other problems the standards have been "a behavioral failure" (ibid) and others have claimed that while regulations may only have a minimal effect on actual programming, perhaps "a community health orientation process (might serve as) a form of lip service to social values" (Ginn and Moseley 2006, p. 342). However, even

community benefit critics observe that the 1969 IRS ruling does provide for a more refined definition of community benefit as “promotion of health”, a concept that could be more closely related to the original intent of charitable purpose (Koprowski and Arsenault 2003, Hall and Colombo 1991).

This paper does not try to add to this already well-worn debate.²⁷ Instead its emphasis is on how well the accepted elements comprising the community benefit standard are defined and reported through existing and proposed methods and how well these standards meet the criteria of philanthropic behavior. It is a contention of this thesis that philanthropy and community benefit, while not synonymous are nevertheless related, with philanthropic behavior as a subset of community benefit. Nevertheless, a brief summary of the origins and situations of the community benefit standard is useful for the purposes of this paper.

The Origins and Evolution of the Community Benefit Standard

There are two important strands within the general debate on tax exemption: whether a charitable purpose refers only to providing charity care for the poor or if it has broader application as “public benefits”. This dichotomy actually dates from the earliest attempts to codify what qualifies as charitable. The distinction has been defined as either a “technical or legal meaning” of charity derived from charitable trust law – being the broader definition of public benefit – or the

²⁷ For examples of extensive explorations of nonprofit hospitals and tax-exemption, see Horwitz (2003, 2007), Colombo (2005), Noble et al (1998), and Gustafsson (1996).

“ordinary and popular” usage of charity meaning aid to the poor and the relief of poverty (Gustaffson 1996, pp. 620-621). This distinction becomes important when defining the relationship of philanthropic behavior to the community benefit standards.

Community benefit is important for the definition of what it means for an organization to have a charitable purpose and be exempt from various forms of taxation – and to enjoy other tax-related benefits such as the ability to issue tax exempt bonds and accept tax deductible contributions. Nonprofit hospital community benefit and the related definition of charity, have roots in two branches of law: one is from tax-exempt corporate law and the other from charitable trust law.

Contemporary tax-exempt corporate legal criteria were established in 1954, with the Internal Revenue Code of 1954, Section 501(c)(3). This code defined categories of corporations that are not subject to federal income tax, particularly those organized and operated exclusively for charitable, religious, educational, scientific, or literary purposes. Legal definitions of an organization’s charitable purpose, specifically related to organizations exempt from corporate tax in the United States, historically date to the initial 1894 Tariff Act that stated an organization was exempt from these taxes if operated for “charitable, religious, or educational purposes.”²⁸ This is the standard that essentially remained in effect

²⁸ This Act was subsequently ruled to be unconstitutional but when revived in 1913 it had essentially the same wording.

for all nonprofit organizations including hospitals, with only slight revisions and differing judicial interpretations,²⁹ until the codification of the 501(c) designations by the IRS in 1954 and their ruling on hospitals in 1956.

The definition of charity in United States charitable trust law is founded in English common law as it evolved from the 1601 Elizabethan Statute of Charitable Uses³⁰ to an 1891 House of Lords ruling written by Lord MacNaughten in the case of *Commissioners v. Pemsel*. The definition of charitable as delineated by Lord MacNaughten was referenced in 1959 in the United States through Treasury Regulation 1.501(c)(3)-1(b)(2), which attempted to refine the differing definitions of charitable and tax-exempt status (Smith and Crabtree 2006).

The Preamble to the Elizabethan Statute of Charitable Uses delineates a wide variety of charitable purposes and while it does not explicitly include a reference to “community benefit” there is the overall implication that the types of activities that are charitable are those that benefit a general community rather than a private individual or group. Many of the itemized charitable uses refer directly to aid to the poor or to charities that may have a relative emphasis on the poor, while other defined purposes have broader uses that provide advantages to

²⁹ See Smith and Crabtree (2006) for a summary of the pre-1954 rulings.

³⁰ Jordan, W.K., *Philanthropy in England 1480-1660: A Study of the Changing Pattern of English Social Aspirations* (1959): 18; cited in Lieber (2001): 733.

everyone in a community (e.g. “repair of bridges, ports, havens, causeways, churches, seabanks, and highways”).³¹

Lord MacNaughten refined the definition of charitable in the Elizabethan Statute of Charitable Uses by enumerating four areas that qualified as charity. His “four heads of charity” included in addition to “relief of poverty” also the advancement of religion and education – and “for other purposes beneficial to the community.”³² It is these criteria that are the basis of the definition of charitable

“in the generally accepted legal sense” – referred to in the 1959 Treasury Regulation and the 1969 IRS Revenue Ruling outlining the community benefit standard. Under charitable trust law in the United States, “the promotion of health” is noted as one of the six general categories of charitable purposes.³³

The 1959 Treasury Department ruling included a clarification of the 501(c) definition of “charitable,” to conform to a broader “generally accepted legal definition,” that goes beyond relief of the poor³⁴ based on the British precedents which also included the advancement of education, religion, and community benefit (CBO 1994, pp. 14-15).

In 1969 the IRS determined community benefit was the critical rationale for the tax exemption of nonprofit hospitals in the United States (IRS, Revenue Ruling

³¹ “An Act to Redress the Mis-Employment of Lands, Goods, and Stocks of Money Heretofore Given to Certain Charitable Uses,” (1601) 43 Eliz., ch. 4 *reprinted in* 7 Stat. At Large 43 (Eng. 1763).

³² *Commissioners for Special Purposes of Income Tax v. Pemsel*, 1891 App. Cas. 531, 543 (H.L.).

³³ Restatement (Second) of Trusts, section 368 (1959).

³⁴ “Relief of the poor” as a definition of charitable had been in effect since a 1923 Internal Revenue Service Ruling (CBO 1994).

69-545). This replaced a previous 1956 ruling (IRS, Revenue Ruling 56-185), in which, along with three other provisions,³⁵ the IRS had determined that nonprofit hospitals served a charitable purpose because they provided charity care and therefore “relief of poverty.” The 1969 ruling was not a decision without precedent. In 1969 – most probably because of the adoption of the Medicaid and Medicare programs – the IRS in accordance with this broader definition, re-defined nonprofit hospitals as deserving the advantages of nonprofit status because they provide services that are “deemed beneficial to the community”. But as has been emphasized from its origins, this definition is vague and lacks any specific requirements or measurements.

Despite the attention given to these “community benefit standards”, the 1969 Ruling only refers obliquely to community benefit. The 1969 Ruling is actually a fairly brief modification of the 1956 IRS Ruling as opposed to a complete re-writing of the ruling. The tax exemption of hospitals is further identified in the 1969 Ruling not through a definition but by outlining two hypothetical hospital situations, one defining a nonprofit hospital example as charitable even though it has an operating surplus (because the organization operates according to the four criteria outlined in the above footnote) and the other example defining a hospital to not be “charitable” since it operates for the financial benefit of

³⁵ The Internal Revenue Service Revenue Ruling 56-185 identified four criteria that must be met by hospitals to be tax-exempt, charitable organizations: 1) “. . . organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick”; 2) “. . . operated to the extent of its financial ability for those not able to pay for the services rendered”; 3) “. . . not restrict the use of its facilities to a particular group of physicians and services”; and 4) “Its net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual.” (*IRS, Revenue Ruling 56-185*)

designated individuals. The 1969 ruling focuses primarily on disallowing private benefit and, only by implication, encouraging community benefit. It emphasizes the modification of the fourth requirement (i.e. the non-inurement of benefit to individuals, see footnote #36 above) rather than the second criteria (i.e. “for those not able to pay for the services rendered”). The 1969 Ruling concludes:

“Revenue Ruling 56-185, C.B. 1956-1, 202, sets forth requirements for exemption of hospitals under sections 501(c)(3) **more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below costs** . . . Section 1.501(c)(3)-1(b)(4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501(c)(3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove there from the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirement four has been modified by section 1.501(c)(3)-1(b)(4) of the regulations.”

- (IRS, Revenue Ruling 69-545, 1969-2 C.B. 117, emphasis added)

In the early 1970s various nonprofit hospital agencies began to try and define criteria for determining community benefit – prompted at least partially by a desire to proactively establish their own standards before external bodies imposed regulations upon the industry. Among those nonprofit advocacy agencies were the Catholic Health Association (CHA), Voluntary Hospitals of America (VHA), and the American Hospital Association (AHA) – and the community benefits included not only providing care to those not able to pay for it but also such programs as research, education, and various services defined as “unprofitable”. In the 1980s and 1990s state governments began to question how well nonprofit hospitals were meeting these community benefit standards

and several states began to take steps to define them.³⁶ In 1990 the United States Congress began similar inquiries, but reached no consensus on the most proper action. However in 2005 Congress again raised the issue and began to more seriously question what nonprofit hospitals should do to “qualify” for tax exemption and how this qualification should be measured. As of 2008, the Congressional examination of the tax exemptions of nonprofit hospitals continues. The primary outcomes to date have been a revision of the IRS Form 990 and, of most relevance to nonprofit hospitals, the introduction of a new Schedule H to be included as part of their year-end report to the IRS. This Schedule H includes detailed information on charity care and other related community benefit data and processes.

Community Benefit Defined: A Brief Overview of the Standard

There have been several efforts to define community benefits – what they should include and how they should be measured. These efforts have primarily been led by the hospital industry and most recently through guidelines jointly developed by the Catholic Health Association (CHA) and Voluntary Hospitals of America (VHA). However, adherence to these guidelines remains voluntary.

The American Hospital Association (AHA) has also developed guidelines for its membership. The IRS community benefit standard has not been officially altered since 1969, except for the 1983 provision (IRS, Revenue Ruling 83-157) that removed the necessity for nonprofit hospitals to maintain emergency rooms (to allow for specialty nonprofit hospitals) and the 1986 regulation to expand the

³⁶ See Chapter Two of this dissertation for a brief outline of these state actions.

requirement for hospitals with emergency rooms and that accept Medicare to admit patients regardless of ability to pay, regardless of their ownership structure – a requirement that applies to for-profit as well as nonprofit hospitals. The latter was instituted as part of the Emergency Medical Treatment and Labor Act (EMTALA 1986), also known as the “anti-dumping legislation,” to prevent hospitals from unnecessarily transferring unprofitable patients.

The EMTALA provision is relevant to the community benefit discussion in that it does mean for-profit hospitals that operate emergency rooms (and accept Medicare) are required to treat any patient who seeks emergency treatment, regardless of ability to pay.³⁷ This expands the concept of the charity care provision of the community benefit standard to encompass for-profit as well as nonprofit hospitals, if they accept Medicare payments. Conversely, because of the 1983 ruling, nonprofit hospitals that do not have emergency rooms also do not have to provide medical services to indigent patients. This complicates the issues surrounding nonprofit hospitals and community benefit even more than the vague language of the 1969 IRS Ruling, as some of the provisions currently also apply to for-profit hospitals, but may not apply to all nonprofit hospitals.

Policy makers as well as scholars have investigated the extent that nonprofit hospitals differ from for-profit hospitals in terms of quality of care, costs, or

³⁷ It should also be noted that for-profit hospitals are not required to report on any other aspects of community benefit that they may provide. But as the Indiana hospital database shows, many for-profit hospitals will voluntarily respond to requests for documentation of other elements of community benefit beyond their treatment of emergency room patients.

delivering care to the poor.³⁸ Much of the definition and controversy surrounding community benefit involve its relation to charity care and what constitutes an adequate provision of charity care to justify tax-exempt status. One point of contention is the difference between charity care and uncompensated care – with the latter defined as the combination of charity care and (some percentage of) bad debt and/or shortfall in Medicaid (and possibly Medicare) reimbursement. The difference is most obviously seen in the guidelines of the CHA/VHA (CHA 2006, CHA/VHA 2006) that recommend counting only charity care (and Medicaid shortfall) and the AHA guidelines that include bad debt (and Medicare shortfall) in its reporting of uncompensated care (AHA 2006). Table 1K compares these basic differences. How charity care/uncompensated care is measured and how it should be evaluated are areas of disagreement found throughout policy interpretation, scholarly treatment, reporting practices, associational guidelines, and state regulations.

Table 1K: Comparison of Definitions of “Charity Care”

	Charity Care	Include Medicaid shortfall	Include Medicare and Medicaid shortfall	Uncompensated Care – including Bad Debt
CHA/VHA (and IRS 2008)	X	X		
IRS (2004)	X	X	X	
AHA	X	X	X	X

³⁸ Especially see the work of Schlesinger, Mitchell, and Gray (2003), and Schlesinger and Gray (2006b).

Recent congressional investigations and judicial challenges to the tax exempt status of nonprofit hospitals have primarily focused on whether nonprofit hospitals deliver a sufficient level of charity care to satisfy their charitable provision and be exempt from taxes. Various states have implemented criteria and/or evaluated the community benefit of hospitals based on charity care. But other elements besides charity care/uncompensated care may also enter into determining potential community benefit (see Chapter Two for an overview of state programs). Broad programmatic approaches (termed Process-oriented) include having a board that represents the community as well as a community health needs assessment and a community benefit plan.³⁹ Prescriptive approaches that are more quantitative include documenting and evaluating the existence of specific community benefit programs or activities as well as the extent of these services through usage and/or expense data. Community benefit elements include – along with charity care/uncompensated care – such activities as research, education, health promotion, and donations.

Perhaps the most widely recommended format for documenting community benefits is the guidelines developed by the CHA/VHA, updated in 2006 (CHA/VHA 2006). These guidelines are fairly comprehensive, with a notable distinction of not including bad debt. The range of activities the CHA/VHA guidelines include within community benefit is fairly extensive. Beyond the figures for charity care and Medicaid shortfalls, broad categories are Community

³⁹ For example, see Olden and Clement (2000), Proenca et al (2003), Seay (1994), and Seay and Sigmond (1989).

Health Services, Health Professions Education, Research, and Financial Contributions. Other areas they recommend including are activities related to Community-Building, losses on Subsidized Health Services (such as Burn Units, Renal Dialysis, and Women's and Children's Services, among others – in short, any service that results in an operating loss), and costs associated with actually providing and reporting community benefits. They also recommend reporting Foundation-Funded Community Benefits, tying in the fund development efforts to community benefit.

There are currently no federally mandated standards or requirements for determining or reporting community benefit by nonprofit hospitals. However, starting in 2009 the Internal Revenue Service (IRS) will include a Schedule H as part of its revised year-end Form 990 for nonprofit organizations. Schedule H asks nonprofit hospitals to document various community benefit activities and expenditures. However this reporting does not correspond to any required levels of expenditures or compliance. Various states have legislatively and judicially established criteria for community benefit, but currently there is a lack of consistency as to what is considered to be community benefit, which of these can be measured, how it should be measured, how these measurements should be evaluated, what is an acceptable level of community benefit, and the consequences if a nonprofit hospital fails to meet these standards. Most states require some level of compliance with at least procedural standards for developing community benefit policies and community needs assessments. But

increasingly there is a call for more quantitative standards. It is one contention of this thesis that the philanthropic behavior of hospitals could provide a valid picture of the efforts of nonprofit hospitals to meet the needs of their communities. How the individual elements of community benefit are able to be quantified and satisfy the philanthropic behavior criteria is outlined in the next section.

The Elements of Community Benefit

This section explores how well the accepted elements comprising the community benefit standard meet the criteria of philanthropic behavior. It is a contention that philanthropy and community benefit, while not synonymous are nevertheless related, with philanthropic behavior being a subset of community benefit. The following outlines the specific elements of nonprofit hospital community benefit as defined by the Internal Revenue Service and the CHA/VHA standards.

As previously stated, according to the Exempt Organizations division of the Internal Revenue Service (Gitterman and Friedlander 2004), “The promotion of health for the benefit of the community is a charitable purpose,” and that it “promotes health as its charitable purpose, (and) the organization must meet the community benefit standard described in Rev. Rul. 69-545, 1969-2 C.B. 117, as well as the other requirements of IRC 501(c)(3) and its regulations” (ibid, p. 2).

This ruling further delineates two categories for determining community benefit: an Organizational Test and an Operational Test (“that it is organized and will be

operated for exclusively charitable purposes”) as specified in section 501(c)(3). To meet the community benefit standard a nonprofit hospital must satisfy five factors: 1) has a board composed primarily of community members, 2) has a medical staff open to all qualified physicians in the area, 3) operates a full time emergency room open to all, regardless of ability to pay, 4) provides non-emergency services to anyone who is able to pay, and 5) serves a broad cross section of the community through research or charity care (ibid, p. 10). The final provision specifically references Rev. Rul. 56-185 and further defines charity care and research as well as training and other related activities. Charity care is defined as not including bad debt but does indicate that treating patients covered through Medicare and Medicaid may “demonstrate community benefit”. This is an interesting observation as it starts to identify a complicating factor in determining the type of patient that is or isn’t charity care, elaborated upon below. The IRS also includes other activities that serve the health care needs of the community, such as medical training or research as well as “additional activities demonstrating community benefit” (and provides five examples of these activities including free health education programs, seminars, or community health fairs) (ibid, p. 15).

These broad IRS statements or definitions have been refined and codified by the Catholic Health Association, joined by Voluntary Hospitals of America, and adopted for the new reporting format adopted by the IRS for use beginning in 2009 (i.e. the Form 990, Schedule H). According to the Catholic Health

Association's (CHA) "Instructions for Hospital Community Benefit Report: IRS Form 990, Supplement to Part III" (CHA n. d.), the community benefit report has two sections. Section 1 is a "Qualitative Description of Community Benefit," and Section 2 is "Quantifiable Community Benefit Information."⁴⁰ The Qualitative Description section asks for written descriptions of the hospital's mission and exempt purpose, their approach to providing community benefit, their financial assistance program as well as how the hospital satisfies the provisions of tax exemption (being the five factors identified above). It also asks for descriptions of specific community benefit programs the hospital offers as well as web links to available financial assistance information or community benefit reports.

The categories of "Quantifiable Community Benefit" according to the Catholic Health Association's (CHA) "Instructions . . ." are: 1) Charity Care; 2) Government Sponsored Health Care; and 3) Community Benefit Programs (net expense). Charity Care is the cost of providing medical services to those determined not to be able to pay and is not to include bad debt. Government Sponsored Health Care is defined as the net expense of "unpaid cost of public indigent care programs (includes Medicaid, SCHIP, other safety net programs; does not include Medicare shortfall)" (CHA n. d., p. 5).

Under the third category "Community Benefit" seven sub-categories are included:

Community Health Services, Health Professions Education, Subsidized Health

⁴⁰ These two sections relate roughly to the Process-Oriented Approach and the Prescriptive Approach (referred to above) as well as to the Organizational Test and Operational Test referred to the 2004 IRS guidelines.

Services, Research, Financial and In-Kind Contributions, Community-Building Activities, and Community Benefit Operations. Table 1L outlines these standards and categories. It should be noted that the Charity Care quantification is the one area of community benefit that has the most disagreement as to what should be counted. One controversy has to do with whether bad debt should be counted or not. The American Hospital Association holds that all “uncompensated care” should be considered as charity care; the IRS and the CHA/VHA standards maintain bad debt is not charity care. A second question is whether the shortfall from government reimbursement programs is counted as charity care. The IRS in their 2004 guidelines say that both Medicare and Medicaid shortfall is part of charity care; the revised IRS standards say only the shortfall from Medicaid should be counted.

**Table 1L: Hospital Community Benefit Report
(According to CHA & IRS Form 990)**

Section 1: Qualitative Description of Community Benefit	Section 2: Quantifiable Community Benefit Information
1. Organizational Commitment to Providing Community Benefit	1. Charity Care – at cost <ul style="list-style-type: none"> • NOT including Bad Debt
A. Hospital’s mission and primary exempt purpose	2. Government Sponsored Health Care <ul style="list-style-type: none"> • Unpaid cost of public indigent care programs • NOT including Medicare shortfall
B. Summarize approach to providing community benefit	3. Community Benefit Programs (net expense)
C. Describe financial assistance programs	<ul style="list-style-type: none"> • Community Health Services • Health Professional Education
2. Organizational Description for Tax Exemption – Indicate	<ul style="list-style-type: none"> • Subsidized Health Services
<ul style="list-style-type: none"> • Operates an open emergency room 	<ul style="list-style-type: none"> • Research
<ul style="list-style-type: none"> • Has an open medical staff 	<ul style="list-style-type: none"> • Financial and In-Kind Contributions
<ul style="list-style-type: none"> • Has a community board 	<ul style="list-style-type: none"> • Community Building Activities
<ul style="list-style-type: none"> • Conducts medical research programs 	<ul style="list-style-type: none"> • Community Benefit Operations
<ul style="list-style-type: none"> • Health professional training 	
<ul style="list-style-type: none"> • Participates in gov’t sponsored health care programs 	
3. Description of Community Benefit Program	

Nonprofit Philanthropic Behavior and the Elements of Community Benefit

In the beginning of this Chapter, nonprofit philanthropic behavior as used in this paper is defined as “non-regulated budgetary or other expenditure of resources that provides a value to a broader public beyond the primary mission and purposes of that private nonprofit.” This definition contains three critical elements for evaluating if a given action by an organization is truly philanthropic. The first element is that it’s non-regulated (related to the concept of voluntary or non-coerced). The second element is that this voluntary action is budgetary and therefore represents a deliberate quantifiable action on the part of the organization. This combines with the first element to define that budgeted expenditure as not being influenced by regulatory requirements. The third element is that the action benefits a broader public beyond the primary mission and purposes of that private nonprofit. Since the purpose of identifying nonprofit philanthropic behavior is to determine the amount of philanthropy given by a hospital, the focus of this evaluation is on the elements included under the Quantifiable Information (Section 2) rather than the Qualitative Description (Section 1).

Applying the proposed philanthropic behavior to the first two categories, we see that the initial criteria of the definition are not met for either category of Charity Care or for Government Sponsored Health Care.⁴¹ Providing care for those unable to pay is a governmental regulation for all hospitals that accept Medicare

⁴¹ Defined as “Unpaid cost of public indigent care programs (includes Medicaid, SCHIPO, other safety net programs; does not include Medicare shortfall” (CHA 2008).

and have an emergency room. Therefore treating these patients is not voluntary (no matter how willing the hospital might be to treat those patients). And the unpaid cost of public indigent programs” is a figure determined by external funders rather than internal decision-makers (although the expense is probably “budgeted” as most hospitals can probably make a reasonable estimate as to the projected expense of charity care and unpaid public assistance programs for a coming year. The distinction is that the internal leadership did not initiate the expense. Rather it was determined by external entities). These categories also do not satisfy the third factor of philanthropic behavior: Benefit to a broader community than determined by their primary purpose. While a broader community might be comforted by knowing that their community’s hospital provides this care and may be appreciative of those efforts, they do not directly benefit from that care or expenditure. If the first two categories of community benefit are not part of the philanthropic behavior subset, this leaves as potential candidates for philanthropic behavior the seven sub-sections of the third category of community benefit elements: “Community Benefit Programs (net expense⁴²).”

The first of the sub-categories is “Community Health Services.” Examples of these programs (given in the CHA “Instructions”) are Community health education, Community-based clinical services, and Health care support services.

These types of programs do satisfy a majority of the philanthropic behavior

⁴² While net expense is a stipulation for quantifying community benefit, there could be an argument that gross expense is more appropriate for determining philanthropic behavior – as it represents the entire organizational budget action of the donation to the community. This is addressed later in this paper in computing philanthropic behavior of Indiana hospitals.

criteria and so would (generally) be considered as a key expression of a hospital's philanthropic behavior. It is entirely voluntary for a hospital to decide to offer these programs, and how much it spends on these programs is a deliberate budget decision. Most programs are made available to a broader community and the provision of these programs goes beyond their primary mission to care for the sick and injured, as they tend to promote general wellness and health.

Health Professions Education is a little more problematic and questionable as a form of philanthropic behavior. This questionability is especially true for a community hospital as opposed to a teaching hospital affiliated with a school of medicine or other formal medical preparatory program. A community hospital does not have a similar primary mission to provide such professional education, nor is there a corresponding expectation by society that it has a mission to provide such training. When continuing professional education opportunities are provided by a community hospital for its employees and medical staff, there is a mixture of public and private benefit. The public benefit is improved medical services that are presumed to be an outcome of the educational expenditures. The private benefit may accrue to both the hospital (that may use these expenses as one form of human relations benefit as well as a way to improve its workforce) and for the employee or physician (who have advanced their own level of medical expertise and potentially their value in the market).

Examples given on the IRS Form 990, Schedule H are programs for “Physicians/medical students, Nurses/nursing students, Other health professional education, and Scholarships/funding for professional education”. These are non-coerced and self-directed budgeted expenses (unless such expenses were mandated by union or other employment agreements), satisfying the first two criteria. However the extent these programs are primarily of direct benefit to the broader public is uncertain. Therefore it is suggested that these expenses do not necessarily satisfy the third criteria: that the program is of broad direct public benefit.

Subsidized Health Services (including programs such as “Emergency and trauma services, Burn unit, Renal dialysis services, Behavioral health services, and Palliative care and hospice”), refer to specific medical care programs that happen to be termed “not profitable”. Some of these may be non-coerced although some programs within this area, primarily emergency services, may be required by various accreditation agencies such as the Joint Committee on Hospital Accreditation and, as previously noted, is a requirement for hospitals that receive Medicare. As in the case of Health Professions Education there is a mix of public and private benefit that fails to completely satisfy the third element of philanthropic behavior.

Research expenses (e.g. “Clinical research, “Community health research”) may satisfy the philanthropic definition, and are generally related to the educational

role of a teaching hospital rather than to the general healthcare role of a community hospital. The programs are voluntarily provided and budgeted, and their eventual purpose is to provide a broad public benefit. However the actual number of community hospitals providing research is limited.⁴³ Because of this limitation – research expenses are indicated as philanthropic behavior for individual hospitals, but are not included in the community hospital comparisons later in the thesis.

Financial and In-Kind Contributions (including “Cash donations, Grants, In-kind donations”) is the second category considered to be part of philanthropic behavior. Making contributions to other organizations is an area that is generally under-acknowledged by the public as a significant action by nonprofit hospitals (with the possible exception of awarding scholarships to students, which is included in this listing under Professional health education). These expenditures are generally non-coerced and self-directed as a budget expense – and are of potential benefit to publics beyond the primary mission of the hospital. As is shown in Chapter Five of this paper, many “donations” may actually be internal transfers, but also include direct financial contributions to other nonprofit organizations. One complicating factor in this category should be acknowledged: as found in the surveys (see Chapter Five), this area has a potentially problematic aspect in the “in-kind” donation description. Hospitals can have varying experiences and processes in how well personnel and overhead

⁴³ For instance, only five of the 107 community hospitals in Indiana reported any consistent or significant level of research expense.

expenses involved with community outreach programs are being captured and reported. This variability can make some of the comparisons somewhat suspect – and also indicate one example where most hospitals may be under-reporting the level of their community benefit.

Community-Building Activities include examples such as “Physical improvements/housing, Economic development, Environmental improvements, and Coalition building”. This has somewhat similar considerations to contributions and is also an area that should be considered as philanthropic behavior, assuming the expenditures are for projects that are not directly related to the development of the hospital’s own facilities (or those of affiliates), but are directed at the broader public. While this is another area that is considered to be part of philanthropic behavior (along with Community Health Programs, Research, and Donations), it is not included in the analysis of Indiana hospitals in this paper. This is because current databases do not specifically identify this category and so become difficult to identify comparable information. Some of this activity is captured in donations and when it can be identified is included under these distinctions.

Community Benefit Operations is the final sub-category under “Community Benefit programs and includes “Dedicated staff and Community health needs/health assets assessment”. This would not satisfy the philanthropic

behavior criteria as the direct benefit is to the organization itself (even though the broader community is the indirect beneficiary of at least some of that activity).

In summary, there are two major areas that are identified as being indicative of philanthropic behavior of nonprofit hospitals and can potentially be equitably compared across general, medical-surgical community hospitals: Community Health Education and Donations. These are the focus of the in-depth study in Chapter Four and Five of this paper. To other areas, Community-building activities and Research, may also satisfy the criteria but are not included in the comparative study since they are either not defined in the existing databases or otherwise are not able to be readily compared among different hospitals.

Conclusion

The community benefit worksheets that will be required from every nonprofit hospital starting in 2009 include donations as one of the elements falling under community benefit. This implies that nonprofit hospitals may not only receive philanthropic support from its community but also may provide such support. One question is: why would nonprofit organizations make contributions to others? As the theoretical literature shows, there are multiple benefits and motivations related to organizational philanthropic behavior. In some cases the benefits attain legitimacy within a particular community or professional institution, leading to isomorphic behavior in relation to the norms of those entities. Philanthropic behavior is decoupled from the primary operations of the organization, allowing it

to conform to the norms while also maintaining operational individuality. In other cases, the benefit fulfills internal goals and is tightly coupled to the operation of the organization. In still other cases the benefits are ethical reflections of the organization's leadership, and this behavior is located at that leadership level. Any of these benefits may accrue to both the organization as well as to the general community, and can apply to for-profit as well as nonprofit organizations – such as hospitals. By examining the specific elements of community benefit we can also see that in addition to donations, health education programs may also be included as an expression of a hospital's philanthropic behavior.

A critical question becomes: If such quantitative behavior is to be evaluated, do we have adequate data resources, procedures and criteria to determine how well hospitals meet those standards? This paper evaluates a database of hospital community benefit data collected by the state of Indiana as an example of how well national self-reporting of community benefit activity might work. This is addressed more completely in Chapters Two, Three, Four, and Five of this paper. It begins by looking at the information that is currently available through national and state databases, the primary focus of Chapter Two.

CHAPTER TWO: THE VALIDITY OF EXISTING DATABASES FOR DETERMINING HOSPITAL COMMUNITY BENEFIT

Nonprofit philanthropy is not regularly reported in national giving studies (e.g. *Giving USA 2007*). As a consequence there are not regular surveys that capture this information. One question is whether appropriate databases exist to evaluate nonprofit philanthropy. Additional questions are: If databases do exist that might be adopted for this use, how valid are they; and: Do organizations keep and report uniform records of these figures? This chapter investigates the types of hospital community benefit data that exists and the relative validity of this information for measuring philanthropic behavior. This investigation focuses on the reliability of the existing databases and how well they provide the information needed to assess philanthropic behavior.

The paper examines a publicly available Community Benefit database from the Indiana State Department of Health (ISDH) data as a viable tool to determine the level of nonprofit hospitals' community benefit and philanthropic behavior within the state of Indiana. This database is subsequently used later in this paper to evaluate the general level of community benefit and compares that information to other existing databases to determine the consistency and comprehensiveness of this particular public reporting mechanism. This information is further applied to evaluate the level of philanthropic behavior evidenced by Indiana hospitals.

An Overview: Do Current Databases Satisfy the Need?

To measure and evaluate a hospital's philanthropic behavior requires reliable and consistent information on a hospital's level of community benefit. This is complicated by the lack of an accepted national database or reporting criteria for community benefit.¹ A further challenge is due to a lack of common definitions or agreements as to what constitutes community benefit or how it should be measured. One basic disagreement is whether *charity care* or *uncompensated care* should be counted and what exactly is included in these categories. Two other disparities are determining when charity care becomes *bad debt* – and agreeing on the relative role of *contractual allowances*? Much of this disagreement stems from varying definitions of these basic terms.

Definitions: The following section attempts to define the key terms used by the various national and state databases related to hospital community benefit information.

Charity care (according to the Catholic Health Association) is defined as:

“free or discounted health services provided to persons who cannot afford to pay and who meet the organization's criteria for financial assistance. Generally, a bill must be generated and recorded and the patient must meet the organization's criteria for charity care and demonstrate an inability to pay. Charity care should be reported in terms of costs, not charges. Charity care does not include bad debt.

Count:

- Free and discounted care

² It should be noted that the most widely used format for reporting community benefits is the “Community Benefit Reporting: Guidelines for Standard Definitions for the Community Benefit Inventory for Social Accountability” (2006), prepared by the Catholic Health Association and Voluntary Hospitals of America (CHA/VHA). Congressional representatives have called for these guidelines to be adopted for national use (Grassley 2006) and recent revisions by the Internal Revenue Service have generally followed the categories outlined in these guidelines.

- Expenses incurred by the provision of charity care
- Indirect costs not already included in calculating costs
- Do not count:
 - Bad debt
 - Contractual allowances or quick-pay discounts
 - Any portion of charity care costs already included in the subsidized health care services category (This would constitute double-counting.)”²

Uncompensated care is defined by the American Hospital Association as:

“ . . . an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided. This happens when patients are unable to pay their bills, but did not apply for charity care, or are unwilling to pay their bills. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.”³

Bad debt is further defined by the American Hospital Association as:

“ . . . services for which hospitals anticipated but did not receive payment. Charity care, in contrast, consists of services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay. In practice, however, hospitals have difficulty in distinguishing bad debt from charity care.”⁴

The differentiation of bad debt from charity care is contested both in the definitions by the various agencies but also in the congressional hearings. Much of the debate has to do with processes (i.e. how “aggressively” does a hospital

² The definition is from the website of the Catholic Health Association, “What Counts as Community Benefit.”
<http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/whatcounts/> (last accessed 9/24/2008).

³ “Uncompensated Hospital Care Cost Fact Sheet” (October 2006) .
www.aha.org/aha/content/2006/pdf/uncompensatedcarefs2006.pdf (last accessed 9/24/2008).

⁴ Ibid.

attempt to collect a bad debt/charity care bill) rather than actual designations.

The American Hospital Association elaborates:

“Hospitals typically use a process to identify who can and cannot afford to pay, in advance of billing, in order to anticipate whether the patient’s care needs to be funded through an alternative source, such as a charity care fund. Hospitals also identify patients who are unable to pay during the billing and collection process. Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt. Bad debt is often generated by the medically indigent and uninsured, making the distinctions between the two categories arbitrary at best. Therefore, it is reasonable to consider bad debt as a component of hospitals’ total cost of care to the medically indigent and underinsured.”⁵

Contractual allowances are defined as “the difference between billed charges and unreimbursed costs,” which primarily refer to third party payers and can be termed as really sales discounts.”⁶ The precise definition of *contractual allowances* varies between states and usually refers only to the discounts hospitals give to private insurance carriers. However it may also refer to the shortfalls of costs (not charges) between what state governments reimburse for Medicaid patients and/or what the federal government reimburses for Medicare patients – also termed “government-sponsored health care community benefits”

by the Catholic Hospital Association:

“Government-sponsored health care community benefits include unpaid costs of public programs—the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. It does not include any shortfall that results from inefficiency or poor management.

⁵ Ibid.

⁶ Cleverly, William O., *Handbook of Health Care Accounting and Finance*, 2nd edition, Rockville MD: Aspen Publishers (1989) P. 274.

Count: Losses related to:

- Medicaid shortfall
- State Children's Health Insurance Programs (SCHIP)
- Public and/or indigent care: Medical programs for low-income or medically indigent persons
- Days, visits, or services not covered by Medicaid or other indigent care programs

Do not count:

- Medicare shortfall (This can be included in other financial reports but not in a quantified community benefit report.)⁷

The CHA maintains that Medicaid shortfalls should be included in charity care as these programs serve the indigent and represent losses incurred by a hospital in serving this population. One additional distinction is whether shortfalls from Medicare patients (applying to all patients over age 65, regardless of their financial situation) should also be counted. The CHA maintains that these shortfalls should not be part of the charity care formula:

“CHA recommends that hospitals not include Medicare losses as community benefit. The reasons are:

- If there are specific programs with large numbers of vulnerable Medicare patients, and if these programs lose money, then they can be included in “subsidized health services.”
- The point of prospective payment was to make facilities efficient. Medicare losses for some hospitals may be associated with inefficiency, not underpayment.
- In many communities, Medicare is one of the best payers. Per diem and per case payments can be higher for Medicare than for managed care payers.
- Serving Medicare patients is not a true, differentiating feature of not-for-profit health care. Hospitals of all kinds compete aggressively to attract Medicare patients. This is not true of Medicaid and charity care patients.
- Including Medicare jeopardizes the credibility of the community benefit report.”⁸

⁸ Catholic Health Association, “What Counts as Community Benefit” (available at: www.chausa.org/Pub/MainNav/ourcommitment/CommunityBenefit/whatcounts last accessed 9/24/2008).

⁸ Ibid.

Definitions can be significantly different between different agencies, even when applied to charity care, a concept that initially appears to be fairly straightforward. Table 2A shows the discrepancy between the AHA and the CHA/VHA criteria that relates specifically to charity care. The table also includes the information that will be gathered by the new Schedule H, from the IRS.⁹

Table 2A: Comparison of Community Benefit and Charity Care Criteria

	Uncompensated Care – including bad debt	Charity Care	Shortfall from Medicaid	Shortfall from Medicare
American Hospital Association	X	X		
Catholic Health Association		X	X	
Collected in the New IRS Form 990: Schedule H	X – collected, But NOT included in Community Benefit cost data	X	X	X – collected, But NOT included in Community Benefit cost data

Considerations on existing databases: Existing healthcare databases provide comprehensive information on inpatient and outpatient categories of disease and outcomes. But these do not focus on the breadth of outreach activities included in community benefit nor do they provide extensive financial data, especially on uncompensated care, charity care, and other community benefit elements. Current nonprofit databases also can have questionable validity.¹⁰ Even the audited financial reports of individual hospitals – the defined “gold standard” of

⁹ See Exhibit 2B, below. Note that the IRS Schedule H collects additional information on bad debt and Medicare shortfall that is not part of the Community Benefit Costs.

¹⁰ See Gronbjerg (2002) for an assessment of nonprofit databases.

financial reporting – vary in detail and are not easily accessible to the public. In this absence, individual states have initiated various reporting requirements, with variations in public availability. Concerns over the validity of the IRS Form 990 further complicate the question of available valid data (Gordon et al 2007, Keating and Frumkin 2003, Froelich, Knoepfle, and Pollak 2000, Froelich and Knoepfle 1996).

Validity of data is important to accountability but also as an aid to organizational planning. Reliable data ensures that fraud is not occurring as well as identifies an organization's most effective programs, for both internal and external application (Brody 2001). Public policy uses reporting requirements to ensure their priorities are being met. However if the priorities are mistakenly identified, reporting processes may not encourage those activities that are most beneficial to the public benefit. If the areas identified in this paper as philanthropic behavior have an intrinsic value to society, limitations on collecting and reporting the data can dilute the societal effectiveness of nonprofit organizations.

The limitations of these databases become evident when the data is refined to apply to philanthropic behavior. One example of this limitation is whether the *donation* and *health promotion* figures represent gross or net expenditures.

Looking at only the hospital financial reports further complicates the donation category, by not considering the actions of an associated hospital foundation – which may contain donation activity and in some cases health promotion

programs. A key question is whether donations to the hospital foundation are considered when reporting contributions – a question that does not seem to be addressed in any of the existing databases or their critiques.

Pervasive weaknesses in the constancy, comprehensiveness, and reporting availability – among national and state sources, as well as from individual organizations – highlight a concern whether additional reporting criteria will in reality provide any better understanding of the activities of nonprofit organizations in general and of nonprofit hospitals in particular. Conversely a more focused categorization based on philanthropic behavior could lead to more consistent reporting and evaluation standards. Even the revised IRS Form 990 (for nonprofit organizations) and Schedule H (for nonprofit hospitals), while being a major step in the right direction, still fails to capture some of the information that might be most important to properly compare and evaluate differing institutions. It is one contention of this paper that the political policy focus on charity care has diminished the attention to health education programs of nonprofit hospitals – a critical element of assessing philanthropic behavior, and potentially of community benefit itself.

Desired Database Criteria for Philanthropic Behavior

To evaluate community benefit, two key data sets are required. The first is uncompensated care that distinguishes between charity care, Medicaid shortfall, Medicare shortfall and bad debt. The second is financial data identifying expenditures for additional community benefit areas, i.e. research, education, health promotion, and donations. To further evaluate philanthropic behavior, two other criteria are essential. One is income data for health promotion and donations, as well as expense data. The other is multi-year financial information (at least three years) that is readily available to the public.

Other considerations for a valid database include whether the community benefit information is collected and centralized for public reporting purposes or left scattered throughout financial reports – and whether it is readily available to the general public in an easily-understood format or might only be accessible by researchers willing to go to the time and effort to seek out the data on site, pay for it, and/or scour through reports for the information. One other attribute of a valid database is whether the information is collected by an agency of the state government or by the state hospital association. This is important because reports from state hospital associations can tend to mirror the standards from the AHA, while state government agencies might be more reflective of legislative regulations.

Indiana provides a test case for this information using a database collected and reported by the Indiana State Department of Health (ISDH). This database provides multi-year information with all community benefit elements easily and consistently identifiable through a convenient, publicly available format. How valid it is as a database for determining nonprofit philanthropic behavior is one of the objectives of this study.

National Databases

The two primary national databases reporting hospital operations are the annual survey of its membership by the American Hospital Association and the yearly reports required by the Centers for Medicare and Medicaid. Both of these databases have limitations in their use for evaluating community benefit. Information from the Internal Revenue Service on nonprofit hospitals can also be found via individual hospital 990 forms (publicly available through *guidestar.org*). None of these existing national databases are particularly satisfactory for analyzing community benefit, although revisions to the IRS Form 990 attempt to address this situation.¹¹

The American Hospital Association (AHA) conducts an annual survey of more than 5,000 hospitals in the United States and makes the results of this survey available through their *AHA Guide to the Health Care Field* (2006a) and *AHA*

¹¹ Two helpful summaries of the available national databases are: Needleman (2003) and Gray and Clement (2002). Another useful source is Wynn, et al (2002) and a critique of databases related to hospital ownership is Mitchell et al (2001/2002).

Hospital Statistics (2005).¹² While these two compilations from the AHA have much information on hospital ownership, size, and services, their use in determining community benefits is limited. One of the categories in the survey is uncompensated care, but financial information specific to an individual hospital (beyond total expenses) is not made public. The AHA does publish an aggregate summary of uncompensated care provided by hospitals during the year, which includes estimated bad debt and charity care costs but not costs associated with Medicaid or Medicare shortfall (AHA 2006b). Details on the breakdown of the uncompensated care figures are not included nor are data on other areas of community benefit.

The Centers for Medicare and Medicaid Services (CMMS) annually collect Medicare Cost Reports as part of their reimbursement process. While these reports do have a wealth of service and financial data they also have limited applicability for determining community benefit, as uncompensated care information or other information on community benefits is not collected. As these reports are not audited, there have also been questions as to the validity of the information shared.¹³

The previous two sources are also expensive for the public to acquire, although the *AHA Guide* is often available in local community and educational libraries. A

¹² For an evaluation of the AHA data see Mullner and Chung (2002): pp. 614-618. Some of the limitations found in the reports are noted as the voluntary nature of the reporting, lack of independent verification, errors in reporting, and a low response rate.

¹³ See: Kane and Magnus (2001) and Chen, et al (2004).

free source to nonprofit hospital financial data is available through www.guidestar.org, which includes access to the Form 990 completed by all nonprofit hospitals in the United States. However, until recently the value of these forms related to community benefit has also been marginal, as there have not been specific requirements by the IRS to detail expenditures on charity care, uncompensated care or other forms of community benefit. Selected hospitals may choose to include information on these programs in supplementary materials, but this has been a voluntary provision and is not consistent or suitable for comparisons or analysis.

Revised Form 990 and Schedule H

Starting in 2009 the Internal Revenue Service (IRS) will require nonprofit organizations to complete a revised IRS Form 990. Nonprofit hospitals will be asked to also submit a Schedule H form that will more definitively identify expenditures related to community benefit. These revisions culminate a three-year process prompted by the Congressional challenges related to nonprofit oversight.¹⁴ The general format mirrors the guidelines developed by the Catholic Health Association and the Voluntary Hospitals of America (CHA/VHA) and are projected to cause few reporting problems for those hospitals that have been in compliance with those guidelines. However, these impending changes have encouraged many other hospitals to better collect and report the level of community benefit they provide. The purposes of the revised Form 990 include

¹⁴ This summary, and detailed overviews of the revisions, are available from the Internal Revenue Service website <http://www.irs.gov/charities/article/.id=176613.00.html>.

promoting improved transparency, increased compliance, and reduced reporting burdens. The third purpose is accomplished by expanding the ability of smaller organizations to file the shorter 990-EZ¹⁵ form. Other key changes to the Form 990 are:

Exhibit 2A: Summary of key changes to the IRS 990, for tax year 2008

- Revised Summary Page, incorporates a two-year financial summary
- Moves program description information, following the summary (page 2)
- A checklist of supplementary schedules¹⁶
- Revised and expanded governance and compensation sections

Evaluation of National Databases – The national databases, with the exception of the IRS Form 990, are relatively ineffective as evaluation tools for community benefit. The revised IRS Form 990 – and especially the Schedule H for nonprofit hospitals – does attempt to address the need for reliable information on community benefit and philanthropic behavior. It will identify and make public information on charity care vs. uncompensated care, information on all areas of community benefit, and income data for programs as well as expense.¹⁷ For the

¹⁵ The 990-EZ form may be used by any nonprofit organization under \$1 million in gross receipts or with assets under \$2.5 million (in 2009). It might be assumed that the Schedule H would also need to be completed for any hospitals that fall in this category – an assumption that is theoretical rather than practical, since the income of community hospitals generally far exceeds \$1 million. ¹⁶ Including Schedule H, for nonprofit hospitals.

¹⁷ While there is not an explicit statement that www.guidestar.org and other sources that collect the IRS 990 forms will also include the Schedule H, there is every expectation that this information will be included, as currently numerous supplements to the form are included. As the new form is only starting to be required by the IRS in 2009, the earliest that the inclusion of Schedule H will be able to be verified will be in 2010.

first two or three years only limited multi-year information will be collected, but this limitation will be addressed as the new form continues to be used.

Exhibit 2B:
Summary of Schedule H “Hospitals” supplement to revised Form 990

Part I: Charity Care and Certain Other Community Benefits at Cost

- Part I: Lines 1a-6b – including:
 - 10 Qualitative (yes/no) questions on community benefit policies and practices
- Part I, Line 7: Charity Care and Certain Other Community Benefits at Cost
 - Activities and costs of “Charity Care and Means Tested Programs” – 3 categories
 - Activities and costs of “Other Benefits” – 6 categories

Part II: Community Building Activities – 9 categories including:

- Activities and costs of Economic development, Environmental support, and community health advocacy

Part III: Bad Debt, Medicare, and Collection Practices

- 1 Qualitative (yes/no) question and 2 financial figures on Bad Debt expenses and practices
- 3 financial figures on Medicare revenue and costs, including the accounting method used to arrive at those figure
- 2 Qualitative (yes/no) descriptions of Collection Practices of debts

Part IV: Management Companies and Joint Ventures

- Ownership descriptions and percentages

Part V: Facility Information

- Describing the various types of health-related facilities operated by the entity

Part VI: Supplemental Information

- 8 Qualitative descriptive narratives expanding upon the various (above) areas

Part 1, Line 7 is the primary area of interest to this paper and for determining the philanthropic behavior of nonprofit organizations. The information that will be gathered in this section is outlined in Exhibit 2C:

***Exhibit 2C: Part I, Line 7
Charity Care and Certain Other Community Benefits at Cost***

- Activities and costs of “Charity Care and Means Tested Programs”
 - a. Charity Care at Cost
 - b. Unreimbursed Medicaid
 - c. Unreimbursed Costs – Other Means-tested Government Programs
 - d. **(TOTAL Charity Care and Means Tested Programs)**

- Activities and costs of “Other Benefits”
 - e. Community Health Improvement Services and Community Benefit Operations
 - f. Health Professions Education
 - g. Subsidized Health Services
 - h. Research
 - i. Cash and In-kind Contributions to Community Groups
 - j. **(TOTAL Other Benefits)**
 - k. **(TOTAL – line 7d and line 7j)**

One shortcoming of Schedule H of the revised Form 990 is that donations (Line 7i: “Cash and In-kind Contributions to Community Groups”) do not necessarily include the activities of a related hospital foundation. Also each of the above areas have extensive worksheets that accompany the categories, but according to the Schedule H instructions these worksheets are not to be filed with the Schedule H, so will not be available for public viewing or available to oversight agencies and researchers.

One other concern is that currently many hospitals detail their community benefit activities in supplements to their Form 990 – providing extensive detail on such

areas as specific expenditures on health programs and donation activities. It's hoped that these hospitals will continue to provide such information as it can provide a high level of detail to anyone who wishes to search for such information. However, such supplements are voluntary and with more extensive formal criteria, it could be that the supplemental information will no longer be included. An additional ongoing limitation to data from the IRS Form 990 is the problem of their validity. They are subject to limited audited scrutiny, meaning that figures noted in various categories may or may not be reliable or uniform. But overall the revised Form 990 and its accompanying Schedule H seem to be positive steps toward providing increasingly useful information on hospital community benefit. In the future, one other improvement might be to require this type of reporting not only from nonprofit hospitals but also from public and for-profit entities.

State Community Benefit Requirements and Databases

A 2008 study in Montana tried to follow the IRS Schedule H criteria, utilizing a survey from the attorney general's office as well as IRS 990 forms. They categorized the components into eight categories: Charity Care, unreimbursed Medicaid costs, unreimbursed costs for other government programs, community health improvements, health professions education, subsidized health services, research, and donations. They found the results were inconclusive due to hospital reporting inconsistency (with the exception of charity care and Medicaid costs), in both the survey and the 990 forms (White 2008). This problem of data

variability is something that the many states attempting to define these standards have had to face. However, these limitations have not prevented states from attempting to define and enforce varying community benefit efforts.

During the past twenty years, in the absence of federal community benefit guidelines, many states have led the legislative and judicial efforts to define community benefit. Some states have challenged the tax-exemption of nonprofit hospitals. However as of 2008, no nonprofit hospital has lost its tax-exempt status solely on the basis of failing to provide a determined level of community benefit (Salinsky 2007). Court challenges in three states in the late 1980s led to legislative actions in the 1990s and the development of various state guidelines give examples of this process. However these cases led to little agreement among the states on how those guidelines should be structured and applied. The following timeline (Exhibit 2D) shows how the challenges to nonprofit hospitals in state courts have led to individual state legislatures passing more defined community benefit requirements. In the following cases, the legislative actions were joint efforts between a state hospital representatives and government officials to codify the guidelines as a way to protect nonprofit organizations from judicial decisions.

The 1985 case of *Utah County v. Intermountain Health Care* marked the first time in recent U.S. history (i.e. since the enactment of the 1969 community benefit standards) that local tax assessors successfully challenged the tax-exemption of

two hospitals and prevailed.¹⁸ The state Supreme Court ruled that the hospitals were not charities since devoted less than one percent of their gross revenues to charity care, and that they “confuse[d] the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide” (Utah County v. Intermountain Health Care, Inc. 709 P.2d 265 (Utah 1985) at 276). In response to this judicial action, Utah’s hospitals and tax commissioners developed proposed standards that were adopted by the state’s legislature in 1990. The Utah State Supreme Court upheld the constitutionality of these guidelines in 1994 (Fremont-Smith 2004, p.131).

In 1985, the Pennsylvania Supreme Court ruled against a hospital support organization in *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985). They issued a five-prong test to establish if an entity is a public charity, including: advances a charitable purpose; donates or renders gratuitously a substantial portion of its services; benefits a substantial and indefinite class of persons who are legitimate subjects of charity; relieves the government of some of its burden; and operates entirely free from private profit motive. Following that ruling other states made similar challenges including noteworthy challenges in Vermont, New Hampshire and Texas, but none prevailed until 2002 when the Director of the Illinois Department of Revenue, brought suit against a hospital in *State of Illinois v. Provena Covenant Medical Center*. As of mid-2008, the case

¹⁸ Between 1928 and 1956 (when the IRS 501(c) rulings were applied to hospitals), several states had challenged the tax exemption of hospitals on the grounds that they did not meet the presumed charitable standard of providing services for the poor (see Mancino 1988).

was still in appeal but subsequently the Illinois legislature has passed more definitive community benefit standards.

A brief historical time line of key state activities illustrates the evolution of these court challenges and the subsequent legislative actions by various states:

Exhibit 2D: State Community Benefit Court and Legislative Actions

State court cases – 1985-1989:

1985 – Utah County v. Intermountain Health Care [Utah]

- Tax exemption revoked – and the court enumerated charity guidelines that apply to hospitals

1985 – Hospital Utilization Project v. Commonwealth [Pennsylvania]

- Tax exemption revoked – and the court enumerated charity guidelines that apply to hospitals. NOT a hospital, but rather a nonprofit hospital support organization;

1989 – Medical Center Hospital of Vermont, Inc. v. City of Burlington [Vermont]

- Tax exemption upheld

1989 – Dartmouth Hitchcock Medical Center et al v. City of Lebanon [New Hampshire]

- Tax exemption upheld

State Legislation – 1990 and forward:

1990: New York becomes the first state to propose state CB legislation¹⁹

- Six others followed with reporting requirements - - - including Indiana.
- Massachusetts initiated voluntary reporting

[Bold = first eight states to enact reporting requirements]

[Italics = significant subsequent state court cases]

1990 – Utah

1991 – New York

1993 – State of Texas v. The Methodist Hospital [Texas]

1993 – Texas

1994 – Indiana

1994 – Massachusetts (voluntary)

1995 – California

1997 – Pennsylvania

1999 – Idaho

¹⁹ Coalition for Nonprofit Health Care 1999.

2000 – New Hampshire
2000 – Rhode Island
2002 – *State of Illinois v. Provena Covenant Medical Center [Illinois]*
2004 – Illinois

As the above notes, Indiana was the fourth state to legislatively require reporting of community benefit activity and the second (after New York) to do so without a preliminary court case. In looking at the relative timing of the court cases and the legislation, it can be seen that it is the court rulings that have had a greater affect on revoking tax exemption than the legislation. In fact it could be conjectured that the primary result (if not the purpose) of legislation is less as a punitive measure than to define the guidelines and encourage compliance.

State Databases

State regulations require varying levels of information reporting processes, with corresponding variability in existing and publicly available databases. Much of this variability is due to their origins in satisfying the specific challenges and rulings from the court cases, rather than being prompted by legislative initiatives.

The National Association of Health Data Organizations (NAHDO) does attempt to collect information on the available state databases covering a variety of hospital procedures and services. However, as in the case of a majority of the national resources, community benefit information is not one of the areas addressed by the NAHDO. Individual states have recently begun to require more specific information on hospital financial operations, including data related to community benefit programs. While the types of information and reporting process vary

across states, many states do provide information that can be helpful to researchers seeking to investigate community benefit behavior.

Several health agencies and consumer advocacy organizations have provided summaries of the states that have community benefit regulations and/or reporting requirements. However, they reveal a wide difference in defining exactly reporting community benefit might mean as well as some discrepancy in identifying which states require which level of accountability. The fluid ever-changing nature of state legislation in this area also limits the comprehensiveness of these compilations. They also vary on whether they focus on charity care procedural guidelines, specific charity care data, a broad range of community benefit processes, or specific community benefit data. Some of the more reliable sources include those compiled by the Minnesota Department of Health (22 states: 2007), the Congressional Budget Office (5 states: 2006), the Missouri Foundation for Health (22 states: 2005), Community Catalyst (47 states: 2003b; 15 states: 2003c), and the Coalition for Nonprofit Health Care (22 states: 2001; 8 states: 1999). The most recent report is from Minnesota (Minnesota Department of Health 2007), and is included in Appendix 2-A, although this compilation does not include all states especially those that require fairly loose reporting requirements. It must be cautioned that not only do different compilations reflect a wide spectrum of state reporting criteria (especially related to whether qualitative reporting include “normal” hospital fiscal reports needed for

Medicaid reimbursement purposes) but also as the compilations become older, the more probable it is that they are out of date.

The hospital financial reports (which can help identify various community benefit line items) required by most states are also somewhat limited, although as of 2001 twenty states collected financial reports that were publicly available in some fashion (Coalition for Nonprofit Healthcare 1999, 2001). Exhibit 2E compiles a list of the states that require Prescriptive (quantitative) reporting from those that ask only Process-oriented (qualitative) standards:

Exhibit 2E: States that Require Prescriptive (Quantitative) Community Benefit Reports and Process-Oriented (Qualitative) Community Benefit Reports²⁰

States that Require Reporting to Meet Prescriptive (Quantitative) Community Benefit Standards

Pennsylvania
Texas
Utah

States that Require Process-Oriented (Qualitative) Community Benefit Reporting

Arizona New Hampshire
California New Jersey
Colorado New York
Florida Ohio
Georgia Oregon
Idaho Rhode Island
Indiana South Dakota
Louisiana Virginia
Massachusetts

Needleman (2003) identifies California, Massachusetts and New York as requiring particularly detailed financial reports and Gray and Clement (2002) single out Texas and Indiana as having a desirable level of detail and public

²⁰ Based on information from the Coalition for Nonprofit Healthcare (2001) and updated using various additional sources including Minnesota Department of Health (2007) and Community Catalyst (2003b).

availability specifically related to community benefit information. The Congressional Budget Office (CBO 2006) focused on California, Florida, Georgia, Indiana, and Texas for their study of uncompensated care – emphasizing that these were five states that did have reliable data. However Florida and Georgia have limited information available on community benefit measurements beyond uncompensated care. The Consumer Health Ratings (n.d.) identifies Indiana, Minnesota, and Missouri as including community benefit information beyond basic financial information.²¹ The Coalition for Nonprofit Healthcare (1999) identifies three states that require quantitative (*prescriptive*) reporting of community benefits: Texas, California, and Pennsylvania. The state of Utah also has a quantitative requirement for tax exemption, although public reporting is not required (Minnesota Department of Health 2007, p. 22).

Research into State Provision of Charity Care and Other Community Benefits

Many researchers have investigated the provision of community benefit in different states at varying levels of detail and analysis. Some of these have focused on qualitative efforts (Process-oriented approaches) while others have tried to analyze quantitative efforts (Prescriptive approaches). Most of the studies that have addressed the prescriptive approach have focused on charity care and/or other types of uncompensated care. A few have also looked at other aspects of community benefit. The research shows a wide variability in the

²¹ Available at http://www.consumerhealthratings.com/index.php?action=showSubCatsandcat_id=213 (accessed 2/10/07).

availability of certain types of data as well as in the potential limitations of available data.

Most of the broader state summaries were done during the 1990s. More recent scholarship tends to focus on individual states. The broad studies include community benefit but also topics such as legislative attitudes toward nonprofit hospital tax exemption (Jervis 2005),²² health reform and the uninsured (Paul-Shaheen 1998), the status of state laws (Sullivan and Karlin 1999), looking at the different effect of voluntary or legislated standards (Boraks 1995), and observations on the potential effects of federal and state policies (Rosenberg 1994, Moskowitz 1993).

Recently researchers have tended to look more specifically at individual states. Since the mid-1990s, California has probably had the most scrutiny of hospital charity care and other community benefit programs. California is particularly attractive for research as its healthcare data is readily available and detailed and the state has a wide variety of market conditions, including a mix of rural vs. urban facilities and for-profit and nonprofit hospitals.²³ Gruber (1994) examined the effect that “price shopping” for hospital services by insurers had on the level of uncompensated care provided by California hospitals. It concluded that a lack of competition also leads to lower levels of uncompensated care.

²² While Jervis' paper is dated 2005, the study it was based on was conducted in 1996. ²³ Jervis 2005, p. 64, n. 65.

Clement, Smith and Wheeler (1994) studied California hospital community benefit practices and helped establish criteria for measuring community benefit. The definition of community benefit they used was extremely broad and in addition to uncompensated care (inclusive of bad debt) and services below cost, they also included net income as a community benefit. They defended this inclusion by maintaining net income was used for future investment in health care in the community, and therefore constituted a community benefit asset. They evaluated the expenditure on community benefit against total hospital assets, providing possible comparative median figures for California hospitals between 1980 and 1987. Clement, Smith and Wheeler concluded that while hospitals did tend to meet the standards (using their criteria) the level of community benefit declined over time and there was a need for hospitals and communities to work more closely to establish mutually beneficial standards into the future.

A study of California hospitals by Buchmueller and Feldstein (1996) differentiated process-based criteria from quantitative standards. Their study reflected California's actual procedural community benefit criteria that emphasizes community benefit needs assessments and plans rather than quantitative standards. It is one of the few studies to look at community benefit elements besides charity care or uncompensated care.

Two doctoral dissertations used California data to assess community benefit. One (Pfaff 1999) offers a comparison of the level of uncompensated care

between California and Pennsylvania (a state with quantitative standards) and concludes that state legislation has an effect on the behavior of nonprofit hospitals. The second dissertation (Finocchio 2001) looks at changes in uncompensated care in California hospitals from 1994-1998. It emphasizes the complexities of determining uncompensated care, determining which elements to include, and varying methods of measuring those elements can dramatically affect a hospital's ability to meet varying community benefit measurement standards. One of its conclusions is that nonprofit hospitals may be "maxing out" the amount of charity care they can reasonably provide and that increasingly stringent regulations may not have the effect of providing an increased level of charity care by nonprofit hospitals.

Other California studies have indirectly included community benefit analysis as part of assessing the level of the "non-poor uninsured" (Yegian et al 2000) and the changes in hospital ownership from 1986-1996 (Spetz, Seago and Mitchell 1999).

Texas – A Model for Defined Quantitative Standards? Texas

was one of the first states to pass legislation addressing community benefit and it is one of the few states that have very defined quantitative standards for reporting community benefit. Its criteria are also the most rigid of the states that have instituted quantitative or prescriptive criteria.²⁴ This is helpful

²⁴ The other two *prescriptive* states are Utah (total Community Benefit as 1-1.5% of operating costs) and Pennsylvania (total Community Benefit as 3% of operating expenses). See below.

as it can seemingly provide a comparison for other states to determine how well they provide community benefits. On the other hand how these quantitative standards are defined and reported – even by state agencies – actually can illustrate some of the problems involved with determining community benefits.

The standards in Texas are fairly straightforward. Texas has a standard that Charity Care should be either 4% of Patient Revenue or that all Community Benefit expenditures should be 5% of Patient Revenue.²⁵ Enacted in 1993, the Texas legislature determined that there are three potential measurements that can be used. Individual hospitals need to satisfy any one of these three requirements, and hospital systems may choose to consolidate the expenditures of the entire system.

The Texas standards are:

1. Charity Care plus Community Benefit = 5% of Net Patient Revenue
2. Charity Care plus government-sponsored Indigent Care = 4% of Net Patient Revenue
3. Charity Care plus government-sponsored Indigent Care = 100% of the value of a hospital's tax-exemption, excluding federal income tax

The accompanying definitions provide further explanation:

- *Charity Care*: Unreimbursed cost of providing care to patients who are financially indigent (income below 200% of the federal poverty line) or

²⁶ Texas Health and Safety Code Section 311.045.

medically indigent (income over 200% of the federal poverty line, but lack cash assets to pay outstanding medical bills).

- *Community Benefits*: Unreimbursed cost of providing charity care and government-sponsored indigent care – AND donations, education, government-sponsored program services, research, and subsidized health services.
- *Government-sponsored Indigent Care*: Primarily costs associated with Medicaid.

These definitions provide several examples of the confusion and misconceptions that can surround community benefit, not only in Texas but also throughout the United States. First, costs associated with treating Medicaid patients (*Government-sponsored Indigent Care*) are defined as being separate from *Charity Care*. This is a significant point, as political and public perception can be that Charity Care applies to all those who are financially indigent. In practice many of the poorest patients qualify for Medicaid and therefore are considered as being insured. The Texas definitions clearly define and combine those categories. However, many other state and national criteria do not always make such a clear distinction. A second source of potential confusion is found within the Texas definitions and formulae themselves. While the definition states that Community Benefit *includes* Charity Care and Government-sponsored indigent care, the first standard states that the 5% standard should be determined by combining Charity Care *plus* Community Benefit (emphasis added). This could

lead to the implication that Charity Care can be counted twice (but not Government-sponsored care). It can be logically concluded that this duplication is not intended, but the potential confusion remains.

The second standard (Charity Care plus government-sponsored Indigent Care = 4% of Net Patient Revenue) seems less confusing than the total Community Benefit standard. However a complication arises from the report prepared from this information by the Texas Department of State Health Services. They report not on Charity Care but on Uncompensated Care (including Bad Debt) and compare this to Gross Patient Revenue (rather than Net Patient Revenue).²⁶

Other States with Quantified Standards and Required Reporting of Expenditures

The Texas standards provide one set of benchmarks for comparisons with other states. The other two states with quantitative or *prescriptive* standards – Pennsylvania and Utah – also provide potential benchmarks, although the standards they present are relatively low. Utah evaluates whether the total level of community benefit (including charity care) is equal to the value of a hospital's property tax exemption, defined as 1-1.5% of annual gross operating expenses. Pennsylvania considers a minimum level of community benefit to be 3% of the institution's operating expenses (Noble, Hyams and Kane 1998, p. 121). Both of these standards have been established by the state legislatures, following state court rulings.

²⁶ "Texas Acute Care Hospitals Fact Sheet" prepared by Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services (2003): www.tdh.state.tx.us/chs/hspssurv.

Other standards used or averages found by researchers involve Uncompensated Care rather than Charity Care – and include Uncompensated Care as 4.5% of Net Patient Revenue (Mann et al 1995) or as 6% of Operating Costs (Mann et al 1997), or as 2.8% of total charges in Minnesota in 1996 – compared to 6% nationally (Blewett et al 2003). The Hill-Burton Act of the 1950s and 1960s established a target figure of 3% of operating costs (ibid). The Congressional Budget Office found that in the five states it studied, Uncompensated Care as a percentage of hospitals' operating expenses was higher at government hospitals (13.0%) than at nonprofit hospitals (4.7%) or for-profit hospitals (4.2%) (CBO 2006, p. 2). The CBO report also provides an estimate of the value of various tax exemptions provided to nonprofit hospitals for the year 2002.

Minnesota

Minnesota Department of Health (2007) conducted an in-depth analysis of community benefit expenditures in the state for 2005. It used multiple survey methods²⁷ and accessed a variety of state records to assess not only a comprehensive picture of the levels and types of community benefit provided by Minnesota hospitals but also the various values of their tax exemptions.

This study is one of the more recent and comprehensive analyses of a state's community benefit provision – and its categories anticipate the IRS Form 990

²⁷ These methods include examining publicly available data, conducting a special survey of Minnesota hospitals, using information from a Minnesota Hospital Association survey, and augmenting this information with data and a survey from the Minnesota Department of Health (Minnesota Department of Health 2007, p. 2).

Schedule H format. It is also based on the CHA/VHA guidelines, mirroring the Schedule H format. It is this study that forms the basis for the Indiana study that is part of this dissertation.

The Minnesota report (2007) noted that even though they had access to a variety of governmental and survey data, the results were at best a rough estimate.

Their caveats are applicable to any method that attempts to capture this type of information. They identified three limitations, which could apply equally to the examples of the states shared earlier in this chapter. First despite extensive and multiple follow-ups, the results were marred by missing information. On any form, information may not be included because a hospital was unable to quantify the question, or did not have activities to report, or merely chose not to report it.

A second limitation was differences found between information reported on the survey and comparable information from a hospital's annual report. And a third limitation was uncertainty about the consistency of data across hospitals. Many categories could be interpreted in different ways and included differing factors in their totals. These concerns are magnified if tried to apply to a much larger field of hospitals in the country, with a minimum of oversight and follow-up as well as only single contacts or sources.

Nonprofit Hospital Databases – A Summary

The wide variety of state standards, methodologies, and data sources illustrate the problem that researchers and oversight agencies face when trying to define objective standards for nonprofit hospital community benefit – much less to compare them across states. The caveats to the Minnesota study emphasize that this process is far from being an exact science. The IRS Form 990 revisions and development of Schedule H should help to provide a partial remedy for this situation and for the first time establish a nation-wide format for reporting of community benefit activities. Yet many of the complexities and limitations noted above will remain. These drawbacks could be an indication that a simpler methodology might also be called for, such as identifying philanthropic behavior. In the absence of alternatives, it is possible that only partial data will be reported as being “significant:” namely, charity care. This could lead to discouraging the very type of organizational behavior that the public sector most wants to encourage from nonprofit hospitals.

While future studies may be able to utilize a vastly improved national database to evaluate community benefit activities, current researchers still face existing limitations. One of the more obvious omissions in current research in this area is a lack of studies of Indiana hospitals – especially considering the strength and longevity of their database. As Gray and Clement (2002) noted, Indiana is one of two states with a particular level of detail and public availability related to community benefit information. Indiana could also be considered as an

“average” U.S. state, particularly in terms of size and geographic location, providing a potential model for testing policies and activities that may have a national intention. The next section of this paper looks specifically at the types of available data and reports that are available from Indiana.

The Indiana Hospital Database

The Indiana database appears to be one of the more comprehensive and accessible databases for analyzing the community benefit expenditures of nonprofit hospitals. It also has the advantage of providing information on for-profit and public hospitals, although not with the depth of information as there is for nonprofit hospitals. The drawbacks revolve around the data being self-reported and unaudited. This not only can lead to questioning the validity of the data, compounded by notable discrepancies in reporting from year-to-year, even by the same hospital.

Background of the Indiana Community Benefit Regulations

In 1994 Indiana enacted legislation requiring the reporting of financial information by all hospitals and of community benefits by nonprofit hospitals in the state. Prior to this action, Governor Evan Bayh had called for a repeal of hospital tax exemption although there was no evidence that Indiana hospitals were not being charitable (as was not the case in Utah or Pennsylvania). At the time Indiana collected very little hospital data, including charity care. A measure to require a defined level of charity care and community benefit expenditures was proposed,

but then abandoned in favor a process-based requirement focused on planning and reporting.²⁸

Indiana laws regulating the hospital reporting of community benefits are contained in two regulations: the *Hospital Financial Disclosure Act* (IC 16-21-6) and the *Provision of Charitable Care by Nonprofit Hospitals* (IC 16-21-9).

The *Hospital Financial Disclosure Act* (IC 16-21-6)²⁹ defines the annual financial data that needs to be filed with the Indiana State Department of Health by all hospitals in Indiana (IC 16-21-6-3) as well as the patient information (IC 16-21-6-6). The financial data includes charity care³⁰ and bad debt³¹ as well as contractual allowances³² from government programs. It also reports donations, research and education – including professional education, patient education, and community health education.

²⁸ Coalition for Nonprofit Health Care (1999), pp. 1-2; Sullivan and Karlin (1999), pp. 288-289. ²⁹ The Indiana Code IC 16-21-6-1 – IC 16-21-6-12 is found at <http://www.in.gov/legislative/ic/code/title16/ar21/ch6.html>.

³⁰ “Charity Care” is defined by the Indiana Code as “the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services to a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient basis.” IC 16-18-2-52.5, available at: www.in.gov/legislative/ic/code/title16/ar18/ch2.html (last accessed 3/21/2009).

³¹ “Bad Debt” is defined by standardized hospital accounting procedures as the “total amount of payments that providers anticipated but did not receive.” This emphasis on whether the hospital expects the payment distinguishes Bad Debt from Charity Care that “consists of the value of services for which providers never expected payment.” J.S. Weissman, “The Trouble with Uncompensated Hospital Care,” *New England Journal of Medicine*, 352:12 (2005): 1171-1173, cited in Center for Health Policy, *Indiana: Research for a Healthier Indiana*, School for Public and Environmental Affairs, Indiana University Purdue University Indianapolis (November 2008).

³² “Contractual Allowances” is defined by the Indiana Code as “the difference between revenue at established rates and amounts realizable from third party payers under contractual agreements.” www.ai.org/legislative/ic/code/title16/ar21ch6.html (last accessed 3/21/2009).

The *Provision of Charitable Care by Nonprofit Hospitals* (IC 16-21-9)³³ defines Community Benefit as including the unreimbursed costs of charity care, government sponsored indigent health care (i.e. Medicaid), donations, education, governmental sponsored program services, research, and subsidized health services (IC 16-21-9-1). It specifies that each nonprofit hospital develop a mission statement and a community benefit plan that identifies goals and specific communities served related to charity care and other community benefits, as well as conducting a community-wide needs assessment (IC 16-21-9-4 and IC 16-21-9-5). The act further states that the hospital must prepare a budget of the expenses involved with providing community benefit. It requires all nonprofit hospitals file an annual report on the activities and expenses with the state health department and that this report is made available to the public. They are further required to post prominently within the hospital a public notice that the report is available (IC 16-21-9-6 and IC 16-21-9-7). If a hospital fails to file that report in a timely manner, they are liable to a fine of \$1,000 per day (IC 16-21-9-8).

Since 1998, the Indiana State Department of Health (ISDH) has issued a yearly report on the provision of community benefit in the state of Indiana.³⁴ It also maintains a web site with individual data from all hospitals in the state.³⁵ It should be noted that in March 2008 the data was posted for 2006. However, due

³³ The Indiana Code IC 16-21-9-1 – IC 16-21-9-9 is found at <http://www.in.gov/legislative/ic/code/title16/ar21/ch9.html>.³⁴ Indiana State Department of Health (ISDH) 2004a.

³⁵ Indiana State Department of Health (ISDH) 2004b <http://www.in.gov/isdh/regsvcs/acc/fiscal/04/index.htm>. The website contains three years of information, 2002-2004. Data from 1998-2001 is available directly from the Indiana State Department of Health.

to a change in staff at the ISDH there has been a delay in posting the complete data from the questionnaires and as of May 1, 2008 the data on the website is partial.³⁶

An Overview of the Indiana Hospital Fiscal Reports

The ISDH database contains more details on the community benefit activities of nonprofit hospitals than it does for either for-profit or county/city owned. However, there is still relevant data collected from the for-profit and city/county hospitals to allow for valid comparisons – especially regarding charity care and a broad assessment on other community benefits.

The Indiana State Department of Health website has four successive pages that provide information leading to the individual hospital databases for a given year. The first page gives the range of reports available for health care providers (see Appendix 2-B).³⁷

An advantage to page one is that three years of information are available. Reports going back to 2001 are also available on the web (although not featured on the website). A drawback to page one is that it does not specify that community benefit information is contained within the Fiscal Reports, making it less than visible to anyone who does not know to look for these reports.

³⁶ Email correspondence with ISDH staff, April 17 and 23, 2008.

³⁷ The examples given are from the 2004 ISDH Fiscal reports. The format for later years is the same as 2004, with only the years changed.

The second page provides the link to the desired Report and Year. A map makes it relatively easy to access a desired hospital and/or location – assuming that the person searching for the information knows the county a desired hospital is located. A potential drawback is that a couple of hospitals have been found to be either misplaced or because of their system affiliations are grouped with other hospitals in a different county. But this seems to be a minor problem.

The map of Indiana can be used to access the health care facilities within a desired county (Example I):

Example I

Vigo County Facilities:

Terre Haute Regional Hospital

Nonprofit Acute Care Hospitals:

Union Hospital

The “County Facilities” are either for-profit or publicly owned facilities, leading to a potential confusion. Nonprofit hospitals are separately categorized. In this example, Terre Haute Regional Hospital is a for-profit facility; Union Hospital is a nonprofit hospital. Specialty facilities are grouped together with general medical-surgical hospitals – but are separately noted on the fourth page under “Peer Group”.³⁸

³⁸ It should be noted on the actual page for “Vigo County Facilities” that one other facility is also included: “Health South Rehabilitation Hospital – Terre Haute”. This facility is a specialty hospital and therefore is not included in the example – nor are other similar specialty facilities included in the subsequent analyses, which focus on general community hospitals, not specialty facilities.

The fourth web page gives the financial data for the individual hospital (Example IV). Information is reported from nonprofit hospitals as well as public hospitals such as those owned by the city or county. The only difference is that nonprofit hospitals are required to give more detailed information about their community benefit activities. However there is still a great deal of information related to community benefits from for-profit and city-county hospitals, allowing ownership comparisons to be made. A serious limitation of the information when used for evaluating community benefit is that the applicable information is a bit scattered throughout the report, although Statements Three and Four are basically devoted to community benefit information.

To demonstrate the level of detail in the reports from all hospitals – including those that are NOT nonprofit – the example used is the for-profit hospital in Terre Haute (a two hospital county, one for-profit and one nonprofit). The information is arranged in four sections – and the first three sections require identical information regardless of the ownership of the hospital. Only the fourth section asks for more detail from nonprofit hospitals.

Terre Haute Regional Hospital is considered to be a “Medium” facility, according to its Peer Group designation (*Example II*).

Example II

ISDH Hospital Fiscal 2004 Report and Statistical Comparison
Hospital: Terre Haute Regional Hospital
Year: 2004 City: Terre Haute Peer Group: Medium

Unfortunately, the ownership designation is not provided and from the available information it can't be determined if this is a for-profit or a city/county facility. There is also not readily available information about how the "Peer Group" designation is defined or determined.

Detailed financial Information then follows, arranged in Four Statements: Statement One: Summary of Revenue and Expenses; Statement Two: Contractual Allowances Statement Three: Unique Specialized Hospital Funds; and Statement Four: Costs of Charity and Subsidized Community Benefits. In addition to the basic information on revenue and expenses, each of these Statements has information that pertains to community benefit.

Statement One: Summary of Revenue and Expenses

This contains the broad financial information on Revenue and Expenses as well as Assets and Liabilities. It also identifies Bad Debt as a separate line item under Operating Expenses. Charity Care is separately identified as a "Deduction from Revenue", in accordance with standard hospital accounting procedures. For Terre Haute Regional Hospital, the figures relevant to community benefit are (Example III):

Example III

1. Total Gross Patient Service Revenue:	\$254,448,613
2. Deductions from Revenue:	\$153,496,010
3. Total Operating Revenue:	\$101,538,948
4. Operating Expenses:	\$ 92,535,966
a. Bad Debt	\$7,170,599
5. Net Operating Revenue over Expenses:	\$9,002,981

Statement Two: Contractual Allowances

Statement Two contains the shortfall from charges through the various contracts carried by the hospital. This includes the government programs Medicare and Medicaid as well as negotiated discounts in commercial insurance (*Example IV*).

Example IV

Revenue Source	Gross Patient Revenue	Contractual Allowances	Net Patient Service Revenue
Medicare	\$120,250,142	\$90,013,547	\$30,114,595
Medicaid	\$32,239,132	\$26,070,765	\$6,168,367
Other State	\$0	\$0	\$0
Local Government	\$3,621,018	\$2,482,870	\$1,138,148
Commercial Insurance	\$98,338,321	\$34,806,828	\$63,531,493
Total	\$254,448,613	\$153,496,010	\$100,952,603

Statement Three: Unique Specialized Hospital Funds

This section includes the Community Benefit categories of Donations, Research, and Education. Both income and expense from these categories are included, allowing the determination of a net expense figure. There is also a section for reporting the number of professionals educated, the number of patients educated, and the number of community members educated (*Example V*).³⁹

³⁹ In 2004 there was also a category "Bioterrorism Grant" (sic; presumably it refers to a "Bioterrorism Preparation Grant") to indicate a special federal program providing grants to all Indiana hospitals to upgrade facilities and processes to be prepared for a bioterrorist threat. For all hospitals, the grant equaled the expenses and therefore there was no net benefit or expense involved with that grant.

Example V

Fund Category	Estimated Incoming Revenue from Others	Estimated Outgoing Expenses to Others	Net Dollar Gain or Loss after Adjustment
Donations	\$0	\$102,209	(\$102,209)
Educational	\$0	\$0	\$0
Research	\$0	\$0	\$0

The information clearly includes both income and expense aspects of the categories, addressing one of the key criteria noted in the previous section of this chapter. An obvious shortcoming of this information is that it is not indicated whether the donations to a separate hospital foundation are included – or if such a foundation even exists. This has a definite effect on the completeness as well as validity of the donation information.

Statement Four: Costs of Charity and Subsidized Community Benefits

Statement Four gives the Charity Care allocation as well as additional costs of other community benefit programs provided. For-profit and city/county hospitals are only required to report are gross figures (*Example VI*). Nonprofit hospitals are asked for more detailed information, as will be shown in the following section.

Example VI

Category	Estimated Incoming Revenue	Estimated Outgoing Expenses	Unreimbursed Costs by Hospital
Charity Community Benefits	\$38,385,535	\$47,222,154	(\$8,836,619)
	\$0	\$836,312	(\$836,312)

There is a final comparison that gives a summary of the financial information by percentages as well as a comparison to other hospitals in their Peer Group.

To provide an example of the additional information asked from nonprofit hospitals, comparable information from Statement Four is shown from Union Hospital, the nonprofit hospital in Vigo County (*Example VII*).⁴⁰

Example VII

**ISDH Annual Fiscal Report of a Nonprofit Acute Care Hospital
Hospital: Union Hospital
Year: 2004 City: Terre Haute Peer Group: Large**

For nonprofit hospitals there is additional information requested under *Statement Four: Annual Summarized Community Benefit Statement on Nonprofit Hospital*.

It further explains:

“This hospital is a nonprofit organization and files an annual community benefit statement with the Department under Indiana Code 16-21-9. Each nonprofit hospital must confirm its mission statement, document the number of persons and dollars allocated under its adopted charity care policy, and describe the progress of the community to achieve specific objectives set by the hospital.”

This includes statements identifying the communities served, unique services available, and a copy of the hospital’s Mission Statement referring to the role of community benefits in that mission.

Union Hospital responded to this 2004 report of these areas under Statement Four in the following manner (*Example VIII*):

⁴⁰ Information from Union Hospital on Statements One, Two, and Three are not included, as they include data in the same format as for the for-profit and county hospitals, as previously illustrated.

Example VIII

County Location: Vigo
Community Served: Clay, Greene, Parke, Vermillion and Vigo counties in Indiana and Clark and Edgar Counties in Illinois

Hospital Mission Statement

“Union Hospital is a nonprofit regional medical center whose primary mission is to be served defined by community needs through the provision of a comprehensive range of quality, cost effective health services”.

Unique Services

- Medical Research NO
- Professional Education YES
- Community Education YES

Type of Initiatives

- Disease Detection YES
- Practitioner Education NO
- Clinic Support YES

Document Available

- Community Plan YES
- Annual Statement YES
- Needs Assessment 2000

Also the form asks for a three-year summary of the Charity Care Allocation and the number of people served by that care (*Example IX*).⁴¹

⁴¹ The text accompanying this category reads: “Most nonprofit hospitals adopt a charity benefit policy to serve the medically indigent. On an annual basis, the hospital will confirm the eligibility and set aside dollars to ensure low-income persons can be offered needed inpatient and outpatient hospital services.”

Example IX

Allocation of Dollars and Persons Served under Adopted Charity Policy

	2002	2003	2004
Persons served in last twelve months	2,724	NR	NR
Charity Care Allocation	(\$2,581,585)	(\$3,258,474)	(\$3,793,367)

The sub-section titled *Hospital Community Benefit Projects and the Projects' Net Cost* allows hospitals to specifically identify community health education programs they have undertaken to improve the community's health: "On an annual basis, all nonprofit hospitals will report on the progress that the local community has made in reducing the incidence of disease and improving the delivery of health services in the community." The form asks for "Name of Program and Description of Progress Made in Achieving Annual Objectives Net Costs of Programs." In practice, there are varying responses to this section, ranging from a single figure under a vague heading (such as "All other initiatives") to a five or six category breakdown defining the individual programs.

Under the sub-section *Hospital Community Benefit Projects and the Projects' Net Cost*, Union Hospital only listed a single figure (*Example X*) – other nonprofit hospitals may choose to provide varying program details and breakdown:

Example X

All other initiatives: (\$2,278,686)

The next sub-section is titled *Funded Programs and Community Benefits* and this attempts to provide a standardized summary of all the community benefits in four categories and a final total: “Based on uniform definitions of costs, each nonprofit hospital must identify the costs of serving its community that are not reimbursed by government and other third party payers.” The report asks for the “Unreimbursed Costs” for each of the four identified “Specialized Programs” and the final “Total Costs of Providing Community Benefits”.

The first category is the (potentially) largest and most comprehensive, being: “Total unreimbursed costs of providing care to patients unable to pay, to patients covered under government funded programs, and for medical education, training.” The other three are: “Community Health Education”; “Community Programs and Services”; and “Other Unreimbursed Costs”.

In the final Summary of Unreimbursed Costs of Charity Care, Government Funded Programs, and Community Benefits, Union Hospital provided the following summary (*Example XI*):

Example XI

<u>Specialized Programs</u>	<u>Unreimbursed Costs</u>
1. Total unreimbursed costs of providing care to patients unable to pay, to patients covered under government funded programs, and for medical education, training.	(\$77,192,168)
2. Community Health Education	(\$13,215)
3. Community Programs and Services	(\$2,389,257)
4. Other Unreimbursed Costs	(\$297,463)
5. Total Costs of Providing Community Benefits	(\$79,892,103)

To conclude, there is a final question under *Identification of Additional Non-Hospital Charity Costs*: “In addition, some hospitals will have non-hospital organizations under its ISDH license that are providing community benefits in this fiscal year.” This provides an opportunity to identify a community clinic or other related organization that provides charity care and the related amount of expense involved with that care. Union Hospital had no other organization identified as *Additional Non-Hospital Charity Costs*.

Evaluation of the Validity of the ISDH Data

The annual Hospital Fiscal Reports are self-reporting and contain un-audited data. In this situation there can be a question as to how valid the information might be. Potential confusion in definitions, variations in record keeping at individual institutions, and error in data entry are also continual problems that can call data validity into question. However this problem with self-reporting can also

affect the validity of data from the IRS Form 990, and is projected to continue to be a problem even after the revised IRS forms are in place.

There are a few tests that can evaluate how much the data can be trusted. One method is to look for unreported data or data that is the same in two years (suggesting that previous figures were copied to the next year). A second method is to look for dramatic variations in data from different years from the same hospital. This could be due to changing record systems, changes in the individuals who record or report the data, or even in shifts of fiscal years. A third method can be to compare data that is in common between the ISDH reports and the IRS 990 (primarily in the case of nonprofit hospitals).

To investigate missing or duplicated data, information from three Years of Reports (2001-2004) for all hospitals was examined: out of 321 records, there were 17 instances of missing data (5.3%). Of these discrepancies, 6 were from nonprofit hospitals (3.3% out of 183 nonprofit hospital records), 5 were from city or county facilities (4.5% of 111 city-county hospital records), and 6 were from for-profit (22.2% of 27 for-profit hospital records). While there was some data missing from nonprofit hospitals, it was at a lower rate than for public or for-profit hospitals – indicating that there can be a level of reliance on the ISDH data as submitted from the nonprofit hospitals.⁴²

⁴² These types of results could also be used to conclude that nonprofit hospitals are more “honest” in reporting data than other ownership types, particularly for-profit. However since the ISDH reports were put into place primarily to assess the community benefit provided by nonprofit

To compare individual hospital consistency from year-to-year, data from individual hospitals compared the consistency of data from four years (2002 to 2005) for “dramatic variations”. Specifically the figure tested was Charity Care as percentage of Operating Expense. For the purposes of this example, “dramatic variations” were defined as having a figure that in one year varied by 300% or more from the other three years. The following lists the incidents of those variations.

of “Dramatic Variations” in Data: 2002-2005

Total:	20 of 107	(19%)
Nonprofit:	9 of 61	(15%)
City/County:	8 of 37	(22%)
For-Profit:	3 of 9	(33%)

Again, nonprofit hospitals were found to be consistent more often than the other ownership forms, particularly for-profit hospitals. And while the frequency of these anomalies does seem to be somewhat high, the figures indicate one incident of a discrepancy that is found in any one of the four years, but (generally) not in any more than one of the years.

If only inconsistencies are included that occur more than once during the four-year period, the nonprofit inconsistencies are at 5%, perhaps an acceptable level for data analysis.

hospitals – and other facilities are included although not required to file (except for broad financial figures of expense and revenue) such a conclusion would probably be rash.

Comparing the IRS Form 990 to the ISDH Data

Another approach to evaluate the validity of the ISDH database is to compare comparable information on the ISDH Fiscal Reports⁴³ with that reported on the year-end IRS Form 990.⁴⁴ Despite the uncertainties involved with the IRS 990 forms, consistency in reporting between the two sources could imply that the information being reported to the state and federal government are based on similar processes and formats. Inconsistency could indicate that various reports are compiled and distributed by different segments of the organization or are based on different criteria, emphasizing a need to further substantiate various reports.

Although the IRS 990 data is self-reported, it has a consistency and a national acceptance that can make such comparisons useful. Two figures – Total Operating Revenue and Total Operating Expense – are found on both the IRS and the ISDH reports (although labeled slightly differently). These financial figures are considered basic information for hospitals, so comparing their level of agreement is one way to determine consistency in reporting. Chart 2-1 illustrates the percentage of agreement of the two databases for Operating Revenue for the year 2005 for 54 nonprofit Indiana hospitals. The data is arranged at random

⁴³ The ISDH Hospital Fiscal Reports (2005) used for this comparison are from fiscal year 2005, being the last year that comparable reports are available for all hospitals on both the IRS and the ISDH databases. While the exact fiscal year for different hospitals varied, they are the same for every hospital on both the IRS and the ISDH reports.

⁴⁴ The IRS Forms 990 used for this comparison, as well as other uses in this dissertation, were accessed through the Guidestar website, www.guidestar.org.

(hospitals are arranged alphabetically, by county). Chart 2-2 shows the same comparisons using Operating Expenses as a basis.

Chart 2-1: Total Operating Revenue (2005) of Nonprofit Hospitals in Indiana
Figure from ISDH Report as percentage of the figure from the IRS Form 990

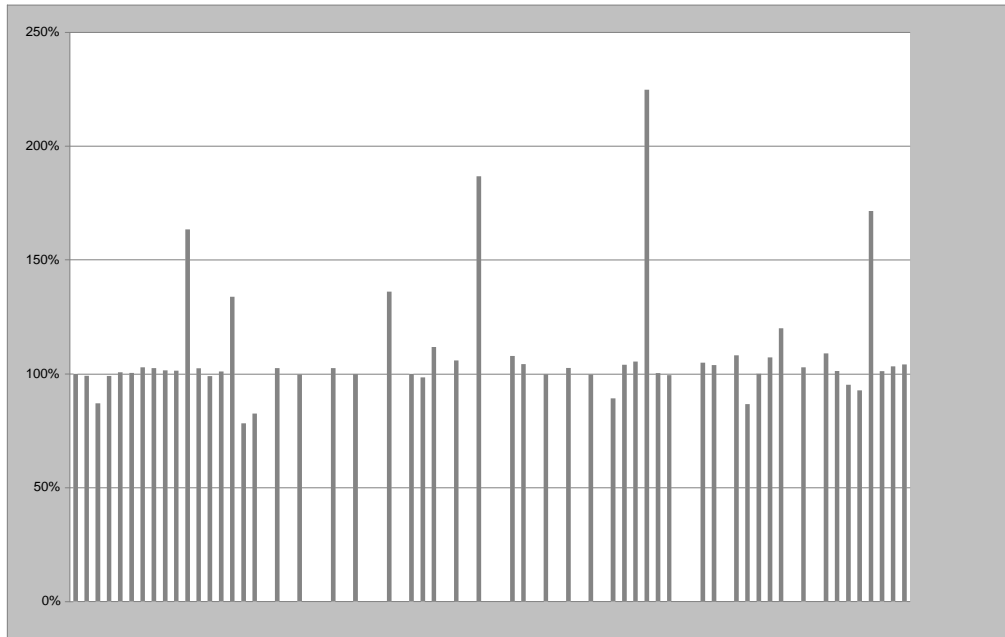


Chart 2-2: Total Operating Expense (2005) of Nonprofit Hospitals in Indiana
Figure from ISDH Report as percentage of the figure from the IRS Form 990

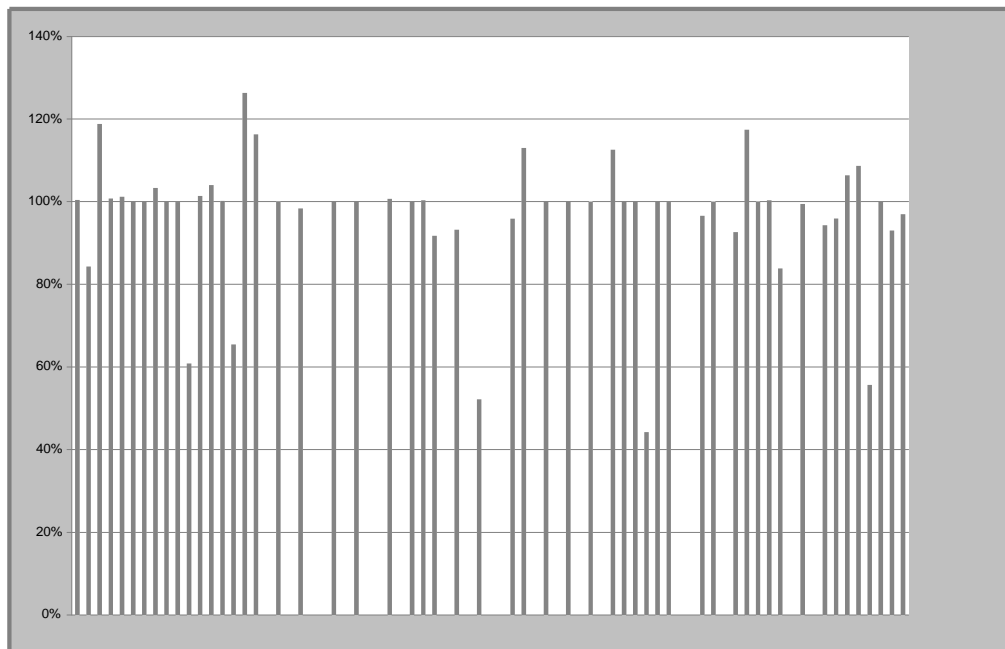


Chart 2-1 shows a relative consistency in Total Operating Revenue between the IRS and the ISDH reports. Only six of the 54 Indiana hospitals show a relatively large discrepancy, or approximately 11% of the hospitals.⁴⁵ Chart 2-2 also shows a relative consistency in Total Operating Expense between the IRS and the ISDH reports.

Again only six hospitals of the 54 Indiana hospitals (four of them the same as for Operating Revenue) have large discrepancies, with the majority of the hospitals (89%) showing relative comparability.

It should be noted that the ISDH Expense is slightly lower than IRS Expense, while ISDH Revenue is slightly higher than IRS Revenue. This could be due to the reports being filled out at separate times after the close of the fiscal year. These figures are continually revised as estimated reimbursement is replaced by actual reimbursement and as anticipated Revenue that becomes uncollected is shifted to Bad Debt, making it a function of Expense rather than Revenue.

In comparing the ISDH Total Operating Revenue and Total Operating Expense, we find some slight variations – and several larger discrepancies. The slight variations are somewhat more explainable, and indicate some of the variability of the record keeping and accounting challenges faced by hospitals. In several

⁴⁵ Gaps in Charts 2-1 and 2-2 indicate nonprofit hospitals that are missing either ISDH or IRS 990 Reports in the databases. 54 of the 75 nonprofit hospitals (71%) in Indiana have both reports available.

conversations with hospital controllers⁴⁶ they indicated that variability in the expense and revenue figures can be due to the timing of precisely when the reports are filled out in relation to the end of the fiscal year. This is due to needed adjustments to the financial reports because of changes in actual reimbursement vs. estimated reimbursements. But these variations should not be dramatic and rarely exceed 5%. Exhibit 2F shows how these two databases compare.

Exhibit 2F: Comparison of ISDH and IRS Financial Reports

Total Operating Revenue:		Total Operating Expense:	
<u>% of IRS/ISDH Report</u>		<u>% of IRS/ISDH Report</u>	
Over 120%	- 4	Over 120%	- 6
106%-120%	- 5	106%-120%	- 6
95%-105%	- 30	95%-105%	- 28
Under 95%	- 6	Under 95%	- 5

In comparing the Indiana ISDH Fiscal Reports for 2005 with the IRS Form 990 for the same year, the ISDH has reports on 62 hospitals defined to be private nonprofit organizations. The IRS Form 990 provides information on 45 of these hospitals.⁴⁷ Of these 45 hospitals, comparing IRS Revenue to ISDH revenue as a percentage (with 100% being a relatively similar match between the two databases, a figure below 100% meaning a higher figure was reported on the

⁴⁶ These conversations were part of the follow-up to the mailed questionnaires, outlined more specifically in Chapters Four, Five, and Six.

⁴⁷ There are several factors that explain "missing" IRS Form 990s for some hospitals. In several cases separate facilities that are part of the same system file ISDH forms separately but the Form 990 compiles information from these two or three facilities into a single report. Also several Catholic hospitals that are part of a system either filed IRS Form 990s together or were not available at all.

ISDH report than on the IRS report, and a figure above 100% meaning a higher figure was reported on the IRS report) the following results were found:

Of the 45 nonprofit hospitals, 28 (62%) had comparable revenue figures - within the seemingly acceptable 5% margin. Of the remaining 17 hospitals, 5 (11%) reported revenue figures on the ISDH reports that were under 95% of the IRS reported revenues and 12 hospitals (27%) reported a figure over 105% of the IRS figure, with the largest discrepancies being 164%, 187%, and 225%. This difference could be due to the different reports being filed at different times, with one report (ISDH) being based on estimates of future reimbursement and the other report (IRS 990) not filed until after actual reimbursement revenue is received.

In the comparison of Total Operating Expense, 30 of the 45 nonprofit hospitals (67%) had comparable revenue figures - within 5%, with 20 of those being nearly identical. The expense level of comparability might be expected to be more consistent than the revenue as it would not be subject to the same reimbursement uncertainties as the revenue figures. However, while more than half were virtually identical the subsequent comparability was slightly less than for the revenue. One-third of the hospitals exceeded the 5% margin of difference. Six hospitals (13%) reported expense figures on the ISDH reports that were less than 95% of the IRS reported expenses. Nine hospitals (20%) reported a figure on their ISDH report that was more than 105% of the IRS figure,

with the largest discrepancies being 164%, 192%, and 226%. This level of difference in the expense figures is a bit harder to explain. With only three exceptions, the discrepancies in the expense and revenue figures for specific hospitals are similar, indicating an internal consistency. In the exceptions it may be that different people – or even different departments – filled out the IRS and the ISDH forms, perhaps at two different times and unwittingly using different figures.⁴⁸

Donations – IRS and ISDH Data: The fact that over 1/3 of Indiana’s nonprofit hospitals hospital showed significant differences in revenue and expense figures between the ISDH reports and the IRS reports (“significant” meaning greater than a 5% discrepancy), can at least raise a question of the validity of the ISDH Reports, as well as potentially with the IRS Form 990. However when a similar comparison between the two reports is made focusing on donation figures, the lack of consistency becomes extreme. Of the nonprofit hospitals filing both the ISDH and IRS Form 990 reports, over half (23 of the 45, or 51%) declared \$0 donated “Incoming Revenue from Others” on the ISDH report; only one of the 45 declared no contributions on the IRS Form 990.

Of the 22 hospitals that did declare donations on both the ISADH and the IRS forms, all reported much greater amounts on the IRS Form 990 than on the ISDH form.

This may be explained because it is stipulated by the ISDH: “The term

⁴⁸ The hospital with the discrepancy of over 200% more on the IRS Form 990 than on the ISDH report was reporting the Gross Revenue and Expense figures on the IRS Form 990 rather than the Net, after deductions from revenue.

does *not include the value of donations designated or otherwise restricted by the donor for purposes other than charity care*” (emphasis added). This stipulation implies that unrestricted contributions should be treated as offsets to charity care. It further means that the reported contribution figure is not equal to the total amount of community support generated by donations. Finally the form focuses on the net amount donated *by the organization as being part of their community benefit, meaning the gross level of community support is further eroded.*⁴⁹

These distinctions are not part of the IRS Form 990.

The ISDH and IRS databases have additional discrepancies. One is while the IRS 990 form separates government grants from private contributions. The ISDH donation figure does not define whether government grants are included in donations. As was previously mentioned, there is also an ambiguity because of the unspecific relationship of contributions to or from a hospital’s foundation – however a hospital foundation’s information can be accessed via a separate IRS Form 990, a situation that is not possible through the ISDH database. There is also not a similar provision in the IRS Form 990 to exclude restricted contributions, making definitive comparisons even more difficult.

This wide variability calls into question how well the ISDH Report can be utilized to evaluate donation figures. It also causes a concern about the criteria used by

⁴⁹ It further states: “The donation statement should include donations from hospital accounts only, and do not include values from other revenue streams” meaning that contributions received by a separate foundation, for whatever purpose, is not part of this figure. This situation is addressed in detail in Chapter Six.

different hospitals to determine those donations. These discrepancies point out the need to try and more specifically determine and verify the process and criteria of the ISDH reports, a process that is outlined in Chapters Five and Six. It also emphasizes that to assess the level of philanthropic behavior of a hospital, the ISDH reports may not be as useful as the IRS Form 990. Finally, this does raise some caveats as the new IRS Form 990 and Schedule H forms come into use. As the forms further define expenditures related to community benefit it is important that they also do not artificially limit the full picture of community support both to and by the hospital.

Evaluating the Indiana Database:

Comparing the ISDH Data with Other Data Sources

The Indiana State Department of Health database, the Hospital Fiscal Reports, seems to be as comprehensive and accessible database for evaluating community benefit as those that are currently available. Not only does it collect information on all areas related to community benefit, it also collects income that might offset donations, education, and research expenses. In addition, for-profit and public hospitals are expected to provide a great deal of information regarding community benefit, although they have no legal requirement to supply this information. It may be that this lack of requirement could be one reason for having zero expenses noted for some of the categories, as there is no advantage to this for-profit facility to track and report this data.

Yet there are questions about the comparability and validity of many of the criteria reported. At the very least it becomes a caveat for any voluntarily provided and unaudited reports. This is a concern that extends to the IRS Form 990 that is considered to be one of the better resources we have for making fiscal analyses of nonprofit organizations. The revised Form 990 – and most particularly the Schedule H for hospitals – should provide a vast improvement in the available data for evaluating community benefit. However, there are still numerous areas that will remain ambiguous. Subsequent chapters of this dissertation will begin to detail many of these ambiguities, particularly those that make it difficult to determine not only the validity of the actual community benefit provided but also the philanthropic behavior of nonprofit organizations. One advantage of the IRS Form 990 is it allows us to examine the data of an individual hospital or other nonprofit entity. A corresponding concern is how these individual hospital reports may be collected into summary reports and used for public policy purpose to develop potential standardized evaluations of those same individual hospitals. Whether those standards accurately reflect the commitment and actions of the individual hospital to meet the identified needs of its defined community, is uncertain.

If we accept the premise that information provided by hospitals is a good-faith effort to provide the relevant information, the ISDH database does provide a potential insight into not only the level of community benefit provided but also the types of information that could be reported nationally once the Schedule H form

becomes routine. As an active state database, it can serve as an example to anticipate the kinds of information that might be reported on the revised IRS 990 form. Using the ISDH data to evaluate comparative information can also highlight potential concerns that might arise through developing subsequent reports and standards. The ISDH database does provide information on health promotion expenditures that the IRS form does not. Conversely the IRS form seems to be more definitive in identifying the donation information than the ISDH form. The next step is to determine what the ISDH database and the IRS Forms 990 reveal about the specific elements of Indiana hospital community benefit and philanthropic behavior. Following that there is a need to evaluate the specific validity of that information related to health promotion programs and donations using information and input from the organizations themselves.

CHAPTER THREE: WHAT DOES THE ISDH COMMUNITY BENEFIT DATABASE TELL US ABOUT INDIANA HOSPITALS?

Chapter Three asks: “What does an existing reporting requirement from one state (Indiana) tell us about nonprofit hospital community benefit and philanthropic behavior?” The primary conclusion is that while reports based on these requirements may provide useful information for investigating individual hospitals, broader conclusions about behavior of hospitals or categories of hospitals, as a group, are limited. The principal reason for this limitation is that averages, median figures, and summaries don’t account for the variety of factors that are necessary to adequately evaluate organizational behavior and motivations.

The chapter maintains that the community benefit reports required by a state, while perhaps gathering data that goes beyond the requirements of the Internal Revenue Service, do not adequately capture the actual behavior of the hospitals. It further maintains that summary reports based upon averages of hospitals and even of sub-categories of hospitals do not accurately reflect the behavior of individual hospitals. The chapter concludes that only by examining individual hospital practices can we properly understand, measure, and evaluate the relative philanthropic behavior of hospitals and their corresponding commitment to the benefit of their communities. This is an important consideration, as current

efforts of policymakers seem to be to evaluate affect that very behavior, especially in regards to the area of providing charity care.

Chapter Three explores the publicly available information from Indiana, a state that requires community benefit reports and has collected detailed financial statements from each hospital in the state since 1997. It analyzes what such summary and individual reports tell us about nonprofit hospitals in general and about the level of the community benefit and philanthropic behavior they provide in particular. Finally it considers what these reports convey about hospitals based on sub-categories based on ownership and involvement with a healthcare system, particularly religious system affiliations.

As a result of these examinations, the chapter first concludes that the Indiana general summaries, and comparisons to external standards based on such broad summaries, could result in misleading conclusions about the level of community benefit actually provided by individual facilities or even groups of hospitals. It further concludes, while reporting requirements and general standards might encourage compliance, specific hospital data has a level of variability and even validity that can frustrate more defined analysis. Finally the chapter observes that to determine the commitment of a hospital to community benefit requires looking at an individual hospital's practices, an approach that is a focus of subsequent chapters. How this reporting process has worked in Indiana provides an indication of the limitations that even revised IRS reports might face

attempting to capture a true picture of the community benefit provided by all hospitals in the United States.¹

Chapter Three is divided into four parts. Part One gives an introductory overview of Indiana hospitals and their statewide structure according to the Indiana State Department of Health (ISDH) reports. Part Two evaluates how well the ISDH Summary reports present a realistic picture of the level of community benefit provided by Indiana hospitals. It does this through a comparison of the ISDH summary to a compilation of the ISDH reports from individual Indiana community hospitals. Part Three uses the compilation of Indiana community hospitals to denote the overall Community Benefit figures provided by all Indiana hospitals. This part also more specifically examines how the reports portray the provision of Charity Care, the element of Community Benefit most often cited by regulatory and legislative oversight agencies. It finally includes a brief analysis of Uncompensated Care, to show how this alternative measurement might affect reports of charity care in Indiana and elsewhere, particularly noting the complicating factor of bad debt. Part Four further segments the examination of the level of Charity Care provided by Indiana community hospitals into sub-categories. It first compares the data from nonprofit hospitals to for-profit hospitals. Two other comparisons are also presented: namely hospitals within a

¹ This limitation is confirmed by a 2009 IRS report of a study of 500 nonprofit hospitals that noted wide diversity and lack of legal standards and accounting consistency among the hospitals. Internal Revenue Service, "IRS Tax Exempt Study" (February 2009), available at www.irs.gov/charities/charitable/article/0,,id=203109,00.html (last accessed 2/16/2009); and "IRS Releases Long-Awaited Report on Hospital Pay and Services," *The Chronicle of Philanthropy*, (February 12, 2009).

system as opposed to independent hospitals, and those with religious affiliation vs. non-religious affiliation. It uses these breakdowns to determine how well these sub-category summaries identify factors that affect hospital community benefit, charity care, and philanthropic behavior. The chapter ends with a summary of the above examinations and draws the conclusion that an assessment of individual hospitals is needed to realistically evaluate the level of Indiana hospital community benefit and philanthropic behavior.

An Overview of Indiana Hospitals

According to the *American Hospital Association Guide to the Healthcare Field* (2005), in 2004² there were 138 hospitals in Indiana.³ 108 of these are noted as being “General medical and surgical” hospitals, the most common designation for a hospital. This designation primarily includes those hospitals considered to be community hospitals – serving the broad healthcare needs of their community by providing emergency services and a reasonable range of surgical and treatment facilities. The American Hospital Association defines community hospitals as:

² In an effort to provide consistent and comparable figures across multiple databases, information for this section is based on 2004 data. As of the time when the data was collected, this is the last year that has consistent data across all sources. Hospital accounting also has a delay in compiling final financial figures, due to adjustments that need to be made due to reimbursement patterns. When comparative data is used in this thesis, the span 2002-2004 is generally used, although 2001-2004 is occasionally used (especially in the first part of the chapter) when it seems to be helpful to show a wider context for data changes.

³ Any “counting” of hospitals has a level of uncertainty depending on whether merged faculties, systems, and satellite clinics report separately or as a single unit. The AHA annual survey relies on reporting entities, generally treating members of systems as separate hospitals, but including merged facilities as single reporting entities. As a comparison, the American Hospital Directory (<http://www.ahd.com> - accessed 2/19/2007) lists 172 hospitals in Indiana, with system hospitals listed separately. Other data sources for updated hospital listings include the US News and World Report (152 Indiana hospitals: http://usnews.com/usnews/health/hospitals/state_dir/dir_in.htm - accessed 2/19/2007) and the Agape Center (219 Indiana hospitals: <http://www.theagapecenter.com/Hospitals/Indiana.htm> - accessed 2/19.2007).

“All nonfederal, short-term general, and special hospitals whose facilities are available to the public.” (AHA 2008) The Indiana State Department of Health (ISDH) further differentiates this definition between general and specialty hospitals, as does this paper. This follows the distinction made by many states that defines a community hospital as one that: 1) provides acute care and outpatient services, including patient education; 2) principally serves a local area (i.e. non statewide); 3) does not have a single specialty focus; and 4) refers complex cases to a tertiary hospital.⁴

The American Hospital Association (AHA), in addition to the 108 general community hospitals in Indiana, also identifies 38 hospitals designated as specialty hospitals. These hospitals provide services either for specific diseases (e.g. psychiatric or tuberculosis), designated treatments (e.g. rehabilitation, alcoholism, or obstetrics), or defined patient populations (e.g. women or children) – or are part of a college, prison, or other type of institution. Besides the AHA, one other reliable source of general hospital information is the Kaiser Family Foundation, which identifies 113 hospitals in Indiana.⁵ The slight variations in these two standard sources show the level of ambiguity that may exist when counting the number of hospitals in a given state.

⁴ Rhode Island Executive Office of Health and Human Services, “What is a Community Hospital?” available at www.ohhs.ri.gov/taskforce/documents/CommunityHospitalWorkingDefinition.doc last accessed 9/28/2008.

⁵ Kaiser figures were only available from 2004, reflecting earlier reports (from 2002-2003), which could also explain some of the discrepancies.

According to the *AHA Guide*, 57 of the community hospitals in Indiana are nonprofit (53%), 38 are city or county government facilities (35% - not counting 2 hospitals operated by the Veterans Administration), and 11 are for-profit (10%). How these figures compare to the Kaiser Family Foundation figures – and how the ownership compares to national percentages – is shown in Table 3A.

**Table 3A:
OWNERSHIP OF COMMUNITY HOSPITALS – Indiana and Nationally**

	AHA Guide (2005): Indiana		AHA Guide (2005): National		Kaiser Family Foundation (2004): Indiana		Kaiser Family Foundation (2004): National	
	# of hospitals	% of hospitals	# of hospitals	% of hospitals	# of hospitals	% of hospitals	# of hospitals	% of hospitals
Total	108		4,936		113		4,919	
Non-profit	57	53%	2,958	59.9%	60	53.1%	2,967	60.3%
City/County	38	35%	1,100	22.3%	37	32.7%	1,117	22.7%
For-profit	11	10%	868	17.6%	16	14.2%	835	17.0%

The data comparison shows Indiana has significantly more public (city/county) hospitals than the national average (57% more public hospitals than the national percentage) and fewer for-profit hospitals (43% fewer nonprofit hospitals than the national percentage). Indiana also has a slightly lower prevalence of nonprofit hospitals than the national average (12% fewer nonprofit hospitals than the national percentage).⁶

The database from the Indiana State Department of Health (ISDH) contains information collected from the financial reports of all hospitals in Indiana – and is

⁶ Differences in percentages were calculated using *AHA Guide* (2005) figures.

the primary source of information used for this study. The ISDH lists 132 hospitals in Indiana in 2004 (the year selected for this comparison). 107 of these are community, medical-surgical general hospitals.⁷ Table 3B compares the numbers of community hospitals in Indiana as designated by the ISDH database with the data from the AHA and Kaiser.

Table 3B: OWNERSHIP OF COMMUNITY HOSPITALS – Indiana

	ISDH Database: Indiana (2004)		AHA Guide (2005): Indiana		Kaiser Family Foundation (2004): Indiana	
	# of hospitals	% of hospitals	# of hospitals	% of hospitals	# of hospitals	% of hospitals
Total	107		108		113	
Nonprofit	61	57%	57	53%	60	53.1%
City/County	37	35%	38	35%	37	32.7%
For-profit	9	8%	11	10%	16	14.2%

The actual ISDH database contains information on 107 hospitals termed “Acute Care Facilities” by the ISDH. These are further differentiated by Peer Group – Large, Medium, and Small – based on number of beds, types of services, number of surgeries performed, and number of discharges.⁸ Table 3C compiles the distribution by Peer Group as well as by ownership type, and the relative percentages of these size and ownership types (as of 2004).

⁷ The remaining 25 hospitals (19% of all Indiana hospitals) are designated specialty facilities either offering long-term care (15 hospitals) or rehabilitation (4 hospitals) or other specific services (6 hospitals).

⁸ As stated in Chapter Two of this thesis, the specific standards for the “Peer Group” differentiation is not defined by the ISDH information, and is an internal designation unique to Indiana. There is not a corresponding national equivalence.

Table 3C:
Distribution of Indiana Hospitals with available reports in the ISDH Database: Peer Group Size; Ownership; and System/Independent Status

	Total	%	Peer Group: Large	%	Peer Group: Medium	%	Peer Group: Small	%
Total	107		25	23%	43	40%	39	37%
System	58	55%	16	64%	25	58%	17	44%
Independent	49	45%	9	32%	19	42%	31	56%
Nonprofit	61	57%	22	36%	23	38%	16	26%
System	42	69%	15	68%	18	78%	9	56%
Independent	19	31%	7	32%	6	22%	6	44%
City/County	37	35%	2	5%	15	41%	20	54%
System	7	35%	0	0%	2	13%	5	25%
Independent	30	65%	2	100%	13	87%	15	75%
For-Profit	9	8%	1	11%	5	56%	3	33%
System	9	100%	1	100%	5	100%	3	100%
Independent	0	0%	0	0%	0	0%	0	0%

Over three-quarters of Indiana’s hospitals are designated either as medium or small, with over one-half of the small hospitals being city or county owned. A majority of these small hospitals are located in rural communities, as sole providers for their town and/or county. It could be that one consequence for these hospitals, related to community benefit, is they may have higher levels of charity care, as patients do not have a choice of facilities nor do providers have the options to easily transfer patients.⁹ Therefore alternative provisions of healthcare are limited. One other aspect of note is that only one for-profit hospital is designated as being “large”, lending credibility to the claim that for-profit hospitals firms will seek smaller hospitals as they have the greater opportunity to be run efficiently (Herzlinger and Krasker 1987).

⁹ How community demographics might affect community benefit and charity care is a factor that is not taken into consideration in this paper. This is because the purpose of the paper is to evaluate the internal behavior and decision processes of hospitals rather than noting the numerous external influences that might affect the level of such care. Evaluating such additional external factors could be a focus for future research.

In relation to hospital systems, the American Hospital Association *Fact Sheet* (AHA 2008) notes that 2,755 community hospitals in the United States are part of systems. This represents 56% of the community hospitals in the United States. 55% of Indiana hospitals are part of systems, comparable to the national average.

59 of the 107 hospitals in Indiana (55%) are part of fifteen health systems.¹⁰

This includes three for-profit healthcare systems:¹¹

- Triad Hospitals, Inc. (Plano, Texas)¹² – 5 hospitals
- Province Healthcare Corporation (Brentwood, Tennessee) – 2 hospitals
- HCA (Nashville, Tennessee) – 1 hospital

Indiana has 51 hospitals affiliated with 12 nonprofit systems. Five of the nonprofit hospital systems are headquartered out-of-state and all of these are religiously affiliated. Four are Catholic systems and one is a Jewish hospital system:

- Ascension Health System (Saint Louis, Missouri) – 13 hospitals
- Sisters of St Francis Health Services (Mishawaka, Indiana) – 7 hospitals
- Jewish Hospital Health Services (Louisville, Kentucky) – 3 hospitals
- Trinity Health (Novi, Michigan) – 3 hospitals

¹¹ As with other hospital listings, this may not be an exact count of actual facilities nor may it be consistent with other listing formats. Some system facilities may report as a combined entity rather than as separate facilities. An example of this is Clarian Health Partners that reports Methodist Hospital, Riley Children's Hospital and the Indiana University Medical Center as a single entity.

¹² It should be noted that the Clarian Health Partners system in Indiana contains one for-profit hospital (in Avon). However, the system is designated as a nonprofit system.

¹³ Cities in parentheses indicate the location of the system headquarters.

- Little Company of Mary Sisters Healthcare System (Evergreen Park, Illinois) – 1 hospital

There are also seven nonprofit systems headquartered within Indiana (all non-religiously affiliated):¹³

- Clarian Health Partners (Indianapolis) – 8 hospitals
- Parkview Health (Fort Wayne) – 5 hospitals
- Community Health Network (Indianapolis) – 4 hospitals
- Community Healthcare (Gary) – 2 hospitals
- Cardinal Health System (Muncie) – 3 hospitals
- Bloomington Hospital and Health System (Bloomington) – 2 hospitals¹⁴

Evaluating the General Level of Indiana Hospitals Community Benefit

Part Two explores how well the ISDH Summary Reports correspond to a compilation of individual community hospitals. This comparison is done first for a specific year (2004) and second over a three-year period (2002-2004). The conclusion of this comparison is that the summary reports may not be particularly helpful when trying to assess the level of philanthropic behavior of Indiana hospitals.

¹³ For consistency, these system designations are based on 2004 data. Because the healthcare system landscape in Indiana – as well as elsewhere in the United States – is continually shifting there have been changes since 2004 in some of this information.

¹⁴ As of the spring of 2008, Bloomington Hospital is considering becoming part of the Clarian Health Partners system.

The Indiana State Department of Health (ISDH) provides two primary sources of information on hospital community benefit. The first is the Fiscal Reports of individual hospitals for each year. The second is a yearly ISDH Summary of all Indiana hospitals for a given year. These Summaries are compiled each year by the ISDH to provide a snapshot of the fiscal and community benefit provision of Indiana hospitals. This is the primary method for the state of Indiana to draw general conclusions about the relative financial and community benefit operation of hospitals in the state. This ISDH Summary is compiled by the state health department and includes all hospitals in Indiana, including specialty hospitals as well as community hospitals. Since community hospitals are included in the ISDH Summary – but are not separated from specialty hospitals, the author of this paper compiled the individual reports of community hospitals in Indiana. This separate (unofficial) compilation is the basis for an overall picture of community benefit as provided by community hospitals in Indiana.

All information on Community Benefit used in this chapter, including data from the Indiana Hospital fiscal reports, is compared with two standards. The first standard is Total Community Benefit as a percentage of total operating expenses, with a suggested standard of 5%. The second is Charity Care as a percentage of total operating expenses, with a suggested standard of 4%. These two percentages correspond to the standards enacted by the state of Texas,¹⁵ which as shown in Chapter Two of this thesis are among the most stringent in the country. Figures used for this analysis, are those provided by Indiana hospitals

¹⁵ Texas Health and Safety Code Section 311.045.

and reported in the ISDH reports, required by all Indiana hospitals since 1994 and publicly available since 1997.¹⁶ As generally defined, Community Benefit is determined as Charity Care plus net donations, net research, and net education expenses in addition to community health program expenses. Where Uncompensated Care is also compared, it is determined as Charity Care plus Bad Debt.¹⁷

An Examination of ISDH Summary Reports: One consequence of doing a separate compilation of individual (community) hospitals from the database is it provides an initial comparison of how well general summaries realistically portray the actual community benefit and philanthropic behavior of individual hospitals. The ISDH Summary is used to report on the general trends and status of hospital community benefit in Indiana, through public press releases as well as in reports to the state legislature. It could be assumed that similar broad summary reports will be shared by the Internal Revenue Service in the future and used to draw conclusions about hospital community benefits in the United States as well as the overall effectiveness of their revised reporting systems in tracking charity care and other forms of community benefit. Therefore it is relevant to look at not only what the ISDH Summaries tell us but also to examine how well they correspond to compilations from individual hospital figures.

¹⁶ See Chapter Two of this paper for details on the legislation behind these reports.

¹⁷ The details outlining the rationale for selecting these criteria are contained in Chapter Two of the dissertation. Also see Chapter Two for further definition of uncompensated care.

The analyses that follow first show comparable data from 2004 ISDH Summary and from a compilation of the 2004 reports of the individual community hospitals. This provides a snapshot of the relative levels of Indiana hospital's community benefit for a given year. The analysis then compares 2002-2004 data – both from the ISDH Summary and the individual hospital compilation – to expand the scope of the analysis as well as to show how the figures change over the years.¹⁸

The comparison of the ISDH Summary and the individual hospitals compilation helps evaluate the validity of the summary reports. These comparisons also help show the relative consistency of the data that are reported and, assuming the data is valid, how the commitment of Indiana hospitals to providing community benefit might be changing.

ISDH Summary of ALL Indiana Hospitals Community Benefit – 2004: According to the ISDH Summary, in 2004 all Indiana hospitals had a total Operating Expense of \$12.065 billion. The total community benefit provided by Indiana hospitals was \$445.3 million, or 3.7% of the operating expense. Charity care was 76% of the community benefit figure, or \$337.7 million. This corresponds to charity care as 2.8% of operating expense. Other community benefit expenses, including research, education, and donations, was \$107.6 million. Figure 3A summarizes these figures.

¹⁸ As of March 2008, data for 2005 and 2006 was also available on line. For 2006, only general financial expense and revenue is reported. Part of this is due to a change in staff at the ISDH and may be altered in the future. As of June 2008, the entire ISDH website was being redone and the specific current data as well as historic data was no longer publicly available.

Figure 3A: 2004 Indiana Hospitals ISDH Summary Figures: ALL Hospitals

- Operating Expense: \$12,065.4 million
- Total Community Benefit: \$445.3 million
 - 3.70% of operating expenses
- Charity Care: \$337.7 million
 - 2.80% of operating expenses
 - 76% of community benefit expenses

Compilation of Indiana COMMUNITY Hospitals Community Benefit – 2004:

According to a compilation of individual hospital reports, in 2004 Indiana community hospitals had a total Operating Expense of more than \$11.6 billion.¹⁹ The total community benefit reported by Indiana hospitals was \$1,496.4 million, or 12.9% of the operating expense. Charity care was 36% of the community benefit figure, or \$542.1 million. Other community benefit expenses, including research, education, and donations, was \$954.3 million (Figure 3B).

**Figure 3B:
2004 Indiana Hospitals Compilation Figures: COMMUNITY Hospitals**

- Operating Expense: \$11,604.8 million
- Total Community Benefit: \$1,496.4 million
 - 12.89% of operating expenses
- Charity Care: \$542.1 million
 - 4.67% of operating expenses
 - 36% of community benefit expenses

¹⁹ These and subsequent figures are based on compilations done by the author, using individual hospital information from the ISDH Fiscal Reports. It should be emphasized that ALL hospitals in Indiana reported in every year and so the figures compared represent a complete panel study.

These figures show how a Compilation of Indiana Community Hospitals differs from the ISDH Summary (which includes all Indiana hospitals, including specialty facilities). This is shown in Table 3D.

Table 3D: Comparison of ALL Indiana Hospital Data (from ISDH Summary) and Indiana COMMUNITY Hospitals only (from Individual Hospital Report Compilation)

- For 2004 (in \$ million – Actual dollars spent, not adjusted for inflation)

	Operating Expense	Total Community Benefit - Expense	Total Community Benefit - As a % of Operating Expense	Charity Care - Expense	Charity Care - As a % of Operating Expense	Charity Care - As a % of Community Benefit
ALL Hospitals (ISDH Summary)	\$12,065.4	\$ 445.3	3.70%	\$337.7	2.80%	76%
COMMUNITY Hospitals only (Compilation of Individual reports)	\$11,604.8	\$1,496.4	12.89%	\$542.1	4.67%	36%

Community hospitals individually reported 60% more charity care in 2004 than was ultimately reported as being provided by all hospitals (adding specialty facilities) in the ISDH Summary. And the level of Total Community Benefit was more than three times as much as the ISDH Summary reported. Lacking information on specific processes, it can only be assumed that the ISDH either disallowed or simply did not count significant amounts of the Charity Care and other Community Benefit Expenses that were claimed by community hospitals – or used different criteria for their calculations. Another possibility is that hospitals reported as Charity Care (or even as other community benefit) costs that should

be more properly reported as Uncompensated Care – although the Charity Care figure is clearly identified in the reports.²⁰

The comparison of the two datasets indicates one of the potential problems that can arise when regulatory agencies compile summary figures. A detailed analysis of why the figures vary is difficult, as there is little information on precisely how the ISDH Summary is determined. The relative similarity of the operating expenses could be due to the smaller budgets of specialty hospitals, which are also a small percentage of the total hospitals in Indiana (25 of the 132 total number of Indiana hospitals, or 19%). However the disparities in charity care and total community benefit expenses seem to be considerably more than can be explained through differences in accounting procedures.²¹

One additional way to examine the validity of the ISDH Summary as compared to the compilation is to look at multiple years of data and evaluate how well the 2004 data reflects other years. Since the Charity Care figures seem to have a disparity, but also should be a more precise figure than the more inclusive and more disproportionate Community Benefit figures, Charity Care would seem to lend itself more readily to comparisons. Charity Care is also the figure that

²⁰ An alternative explanation for the percentage discrepancy is that the ISDH Summaries include specialty hospitals, and these hospitals may provide a relatively low level of Charity Care. These low levels could cause the percentage of Charity Care reported in the Summaries to also be low. However this does not explain why community hospitals might have a higher level of total Charity Care than the Summary records, making this explanation invalid.

²¹ A 2007 change in personnel responsible at the ISDH for these reports complicated efforts by the researcher to reconcile these variations. Three contacts with the new staff finally elicited 2006 data, but it was presented in raw form and did not contain delineations comparable to previous years. A final contact did provide a key to the numerous raw data categories, but was not helpful in providing comparable data or in being able to reconcile past disparities.

policymakers focus on most frequently. Charity Care as reported on the ISDH Summary report is therefore compared to the Community Hospital Compilation, over a three-year period.

Table 3E shows the change in Operating Expense and Charity Care from 2002-2004 for all Indiana hospitals (from the ISDH Summary reports) compared to the Operating Expense and Charity Care reported during the same period for Indiana community hospitals.²² (All ratios are expressed as a function of Total Operating Expenses.)

Table 3E: Charity Care as a % of Total Operating Budget – ISDH Summary Figures and Community Hospital Compilations (in \$ Millions – Actual dollars spent, not adjusted for inflation)

	ISDH Summary Operating Expense	Community Hospital Compilation Operating Expense	ISDH Summary Charity Care Allocation	Community Hospital Compilation Charity Care Allocation	ISDH Summary RATIO CC/ Operating Expense	Community Hospital Compilation RATIO CC/ Operating Expense
2002	9,870.0	\$9,423.9	\$320.9	\$455.1	3.3%	4.8%
2003	11,121.6	\$10,703.6	\$305.3	\$506.6	2.7%	4.7%
2004	12,065.4	\$11,515.1	\$337.7	\$542.1	2.8%	4.7%

The table shows a regular increase in Operating Expense for both the ISDH Summary and the community hospital compilation. The community hospital budget is approximately 95% of the ISDH Summary for all three years, with both figures growing at a comparable rate.²³ However the discrepancy noted in the

²² As emphasized earlier in the chapter, ALL hospitals in Indiana reported in every year and so the figures compared represent a complete panel study.

²³ The actual percentages are – 2002: 145.5%; 2003: 174.1; and 2004: 167.9%.

2004 Charity Care figure is replicated in both 2002 and 2003.²⁴ Both 2002 and 2003 show a similar situation of the community hospital compilation exceeding the ISDH Summary – by a factor of more than 150%.²⁵ The ISDH Summary records not only a Charity Care figure that is below the 4% standard but that also declines from 2002 to 2003 and 2004. In contrast the community hospital compilation remains constant at approximately 4.7% of the Operating Budget, a figure that would exceed the 4% standard.

The significance of this particular discrepancy has two related factors. First it indicates how summary reports and conclusions of general figures (such as a report on the “percentage of charity care provided by Indiana hospitals”) can be misleading. Second it indicates that more in-depth and individualized information is needed to determine precisely what is being reported as well as the process of that reporting. This leads to a conclusion that while government reporting requirements might encourage general compliance, the validity of cumulative summary data and resulting conclusions could be suspect – especially if the purpose is to use these summaries to draw conclusions about hospital philanthropic behavior.

²⁴ These expense figures are actual dollars, not adjusted for inflation. As the primary use of the figures in these sections is to compare percentages of different expenditures during the same years – and changes in those actual percentages – inflation-adjustment is not necessary. In this thesis, the figures have not been adjusted for inflation, except where significant and these are noted accordingly.

²⁵ The actual percentages are – 2002: 142%; 2003: 165%; and 2004: 161%.

Since the ISDH does not do more specific summaries of different categories of hospitals (such as by ownership or size), and because of the uncertainties involved in these reports, there is no further investigation and analysis of the Summary Reports in this paper. The preceding analysis shows that to determine the charity care and community benefit levels of specific sub-categories of hospitals – or even of individual hospitals – requires more individualized examination, such as investigating and compiling the specific reports of individual hospitals. The next section and subsequent sections of this paper examine data based on the Compilation, in more detail.

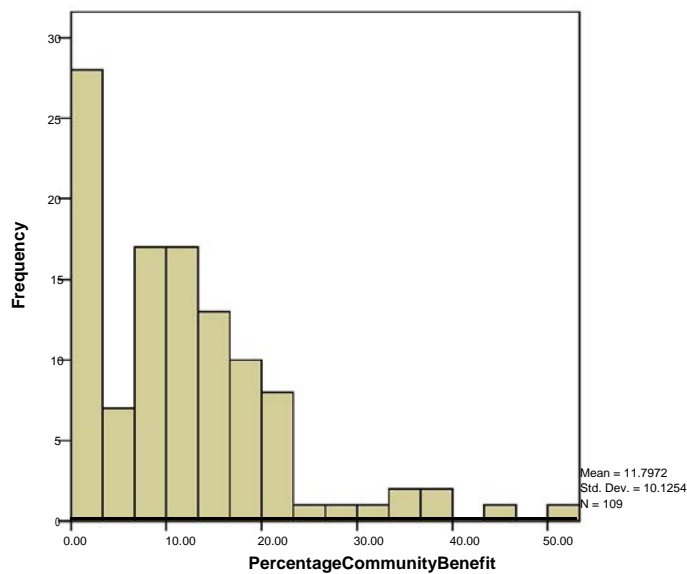
The Community Benefit of Indiana Community Hospitals

In 2004 Indiana community hospitals (according to the compilation of individual reports) spent \$1,496.4 million on community benefit, or 12.86% of their total operating expenses. This compiled figure far exceeds the 5% standard. One interpretation of this figure could be that Indiana community hospitals provide an exceptional level of programs for the benefit of their communities. However, an alternative conclusion could be that because this figure is so much higher than the standard of 5%, additional information may be reported.²⁶ There can be a caution in drawing conclusions from gross figures such as this compilation. If the purpose of a statistical comparison is to evaluate the commitment of an individual hospital to its community, it can be more illustrative to compare that hospital to

²⁶ This questioning is also encouraged due to the fact that the Compilation figure is much higher than the ISDH Summary, as observed earlier in this chapter. Even though this Summary is shown to have limited usability as an evaluation standard, the discrepancy between the Summary and the Compilation at least indicate that further verification of the Compilation figure is warranted.

an average of the hospitals or to the median hospital – rather than to a total compilation. Looking at the compilation figure in terms of the individual hospitals, the overall discrepancies might indicate problems with how some individual hospitals report the figures – or at the least there is a wide disparity in the reports from individual hospitals due to some factor. Figure 3C shows the distribution of community benefit for Indiana community hospitals.

Figure 3C: 2004 Community Benefit Compilation – All Community Hospitals
Community Benefit Expense as a % of Total Operating
Expense Test Value = 5.0



Null Hypothesis - H_0 : The % of community benefit expense is = 5%²⁷ N: 109
 Median Hospital: 10.5% Mean: 11.7972
 SD: 10.125
 t: 7.009

The primary purpose of Figure 3C is to graphically portray the wide disparity in the level of individual hospital reports of community benefit. The average of the

²⁷ Test for H_0 : The mean = 5.0 can be rejected with a high degree of significance (t = 7.009).

individual hospitals (11.79%) far exceeds the 5% standard;²⁸ the median figure of a “typical” Indiana hospital is 10.5%, slightly lower but still far exceeding the 5% standard. The conclusion is that Indiana hospitals do provide more than 5% community benefit (i.e. 11.8%) and therefore are in compliance with national standards.

However, when arranged individually, more than one-quarter of the Indiana hospitals (31 hospitals or 29%) are under the 5% standard; 27 of those hospitals are under 4%. At the other extreme, 26 hospitals (24%) report over 17% of their budget is devoted to community benefit; 16 of those hospitals (15%) report more than 20% of their total operating expense budget is spent on Community Benefit, further showing the wide disparity. The highest reported expenditure is 52.4%. The results shown in Figure 3C also indicate that there is a very significant difference in the mean level of community benefit reported by individual hospitals and the 5% standard.

In 2004, the median Indiana hospital provided 10.5% of its total operating budget for community benefit, more than double the national standard. The standard deviation of over 10 (SD = 10.125), indicates a high degree of variability among individual hospitals in actual reported community benefit expenditures. The exceptionally high t- score of 7.009 allows us to reject the null hypothesis with a very high level of significance and we cannot assume that most hospitals expend

²⁸ The difference in the figures of 12.86% and 11.7% is that the first is the ratio of total community benefit as a percentage of total operating expenses, for all community hospitals in aggregate. The latter is an average of individual hospital community benefit/operating expense ratios.

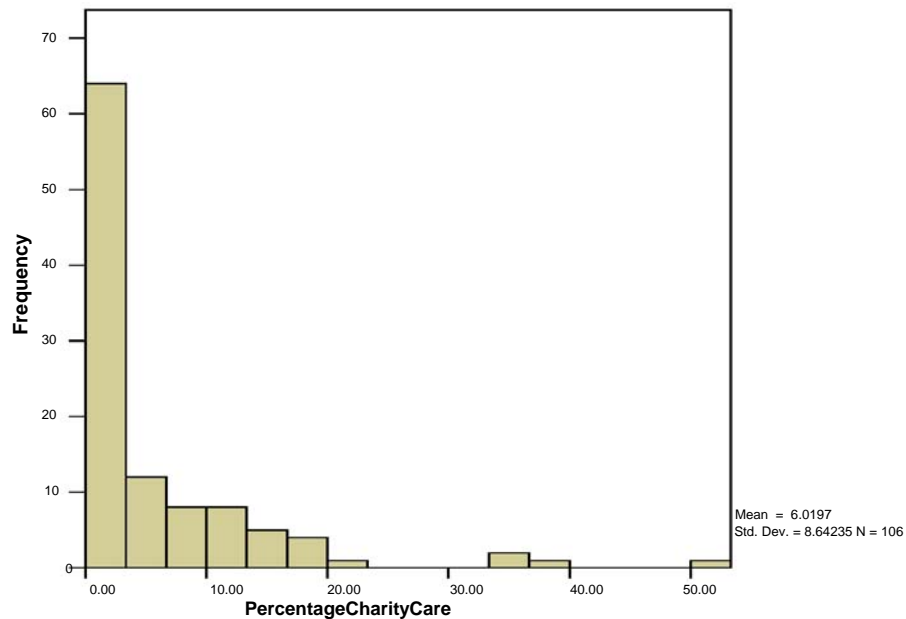
5% on community benefit. The alternative hypothesis is – H_a : The % of community benefit expense is $<$ or $>$ 5%. Because both the mean and the median hospital exceed the 5% standard, the hypothesis that H_a : The % of community benefit expense is $>$ 5% can be verified.

However, one uncertainty in this breakdown is determining which hospitals fall into the various quartiles and why their reporting should vary so greatly. One possibility is that some hospitals have an extraordinary commitment to providing benefits to their community while others are far more self-serving. Another conclusion is this difference might be due to varying ownership or other factors – such as management styles or community demographics. A further consideration is that these figures do not tell precisely what is being counted as Community Benefit – or even whether Charity Care is separated from other forms of community benefit. As Charity Care is a primary focus of governmental evaluation and potentially could be more specific as to what exactly is being recorded, this subset of Community Benefit is examined next.

Evaluation of Charity Care: According to the compiled data, community hospitals in Indiana in 2004 appear to provide an adequate level of charity care. In 2004, the 105 community hospitals in Indiana (those with viable charity care data for that year, out of 109) reported in aggregate \$542.1 million in Charity Care, or 4.67% of total operating expenses, satisfying the Texas 4% standard. However, as Figure 3D shows, the distribution of charity care reported by individual

community hospitals in 2004 has a wide disparity among individual hospitals – with a high number concentrated at the low end.

Figure 3D: Charity Care: All Community Hospitals in Indiana – Compilation 2004
Charity Care Expense as a % of Total Operating Expense
Test Value = 4.0



Null Hypothesis - H_0 : The % of charity care expense is = 4%²⁹ N: 106
 Median Hospital: 2.8% Mean: 6.0197
 SD: 8.64235
 t: 2.406

The average (mean) for community hospitals is higher than 4% charity care: 6.06%. The standard deviation of 8.64 indicates a high degree of variability among individual hospitals in actual reported charity care expenditures. The t-score of 2.046 allows us to reject the null hypothesis with a level of significance

²⁹ Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = 2.406).

and we cannot assume that most hospitals expend 4% on charity care. If we use the average to draw conclusions, we could conclude that Indiana hospitals do provide much more than 4% charity care and therefore are in compliance with national standards. However, the median hospital reports only 2.8% charity care, significantly lower than the average and the 4% standard. The results indicate that there is significant difference in the level of charity care reported by individual hospitals and the 4% standard, with an extremely high standard deviation ($SD = 8.64$).

If we use the charity care standard of 4% of operating revenue, 70 hospitals (67%) report providing charity care at less than the 4% standard; 34 hospitals report providing more than 4% charity care. At the low extreme, 42 hospitals (40%) reported less than 2% in charity care; 21 hospitals (20%) reported less than 1%. At the high extreme, three hospitals reported providing more than 30% in charity care, with one hospital reporting 52%.

While 25% of the hospitals report devoting 10% or more of their operating budget to charity care, these help raise the Indiana average. This not only helps skew the averages and medians, but it raises questions about whether these hospitals are unusually beneficent in providing charity care, have reported information based on different criteria, or are hospitals that provide significant charity care due to being a sole provider, possibly being located in a particularly poor

community, not located near public hospitals, or other environmental factors. This disparity also calls into question conclusions based solely on these reports. A brief look at three-year figures (2002-2004) reveals a consistency in reporting, meaning 2004 is not an unusual year. Table 3F shows how the overall level of Charity Care by community hospitals (of all ownership types) in Indiana changed over a three-year period, as well as the percentage of the operating expenses represented by that charity care.

Table 3F: Community Hospital Compilation – 2002-2004
(Actual dollars spent, not adjusted for inflation)

	Operating Expense	Charity Care Allocation	<u>Charity Care/Expense</u>
2002	\$ 9,481.4 million	\$ 454.7 million	<u>4.80%</u>
2003	\$ 10,752.4 million	\$ 467.8 million	<u>4.35%</u>
2004	\$ 11,604.8 million	\$ 542.1 million	<u>4.67%</u>

As Table 3F shows, there appears to be a relative consistency in the percentage of charity care reported by all Indiana community hospitals, exceeding the 4% standard. While between 2002 and 2003 there is a drop of nearly 10%, it still remains above the 4% level and the subsequent rise in 2004 gives the impression that the level of charity care by community hospitals remains sufficient and relatively consistent.

Table 3G shows a statistical analysis of charity care presented by individual Indiana community hospitals over the three-year period.

Table 3G:
Charity Care Provided by All Indiana Community Hospitals (Compilation)

	2002	2003	2004
N	107	109	105
Mean	5.6578%	6.0727%	6.0637%
^{t30}	2.340	2.332	2.439
Median	2.00%	2.19%	2.80%

The level of charity care appears to be even higher than it is in the aggregate, with the mean level of charity care being 5.6% and higher, while showing the same small fluctuations in 2003 and 2004. The median level of charity care, while still below the 4% standard, shows an increase in 2004. The $t = 2.332$ to $t = 2.439$ indicates that the null hypothesis can be rejected with a degree of significance that is similar to the $t(104) = 2.439$ for 2004.

These figures lead to a conclusion that the high Indiana figure of hospital providing more than 4% of expenses for charity care (both as a means and as a median) is due to a few hospitals reporting an extremely high percentage of charity care rather than there being a broad state compliance with specific charity care levels. More individualized analyses are needed to determine how well these reports reflect individual hospital behavior. The preceding analysis of Charity Care shows how a few hospitals with extraordinary reports can skew average or compilation figures. Median figures help provide a more clear picture of a “typical” hospital, but still provide few clues to the underlying motivations, practices, or other factors that might affect these results.

³⁰ Test for H_0 : The mean = 4.0 can be rejected with a degree of significance ($t = 2.332$ to 2.439).

The above raises the question of how and why individual hospitals have discrepancies. To determine this requires looking at varying types of hospitals as well as individual hospital data. But before further evaluating individual hospital data or various sub-categories of the Indiana hospital sector, a comparable summary of Uncompensated Care shows how factors related to charity care – especially the issue of bad debt – could indicate one variability in how hospitals are recording non-revenue producing care. Since Uncompensated Care is the standard advocated by the American Hospital Association (as opposed to the Charity Care of the Community Benefit standard used by the CHA/VHA) – this could be the figure that different hospitals might use (especially for-profit and public hospitals. See section on “Hospital Ownership” below). One evaluative standard that is used is Uncompensated Care as 6% of total operating expenses, corresponding to standards of the American Hospital Association (Mann et al 1997).

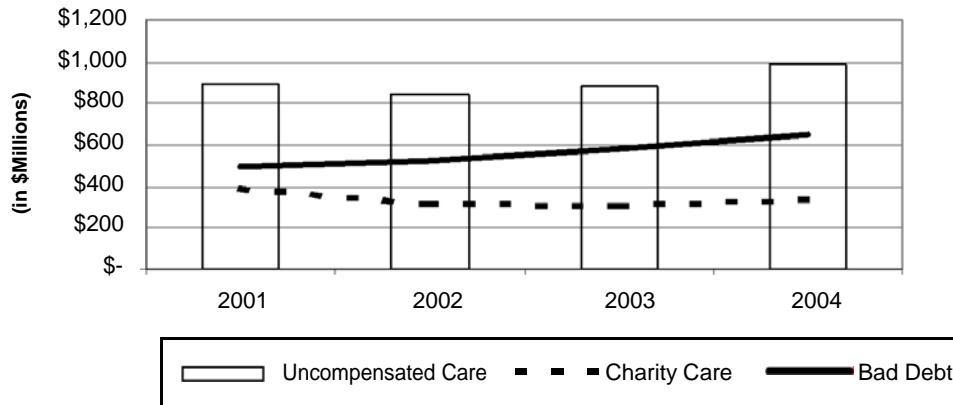
Uncompensated Care in Indiana Community Hospitals: Table 3H shows how Uncompensated Care has changed for Indiana community hospitals from 2002-2004.

**Table 3H: Uncompensated Care as a % of Expense
 – Indiana Community Hospitals Compilation**
 (in \$ Millions – Actual dollars spent, not adjusted for inflation)

	Uncompensated Care	Ratio UC/Exp	Change in UC Ratio from 2002	<i>Ratio: Charity Care Expense</i>
2002	\$ 939.5	9.52%		4.80%
2003	\$ 1,069.8	9.54%	+ 2.1%	4.35%
2004	\$ 1,097.4	9.10%	- 4.4%	4.67%

Despite a decline in Uncompensated Care, the overall percentage of Operating Expense is more than 9%, over 50% higher than the standard of 6%. During the same period, the average Charity Care provided by Indiana community hospitals varied between 4.35% and 4.8% of total operating expense, more than the 4% standard but by much lower a factor than for Uncompensated Care (20% higher than the standard in the highest year, 2004). As Uncompensated Care is considered to be charity care plus bad debt, a comparatively lower level of Charity Care than Uncompensated Care could suggest that Indiana hospitals have a high percentage of Bad Debt compared to Charity Care. Chart 3-1 shows the level and changes in Bad Debt in relation to Charity Care from 2002-2004.

Chart 3-1: Community Hospital Uncompensated Care



While the actual amount of Bad Debt by Indiana community hospitals has steadily risen, there has been a slight fluctuation in Uncompensated Care due to the variability of Charity Care. When Bad Debt is compared as a percentage of Operating Expenses (Table 3I), a slight increase is noted, while the percentage of Charity Care and Uncompensated Care show a slight decline.

**Table 3I: Bad Debt as a % of Expense
– Indiana Community Hospitals Compilation**
(in \$ Millions – Actual dollars spent, not adjusted for inflation)

	Operating Expense	Bad Debt	Ratio: Bad Debt/Expense	Ratio UC/Exp	Charity Care Allocation	Ratio: Charity Care Expense
2002	\$ 9,481.4	\$ 519.2	5.47%	9.52%	\$ 454.7	4.80%
2003	\$ 10,752.4	\$ 578.5	5.38%	9.54%	\$ 467.8	4.35%
2004	\$ 11,604.8	\$ 652.1	5.61%	9.10%	\$ 542.1	4.67%

Indiana hospitals seem to identify more shortfall as bad debt than charity care (e.g. bad debt is 20% higher than charity care in 2004). This reflects one potential concern of policymakers that there may be an incentive for hospitals to declare less lost revenue as bad debt and shift this over to charity care,

especially as government policy increasingly focuses on charity care as an evaluative standard. The uncertainty of how individual hospitals report bad debt and whether they include some of this bad debt as part of charity care further complicates reported figures.

Summary of Part Three: There are notable disparities between summary figures compiled by the state of Indiana and aggregate information determined by individual hospitals reports. According to the ISDH Summary, Indiana hospitals are significantly under the desired levels of charity care and community benefit. Conversely, according to a compilation of community hospitals using individual ISDH reports, Indiana hospitals exceed those levels of expenditure. When individual hospitals are arrayed according to their percentage of community benefit and charity care expenditures, a wide disparity is noted. This disparity calls into question how useful average, median, compilation, or summary figures might be for evaluating individual hospitals or even different groups and types of hospitals. When the uncertainties surrounding uncompensated care and its relation to community benefit and charity care are considered, this compounds the questions of the validity of the comparability of the reported figures. To further examine how Indiana hospitals actually provide charity care, serve community benefit, and exhibit philanthropic behavior requires a more detailed and individualized investigation. The next section provides breakdowns differentiating for ownership types, system membership, and religious affiliation.

Analysis of Indiana Aggregate Data: Hospitals Differentiated by Ownership,
System Membership, or Religious Affiliation

Part Four uses individual hospital ISDH data reports to compare the general level of charity care based on two comparisons – hospital ownership and system affiliation. The system analysis is further segmented into religiously affiliated systems and non-religious systems. The purpose of this examination is to determine if the variability in reporting by community hospitals as a whole seen in the previous section becomes more consistent when sub-categories of hospitals are investigated. One consequence of this examination is to determine whether valid conclusions can be made regarding the affect of these factors on community benefit and charity care.

The first evaluation is based on hospital ownership. Since policy makers specifically focus on the community benefit standard and nonprofit hospitals, how nonprofit hospitals differ particularly from for-profit hospitals is a recurring question in previous studies. One implication of various policy makers is that nonprofit hospitals should provide a higher level of charity care and community benefit than for-profit hospitals. This section examines whether this is true in practice for hospitals in Indiana – or if the voluntary reporting process even allows us to make this determination. A second evaluation is based on system affiliation. Centralized systems can have an influence on the practices and procedures of their member hospitals, an influence that could be an expression of coercive isomorphism (as outlined in Chapter One). This section looks at the

relevance of differences in the levels of community benefit and charity care provided by system-affiliated hospitals from facilities that are independent. As one aspect of system affiliation, the next section specifically looks at the affect of religious affiliation on Indiana hospital charity care. Religiously affiliated hospitals are not only part of systems, most are also part of the Catholic Health Association (CHA), a primary architect of the most widely accepted community benefit standards. How this religious affiliation might encourage charity care and community benefit is the focus of the third evaluation.

Evaluation #1: Hospital Ownership

An extensively debated and studied aspect of hospital community benefit revolves around the question of whether nonprofit hospitals differ from for-profit hospitals in the level of charity care and community benefit they provide. One summary of this research found a greater number of studies indicated that nonprofit hospitals provide a higher level of community benefit than for-profit hospitals, although the differences were not overwhelming nor were the criteria used in the different studies necessarily similar (Schlesinger, Mitchell, and Gray (2003), and Schlesinger and Gray (2006b). The data on Indiana hospitals is evaluated to determine if it is possible to make a meaningful comparison in Indiana based on hospital ownership – and whether ownership differences might explain differences in hospital percentages of charity care and community benefit.

Table 3J presents the total levels of community benefit and charity care (as reported on the ISDH forms for 2004) according to the ownership of the hospitals.

**Table 3J:
Indiana Community Hospitals Compilation –
Percentage of Community Benefit and Charity Care:
By Ownership Type (2004)**

<u>OWNERSHIP</u>	Total Community Benefit	Charity Care
Nonprofit	13.7%	2.7%
City/County	9.5%	10.8%
For-Profit	7.4%	8.0%

Table 3J shows two significant factors. The first is that the level of charity care reported by nonprofit hospitals is significantly below that of public and for-profit hospitals. The second is that the level of total community benefit for both city-county hospitals and for-profit hospitals is LESS than (sic) what is reported for charity care alone. One possible conclusion from the second factor is that the ISDH reporting formats and requirements are different for nonprofit hospitals than they are for other ownership types: i.e. for-profit and public hospitals report community benefit separately from charity care – while nonprofit hospital include charity care in their total community benefit figures. However this is only speculative and a lack of more detailed data available from public and for-profit hospitals makes verification difficult.

A further complication to this comparison is whether hospitals report gross or net community benefit. As the nonprofit hospitals report two different community benefit figures in two different sections of the ISDH report it is difficult to

determine how comparable the different compilations are (as an example, in 2004 only one of the 67 nonprofit hospitals shows a correspondence in the figures from the two sections). This discrepancy points up the problem of requiring additional information without also ensuring that the data that show the relationship between the two is also shared. Because of this uncertainty of what is counted as community benefit, only charity care is evaluated for the remainder of this chapter. The next two chapters of this dissertation will investigate factors that specifically affect community benefit for nonprofit hospitals.

Before attempting to interpret the charity care figure, one other important caveat to raise is whether for-profit and public hospitals are actually reporting “charity care” as being uncompensated care (as defined by the American Hospital Association), which includes bad debt as part of “charity care.” This is an important question, since the exclusion of bad debt from charity care is a criteria developed by nonprofit hospital associations (i.e. the Catholic Health Association and Voluntary Hospitals of America) and there does not seem to be an incentive for hospitals that are not nonprofit (i.e. public or for-profit) to also adopt those specific reporting criteria.

Noting these caveats, Table 3K shows a statistical comparison of the three ownership types.

**Table 3K:
Indiana Community Hospitals –
Percentage of Charity Care: By Ownership Type (2004)**

	Nonprofit	For-Profit	Public
N	60	8	37
Mean	2.7003	9.2288	10.8714
Std. Deviation	2.45784	6.54767	12.39995
t³¹	-4.096	2.259	3.371
Median	2.06	8.49	7.54

The average (mean) percentage of charity care reported by for-profit and public hospitals is much higher than the mean charity care reported by nonprofit hospitals. This is also true for the median hospital. However extremely high standard deviations (for-profit: 6.5; public: 12.4; and nonprofit: 2.5) – approaching or exceeding the mean of each of the types – indicates a wide degree of variation within each of the types. The t- scores allow us to reject the null hypothesis with a level of significance and we cannot assume that most hospitals expend 4% on charity care, regardless of ownership type. For each ownership type, the median hospital reports less charity care than the average, although nonprofit hospitals still report considerably less than for-profit and public hospitals. For-profit hospitals and public hospitals exceed the 4% standard while nonprofits are considerably under that 4% standard.

Another comparison is to evaluate the percentage of hospitals in each ownership type that report less than the 4% standard. Table 3L shows this comparison for 2004:

³¹ Null Hypothesis - H₀: The % of charity care expense is = 4%. Test for H₀: The mean = 4.0 can be rejected with a degree of significance for all ownership types (t = 2.259, 3.371, and -4.096).

Table 3L: Percentage of Indiana Hospitals with less than 4% Charity Care in 2004: By Ownership Type

	Total Number of Hospitals	Number of Hospitals with less than 4% Charity Care	% of Hospitals with less than 4% Charity Care
Nonprofit	60	50	83%
For-Profit	8	3	38%
Public	37	17	46%

Table 3L shows a very high percentage of nonprofit hospitals reporting less than 4% Charity Care, giving credence to the average and median figures. A Mann-Whitney (U test) indicates the difference in the percentage of charity care provided by different hospital ownership types in 2004, is not statistically significant:

Percentage of charity care provided by nonprofit and for-profit hospitals in 2004:

Nonprofit - n_1 : 60
 For-Profit - n_2 : 9
 U: 143.5
 Z = 2.24

$P_{(1)} = 0.0125$ $P_{(2)} = 0.0251$

Percentage of charity care provided by nonprofit and public hospitals in 2004:

Nonprofit - n_1 : 60
 Public - n_2 : 37
 U: 709
 Z = 2.97

$P_{(1)} = 0.0015$ $P_{(2)} = 0.003$

Percentage of charity care provided by public and for-profit hospitals in 2004:

Public - n_1 : 37
 For Profit - n_2 : 9
 U: 174
 Z = -0.19

$P_{(1)} = 0.4247$ $P_{(2)} = 0.8493$

The comparison of the medians of both for-profit vs. nonprofit hospitals and of nonprofit vs. public hospitals, the z value and U value yield a $p < 0.05$, indicating the difference between the two samples is significant (p as a two-tailed test), but not highly so. This allows us to reject the null hypothesis that the two samples have similar medians and are from similar populations. However the low z value and higher p-values between public and for-profit hospitals do not allow us to reject the null hypothesis, and indicate there could be a degree of similarity between the medians of charity care provided by for-profit and public hospitals. However uncertainty of the figures reported by for-profit hospitals (as well as potentially of public hospitals) could also call these conclusions into question, as is detailed below.

There is another approach to evaluate the validity of the charity care figures of different hospital types: the consistency of reporting from year-to year. While it is possible that one year would see a high influx of charity care patients for a specific hospital while a following year would see very few, it is unlikely this would be a prevalent situation, as most hospitals serve relatively similar populations each year.³² Tables 3M, 3N, and 3O show how the percentage of charity care for each of three years compares for nonprofit hospitals, for-profit hospitals and public hospitals, respectively.

³² A further consideration is, if vast fluctuations in yearly charity care figures are determined to be a “normal” phenomenon, then evaluating yearly charity care figures becomes a questionable policy practice. If this is a typical situation, that data might be better compared over a two or even a three-year period rather than one year.

**Table 3M:
Indiana Community Hospitals – Percentage of Charity Care:
By Ownership Type: Nonprofit (2002-2004)**

	2002	2003	2004
N	60	62	60
Mean	2.3735	2.6645	2.7003
Std. Deviation	2.16913	2.67042	2.45784
† ³³	-5.808	-3.938	-4.096
Median	1.67	1.74	2.06
% of Hospitals under 4% standard	80%	82%	83%

**Table 3N:
Indiana Community Hospitals – Percentage of Charity Care:
By Ownership Type: For-Profit (2002-2004)**

	2002	2003	2004
N	6	8	8
Mean	11.2233	8.8013	9.2288
Std. Deviation	7.74918	7.65054	6.54767
† ³⁴	2.283	1.775	2.259
Median	11.58	6.94	8.49
% of Hospitals under 4% standard	33%	38%	38%

**Table 3O:
Indiana Community Hospitals – Percentage of Charity Care:
By Ownership Type: Public (2002-2004)**

	2002	2003	2004
N	38	38	37
Mean	10.4113	11.2187	10.8714
Std. Deviation	9.48068	13.38912	12.39995
† ³⁵	4.169	3.324	3.371
Median	10.27	7.21	7.54
% of Hospitals under 4% standard	34%	47%	46%

³³ Null Hypothesis - H₀: The % of charity care expense is = 4%. Test for H₀: The mean = 4.0 can be rejected with a degree of significance (t = -3.938 to -5.808).

³⁴ Null Hypothesis - H₀: The % of charity care expense is = 4%. Test for H₀: The mean = 4.0 cannot be rejected with a degree of significance (t = 1.775 to 2.283) for all three years.

³⁵ Null Hypothesis - H₀: The % of charity care expense is = 4%. Test for H₀: The mean = 4.0 can be rejected with a degree of significance (t = 3.371 to 4.169).

There appears to be a relative consistency across the three-year figures for each of the ownership types, giving a level of validity to the reported figures. A Mann-Whitney (U test) shows the difference in the percentage of charity care provided by different hospital ownership types over the three-year period is not statistically significant. This is similar to the results for 2004 (above):

Comparison of the medians of the percentage of charity care provided by Nonprofit and For-profit hospitals – 2002-2004:

Nonprofit - n_1 : 182
 For Profit - n_2 : 27
 U: 1845
 Z = 2.09
 $P_{(1)} = 0.0183$ $P_{(2)} = 0.0366$

Comparison of the medians of the percentage of charity care provided by Nonprofit and Public hospitals – 2002-2004:

Nonprofit - n_1 : 182
 Public - n_2 : 113
 U: 6222.5
 Z = 5.7
 $P_{(1)} = <.0001$ $P_{(2)} = <.0001$

Comparison of the medians of the percentage of charity care provided by Public and For-profit hospitals – 2002-2004:

Public - n_1 : 113
 For-Profit - n_2 : 27
 U: 1757
 Z = -1.22
 $P_{(1)} = 0.1112$ $P_{(2)} = 0.2225$

The high z value and U value for the three-year public vs. nonprofit comparison yield a $p < 0.001$, indicating the difference between the two samples is highly significant (p as a two-tailed test). This allows us to reject the null hypothesis with a high degree of significance that the two samples have similar medians and are from similar populations. The for-profit vs. nonprofit comparison also has a p value of $< .05$, indicating the difference between the two samples is significant

but less so than between public and non-profit hospitals. The higher p value of the comparison between public and for-profit hospitals does not allow us to reject the null hypothesis, indicating a potential comparability between the medians of the two populations.

The above comparisons permit three conclusions. First, the relative consistency of figures over the three years allows us a degree of trust that the figures reported are consistent. All three ownership comparisons show a relative level of consistency in the reported figures, with only for-profit hospitals indicating a high degree of difference in the 2002 figures as compared to the other two years. This could be due to three hospitals not reporting for that year (as opposed to other years when all but one of the nine Indiana for-profit hospitals reported).

This also leads to one conclusion that differences found in computations involving for-profit hospitals could be due to the relatively small number of for-profit hospitals in Indiana. This small number of hospitals can mean a single hospital could cause a significant shift in the averages for that category. If there are noteworthy yearly fluctuations in the data reported by that hospital, the comparative data might be skewed even more.

Second, the means and median figures showing nonprofit hospitals providing less charity care than for-profit and public hospitals can be assumed to have a relative degree of validity. To understand why nonprofit hospitals might provide (or report) less charity care requires further research into demographic and

operational criteria that might account for the difference. Third, for-profit hospitals and public hospitals seem to have a relative similarity in their percentage of charity care. However, this conclusion also assumes validity in the for-profit hospital charity care figures, an assumption that might not be warranted. An examination of for-profit hospitals charity care figures is the topic of the next section.

For-Profit Charity Care: One specific example shows how the for-profit charity care figure might be questioned. This example also demonstrates how individual hospital situations can unduly influence broader conclusions from self-reported data, without also taking into consideration individual hospital processes and contexts. St. Joseph Hospital in Fort Wayne, Indiana is a 211-bed facility that was originally founded as a Catholic hospital. Situated within a relatively poor area of central Fort Wayne, its location encourages a comparatively frequent use by individuals and families with inadequate health insurance or private means. In 1998 St. Joseph was acquired by Quorum, a for-profit hospital chain (which in 2000 was bought by another for-profit system, Triad). St. Joseph converted from a non-profit Catholic hospital to a for-profit hospital in 1999, yet maintained the original name. There continued to be a high level of charity care from St Joseph Hospital, providing 14% in 2002 and 17% in 2003. However these figures are now counted as for-profit charity care, although the hospital itself has not changed location or (presumably) the population of patients it serves. One additional factor in this example is that in 2004 there was NOT a high level of

charity care reported at St Joseph (3.3%), but there is no explanation or other information available as to why this might have dropped. This example is one instance of how specific data from any hospital, but particularly a for-profit hospital that is less subject to some types of policy scrutiny than a nonprofit hospital, can vary with seemingly little explanation or clear rationale.

To further illustrate the variability in individual for-profit hospitals, Table 3P shows the percentage of charity care reported by the nine for-profit hospitals in Indiana for the years 2002-2004 (in the table, every other hospital is designated as bold and centered –to more clearly define the figures for individual hospitals).

**Table 3P:
Charity Care as a Percentage of Operating Expense
Reported by Indiana For-profit Hospitals (2002-2004):**

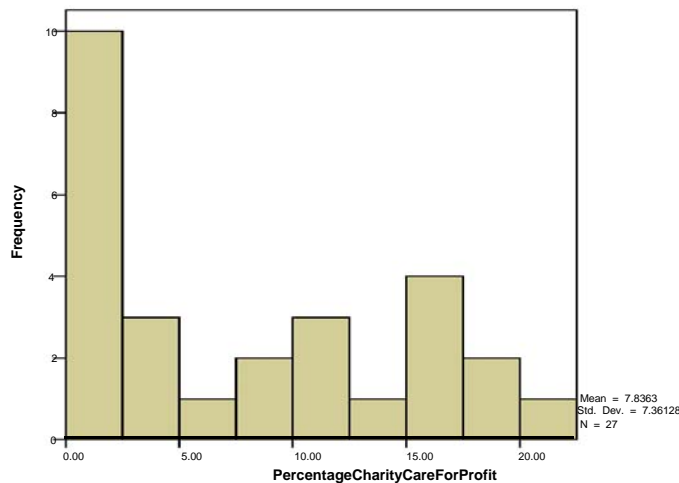
<u>Year</u>	<u>For-Profit Hospital</u>	<u>%Charity Care / Operating Expense</u>	
2004	A	8.49%	
2003	A	15.40%	
2002	A	2.90%	
2004		B	19.60%
2003		B	16.54%
2002		B	16.51%
2004	C	3.97%	
2003	C	0.94%	
2002	C	NR	
2004		D	NR
2003		D	NR
2002		D	NR
2004	E	16.00%	
2003	E	0.46%	
2002	E	11.58%	
2004		F	0.61%
2003		F	0.00%
2002		F	NR
2004	G	3.33%	
2003	G	17.85%	
2002	G	14.62%	
2004		H	12.28%
2003		H	12.28%
2002		H	20.64%
2004	I	9.55%	
2003	I	6.94%	
2002	I	1.09%	

Only one hospital (For-Profit Hospital “B”) has less than a 50% fluctuation in their level of reported charity care in any two years,³⁶ although Hospital “B” did report an increase of nearly 20% between 2003 and 2004. Three of the nine hospitals (33%) did not report figures for at least one year. One hospital (For-Profit Hospital “H”) reported the exact same operating expense and charity care figures

³⁶ In a similar three-year comparison of public hospitals, 21 of the 37 hospitals (57%) reported a charity care fluctuation of more than 50% in two years.

in 2004 as they had in 2003³⁷ – leading to the suspicion that they may have simply copied the 2003 figures to complete the form for 2004. Figure 3E shows the relative distribution of charity care by for-profit hospitals over a three-year period, indicating the wide variability in the reported figures.

Figure 3E: For-Profit Charity Care – 2002-2004
Test Value = 4.0



Null Hypothesis - H_0 : The % of charity care expense is = 4%³⁸ N: 22
Mean: 9.6173
t: 3.758
Median Hospital: 11.6%

The standard deviation that exceeds the mean shows a wide disparity of individual for-profit hospitals. However the relatively low t-score (especially in 2003) does not allow us to reject the null hypothesis with a high degree of significance. Because of this disparity and seeming contradiction, conclusions are difficult to draw based upon the limited statistical evidence. Table 3Q shows the for-profit charity care figures over a three-year period.

³⁷ Not only the ratio of charity care was similar but also the actual dollar figure for both operating expense and charity care were exactly the same for those two years.

³⁸ Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = 3.758).

Table 3Q: For-Profit Hospital Charity Care – 2002-2004

Test Value = 4.0

	2002	2003	2004
N	6	8	9
Mean	11.2233%	8.8013%	9.6173%
Std. Deviation	7.74918	7.65054	6.54767
³⁹	2.283	1.775	3.758
Median	11.58%	6.94%	11.6%

Table 3Q shows a significant variability in the yearly data, indicating a potential lack of consistency in individual hospital data as well as for the entire population. The median especially shows a considerable fluctuation in 2003 as well as yearly differences in the mean that allow for limited conclusions. Running a Mann-Whitney (U test) to compare the medians of for-profit and nonprofit hospital charity care over the three-year period also finds a lack of comparability:

Nonprofit - n_1 : 182
For-profit - n_2 : 22
U: 3069.0
Z = 4.07973

The high z value and U value yield a $p < 0.001$, indicating the difference between the two samples is highly significant (p as a two-tailed test). This allows us to reject the null hypothesis that the two samples have similar medians and are from similar populations.

The initial compilations indicate that there would seem to be a significant difference in the charity care provided by nonprofit and for-profit hospitals – with for-profit hospitals far out-performing nonprofit hospitals. However because of

³⁹ Null Hypothesis - H_0 : The % of charity care expense is = 4%. Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = 1.775 to 3.758) for two of the three years; it is confirmed for 2003.

the questionable data from for-profit hospitals – and the limited number of for-profit hospitals – any conclusions that might be drawn from these figures are suspect. The variability of the for-profit charity care figures coupled with the uncertainty of what precisely is being reported as charity care and as community benefit – along with the small number of for-profit hospitals in Indiana – make further comparisons of for-profit to nonprofit hospitals difficult. A similar lack of detail from the ISDH Reports on public hospitals also makes meaningful analysis difficult. Because of the lack of clarity of for-profit hospital information and as the focus of this paper is on nonprofit philanthropic behavior and community benefit standards, no additional comparisons with for-profit hospitals are included as part of this paper. Although the focus of this paper is on nonprofit hospitals, a brief look at how nonprofit and public hospitals compare is warranted.

Public Hospital Charity Care: Running a Mann-Whitney (U test) to compare the medians of public and nonprofit hospital charity care over the three-year period (2002-2004) finds a lack of comparability similar to that of nonprofit hospitals and for-profit hospitals:

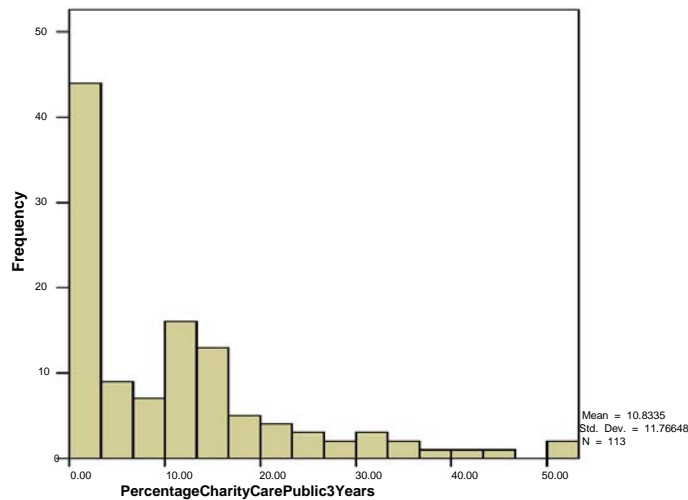
Nonprofit - n_1 : 182
Public - n_2 : 113
U: 6222.5
Z = 5.7

$P_{(1)} = <.0001$ $P_{(2)} = <.0001$

The high z value and U value yield a $p < 0.001$, indicating the difference between the two samples is highly significant (p as a two-tailed test). This allows us to reject the null hypothesis that the two samples have similar medians and are

from similar populations. Figure 3F shows the level of charity care reported by public hospitals from 2002-2004.

Figure 3F:
Charity Care: Public Hospitals in Indiana – Compilation 2002-2004
 Charity Care Expense as a % of Total Operating
 Expense Test Value = 4.0



Null Hypothesis - H_0 : The % of charity care expense is = 4%⁴⁰ N: 113
 Mean: 10.8335 %
 Standard Deviation: 11.76648 t: 6.174
 Median Hospital: 8.68 %

As Figure 3F shows, although the average and median of public hospitals in Indiana is well over the 4% standard, there is a great deal of variability in individual hospitals. Table 3R provides a statistical comparison of the three-year figures, indicating a relative consistency in reporting and in the high standard deviation as well as t-values.

⁴⁰ Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = 6.174).

**Table 3R:
Indiana Community Hospitals –
Percentage of Charity Care:
By Ownership Type: Public (2002-2004)**

	2002	2003	2004
N	38	38	37
Mean	10.4113	11.2187	10.8714
Std. Deviation	9.48068	13.38912	12.39995
t ⁴¹	4.169	3.324	3.371
Median	10.27	7.21	7.54
% of Hospitals under 4% standard	34%	47%	46%

As the final row shows, nearly 50% of public hospitals report less than the 4% standard, despite the high medians and means. Because public hospitals have the same lack of detail on information as for-profit hospitals, no further comparisons are made in this paper. But it can be concluded that despite the variability, public hospitals have a higher reported level of charity care than nonprofit hospitals (see Table 3S, below). Whether this is due to their location, or other factors is beyond the scope of this current paper, but could be the subject of further investigation.

Evaluation #2: Nonprofit Hospitals in Indiana – Charity Care: 2002-2004

The next examination is of nonprofit hospitals, to determine whether their consistency of charity care figures has the same variability as found in for-profit and public hospitals. Table 3S shows a statistical comparison of the charity care provided by nonprofit hospitals over a three-year period of time.

⁴¹ Null Hypothesis - H₀: The % of charity care expense is = 4%. Test for H₀: The mean = 4.0 can be rejected with a degree of significance (t = 3.371 to 4.169).

Table 3S: Nonprofit Hospital Charity Care – 2002-2004

Test Value = 4.0

	2002	2003	2004
N	60	62	60
Mean	2.3735	2.6645	2.7003
Std. Deviation	2.16913	2.67042	2.45784
⁴²	-5.808	-3.938	-4.096
Median	1.72%	1.94%	2.00%

Nonprofit hospitals in Indiana seem to be relatively consistent in the aggregate level of charity care they provide. Both the mean and the median figures show a slight increase over the three-year period, but both figures are well below the 4% standard. The high t-scores indicate that the null hypothesis can be rejected with a high degree of significance. The standard deviation that approximates the means in all three years indicates that there is a high degree of variability in the reported figures from individual hospitals. However, from 2002-2004, 19 of the 59 nonprofit hospitals in Indiana (32%) had a fluctuation in charity care of more than 50% between any two years, a lower percentage than either for-profit (88%) or public hospitals (57%). In addition, 10 of these 19 hospitals had charity care of less than 4% (in the year with the highest percentage). This encourages further investigations into other factors affecting a hospital's charity care. One organizational aspect that might affect the extent and reporting of charity care is involvement with a healthcare system.

⁴² Null Hypothesis - H_0 : The % of charity care expense is = 4%. Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = -3.938 to -5.808).

Evaluation #3: Hospital Systems

As outlined in Chapter One, the concept of coercive isomorphism leads to the hypothesis that a system could encourage member hospitals to practice and/or report a higher and more consistent level of charity care than might be seen in independent hospitals. A further hypothesis is that hospitals affiliated with a religious system – especially a Catholic system – might have an even higher and more consistent level of charity care, as it is the Catholic Health Association that has emphasized standardizing the community benefit standards and presumably encourages their member hospitals to comply with those standards.

As stated earlier in this chapter, 42 of the 61 nonprofit community hospitals in Indiana (69%) are part of a system; the other 19 (31%) are independent. Table 3T shows how charity care and community benefit compares based on system affiliation.

**Table 3T:
Community Benefit and Charity Care Compilation based on
Nonprofit Hospital System Affiliation – 2004**

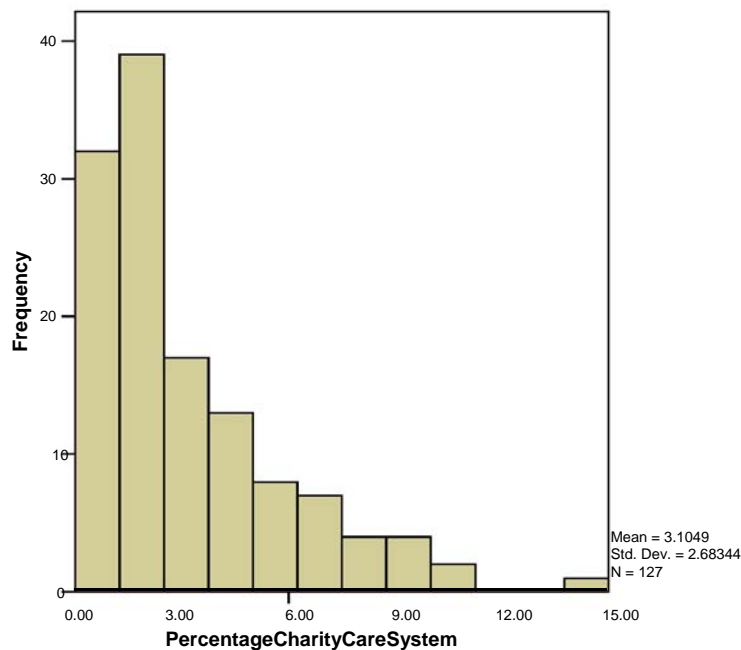
	Charity Care	Total Community Benefit
In System	3.0%	13.0%
Independent	1.7%	15.6%

Hospitals in systems seem to provide more charity care than independent hospitals, although their total community benefit expenditures seem to be similar (although system hospitals report slightly less community benefit). As stated earlier, the broader data of community benefit is not specifically evaluated in this

chapter but it is included in this table to show how reporting can vary. If all community benefit is included, independent hospitals seem to report a higher level (17% higher) than system hospitals. But if only charity care is recorded, then independent hospitals report nearly 50% less than system hospitals. An individual hospital analysis of community benefit is the subject of the next two chapters. Figures 3-G and 3-H show how the charity care provided by Indiana hospitals in systems and not in systems compare graphically.

**Figure 3G: Charity Care: System Hospitals in Indiana – Compilation
2002-2004**

*Charity Care Expense as a % of Total Operating
Expense Test Value = 4.0*

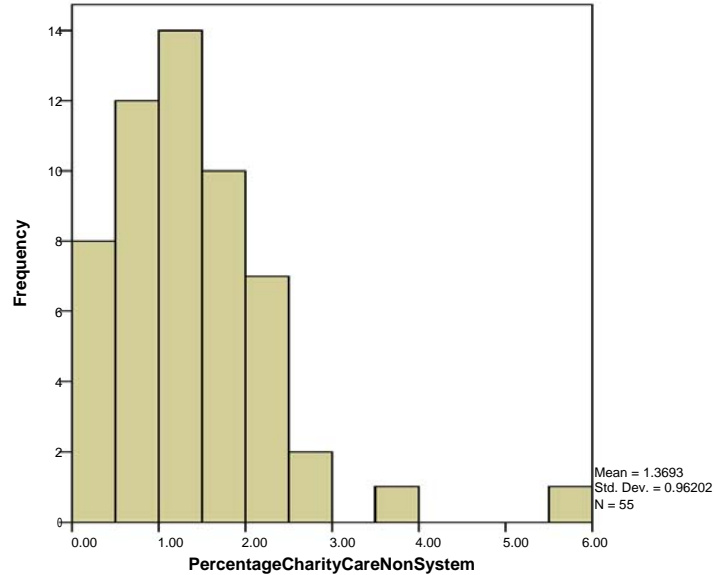


Null Hypothesis - H_0 : The % of charity care expense is =
4%⁴³ N: 127
Median Hospital: 2.19
% Mean: 3.1049 %
SD: 2.68344
t: -3.759

⁴³ Test for H_0 : The mean = 4.0 can be rejected with a degree of significance (t = -3.759).

**Figure 3H: Charity Care: Indiana Non-System Hospitals – Compilation
2002-2004**

Charity Care Expense as a % of Total Operating
Expense Test Value = 4.0



Null Hypothesis - H_0 : The % of charity care expense is =
4%⁴⁴ N: 55
Median Hospital: 1.22
% Mean: 1.3693 %
SD: 0.96202
t: -20.280

Hospitals that are not affiliated with systems report a much lower level of charity care than those in systems. Looking at the figures of charity care reported by independent vs. system hospitals (Table 3U) further compares these disparities.

⁴⁴ Test for H_0 : The mean = 4.0 can be rejected with a very high degree of significance (t = -0.280).

Table 3U: Nonprofit Hospital Charity Care based on Nonprofit Hospital System Affiliation – 2002-2004
Test Value = 4.0

	System	Non-System
N	127	55
Mean	3.1049%	1.3693%
Standard Deviation	2.68344	0.96202
⁴⁵ t	-3.759	-20.280
Median	2.19%	1.22%

Hospitals affiliated with systems have both a higher mean and median of charity care than independent hospitals. The figures seem to confirm that system hospitals provide a higher and a more consistent level of charity care than do independent hospitals. The difference in system and non-system hospitals could be due to system hospitals placing a higher degree of standardization on their members. However, even system hospitals have a standard deviation (2.68) that approaches the mean (3.10), showing a wide difference in individual hospitals.

Running a Mann-Whitney (U test) to compare the medians of systems and independent hospital charity care over the three-year period also finds a lack of comparability:

System - n_1 : 127
 Independent - n_2 : 55
 U: 5033.5
 Z = 4.72155

The high z value and U value yield a $p < 0.001$, indicating the difference between the two samples is highly significant (p as a two-tailed test). This allows us to

⁴⁵ Null Hypothesis - H_0 : The % of charity care expense is = 4%. The t-score for system hospitals (-3.759) indicates the null hypothesis can be rejected with a degree of significance. The high t-score for non-system hospitals (-20.280) indicates the null hypothesis can be rejected with a very high degree of significance.

reject the null hypothesis that the two samples have similar medians and are from similar populations.

These comparisons suggest that when evaluating a hospital's charity care, differences in system membership may indicate a potential influence. However, a high variability makes it difficult to conclude how much membership in any system might affect individual hospital behavior, as distinct from other demographic or operational factors such as larger societal and governmental expectations. One final comparison is appropriate before looking at the individual practices of nonprofit hospitals related to community benefit and philanthropic behavior. Since system affiliated hospitals are seen to have a significantly higher level of charity care – and since a majority of system hospitals are affiliated with Catholic religious systems – there can also be the supposition that religious affiliation could make a difference.

Evaluation #4: Hospitals Differentiated by Religious Affiliation: Whether religious hospitals are any different from other nonprofit hospitals is a matter of some debate. This is particularly true of Catholic hospitals, most of which are currently part of large systems that can have notable financial and political resources. There have been limited studies of the differences between religiously affiliated hospitals and secular nonprofit hospitals, partially because of the indeterminacy of what might define a “religious” hospital. In an era that has seen numerous purchases, mergers, and conversions of hospitals, the distinction

of religious hospitals is becoming less pronounced. Two studies of the affect of hospital ownership in California did include religious designation as a factor and found religious hospitals delivered a slightly higher incidence of uncompensated care than non-religious nonprofit hospitals (Campbell and Ahern 1993, Gruber 1994). Conversely, a study of Connecticut hospitals' uncompensated care that included religious affiliation as part of their research found ambiguous results based on Catholic vs. non-Catholic affiliation (White and Begun 1998) although it did find a higher availability of what the authors termed "compassionate care services" (such as home health programs, social services, and patient representative services). Studies of nursing homes have found a similar ambiguity in the measurement of the affect of religious affiliation as opposed to nonprofit designation, although some interpretations have indicated an improved level of quality of care from religiously affiliated institutions (Bradley and Walker 1998, Schlesinger and Gray 2006a, pp. 404-405, fn. 34,).

Contemporary religious hospitals are seen as responding to the same pressures and considerations as other nonprofit hospitals, including a need for more efficient business operations (Harrison and Sexton 2006) and the movement toward multi-corporate, multi-state models of organization (Singer 2006). When differences of religious hospitals (especially Catholic facilities) are noted in the literature, they usually focus on the extent that healthcare practices are affected. A particular concern is how mergers between religious and secular entities affect the availability of reproductive services with religious and ethical considerations,

such as abortions and sterilizations (e.g. Singer 2006, White and Begun 1998-1999, Bellandi 1998, and Tokarski 1995).

The specific designation of what defines a religious hospital can be difficult to identify, unless the hospital is specifically affiliated with a religious system. Names of hospitals can be misleading as any public or for-profit hospital can choose to either adopt a name with a religious context or to preserve the religious name of a hospital acquired during an ownership change.⁴⁶ However it has been noted that in 1994 about half of all community hospitals in the United States were religiously affiliated (Becker and Potter 2002). In particular Catholic Church affiliation is the most identified religious designation for hospital in the United States. Approximately 12.5% of all community hospitals in the United States are Catholic Hospitals.⁴⁷

Much of the difference of religious, Catholic-affiliated hospitals⁴⁸ is attributed to historical influences and locations. In the late nineteenth and early twentieth century religious orders and congregations established hospitals for the poor in neighborhoods where those needy individuals lived (White 2000). In many

⁴⁶ As previously noted, St Joseph Hospital in Fort Wayne, Indiana is one example of the conversion of a Catholic hospital to for-profit status, while keeping its Catholic name. This difficulty in measuring religious affiliation has also been noted in studies of nursing homes (Jeavons 1993, cited in Bradley and Walker 1998, p. 347 and 353).

⁴⁷ According to the Catholic Health Association, www.chausa.org/Pub/MainNav/AboutCHA/overview.htm (last accessed 9/14/2008).

⁴⁸ For the purpose of this description, "religious hospitals" primarily refers to Catholic hospitals. Catholic hospitals dominate the religiously affiliated hospitals in the United States and have significant influence. The federal adoption of the Catholic Health Association community benefit standards is one example of this influence. In the state of Indiana, 24 of the 107 community hospitals (22%) are religiously affiliated. 21 of these hospitals are Catholic hospitals (21%), within four Catholic systems. This percentage is significantly higher than the national percentage of Catholic community hospitals, 12.5%.

communities these neighborhoods remain home to poorer individuals and working families and are less likely to have health insurance or possibly, if working, to qualify for Medicaid. Hospitals located in these areas are likely to continue to have a higher level of charity care (Schlesinger and Gray 2006a, pp. 397-398, citing Gray 1991 and Norton and Staiger 1994).

While various factors may affect individual situations, an opinion may exist that religiously affiliated hospitals provide more charity care and community benefits than secular hospitals. If this is true, it could be due to their ethical traditions, because of where they were initially located (in poorer areas of a community), or because of pressures by their system to adopt the CCA/VHA guidelines. To test this opinion, looking at those hospitals with religious connections yielded the following results, outlined in Table 3V.

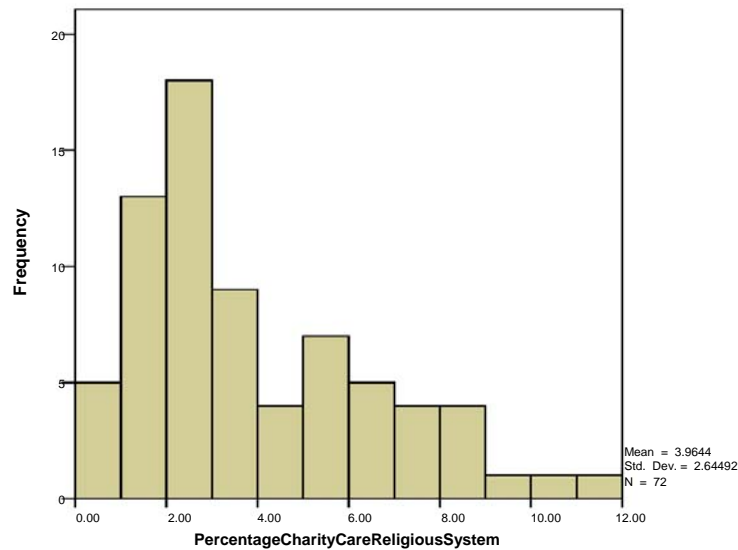
**Table 3V: Percentage of Charity Care and Community Benefit:
By Religious Affiliation (2004)**

Actual dollars spent, not adjusted for inflation

	Charity Care	Ratio: CC/ Operating Exp
Religious System	\$119,241,960	4.47%
Non-Religious System (NP)	\$70,566,735	1.94%
No System (NP)	\$35,802,864	1.69%

Religious hospitals in systems seem to far outperform nonreligious hospitals in terms of their levels of charity care. Figure 3I shows three-year figures for the 24 hospitals in religious systems:

Figure 3I: Nonprofit Religious System 3 year Charity Care (2002-2004)



Null Hypothesis - H_0 : The % of charity care expense is = 4%⁴⁹ N: 72
 Median Hospital: 2.64 Mean: 3.9644
 SD: 2.64492
 t: -.114

The mean of 3.96% is nearly at the 4% standard, although the median hospital (2.64%) is well below the standard. A relatively low t-value (-.114) indicates that the null hypothesis cannot be rejected and that the population means does approach the standard. There seems to be a consistency in reporting charity care by religious hospitals that is lacking in other nonprofit hospitals. It should also be noted that five of the top six figures represent rural, sole providers hospitals. However, only nine of the 24 religious hospitals have a higher level of charity care than the standard of 4%. The median hospital provided charity care of 2.64%, meaning well over half of the religious hospitals (i.e. 15 religious hospitals or 65%) are significantly below the 4% standard.

⁴⁹ Test for H_0 : The mean = 4.0 cannot be rejected with a degree of significance ($t = .114$).

Running a Mann-Whitney (U test) to compare the medians of religiously affiliated (system) and non-religiously affiliated (system) hospital charity care over the three-year period finds a lack of comparability:

Religious - n_1 : 72
Nonreligious - n_2 : 54
U: 3042.5
Z = 5.41534

The high z value and U value yield a $p < 0.001$, indicating the difference between the two samples is highly significant (p as a two-tailed test). This allows us to reject the null hypothesis that the two samples have similar medians and are from similar populations.

The conclusions of this comparison are varied. On one hand it could be concluded that religious hospitals provide a higher level of charity care than non-religious hospitals. However, it could also be observed that a few rural hospitals that have a high level of charity care skew the averages, as the median figure shows. An advocate for religious hospitals could state that this is an instance of the religious system affiliating with needy hospitals because of fulfilling their mission of providing care to those in need. However, other factors such as location could also be affecting this level of charity care. In order to better understand these differences requires looking at the details of the individual hospitals. If this individualized level of investigation is needed to properly evaluate charity care – a relatively well-defined standard when compared to other community benefit elements – then individual hospital analysis is even more necessary when trying to assess philanthropic behavior.

Summary of Part Four: Compilation of individual community hospital reports shows that in 2004 Indiana community hospitals provided 4.67% of the total operating expenses for charity care and 12.89% for total community benefit. This compilation seems to indicate that Indiana hospitals meet the standard of 4% charity care and far exceed the standard for 5% total community benefit. However, by breaking down Indiana hospitals by different factors, varying evidence emerges. In actuality, a majority of Indiana hospitals provide less than 4% of care. A few hospitals reporting much larger percentages of charity care help to influence the averages.

Nonprofit hospitals seem to report less Charity Care than for-profit hospitals or public hospitals. Hospitals that are part of systems, especially religious systems, seem to provide more charity care than independent nonprofit hospitals. However, the variability among individual hospitals makes averages or even median comparisons inconclusive, even when categorized according to system affiliation or religious connections. To uncover the factors that might lead to various differences requires looking at those individual hospitals rather than relying on averages, medians, and compilations. That investigation is the topic for the next two chapters.

Summary of Chapter Three: Chapter Three asks: “What does an existing reporting requirement from one state (Indiana) tell us about nonprofit hospital community benefit and philanthropic behavior?”

The primary conclusion is that while reports based on these requirements may provide useful information for investigating individual hospitals, broader conclusions about behavior of hospitals or categories of hospitals as a group are limited. Averages, median figures, and summaries don't account for the variety of factors that are necessary to adequately evaluate organizational behavior and motivations. If nonprofit hospitals responded to regulatory or mandated pressures to conform as a group, it might be expected that more similarity would exist among hospitals as a whole as well as among similar types of hospitals. However the theories surrounding philanthropic behavior indicate that pressure to provide community benefit stems from internal operational or leadership factors or a desire to attain legitimacy from either a defined community or professional standards of behavior. These theoretical criteria help confirm variations among individual hospitals, rather than similarities expected by the external mandates presented by regulations or systemic guidelines.

In conclusion, how well the ISDH data can be used to identify and quantify the philanthropic behavior of hospitals is problematic. Whether general summaries can be used to draw conclusions about the individual actions of hospitals is questionable. This is even more difficult when looking at the actual philanthropic behavior by Indiana nonprofit hospitals and the categories of community health education programs and donations. To further investigate these areas, the next two chapters specifically look at Health Promotion and Donations as reported on the IRS Form 990 by individual Indiana hospitals. Those chapters also include

information from a survey and follow-up interviews with representatives from Indiana hospitals – which help to not only verify the information but also can provide clues to help determine the type of process that is used by nonprofit hospitals to determine and report this type of organizational behavior.

CHAPTER FOUR: COMMUNITY HEALTH PROMOTION AND INDIANA HOSPITALS

The next two chapters explore available data from Indiana hospitals and their practice related to community health education and donation programs. Chapter Four specifically focuses on the area of Community Health education. The thesis hypothesizes that in practice these health education and donation activities are operated in different locations of the organization, making it difficult to present the two behaviors as a unified effort. The hypothesis is that health education programs are motivated by normative values held by professional healthcare workers throughout the organization and so decisions and practices are scattered throughout the organization. Conversely, donation programs are either located in a separate department or at the hospital leadership level. This separation of community health education and donation programs leads to the conclusion that nonprofit hospitals do not unify the planning or reporting of their philanthropic benefit activities.

The primary focus of the chapter is to determine how centralized and consistent the health education and health promotion programs are for hospitals in Indiana. This tests the first part of *Hypothesis #2: Community health education programs are motivated by normative Stakeholder values and are scattered throughout the organization.*

Introduction – Community Health Promotion and Education

A hospital's community health education program¹ is one of the two areas (along with donations) that in Chapter One are identified as indicators of a nonprofit hospital's philanthropic behavior. This chapter investigates the expenses of community health education provided by Indiana hospitals. It first uses the Indiana State Department of Health (ISDH) data to determine the financial commitment to this program as reported by Indiana hospitals. It then reviews a survey of Indiana hospitals to determine the validity of this data and the process each hospital uses to collect and report that information. It concludes by relating these findings to the hypothesis that health education programs are found throughout a hospital's organizational structure, reflecting the values of the health care profession to provide health information beyond the provision of primary healthcare. This corresponds to a desire to respond to the needs of various stakeholders rather than being driven by a coordinated strategy of the organization.

The Theoretical Basis for Health Promotion and Education Programs

Chapter One developed the theoretical background for nonprofit philanthropic behavior. This theoretical approach identified five potential motivations for a nonprofit hospital to engage in philanthropic behavior: Externally mandated

¹ Throughout this chapter – and this paper as a whole – the terms Health Education and Health Promotion may be used interchangeably. The two terms are generally synonymous and refer to preventive medicine and wellness information programs generally intended for the general public. This synonymous context should be assumed when the terms are used descriptively and singly. They are distinguished primarily when referring to the ISDH data, which does list them separately and so may reflect different figures reported by the individual hospitals under the separate categories. Even with the ISDH data, there is not always a well-defined difference to how the terms are interpreted – a situation that is addressed in this chapter.

behavior; a management function; leadership directed; separate organizational approach; and stakeholder discretion (Table 4A).

Table 4A: The Nonprofit Hospital Philanthropy Models

Nonprofit Philanthropy Model	External Mandate (System)	Management Function	Leadership Directed (CEO or Board)	Separate Organizational Function - Political	Stakeholder Discretion
Organizational Motivation (from Young and Burlingame)	To comply with External Criteria	To ensure and/or increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Organizational Structure	Imitative of Mandates	Embedded in Dep't and Manager Hierarchy	Practices at Leadership Level	Separate foundation or identified and publicly-visible department	Dispersed throughout organization
Location of Philanthropic Activity	Similar to others in a System	Department Level ("D")	Administrative Level ("A")	Foundation or separate organizational entity ("F")	Line-level Staff ("S")

Program decisions related to these models (or motivations for philanthropic organizational behavior) could be located within different places in the organization: Department ("D"), Administrative ("A"), separate organization or Foundation ("F"); or Staff level ("S").² An organization motivated by the External Mandate Model would be expected to reflect the structure and decision location of the system and other organizations within that system.

² The letter designations are for categorization convenience and coincide with the categories identified in Appendix 4-8. These designations are used later in this chapter and are included here to clarify their later use.

The hypothesis of this thesis that the health education programs will be located throughout the organization corresponds to the stakeholder model of organizational philanthropy. This model maintains that this behavior is a variable, normative response to different stakeholder groups on the part of the healthcare professionals working with those different groups. The Stakeholder Discretion Model incorporates practices that arise at different levels in the organization as responses by various internal professionals to diverse external stakeholder requests and situations. It is expected that since health education expenses are driven by the actions and reporting practices of individuals within the organization, there will be little correlation among the health education expenses based on various organizational types or even within specific systems.

Indiana Health Promotion Data

On the new IRS Form 990, Schedule H, Part 1, Line 7e, hospitals are asked to report: *Community Health Improvement Services and Community Benefit Operations*. The form asks for total and net expenses as well as the number of programs and people served. No further definition of these programs is asked for and there are there no guidelines on what types of programs might qualify. These decisions are left to the discretion of the hospitals completing the forms. It is noted that the figures are to be determined by filling out Worksheet 4, but the worksheet is not included in the report. Therefore this worksheet is simply a convenience for a hospital to compute those figures and does not allow for public scrutiny of the individual program components. Worksheet 4 simply indicates

lines for specific programs, and there is no further delineation or requirements except for separating *Community Health Improvement Services* from *Community Benefit Operations*. This separation is not kept in the final figures that are reported, but grouped together as a single expense item (both gross and net). This latitude in reporting practices and decisions is also seen in the Indiana ISDH reports. Although the ISDH reports actually ask for more detailed breakdowns, there is a similar lack of specificity in precisely what “should” be reported. This is left to the discretion of the specific hospitals as well as those individuals actually reporting the information.

There are two categories of the ISDH Fiscal Report that seem to primarily report budget information on Community Health Promotion of every nonprofit hospital in Indiana: “Community Health Education” and “Community Programs and Services” (#2 and #3 itemized under “Summary of Unreimbursed Costs of Charity Care, Government Funded Programs and Community Benefits”, Statement Four). There is not a clear definition of what is included in either of these – and the ISDH “Instructions for Completing the Hospital Fiscal Report” (2005) actually reveal a significant weakness in the reports themselves. The reports filled out by the hospitals include a breakdown under “Section Three: Education” of both income and expense involved with “Medical Professionals”, “Hospital Patients”, and “Community Education”. However the public reports simply group the expenses under a generic “Educational” category and do not differentiate educational programs for professionals from programs for the

community.³ It is assumed the “Community Health Education” figures under the “Summary of Unreimbursed Costs . . .” is taken from these figures, but that is not clear. It also means that this detailed information is collected for all hospitals in Indiana, including for-profit and publicly owned facilities, but not reported for those hospitals – further limiting potential use.⁴

The other category, “Community Programs and Services”, is collected in a separate part of the report from the hospital. The explanations offered by the ISDH define these two areas:

“Community Health Education” means the reporting of the costs of providing these programs, and subtracting any revenue targeted toward these programs. Programs offered include targeting specific health issues such as stress management, smoking cessation, weight control, and disease-specific programs. Do not include in-service education programs, or programs designed to “market” the hospital” (ISDH “Instructions . . .” 2005, page 7).

“Community Programs or Services” are the hospital’s costs of non-inpatient programs or services offered to residents of the community that increase access to necessary health care services. These services typically receive no or partial reimbursement. Examples include programs or rural care clinics, immunizations, school health programs, health screening, and transportation services. Do not include previously reported donations, research, education, and/or charity net gains or losses (ISDH “Instructions . . .” 2005, page 9).

³ There is another section of the report that collects information of the number of professionals and patients educated – and the “Number of Citizens Exposed to Health Education Messages”. However this latter figure also is limited for evaluating the commitment of the hospital to community health education. It should also be noted that, several hospitals report the population of the entire service area as being “exposed” to the message (e.g. three Indianapolis hospital reports list 1.5 million, 1 million, and 1 million as the figures) – rendering them relatively meaningless.

⁴ The ISDH contact was asked whether this data might be directly accessed, since it was part of the reports from the hospitals. The reply was that since these figures were not in a consistent format for public reporting, the reports from the hospitals couldn’t be shared by the ISDH but would need to be secured from each individual hospital.

The final sentence of the “Community Program or Services” definition helps discourage double counting. However, there can be confusion as to how to locate a specific program. For instance, a cholesterol or blood pressure test could be either “targeting a specific health issue” or a “health screening.” A question could be where to locate the program’s expense (i.e. as “Community health Education” or Community Programs or Services”). Is the determining factor the type of program that is offered or whether there is payment or reimbursement involved? Some other potential confusions are whether staff time and facility overhead should also be included (which can be a considerable part of the cost), and how to specifically differentiate whether any education program “markets” the hospital as opposed to educates the public. It should be noted that in the subsequent research interviews Community Benefit personnel raised these same confusions.

Two other places that could identify community health promotion expenses are the “Educational” category and the number of citizens exposed to the message. These are reported under Statement Three and as a category under Statement Four titled “Hospital Community Benefit Projects and the Projects’ Net Costs”. The latter has variable responses, with a majority of hospitals merely giving a single figure as “All Programs”, a figure that usually – but not always – mirrors the figure reported under “Community Health Education”. Other hospitals give a variety of levels of detail. One other source of confusion is the category under the “Summary . . .” compilation as “Other Unreimbursed Costs”. This category is

not defined by the ISDH (beyond stating it “offers an opportunity to insert other costs” – and several Indiana hospitals report this as a fairly significant percentage of the “Total Cost of Providing Community Benefits”. While it is easy to dismiss these problems as being the weaknesses of one state’s reporting process, it should be noted that similar factors are in the Schedule H format developed by the IRS. Due to these similarities, an evaluation of the Indiana data is an opportunity to see how valid similar self-reported information from national efforts might be.

The following analyses use two figures: the first is *Health Education* and the second is *Health Promotion*.⁵ *Health Education* is only the expense reported by Indiana nonprofit community hospitals under the ISDH designation “Community Health Education”. *Health Promotion* includes both: i.e. “Community Programs and Services” added to “Community Health Education”. The first term (i.e. *Health Education*) is a lower figure and is self-identified as specifically limited to those health education programs specifically designed for the general community. The second category (i.e. “Community Programs and Services”) is a larger and more inclusive figure. It potentially includes other community building and involvement efforts, intended to benefit the larger community. Neither figure includes the larger designation “Total Cost of Providing Community Benefits”,

⁵ In the interest of simplicity, the word “Community” is omitted both from references to *Health Education* and to *Health Promotion*. Throughout the following chapters, both terms refer to programs offered for the benefit of the community rather than for patient or professional education.

which includes Charity Care as well as the unspecific “Other Unreimbursed Costs.”

Evaluating the ISDH Health Education Data

This section investigates Community Health Education expenses from the individual nonprofit community hospital ISDH reports and attempts to determine what kind of pattern might emerge.⁶ It first compiles and compares the Health Education and Health Promotion expenses reported in 2004 by all nonprofit hospitals in Indiana.⁷ It then evaluates these expenses based on the percentage of their operating budget spent on health education programs. Providing these types of programs is not a specifically delineated requirement of nonprofit hospitals, separate from the broader community benefit designation. Therefore the percentage of the operational budget hospitals expend on this activity is one way to investigate the relative commitment the organization has to this type of philanthropic behavior.

The expenses of *Health Education* Programs reported in 2004 by all 62 nonprofit hospitals in Indiana⁸ are summarized in Appendix 4-1.⁹ Appendix 4-1 also shows

⁶ For this chapter and for Chapter Two, only nonprofit community hospitals are examined.⁷ To clarify year designations: the data from fiscal year 2004 is reported on the 2005 ISDH Reports. Throughout this paper, if the data itself is referred to it is referred as from (fiscal year) 2004. If the report itself is referred to, it is the 2005 report.

⁸ It should also be noted that there are 62 nonprofit hospitals in the listings, although ISDH data in Chapter Three indicated 61 nonprofit hospitals in Indiana. This discrepancy is because two hospitals that are considered as one hospital for some reporting practices actually filed separate ISDH reports for 2004. Information on both hospitals is included in this analysis.

⁹ The ranking reflects the size of the hospital's expenses devoted to total *Health Promotion*, with “A” reporting the largest expenditure of nonprofit community hospitals in Indiana and “MMM” reporting the smallest level of these expenditures (both in actual dollars and as a percentage of total operating expense). The ranking is included simply to allow for individual hospital comparisons between the charts in the Appendices.

how these same hospitals rank when *Health Education* Expenses are defined as a percentage of the Total Operating Budget of the hospital. Appendix 4-2 compares the total funding for *Health Promotion* – when the category reported as “Community Programs and Services” is added to “Health Education.”

The purpose of this analysis is to determine if there is any consistency in the level of health education expenses when individual data is looked at in detail. The separation of the individual hospitals also allows a comparison of the data that is subsequently used in the individual hospital surveys.

Health Education and Health Promotion expenses of Indiana hospitals: One challenge in evaluating reported data is to determine how well aggregated, mean, and median figures reflect the behavior of individual hospitals or groups of hospitals. This section compares these differing figures. It could be presumed that if there is a level of consistency among data from a defined group of hospitals that the aggregate, mean and median figures should be somewhat comparable. Conversely, the greater the disparity among these figures the more standards based on any one of these criteria could give an invalid comparison.

Several clarifications should be made about the classification of the hospitals: First, the “Hospital Designations” are included to preserve the relative confidentiality of the hospitals. Even though the ISDH information is public, further analysis involves personal conversations and responses from selected individuals and their confidentiality was assured. Second, there are slight discrepancies in some of the Nonprofit and County hospital designations. The Ownership designation was assigned based on the AHA Guide (2006) while the ISDH designation did not always indicate the same Ownership. For the purposes of this study, all hospitals reported by the ISDH as nonprofit hospitals are included –including three hospitals that are designated by the AHA as City- or County-owned. Finally, for-profit hospitals and public hospitals In Indiana are not required to provide this same information on health education expense to the state, so they are not included in this analysis.

This section compares these figures for Health Education and Health Promotion expenses of Indiana nonprofit hospitals.

In 2004, the 62 Indiana nonprofit community hospitals (as an aggregate) reported in the ISDH Reports spending \$21,401,403 on *Health Education*, an average of .25% of their total operating budget. The median hospital spent .08% of their budget on Health Education. As *Health Education* is part of the broader category of Health Education, the same hospitals reported spending \$166,686,707 on *Health Promotion*, or 1.98% of their total operating budget. The median hospital was .40%. Table 4B compares these figures:

Table 4B: Health Education and Health Promotion Expenses for Indiana Nonprofit Community Hospitals –2004

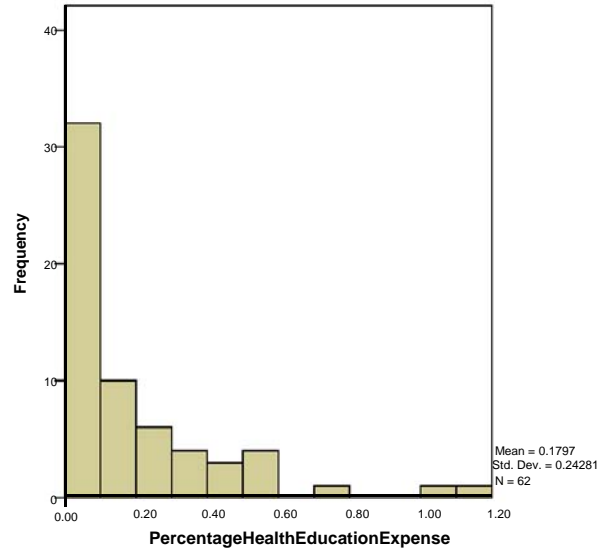
	Total Expenditures by Indiana NP Hospitals	% of Operating Budgets - Total	% of Operating Budgets - <u>Mean</u>	% of Operating Budgets - <u>Median</u>
Health Education	\$ 21,401,403	.25%	.18%	.10%
Health Promotion	\$166,686,707	1.98%	1.37%	.44%
Ratio: HE/HP	12.65%	12.62%	13.13%	22.72%

According to these figures, actual aggregate expenditures for Health Education are 12.65% of Health Promotion – a percentage that is similar to the ratio of their expenses as a percentage of the operating budget (12.62%). Comparing these ratios to the mean shows a relatively similar percentage (13.13%), 4% higher than the aggregate figures. However, the ratio of percentage of Health Education to Health Promotion for a median hospital is 22.72%, nearly

double that of either the aggregate (+179%) or the mean (+173%). This large disparity between mean and median call into question the relative consistency of the figures recorded and reported. These differences also illustrate that how an individual hospital is evaluated depends on which “standard” is used to determine a “typical” program.

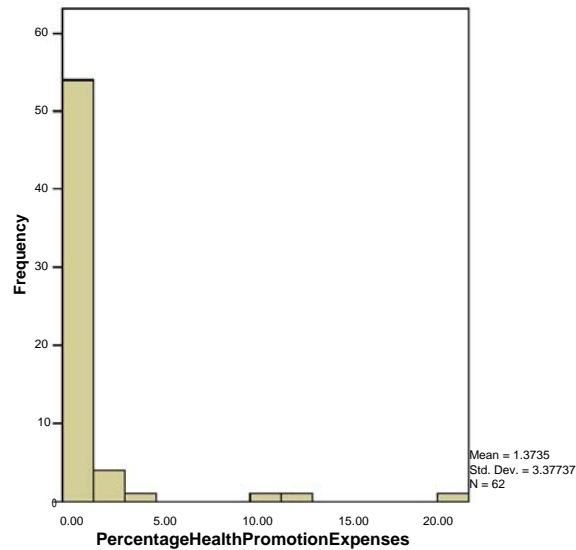
As Table 4B also shows, Health Education and Health Promotion expenses (as a percent of operating expense) decline when looked at in the aggregate, the mean, or the median. For Health Education, the mean is 28% lower than the aggregate while the median is 60% lower than the aggregate and 44% lower than the mean. For Health Promotion, the mean is 30% lower than the aggregate while the median is 78% lower than the aggregate and 67% lower than the mean. To better evaluate this disparity, the figures related to individual hospital need to be further investigated. Figures 4A and 4B graphically present how individual hospitals are distributed according to their percentage of operating budgets spent on Health Education and Health Promotion.

**Figure 4A: Health Education as a % of Operating Expense
(2004) All Indiana Nonprofit Community Hospitals**



N: 62
t: -2.280
Aggregate of Hospitals: .25%
Mean of Hospitals: .18%
Median Hospital: 0.10%

**Figure 4B: Health Promotion as a % of Operating Expense
(2004) All Indiana Nonprofit Community Hospitals**



N: 62 t:
2.037
Aggregate of Hospitals: 1.98%
Mean of Hospitals: 1.37%
Median Hospital: 0.24%

Figures 4A and 4B show that a high number of hospitals are grouped at the lower end of the percentage of operating expenses, reinforcing the figures that indicate the median hospital is significantly lower than the average or aggregate. The disparity between the median and mean figures – as well as the difference with the aggregate percentage – shows how aggregate figures and averages can be misleading. This is especially noteworthy when specific hospital data are examined. As an example, the *Health Promotion* figures are dominated by three hospitals reporting over 4% (specifically: 21.57%, 12.78%, and 10.98%). All three of these hospitals are part of the same system and are larger hospitals in Indianapolis. Also, none of these hospitals reported any expense under Health Education, further skewing the aggregate and average figures. Since this paper is primarily interested in the behavior of individual hospitals, only the mean and median figures are evaluated in the following investigation. As the paper is also interested in individual hospitals, a focus is on comparing median figures as these compare a “typical” hospital (rather than a broader average).

Health Education and Health Promotion – Systems: It might be expected that hospitals affiliated with a system might have more consistency with other hospitals also in systems, as systems could encourage common recording and reporting processes among their affiliates. A further supposition is that due to isomorphic influences, systems could also resemble each other, leading to a greater consistency among hospitals in systems than among independent hospitals. A more delineated comparison of *Health Education and Health*

Promotion is based on system affiliation. The following compares whether a hospital that is a member of a system has a similar level of community health education and promotion expenses with other system-affiliated hospitals.

In 2004, of the 62 nonprofit community hospitals in Indiana, 44 are designated as being part of a system; 18 are independent.¹⁰ Table 4C shows the relative difference in the mean and median of *Health Education* and *Health Promotion* as a percentage of operating expenses.

Table 4C: Health Education and Health Promotion Expenses for System and Non-System Indiana Nonprofit Community Hospitals –2004

	System: Health Education	Non-System: Health Education	System: Health Promotion	Non-System: Health Promotion
% of Operating Budgets - <u>Mean</u>	.19%	.15%	1.61%	.77%
% of Operating Budgets - <u>Median</u>	.09%	.10%	.40%	.34%

The mean figures show a slight difference between system and non-system Health Education (with non-system hospitals reporting 21% less than system hospitals), and a noteworthy difference between system and non-system hospitals related to *Health Promotion* (with non-system hospitals reporting 52% less than system hospitals).¹¹ However, when the medians are compared the difference between system and non-system hospitals is less pronounced,

¹⁰ As previously noted, this number is slightly different than as reported in Chapter Three. This is due to the shifting nature of system affiliation as well as different designations from in different sources (i.e. AHA Guide, ISDH reports, Internal Revenue Service, and Indiana Hospital Association).

¹¹ The latter discrepancy could be affected by the three large reporting Indianapolis system hospitals as previously noted in the above example.

especially for *Health Education*. A Mann-Whitney (U test) shows the differences between system and non-system hospitals are not statistically significant, both for Health Education and for Health Promotion:

*System and Non-System HEALTH EDUCATION*¹²

P (two-tailed) = 0.83566

P >= 0.05, two-tailed test – The two samples are not significantly different

*System and Non-System HEALTH PROMOTION*¹³

P (two-tailed) = 0.64957

P >= 0.05, two-tailed test – The two samples are not significantly different

The null hypothesis is that the median expenditures for health education and health promotion for hospitals that are part of systems are similar to those that are independent. Since the health education and health promotion comparisons both have a p-value > 0.05, we cannot reject the null hypothesis and conclude the median health education and health promotion expenditures of system and independent hospitals are not significantly different. The next section makes the same comparison for religious and non-religious hospitals.

Health Education and Health Promotion – Religious Systems: One hypothesis is that religious hospitals in systems could spend a higher level on these programs than nonreligious hospitals, due to being influenced by the Catholic Health Association's emphasis on collecting and reporting an extensive amount of

¹² System - n_1 : 44, Independent - n_2 : 18, U: 410, Z = 0.217113.

¹³ System - n_1 : 44, Independent - n_2 : 18, U: 426, Z = 0.465242.

community benefit information, including health education. The following investigates this supposition.

In 2004, of the 44 nonprofit community hospitals in Indiana designated as being part of a system; 25 are part of a religious system; 10 are part of non-religious systems.¹⁴ Table 4D shows the relative difference in the mean and median of *Health Education* and *Health Promotion* as a percentage of operating expenses

Table 4D: Health Education and Health Promotion for Religious System and Non-Religious System Indiana Nonprofit Community Hospitals – 2004

	Religious System: Health Education	Non-Religious System: Health Education	Non-System: Health Education	Religious System: Health Promotion	Non-Religious System: Health Promotion	Non-System: Health Promotion
% of Operating Budgets - <u>Mean</u>	.18%	.21%	.15%	.69%	2.84%	.77%
% of Operating Budgets - <u>Median</u>	.04%	.13%	.10%	.39%	.40%	.34%

The mean figures show a significant difference between religious and non-religious system hospitals, especially for *Health Promotion*.¹⁵ However, when the medians are compared the difference between religious and non-religious system hospitals is less pronounced, especially for *Health Promotion*. What is surprising is the median non-religious system hospital reports a significantly

¹⁴ As previously noted, this number is slightly different than as reported in Chapter Three. This is due to the shifting nature of system affiliation as well as different designations from in different sources (i.e. AHA Guide, ISDH reports, Internal Revenue Service, and Indiana Hospital Association).

¹⁵ Again, the Non-Religious System Health Promotion mean figure is supposedly affected by the three large reporting Indianapolis system hospitals, as previously noted.

greater percentage of spending on Health Education than the median religious system hospital.¹⁶ A Mann-Whitney (U test) shows the differences between religious and non-religious system hospitals are not statistically significant, either for Health Education or for Health Promotion:

*Religious and Non-Religious System HEALTH EDUCATION*¹⁷

P (two-tailed) = 0.654988

P >= 0.05, two-tailed test – The two samples are not significantly different

*Religious and Non-Religious System HEALTH PROMOTION*¹⁸

P (two-tailed) = 0.924772

P >= 0.05, two-tailed test – The two samples are not significantly different

Since the health education and health promotion comparisons both have a p-value > 0.05, we cannot reject the null hypothesis and conclude the median health education and health promotion expenditures of religious and non-religious hospitals are not significantly different. A final comparison looks at the two largest Catholic systems in Indiana. It could be hypothesized that their results should also be similar, since both systems are part of the Catholic Health Association and have similar values as well as systemic pressures to provide health education programs for their communities.

¹⁶ Since Health Promotion includes Health Education, one possible explanation is that religious systems report less activity as Health Education than non-religious hospitals, moving related expenses under a different category. However this would only be able to be verified through tracing individual hospital internal records and reports, sources generally of limited availability. ¹⁷ System - n_1 : 25, Independent - n_2 : 19, U: 256.5, Z = 0.450185.

¹⁸ System - n_1 : 25, Independent - n_2 : 19, U: 241.5, Z = 0.0947758.

Health Education and Health Promotion – Two Religious Systems: In 2004, of the 25 nonprofit community hospitals in Indiana designated as being part of a religious system, 21 belong to either the R1 system (12 hospitals) or R2 system (9 hospitals).¹⁹ Table 4E shows the relative difference in the mean and median of *Health Education* and *Health Promotion* as a percentage of operating expenses.

Table 4E: Health Education and Health Promotion for Indiana Nonprofit Community Hospitals: R1 and R2 Catholic Systems– 2004

	R1: Health Education	R2: Health Education	ALL Religious System: Health Education	R1: Health Promotion	R2: Health Promotion	ALL Religious System: Health Promotion
% of Operating Budgets - <u>Mean</u>	.08%	.31%	.18%	.41%	.97%	.69%
% of Operating Budgets - <u>Median</u>	.06%	.15%	.04%	.39%	.75%	.39%

A Mann-Whitney test shows that the difference between R1 and R2 hospitals is not statistically significant:

¹⁹ In order to preserve confidentiality, as indicated in subsequent hospital surveys, these systems are designated as “R1” and “R2”. These designations parallel designations used in the Appendices.

R1 and R2 Health Education²⁰

P (two-tailed) = 0.1930052

P >= 0.05, two-tailed test – The two samples are not significantly different

R1 and R2 Health Promotion²¹

P (two-tailed) = 0.277318

P >= 0.05, two-tailed test – The two samples are not significantly different

Since the health education and health promotion comparisons both have a p-value > 0.05, we cannot reject the null hypothesis and conclude the medians of the health education and health promotion expenditures of the two Catholic hospital systems are not significantly different.

The preceding Mann-Whitney tests indicate that the difference in the percentages of Health Education and Health Promotion expenses by system or non-system hospitals religious or non-religious hospitals, or between two systems are not statistically significant (p-value of > 0.05). However with the exception of Religious vs. Non-religious Health Promotion, a comparison of the actual p-values (two tailed) shows a declining level of p-value with each subsequent test (Table 4F):

²⁰ System - n_1 : 12, Independent - n_2 : 9, U: 72.5, Z = 1.13147.

²¹ System - n_1 : 12, Independent - n_2 : 9, U: 69.5, Z = 1.10154.

Table 4F: Comparison of p-values (two tailed) from Mann-Whitney Tests

	System vs Non-System:	Religious vs Non-Religious	R1 vs R2
Health Education	0.83	0.66	0.19
Health Promotion	0.64	0.92	0.28

The p-value for the comparison between the two Catholic systems for both Health Education and Health Promotion is quite a bit lower than for the other comparisons, nearing the .05 level below which would start to indicate a significant difference between the two samples. This starts to confirm the means and median comparison between the two systems indicating that R2 seems to invest more than twice as much of their budget for Community Health programs. But it also leads to a possible conclusion that religiously-affiliated hospitals are actually less similar to each other than they are to non-religious hospitals.

There are two primary observations that seem to be drawn from the ISDH data: the first is the disparity between ratios based on aggregate, means, and median figures. This difference casts doubt on the consistency of reporting systems as well as on standards based on any one of these criteria. Median figures seem to provide the most consistent comparisons. The second observation is that the differences between hospitals do not seem to become less when looking at more defined levels of sub-groups. In the case of the two religious hospital systems, there is actually a greater level of disparity within these systems than in the more aggregated levels. Only by looking at individual hospitals might we be able to draw useful conclusions.

Survey of Indiana Hospitals

To compare health education data of different hospitals, individual contact was made with hospitals via a written questionnaire and personal follow-up conversations. In the winter of 2007/2008, questionnaires were sent to 107 Indiana hospitals to better identify the processes used by Indiana hospitals to determine and report expenditures for health education and donations on their ISDH Report. Hospital representatives were asked if they would also be willing to take part in a short telephone or in-person conversation to elaborate on their responses. The purposes of this questionnaire and survey process were two-fold. First was to better determine the relative validity of the figures reported by the hospitals on the ISDH Hospital Fiscal Report. The second purpose was to determine the organizational process used to identify and report these figures. The former is important to better determine how well self-reported figures might be when used in public databases. The latter identifies the organizational processes that most influence decisions for nonprofit hospitals to engage in philanthropic behavior.

All hospitals were sent a two-page questionnaire with a cover letter (see Appendix 4-5²²). The letters were personally addressed to the individual identified as the “Community Benefit Representative” on each hospital’s 2005 Hospital Fiscal Report. The position or department of this designated representative was not consistent, but was assumed to be the person who

²² Appendix 4-5 of this chapter does not include the questionnaire for donations. That example is attached to Chapter Five. For the mailing, both were sent as one document and filled out at the same time.

actually filled out the report form, which can vary from hospital to hospital. In most cases this individual was in the public relations or marketing departments. If there was a defined community benefit or health education position, that person was the designated representative. In some cases it was someone in finance. In several small hospitals it was the administrator or chief executive officer.

The letters were sent in an Indiana University envelope to encourage it being opened and the cover letter was on Indiana University stationery to emphasize the credibility to the request. A self-addressed, stamped envelope was enclosed to help encourage a return. The questionnaire was designed so it could be relatively quickly filled out and returned. The first page of the questionnaire addressed community health education programs; the second page sought information on donations.

All acute-care hospitals in Indiana were contacted, including for-profit and government-owned facilities. Although these types of hospitals are not legally required to report on community benefit, they are included in the ISDH Hospital Fiscal Reports. Out of the 107 community hospitals in Indiana, 9 are for-profit, 37 are city or county facilities, and 61 are nonprofit.

Of the 107 questionnaires sent out, 42 were returned, from 36 actual respondents. Three respondents filled out one questionnaire each but indicated

their responses applied to 2 other hospitals. The returned questionnaires represented 53 hospitals, as multiple hospitals in five systems have community benefits coordinated by a single department, so that individual's responses also applied to those other hospitals. Two envelopes were undelivered and returned marked "Addressee Unknown," leaving 105 envelopes delivered, for a 51% response rate from represented hospitals – or a 40% response in actual questionnaires returned. In several cases the person responding was not the same person the information was addressed to. This was usually due to turnover in this position rather than mistaken information. 40 nonprofit hospitals returned the questionnaires, 66% of nonprofit hospitals. 13 city or county facilities returned the questionnaire, 35% of government-owned facilities. No for-profit hospital returned the questionnaire. 29 of the questionnaires indicated a willingness to participate in a follow-up in-depth conversation and 23 of these actually occurred.

The written survey questions were chosen for three primary reasons. Each question was designed to better understand the organizational location of the health education program activities, management, and data reporting process. The first question (#1) identifies where in the organization the actual reporting of this data occurs. One hypothesis of the paper is that health education program decisions are scattered throughout the organization. If true this would indicate there are multiple decision processes responding to varied publics, confirming stakeholder theory is an influence. In such cases, the activities, management,

and reporting of health education programs will also be scattered rather than focused in one department. This question helps identify whether the person indicated as being most responsible for reporting the figures is also the person who is the designated community benefit representative (or the person who completed the survey, if different). If the same person isn't responsible for both processes, it can indicate that verifying the validity of data may also be more difficult.

The second question (#2) identifies the department in the organization responsible for managing the health education program. This helps determine how closely the management of the health education programs is tied to the actual operations of those programs (to be identified in Question #3). The third question (#3) determines where in the organization the actual health education programs are located. The more departments that are involved with health education programs, the more the programs scattered throughout the organization. A secondary purpose for the question is to determine the possibility that the health education programs are actually under-reported. The less these programs are centrally controlled and reported, the more the possibility exists that additional unreported programs might also exist. Appendix 4-3 summarizes the responses (including the Hospital Designations). The results of the community health education portion of the surveys follow:²³

²³ To avoid possibly skewing the results, only the actual responses from the returned 40 questionnaires are shared. Even though community benefit programs for multiple hospitals may be coordinated by one individual it doesn't mean the decision process is always the same for all affiliated institutions. However some results will add up to more than 40 because of input that

Community Benefit – Health Promotion Programs Responses:

1. Who in the hospital is most responsible for reporting those figures?

<u>Item Response</u> ²⁴	<u>Survey Response</u>	
<u>6</u>	<u>3</u>	CEO
<u>14</u>	<u>12</u>	Other Administration
<u>18</u>	<u>12</u>	Department Head
<u>6</u>	<u>4</u>	Support Staff
<u>9</u>	<u>5</u>	Other (please specify):
		Community Development Department – 6 Items; 2 Surveys
		3 Departments (Finance, PR, Education) – 1 Item; 1 Survey
		Controller – 1 Item; 1 Survey
		Community Benefits – 1 Item; 1 Survey

2. Which department is most responsible for managing health promotion programs and budget?

<u>Item Response</u>	<u>Survey Response</u>	
<u>1</u>	<u>1</u>	Administration
<u>29</u>	<u>22</u>	Public Relations/Marketing
<u>12</u>	<u>8</u>	Health Education ²⁵
<u>6</u>	<u>2</u>	Fund Development/Foundation ²⁶
<u>12</u>	<u>8</u>	Other (please specify):
		Community Development Staff – 6 Items; 2 Surveys
		Health Promotions and Community Relations – 2 Items; 2 Surveys
		Education Department – 1 Item; 1 Survey
		Nursing Administration – 1 Item; 1 Survey
		Community Health Enhancement Division – 1 Item; 1 Survey
		Community Health Improvement Manager – 1 Item; 1 Survey

was shared in personal interviews when it was indicated that a response represented a single process that covered more than one of the affiliated hospitals. In a few cases, a response may not have been given, leading to response rates less than the total.

²⁴ “Item Response” indicates the number of hospitals that the response applies to. “Survey Response” indicates the number of actual individuals responding. Because several hospitals systems a designated single person as the Community Benefit Representative, the Item Response exceeds the Survey Response. Unless a category was left blank, 53 hospitals are represented under Item Response and 36 individuals under Survey Response. The actual number of surveys returned was 42, because eight separate questionnaires were filled out by two people representing one multiple hospital system.

²⁵ One respondent indicated both PR and Health Education – and one multiple hospital representative indicated it was managed by PR, Health Education, and Other (Community Development). Each is counted, meaning 60 and 41 responses are tabulated in this category. ²⁶ The figures include Community Health Improvement as a department within the Foundation. This is from one respondent representing five hospitals.

3. Are the above programs determined and operated by more than one department or entity?

<u>Item</u> <u>Response</u>	<u>Survey</u> <u>Response</u>
<u>44</u>	<u>27</u> Yes
<u>9</u>	<u>9</u> No

- If the answer to #3 is "Yes", how many departments or entities offer health promotion programs?

<u>Item</u> <u>Response</u>	<u>Survey</u> <u>Response</u>
<u>3</u>	<u>3</u> Two
<u>3</u>	<u>3</u> Three
<u>1</u>	<u>1</u> Four
<u>37</u>	<u>20</u> Five or more

Discussion on Written Questionnaire Responses

The primary impression from the questionnaires is that health education is handled in a wide variety of ways by Indiana hospitals, and in most hospitals the health education programs are widely scattered throughout the organization. This seems to support the hypothesis that health education is motivated by the stakeholder theory of philanthropic behavior.

Responses from the questionnaires indicate that the management, budgets, and reporting of health education programs are handled by various mid-level administrative staff and department heads. Of the five responses that the (Chief Executive Officer (CEO) is the primary person who reports the results, four were small rural hospitals (part of a larger system) and one was a small county hospital. This mirrors a common situation of the smaller hospitals where the

hospital CEO was also listed as the “Community Benefit Representative” on the ISDH report.

The most significant response is that 44 of the 53 hospitals (83%) indicated more than one department offers community health education programs, with 38 having five or more departments involved with some kind of outreach programs (72% of all hospitals surveyed). This indicates that rather than being a centrally controlled, top-down administrative directive, instead efforts to reach out into the community are found in many layers of the organization. This suggests that these types of philanthropic programs are a product of organizational or professional culture rather than a leadership strategy. This is one area explored further in the personal conversations.

Many of the returned questionnaires included written elaborations of the responses. Many of these provide additional information on the process of providing community health education programs. Following are specific written responses to individual questions.

Who in the hospital is most responsible for reporting those figures?

This question received few written comments. Three who checked “Other Administration” indicated this was the Chief Financial Officer, one that it was the Director of Public Relations, and one that it was the “Manager of Community Health”. Under “Other”, one response indicated that the “Community Benefits

Department” was responsible for reporting the information, while two defined the “Controller” as being the one responsible. One response indicated that the reporting was shared among three departments: “Fiscal”, “Community Relations”, and “Education”.

These responses indicate that reporting health education figures is a mid-level responsibility and the financial results – and possibly the entire report – are either reported at a department level or collected in one department and then passed along to another department (possibly finance) to complete the ISDH report. This is another area to further explore during the personal interviews.

Is the person indicated as being most responsible for reporting the figures also the designated community benefit representative? Is it also the person who is completing the survey?

17 of the 36 respondents (47%) were the same person named on the ISDH website as the community benefit representative. Only 5 survey respondents (14%) were also the person responsible for reporting the figure, or even at the same management level. This leads to question how familiar they might be with the figures that are reported. This is an area included in the follow-up interviews.

Which department is most responsible for managing health promotion programs and budget?

The management of the health education programs and budget is primarily done by Public Relations or Marketing. Eight responded that they had a Health Education Department who managed these programs. “Other” responses included “Community Health Improvement Manager”, “Community Health Enhancement Division”, “Education” and “Nursing Administrator” (“ . . . coordinates many or a majority of these programs”). Five responses (from one system) indicated that “Community Development” staff coordinated the programs. One response noted that programs were run by a Community Health Improvement position in the Foundation office.

One impression from these responses is the health outreach efforts primarily serve a Public Relations or Marketing role, rather than a healthcare function. A second impression is that Health Education in general, and Community Health Education in particular, is a separately designated departmental function in many hospitals. These are two areas to confirm during the personal interviews.

Are the above programs determined and operated by more than one department or entity? Which ones?

A majority of the respondents (37 hospitals, or 70% of respondents) indicated that five or more departments operated health education programs (see Appendix 4-4 for individual responses). One question to be explored in the

personal interviews is if this multi-department situation is a deliberate hospital leadership strategy to implement health education throughout the hospital or if the variety of locales for these programs is primarily because of grassroots efforts by employees in the departments.

Of those who answered “No” to this question, one identified “Administration” as responsible for the management of the health education program. The others indicated public relations is responsible for the operation as well as the management of the programs.

Those who responded that multiple departments operated the various health education programs, identified the following departments (the number of responses that identify each department is in parenthesis):

- GENERAL DEPARTMENTS IDENTIFIED (listed in the order of the number of responses): Community (Health) Education (6), Marketing/Public Relations (6), Family Medicine Center (3), Laboratory Department (3), Nursing (3), Women’s Services (3), Emergency Medical Services/Ambulance (2), Obstetrics (2), Physical Therapy (2), Radiology (2), (Community) Wellness (2), Occupational Therapy/Health (2), Oncology Services (2), Community Outreach, Diabetes Center, Dietary Education, Education, Foundation, Imaging Department, Infection Control, Medical Education, Mental Health, Outpatient Physician Clinic, Pediatric

Services, Primary Care Clinic, Sports Medicine, and (other) Ancillary Services.

Other specific written responses are identified in Appendix 4-6:²⁷

While the most frequently cited departments were Community Health Education and Marketing/Public Relations, an additional 25 departments were listed.²⁸

These varied responses suggest that community health education could be seen as part of organizational values – or even a professional ethos of the health workers in the hospitals – rather than a deliberate administrative policy. As previously stated, this is an area further explored in the personal conversations.

Do you have any other comments that help clarify any of the above?

Specific responses to this question are listed in Appendix 4-7. Two aspects are of particular note. The first is the comment that the figures themselves were either unknown or did not coincide with departmental records. The second is that for at least one hospital, program costs did not include staff costs. While this could suggest that healthcare workers provide many of the outreach programs relatively informally as part of their jobs, it's of particular importance when trying to define the financial commitment to these programs by the hospital. These are areas further explored in the personal interviews.

²⁷ NOTE: any specific departments mentioned in these comments are also included in the tabulation above.

²⁸ The prevalence of Health Education Department responses should be qualified, due to multiple responses from one system that centrally coordinates the outreach efforts of several hospitals.

Discussion on Personal Interviews

As stated earlier, 29 of the questionnaires indicated a willingness to participate in a follow-up in-depth conversation and 23 of these actually occurred. These 23 individuals represented 34 hospitals.²⁹ Three interviews (with six individuals representing 12 nonprofit hospitals³⁰) were done in person, with the other 17 done via telephone. Four of the telephone interviews were with county hospitals; the other 13 were with nonprofit hospitals. The three personal interviews were with representatives of three of the largest hospital systems in Indianapolis, two of them Catholic systems. The telephone interviews included two other large Indiana hospital systems. The personal interviews lasted between 30 and 60 minutes; the telephone conversations were between 5 and 15 minutes (with one lasting nearly 30 minutes).

The conversations were structured to encourage respondents to share the thoughts they felt were most significant. Every interview discussed each of the items on the questionnaire. They also sought reaction to five specific questions prompted by the written responses (noted in the discussion above):

1. How aware of the reported figures is the designated Community Benefit Representative – and how well do those figures coincide with other departmental records?

²⁹ It should be noted that consent to the interviews was entirely voluntary and therefore the respondents were self-selected. 14 of the respondents represented multi-hospital systems with formal designations for health education or similar labels. One respondent was the Chief Executive Officer of a small county hospital. It is likely that the reactions from the interviews reflect a multi-hospital and formal health education program bias.

³⁰ One meeting was with four representatives who represented six system hospitals.

2. Do these figures include staff time and other overhead expenses?
3. Are the expenses and programs dedicated to community health education a deliberate administrative and board decision, directed by middle management within departments, or determined by line-level employees providing programs as they see they are needed?
4. Do the outreach efforts within the hospital fill primarily a Public Relations/Marketing role – or a healthcare service role?
5. Is Community Health Education becoming a more formal department and/or program of the hospital than it has in the past?

Overview of the Interviews

The primary impression from the interviews is that attention to Community Benefit in general and Community Health Education in particular is becoming increasingly important among hospitals in Indiana. Part of this could be due to those who responded to the questionnaire and agreed to the interviews were organizations and employees who had a particular interest in the topic and commitment to the process.

We might expect those hospitals that responded to the questionnaire as having and/or reporting a higher percentage of health education expenses than those who might have less of an emphasis on this practice. Appendix 4-1 and Appendix 4-2 identify how the responding hospitals ranked in relation to their indicated expenditures on Health Education and on Total Health Promotion – as a percentage of Total Operating Expense. While slightly more than half of the

respondents in each table fell into the top 50% of both the percentage of health education and of total health promotion expenditures, the differences are not significant. The overall dispersal is fairly random, even among single systems (and particularly Catholic systems) that state they are more formally emphasizing centralized reporting of Community Benefit expenses.

The random nature of the respondents gives broader validity that the conclusions of the questionnaire are an indication that responses could be applied to all Indiana hospitals and that there is a growing awareness of community benefit. 13 of the respondents were publicly owned hospitals strengthening the conclusion that the awareness of and commitment to community benefit is not confined to nonprofit facilities.

During 19 of the 23 interviews (83%) the interviewee expressed a desire to more efficiently and completely collect available health education data. However 18 of the interviewees (78%) indicated that the wide variety of programs done by different departments made this a challenge. Even the hospital systems that have formalized and centralized the management of these programs indicated they were continually finding departments that were conducting qualified programs that they did not know about. Nevertheless, 16 respondents (70%) said they were taking steps to have a more comprehensive reporting system. They also indicated that the new IRS reporting system was encouraging these steps, but that for the most part it was an effort that had been going on for

several years at the hospital. 15 specifically (65%) said they were instituting reporting criteria based on or similar to the CHA/VHA guidelines.³¹

Responses Related to the Questionnaire

The interviews reinforced the conclusion that the operation and reporting of health education programs is dispersed throughout the hospital rather than being strategically focused. This was true even for organizations that had taken steps to more centralize the health education/community benefit activities.

Who in the hospital is most responsible for reporting those figures?

In 12 interviews (52%), it was indicated that finance submits the ISDH Report to the state of Indiana (with two interviewees saying as the person responsible for community benefit, they are the ones who filled it out). In seven cases it wasn't known who exactly had this responsibility (this uncertainty was also expressed in one follow-up conversation with the hospital's controller). However 17 of the 23 interviewees stated the figures were pulled from various departments of the hospitals, with the data being self-reported by different departments. Five interviewees said they were not currently getting data from other departments, but three expected to have this capability by the end of the year. The other two stated they were moving in that direction. Approximately half of the respondents (12 of the 23, all representing larger hospital systems) said their community

³¹ One reaction related to this reporting criteria was expressed by five of the respondents: because the name of the manufacturer of the industry-accepted software for reporting community benefit data (Community Benefit Information System Accounting, or CBISA) is Lyon Software, the similarity of the last name of the researcher encouraged them to return the questionnaire, assuming there might be a relationship to the software firm.

benefit program was a formal system-wide process that was standardized and centralized. Three of these said a pre-determined annual amount from the hospital was identified as going to community health programs, a budget figure determined by the board and administration. The other nine said that individual departments did their own recording and sent the results to one department for preparing the final report. Two hospitals said that two or three departments filled out different sections of the report form, acting separately with their own information. Even those with centralized systems said they weren't always sure exactly what was included in some of the figures or how consistently they were reported year-to-year or across different areas of the hospital.

Which department is most responsible for managing health promotion programs and budget?

The response to this varied across hospitals. Three indicated there was a "Community Benefit Team" or Management Team of various department managers that coordinated the overall efforts and one said that there was a board committee to review the programs. Two indicated health promotion program management was actually coordinated by the hospital foundation that also helped with tracking and reporting. Fifteen said there was no formal process or set budget but was rather the responsibility of individual departments to conduct programs as they saw fit, approved by the department head. One observed they were not sure if there was an actual budget for health education programs.

In terms of hospital policies, three said there was a formal hospital policy encouraging departments to initiate and conduct these types of programs. One respondent outlined a process that seemed to reflect the approach of many hospitals: “Education assesses the needs. Administration encourages departments to participate. Community Relations publicizes the needs and receives requests, both internally and externally. Education approves the expenditures. Finance tracks and reports the expenses.” Two indicated the expense actually came from three different budgets (but not the same three, i.e.:

#1: “Community Education, Social Responsibility, and Health Education/Community Benefit”; and #2: “Administration, Accounting, and Community Benefit”).

Are the above programs determined and operated by more than one department or entity? If “Yes”, how many departments or entities offer health promotion programs?

In every case, the reaction to this question during the interviews is that more departments actually conducted programs than they had listed on the questionnaire. Many of the programs were not formally shared with others in the hospital and in some cases with administration. This was even true for those who initially checked “No”.

Responses to the Identified Questions

Many of the identified additional questions were addressed in the conversations about the above. If they were not brought up in the conversations, the questions were asked as an additional part of the interview.

- 1. How aware of the reported figures is the designated Community Benefit Representative – and how well do those figures coincide with other departmental records?*

Only three of the respondents knew whether the figures were correct or could specifically identify their origins. Although 18 of the respondents were “officially” listed as “Community Benefit Representative” on the ISDH report, 15 did not actually fill out the form. This uncertainty or questioning of the figures was the most common reaction expressed during the interviews, mentioned by 17 of the 23 interviewees (74%). Two interviewees mentioned one other complication: additional grants were used to cover health promotion costs and they did not think those expense or income figures were part of the reported figures (in one case, 34% of health promotion expenses were covered by these grants).

- 2. Do these figures include staff time and other overhead expenses?*

Two said that staff time but not overhead was part of the expense figures. Three said neither staff time nor overhead was included. The other 21 said they didn't know since the information came from other departments. One of those said they suspected it varied depending on “what the department head wants to

claim”. Another respondent mentioned the expense figures included the education of professional healthcare staff, a practice they were seeking to change.

3. Are the expenses and programs dedicated to community health education a deliberate administrative and board decision, directed by middle management within departments, or determined by line-level employees providing programs as they see they are needed?

This was fairly evenly split. Six respondents (26%) said that there was a centralized administrative directive. Nine (39%) noted it was up to the various departments while eight (35%) indicated decisions were made on a staff level (see Appendix 4-4 and Tables 4G and 4H). However, even those who said there was a formal process indicated that it allowed for or even encouraged initiatives by individual departments and their employees. For those who said decisions were the discretion of the various departments, programs were usually undertaken with the approval of the department head. However there was uncertainty expressed by six interviewees whether that meant the department head initiated the programs or if they originated with line-level employees and the department head simply approved them.

Designations for health education direction were created to better identify the various decision-making levels. There are four Designations: “A” is Administrative Direction, “D” is Department head Direction, “F” is Foundation Direction (or other

separate entity), and “S” is line level Staff Direction. These are subjectively assigned by the researcher, but are based on the input from the questionnaires and the interviews. These designations are based on where in the organization decisions are made to implement programs, fund new activities, evaluate current programs, and determine future community outreach goals, programs, and needs. They also correspond to the nonprofit philanthropy models developed in Chapter One (Exhibit 4A):

Exhibit 4A: The Nonprofit Philanthropy Models

Nonprofit Philanthropy Model	<i>External Mandate</i>	<i>Management Function</i>	<i>Leadership Directed (CEO or Board)</i>	<i>Separate Organizational Function</i>	<i>Stakeholder Discretion</i>
Organizational Motivation (from Young and Burlingame)	To comply with External Criteria	To ensure and/or increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Organizational Structure	Imitative of Mandates	Embedded in Dep't and Manager Hierarchy	Practices at Leadership Level	Separate foundation or identified and publicly-visible department	Dispersed throughout organization
Expected Organizational Location of Philanthropic Function	(Similar to regulatory mandates or system structures)	Linked with primary mission or operation: <i>DEPARTMENT (D)</i>	Board or CEO leadership: <i>ADMINISTRATIVE (A)</i>	Separate foundation or identified and publicly-visible department: <i>FOUNDATION (F)</i>	Dispersed throughout organization <i>STAFF (S)</i>

Administrative Direction (“A”) indicates a top-down organizational commitment to health education and outreach programs, with the board and/or administration implementing a definitive policy establishing program and funding parameters. In “A” hospitals community outreach is a key strategic priority of the entire organization and has strong administrative and/or board or even system-wide oversight and direction. The community outreach effort in these hospitals is formal but the specific organizational form the program takes seems to be more varied. For “A” hospitals, the community outreach efforts have helped to re-shape the system structure rather than fitting within a pre-existing administrative organizational structure.

Department direction (“D”) indicates health education and outreach programs are the responsibility of a designated department – established by administration but with program operation delegated to that department, that has a degree of latitude to plan, coordinate, and report on activities. In “D” designated hospitals, community outreach tends to be seen as one activity of the hospital but is no higher an administrative priority than any other department or function. “D” hospitals seem to have health education programs fairly well “compartmentalized” within a single area and as a defined segment within a formal administrative structure. In these hospitals, various departments may still do program operation but they are initiated and evaluated by the mid-level department and/or director. In these hospitals there were fewer departments identified as operating community education programs – with many of these indicating no other department operating such programs. Many “D” hospitals are larger hospitals with the resources to have Health Education as a separate department. However several small hospitals also had separate departments, with outreach programs indicated as one responsibility of a single public relations director.

Foundation direction (“F”) identifies that the health education programs are operated out of the hospital foundation. In this case the health education program budget and operation is managed by the foundation staff and board, generally in addition to having a responsibility for also raising funds from individual, corporate, and grant sources. One (non-religious) hospital system

identified this structure for their programs and responsibility of the foundation. Interestingly in this case, the hospital's foundation actually had limited responsibility for raising additional contributions, a typical role for most hospital foundations. Funding for the health education expenses was done through an annual transfer of funds from the hospitals.

Staff direction ("S") indicates that health outreach programs are scattered throughout the hospital with seemingly little administrative or departmental direction. In "S" hospitals it is the various staff members in multiple departments that appear to take the initiatives and create the opportunities to conduct a variety of health outreach activities. "S" hospitals tend to be informal in their approach to health education. They expressed some uncertainty as to how many outreach programs are done or who is doing them. Many questionnaires of "S" hospitals indicated responsibilities for management, reporting, and operation of the program were often located at different levels of the organization. Some "S" hospitals are part of a larger system with a centralized health education division, but in practice the programs seem relatively dispersed throughout the organization. In these cases the department is primarily a reporting mechanism rather than providing program direction and initiation.

Tables 4G and 4H show the different levels of health education program decisions, from the questionnaires (if the hospital was not interviewed) and from the interviews. The interviews confirmed (and in cases revised) the information

from the questionnaires. There could be a suspicion that larger hospitals would be more formalized (and perhaps more likely to have separate departments and more formal processes). Table 4G further divides the responses by hospital size (according to the ISDH designation) to show how the figures might vary depending on the relative size of the hospital. To identify the effect and consistency of system membership on health education program decisions and reporting (the External Mandate Model, above), Table 4H divides the responses by religious system, nonreligious system, and independent ownership.

**Table 4G: Location of Community Health Education Decisions –
By Hospital Size**

	Total	Large	Medium	Small
FROM INTERVIEWS	23	6	7	10
Administrative level: "A"	3	2	-	1
Department level: "D"	9	1	3	5
Staff level: "S"	7	2	3	2
Foundation level: "F"	4	1	1	2
FROM QUESTIONNAIRE (No Interviews)	22	4	8	10
Administrative level: "A"	1	-	-	1
Department level: "D"	12	2	4	6
Foundation level: "F"	1	-	-	1
Staff level: "S"	8	2	3	3

**Table 4H: Location of Community Health Education Decisions –
By System Designation**

	<u>Total</u>	<u>Religious</u> <u>System</u>	<u>Non-Religious</u> <u>System</u>	<u>No</u> <u>System</u>
FROM INTERVIEWS	23	10	7	6
Administrative level: "A"	3	-	2	1
Department level: "D"	8	2	2	4
Foundation level: "F"	4	-	4	-
Staff level: "S"	8	8	-	1
FROM QUESTIONNAIRE (No Interviews)	22	5	1	16
Administrative level: "A"	1	-	-	1
Department level: "D"	12	4	-	8
Foundation level: "F"	1	-	1	-
Staff level: "S"	8	1	-	7

Tables 4G and 4H show a relative lack of consistency of the location of the health education function related to organizational size or system involvement. The only category that seemed to reflect one hypothesis of this chapter – that health education programs would be found scattered throughout the hospital – were Catholic systems. Interestingly, those same Catholic hospitals actually might have been expected to be primarily "D" hospitals – as Catholic systems might be more apt to follow standardized department criteria in accord with the CHA/VHA community benefit guidelines. This could lead to the hypothesis that Catholic hospitals would be more inclined to have a formal Community Benefit Department to coordinate these programs. However this was not the case as Catholic systems was found to vary in how centralized the efforts were, with most

of them locating community health education programs scattered throughout the hospital and occurring on the staff level.³²

Three respondents (representing seven hospitals) indicated their organization has a tithing program – meaning the board and administration passed a policy that 10% of the net revenue (after expenses) is to be spent on community outreach programs. In one case this was a formal granting program to other agencies. In the other two it was a transfer of funds to the hospital's foundation, and the foundation subsequently either disbursed the money back to the appropriate departments, or the foundation actually administered and conducted the outreach programs. The first hospital is designated as an “A” decision-making process; the other two as an “F” process.

4. Do the outreach efforts within the hospital fill primarily a Public Relations/Marketing role – or a healthcare service role?

Responses to this question were varied – with 19 responding “a little of both”. The reactions indicated that these programs have multiple benefits and attempts to “define” their purpose as one or the other are probably artificial at best. One potential misleading aspect of this question is how the practice of “public relations” is defined or interpreted by different individuals – and subsequently whether the interpretation of the function of public relations is self-serving (i.e. as simply a means to influence public and/or consumer image of the organization)

³² This variability was even found within the each of the two Catholic systems that participated in the survey and took part in the interviews. Neither of the two systems interviewed had a completely consistent response (see Appendix 4-8).

or customer-serving (i.e. primarily serves as a means of communication between the organization and its publics).³³ A third possibility is that the health education efforts of the organization may merely be “assigned” to a public relations department for purposes of organizational convenience (i.e. it is considered by administration as the “logical” department to put these programs under). This latter conclusion is especially consistent with the response from a majority of hospitals that multiple departments actually conducted the various programs. In this case it may simply be the role of the public relations department to collect and report this information. The reality is that each public relations or marketing program can serve multiple roles and can reflect several motivations simultaneously. It is beyond the scope of this paper to parse out the nuances of this definition, and the conclusion “a little of both” is probably the most accurate observation that can be made within the limitations of this study.

5. Is Community Health Education becoming a more formal department and/or program of the hospital than it has in the past?

Even those without a formal department felt the answer to this was “Yes”. The IRS Schedule H requirement was credited for accelerating the trend but nearly $\frac{3}{4}$ of the respondents (16 of 22) indicated this was part of a direction that had existed within the healthcare organization before those governmental actions.

This trend confirms the isomorphism explanation for this type of behavior,

³³ A problematic consideration for those critics who maintain public relations is primarily self-serving is the example of a hospital developing a needed community health education program but in order to not seem self-serving the existence of that program is not communicated to potentially interested publics. In such an extreme situation, there would be no way for the public in need to know this “pure” service program even existed!

whether influenced (“coerced”) by federal regulations or by the increased systemic guidelines such as those developed by the CHA/VHA related to community benefit standards. Earlier in the chapter (e.g. Table 4C and 4D) the systemic influence is called into question, but later in this chapter a comparison is made of the differences in expenditures by systems as opposed to independent hospitals that might shed some additional light on this question.

Relationship between Location and Health Education/Promotion Expenditure

One key question that arises from this identification of the location of the decision-making process in the organization is whether there is a relationship between where in the organization the decisions and reporting occur and the percentage of health education and health promotion expenditure spent by an organization on these programs. Table 4I shows the hospitals that were interviewed and their program location, arranged from the highest to lowest percentage of health promotion expenditure:

Table 4I: Interviewed Hospitals - Percentage of Expenditures on Health Education/Promotion Programs and Organizational Location
By Percentage of Expenditure (Highest to Lowest Health Promotion%)

Hospital <u>Desig.</u>	2005 <u>Own.</u>	2005 <u>System?</u> ³⁴	Peer <u>Group Or</u>	Direction <u>Admin.</u> <u>Dept</u> <u>Fdn.</u> <u>Or Staff?</u>	% TOTAL <u>HP/Oper</u> <u>Exp</u>	Com. Hlth Ed <u>Exp / Tot.</u> <u>Oper</u> <u>Expense</u>
<u>INTERVIEWS</u>						
F	NP	NR4	S	D	<u>2.821%</u>	<u>0.297%</u>
G	NP	No	M	D	<u>2.430%</u>	<u>0.498%</u>
I	NP	No	S	D	<u>1.471%</u>	<u>0.736%</u>
M	NP	No	L	S	<u>1.094%</u>	<u>0.015%</u>
P	NP	R1	M	S	<u>1.044%</u>	<u>0.322%</u>
V	NP	R2	L	A	<u>0.748%</u>	<u>0.594%</u>
U	NP	NR1	L	F	<u>0.790%</u>	<u>0.404%</u>
X	NP	NR2	L	D	<u>0.732%</u>	<u>0.557%</u>
Y	NP	R1	S	D	<u>0.640%</u>	<u>0.000%</u>
AA	NP	No	L	A	<u>0.528%</u>	<u>0.000%</u>
BB	NP	R1	M	S	<u>0.479%</u>	<u>0.028%</u>
EE	NP	R1	M	S	<u>0.414%</u>	<u>0.313%</u>
FF	NP	NR1	S	F	<u>0.397%</u>	<u>0.237%</u>
II	NP	R1	S	S	<u>0.367%</u>	<u>0.119%</u>
JJ	NP	R1	S	S	<u>0.361%</u>	<u>0.070%</u>
NN	NP	NR1	S	F	<u>0.327%</u>	<u>0.300%</u>
SS	NP	R1	L	S	<u>0.233%</u>	<u>0.057%</u>
VV	NP	NR1	M	F	<u>0.200%</u>	<u>0.029%</u>
WW	NP	NR3	M	D	<u>0.192%</u>	<u>0.128%</u>
XX	NP	No	M	D	<u>0.188%</u>	<u>0.066%</u>
CCC	NP	R1	S	S	<u>0.065%</u>	<u>0.000%</u>
GGG	NP	No	S	A	<u>0.006%</u>	<u>0.006%</u>
KKK	NP	R1	S	D	<u>0.000%</u>	<u>0.000%</u>

There appears to be little correlation between amount of expenditure and the organizational location of the program. Table 4J summarizes these variations among departments

³⁴ System Designations are: R = Religious System; NR = Nonreligious Systems; No = No System. The numbers correspond to common systems (e.g. R1 = all hospitals part of the same Religious System #1; R2 = all hospitals part of Religious System #2; and so on).

Table 4J: Percentage of Operating Expenditures on Health Education and Health Promotion – By Location: 2004 Interviews Only

Location (Number)	Health Promotion Expense as % of Operating Budget		Health Education Expense as % of Operating Budget	
	Average	Median	Average	Median
A (3)	.32%	.53%	.20%	.01%
D (8)	1.05%	.64%	.32%	.13%
F (4)	.43%	.33%	.24%	.24%
S (8)	.51%	.37%	.12%	.06%

Those programs that are located at a department head (“D”) level appear to spend significantly more than hospitals that locate the program elsewhere in the organization. This holds true for both Health Promotion and Health Education expenses. Health Promotion programs located at the Staff (“S”) line level are next, followed by Foundation (“F”) and Administration (“A”) having the lowest level – although for Health Education expenses, these are slightly different.

Table 4K shows the figures for all hospitals that returned the questionnaire (and also had reported ISDH Health Promotion and Education figures).

Table 4K: Percentage of Operating Expenditures for Health Education and Health Promotion – By Organizational Location within the Hospital: 2004³⁵ All that Responded to the Questionnaire

Location (Number)	Health Promotion Expense as % of Operating Budget		Health Education Expense as % of Operating Budget	
	Average	Median	Average	Median
A (3)	.32%	.53%	.20%	.01%
D (13)	1.07%	.73%	.21%	.10%
F (5)	.55%	.40%	.40%	.30%
S (11)	.50%	.39%	.15%	.09%

³⁵ Only hospitals are included that BOTH reported ISDH data AND ALSO responded to the questionnaire. It is noted that 10 hospitals responded to the questionnaire that did not have ISDH financial data.

Again, those hospitals that located the programs at the Department level had significantly larger percentages of Health Promotion expenditures than other locations, although Foundation-based programs reported a higher percentage of Health Education programs. It should be re-emphasized that the more important expense figure is Health Promotion, as this seems to (generally) include Health Education programs but also takes into account other programs to improve health in the community.

While the limited nature of this study makes generalized conclusions difficult, there are some preliminary observations that can be made from these figures. The first is the variability found in the location of the management of these programs. There appears to be little consistency in the studied Indiana hospitals in how and where various programs are located. The second observation is that when the programs are managed at a departmental level, a higher percentage of health promotion expenses are found. This could be because if there is a designated department there is also a more formalized program for creating and managing these programs. This formalized responsibility could also motivate a department head to better collect and report the programs offered throughout the hospital, since a majority of hospitals indicated that five or more departments actually provided health education programs – including those that were managed at a departmental level.

The seeming lack of consistency in the Indiana nonprofit hospitals as a whole raises the question whether hospitals that are part of a system show a greater consistency. Isomorphism theory would suggest that systems would influence their member hospitals to structure themselves in a similar manner. There could be the implication that this similarity could also lead to similar levels of expenditures. Table 4L shows the interviewed hospitals arranged by system affiliation.

Table 4L: Interviewed Hospitals - Percentage of Expenditures on Health Education/Promotion Programs and Organizational Location – By System

Hospital <u>Desig.</u>	2005 <u>Own.</u>	2005 <u>System?</u>	Peer <u>Group</u>	Direction <u>Admin.</u> <u>Dept</u> <u>,</u> <u>Fdn.</u> <u>Or Staff?</u>	% TOTAL <u>HP/Oper</u> <u>Exp</u>	Com. Hlth Ed <u>Exp / Tot.</u> <u>Oper</u> <u>Expense</u>
<u>INTERVIEWS</u>						
P	NP	R1	M	S	<u>1.044%</u>	<u>0.322%</u>
Y	NP	R1	S	D	<u>0.640%</u>	<u>0.000%</u>
BB	NP	R1	M	S	<u>0.479%</u>	<u>0.028%</u>
EE	NP	R1	M	S	<u>0.414%</u>	<u>0.313%</u>
II	NP	R1	S	S	<u>0.367%</u>	<u>0.119%</u>
JJ	NP	R1	S	S	<u>0.361%</u>	<u>0.070%</u>
SS	NP	R1	L	S	<u>0.233%</u>	<u>0.057%</u>
CCC	NP	R1	S	S	<u>0.065%</u>	<u>0.000%</u>
KKK	NP	R1	S	D	<u>0.000%</u>	<u>0.000%</u>
V	NP	R2	L	A	<u>0.748%</u>	<u>0.594%</u>
U	NP	NR1	L	F	<u>0.790%</u>	<u>0.404%</u>
FF	NP	NR1	S	F	<u>0.397%</u>	<u>0.237%</u>
NN	NP	NR1	S	F	<u>0.327%</u>	<u>0.300%</u>
VV	NP	NR1	M	F	<u>0.200%</u>	<u>0.029%</u>
X	NP	NR2	L	D	<u>0.732%</u>	<u>0.557%</u>
WW	NP	NR5	M	D	<u>0.192%</u>	<u>0.128%</u>
F	NP	NR4	S	D	<u>2.821%</u>	<u>0.297%</u>
G	NP	No	M	D	<u>2.430%</u>	<u>0.498%</u>
I	NP	No	S	D	<u>1.471%</u>	<u>0.736%</u>
M	NP	No	L	S	<u>1.094%</u>	<u>0.015%</u>
AA	NP	No	L	A	<u>0.528%</u>	<u>0.000%</u>
XX	NP	No	M	D	<u>0.188%</u>	<u>0.066%</u>
GGG	NP	No	S	A	<u>0.006%</u>	<u>0.006%</u>

There seems to be less consistency than might be expected, especially between the two religious systems. Even within the R1 system, two hospitals locate the management of health promotion programs in departments, while the others are at the staff level. Table 4M summarizes the hospitals by type of system:

Table 4M: Percentage of Operating Expenditures on Health Education and Health Promotion – By System: 2004 Interviews Only

<u>System</u> (Number)	<u>Health Promotion Expense as % of Operating Budget</u>		<u>Health Education Expense as % of Operating Budget</u>	
	<u>Average</u>	<u>Median</u>	<u>Average</u>	<u>Median</u>
Catholic System (10)	.44%	.37%	.15%	.06%
Nonreligious System (7)	.78%	.40%	.28%	.30%
No System (6)	.95%	.53%	.22%	.02%

What is surprising is that independent hospitals report a much higher percentage of Health Promotion expense than the system hospitals – and the religious system hospitals report the lowest level of expense. This could be counter to expectations that might assume that religious hospitals would provide a higher level of health promotion expenses because of their mission as well as the influence of the CHA Community Benefit guidelines to better collect this type of information. This lower level of reporting by the religious (Catholic) hospitals is also seen in the (seemingly) more defined Health Education expenses.

Table 4N shows a similar situation in a summary of all hospitals that returned the questionnaires.

**Table 4N: Percentage of Operating Expenditures on Health Education and Health Promotion – By System: 2004
All that Responded to the Questionnaire**

NOTE:

10 hospitals responded to the questionnaire that did not have ISDH financial data

System (Number)	Health Promotion Expense as % of Operating Budget		Health Education Expense as % of Operating Budget	
	Average	Median	Average	Median
Catholic System (13)	.45%	.48%	.13%	.12%
Nonreligious System (8)	.81%	.79%	.37%	.40%
No System (11)	1.01%	.75%	.19%	.10%

Again, definitive conclusions based on this limited study are difficult to make.

However the figures seem to indicate that it is not religious system hospitals that provide the highest level of health education and promotion programs for their communities. Instead independent hospitals show a much higher level of health promotion expenditure. The reasons for this is speculative, but one possible explanation could be that independent hospitals are more influenced by local boards and control and therefore more concerned about the needs of their community than a centralized system. One explanation could be that Catholic hospitals are more honest and therefore don't inflate their figures. It could also be explained that where more formalized reporting systems are in place (in systems) there is a more limited definition of health promotion. Regardless, these findings provide a potential question to further investigate in future research as well as in the analysis of donations in the next chapter,

Conclusions

The initial hypothesis of this chapter (related solely to health education/promotion programs) is: *Community health education/promotion programs are motivated by normative Stakeholder values and are scattered throughout the organization.* That hypothesis seems to be both confirmed and expanded by the evaluation of the hospitals as reported in the chapter. The majority of questionnaires and interviews indicate five or more departments conduct such programs, regardless of where in the organization the programs are reported or managed. This alone seems to confirm the hypothesis. At the same time, the general commitment to the concept of providing health education programs does seem to be a formal part of a large percentage of the responding hospitals, with departmental responsibility ("D") being the largest designation for this management (although less than half of the hospitals fall within this location for program management).

However even in Department coordinated programs, the specific decisions of what programs are presented, which publics to address, and how the expenses and other details of the program operation are reported are primarily left to the individuals throughout the hospital hierarchy. The next largest designation is the staff level ("S") that reflects the Stakeholder motivation. Only a small percentage of hospitals indicated the administration ("A") was the primary organizational level for the program management, a designation that would indicate a different Leadership motivation.

This emphasis on staff and departmental location for health education programs, indicates that the primary interest of the hospital leadership is to have a structure in place that addresses health education – and/or to encourage programs that serve these purposes – but that it is less interested in controlling the details of the specific programs that are actually executed or publics addressed. This multi-level situation complicates the conclusions that can be drawn. On the one hand the departmental management focus seems to indicate a more revenue-based motivation behind the programs, based in resource dependency theory or encouraged through coercive isomorphism by an overall system. Conversely those hospitals indicating a staff-level of management strengthen the normative isomorphism explanation behind the Stakeholder Discretion Model for philanthropic behavior. In addition, in the departmentally focused programs there is still the situation of having programs operated within multiple departments throughout the hospital, even though the information is collected in a centralized structure. This means the programs may be managed on a departmental level but are still loosely coupled within the broader organization. The combination of formal structure and individual staff autonomy could be an organizational approach for health education programs to meet the organizational needs as well as the interests and needs of a variety of stakeholders. However it can complicate policy efforts that seek to standardize and compare different hospital programs.

The ISDH data suggests that system hospitals spend more on health promotion than independent hospitals; within systems, non-religious hospitals seem to spend more than religious hospitals. However these generalizations also have noteworthy variations – and the hospitals interviewed and surveyed actually report lower expenditures for system hospitals than independent hospitals. Only by looking at individual hospitals within their specific management and community context are we able to understand meaningful differences or similarities.

By examining the data from the ISDH Hospital Fiscal reports and the results of the written questionnaire and the personal interviews, four other conclusions seem to emerge. First, the data that are currently shared regarding hospital community health education expenses are variable and uncertain. The fact it is self-reported not only by the hospital itself but even within the hospital leads to a broad uncertainty as to what is included and how definitive those figures are. It is unlikely that the new IRS Form 900 and Schedule H will change this, as the information on health education that is being collected is relatively undefined, meaning the results from the Indiana database could be a fairly good indicator of how national responses may also be reported. Another weakness is an uncertainty whether personnel and overhead costs are also included in expense figures. The guidelines of the CHA/VHA do include these,³⁶ but to be reliable this

³⁶ It also should be observed that while the CHA guidelines indicate that staff time should be reported as a community benefit expense, it might be assumed that Catholic hospitals would be more inclined to report this personnel figure along with direct program expense. In this case Catholic hospitals could be expected to have a significantly higher level of health education

information will need to be communicated throughout the hospital rather than just to those who are assigned this responsibility. Even in hospitals and systems with formal programs, this hospital-wide awareness will need to be implemented to accurately collect this type of information. Because of this variability, it is probable that there could be an under-reporting of community health education expenses by nonprofit hospitals.

Conversely, a second conclusion also emerges: the IRS has accelerated the adoption of the CHA/VHA criteria for reporting community benefit through the process of asking for the information. This could have the eventual effect of a more consistent reporting process throughout the nonprofit hospital field. One question will be how many of the details on community health education will be made public.

Third, the responses seem to suggest that a charity care emphasis by policymakers may be at the expense of improved community health education. That less attention is paid to this area is reflected in that none of the data or consistency problems that have been identified in this paper are addressed in the revised IRS regulations.

expenditure than non-Catholic hospitals. However, the surveys found that Catholic hospitals actually report spending less on health expense than non-religious hospitals, meaning it is doubtful the staff expense is included. This lack of inclusion may be due to those Catholic hospitals ignoring the CHA guidelines or it may be that the ISDH reporting process discourages including staff expenses.

Finally, the variety of internal processes within different organizational levels for determining and reporting community health education programs confirm the neo-institutional approaches that emphasize the decoupling of decision-making in nonprofit organizations. These processes also demonstrate the importance of professionalization as an impetus to legitimacy and to shape a standard organizational culture and ethics. The empowerment of departments and employees at the organizational grassroots or staff level becomes a primary way for a hospital to encourage the philanthropic behavior by those within the organization. This staff empowerment also helps the hospital demonstrate its commitment to nonprofit organizational philanthropic behavior, beyond the self-interested behavior implied by resource dependency motivations. The hypothesis that donations are treated differently by hospitals than health education programs is the next area to investigate.

APPENDIX 4-1: Health Education Expenses: 2005³⁷

<u>Hospital Designation</u>	<u>2005 Owner-ship</u>	<u>2005 System?</u>	<u>Peer Group</u>	<u>Community Health Education Expenses</u>	<u>Com. Health Ed Exp / Total Oper Expense</u>
<u>X</u>	<u>NP</u>	<u>NR2</u>	<u>L</u>	<u>\$8,254,240</u>	<u>0.557%</u>
<u>V</u>	<u>NP</u>	<u>R2</u>	<u>L</u>	<u>\$2,419,335</u>	<u>0.594%</u>
<u>U</u>	<u>NP</u>	<u>NR1</u>	<u>L</u>	<u>\$1,714,949</u>	<u>0.404%</u>
K	NP	R2	L	\$1,509,614	1.131%
<u>W</u>	<u>NP</u>	<u>No</u>	<u>L</u>	<u>\$870,562</u>	<u>0.331%</u>
D	NP	R2	L	\$551,289	0.313%
J	NP	R2	M	\$533,953	0.538%
LL	NP	No	L	\$498,006	0.160%
KK	NP	NR6	L	\$480,870	0.186%
GG	NP	NR3	L	\$401,370	0.395%
O	NP	R3	L	\$361,315	0.204%
<u>SS</u>	<u>NP</u>	<u>R1</u>	<u>L</u>	<u>\$350,000</u>	<u>0.057%</u>
<u>Q</u>	<u>NP</u>	<u>NR1</u>	<u>M</u>	<u>\$338,245</u>	<u>1.019%</u>
<u>T</u>	<u>NP</u>	<u>No</u>	<u>L</u>	<u>\$312,655</u>	<u>0.097%</u>
<u>EE</u>	<u>NP</u>	<u>R1</u>	<u>M</u>	<u>\$300,000</u>	<u>0.313%</u>
AAA	NP	NR5	L	\$282,589	0.107%
<u>I</u>	<u>NP</u>	<u>No</u>	<u>S</u>	<u>\$230,777</u>	<u>0.736%</u>
<u>G</u>	<u>NP</u>	<u>No</u>	<u>M</u>	<u>\$212,282</u>	<u>0.498%</u>
<u>MM</u>	<u>NP</u>	<u>No</u>	<u>M</u>	<u>\$179,446</u>	<u>0.299%</u>
DD	NP	NR2	M	\$172,642	0.138%
ZZ	NP	R2	M	\$161,531	0.150%
L	NP	R3	M	\$160,409	0.413%
<u>WW</u>	<u>NP</u>	<u>NR5</u>	<u>M</u>	<u>\$149,563</u>	<u>0.128%</u>
<u>XX</u>	<u>NP</u>	<u>No</u>	<u>M</u>	<u>\$114,825</u>	<u>0.066%</u>
<u>N</u>	<u>NP</u>	<u>R4</u>	<u>M</u>	<u>\$112,672</u>	<u>0.132%</u>
<u>UU</u>	<u>NP</u>	<u>No</u>	<u>M</u>	<u>\$111,552</u>	<u>0.208%</u>
<u>JJ</u>	<u>NP</u>	<u>R1</u>	<u>M</u>	<u>\$101,868</u>	<u>0.070%</u>
H	NP	No	L	\$87,884	0.036%
Z	NP	NR6	M	\$86,660	0.073%
<u>P</u>	<u>NP</u>	<u>R1</u>	<u>M</u>	<u>\$81,878</u>	<u>0.322%</u>
RR	NP	R2	M	\$52,000	0.038%
<u>M</u>	<u>NP</u>	<u>No</u>	<u>L</u>	<u>\$34,362</u>	<u>0.015%</u>
<u>NN</u>	<u>NP</u>	<u>NR1</u>	<u>S</u>	<u>\$33,963</u>	<u>0.300%</u>
<u>II</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$30,558</u>	<u>0.119%</u>
<u>E</u>	<u>NP</u>	<u>No</u>	<u>S</u>	<u>\$25,221</u>	<u>0.059%</u>
<u>BB</u>	<u>NP</u>	<u>R1</u>	<u>M</u>	<u>\$21,686</u>	<u>0.028%</u>

³⁷ Financial data on this and other tables are from the 2005 ISDH reports – with data from the hospitals' 2004 fiscal year.

<u>Hospital Designation</u>	<u>2005 Owner-ship</u>	<u>2005 System?</u>	<u>Peer Group</u>	<u>Community Health Education Expenses</u>	<u>Com. Health Ed Exp / Total Oper Expense</u>
BBB	NP	No	M	\$19,879	0.100%
HH	NP	R1	S	\$15,000	0.088%
VV	NP	NR1	M	\$7,868	0.029%
CC	NP	No	S	\$7,330	0.082%
OO	NP	NR2	S	\$6,098	0.015%
R	NP	R2	M	\$3,335	0.009%
QQ	NP	R3	M	\$621	0.001%
<u>GGG</u>	<u>NP</u>	<u>No</u>	<u>S</u>	<u>\$501</u>	<u>0.006%</u>
<u>KKK</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$0</u>	<u>0.000%</u>
PP	NP	R2	M	\$0	0.000%
LLL	NP	NR5	M	\$0	0.000%
A	NP	NR3	L	\$0	0.000%
B	NP	NR3	L	\$0	0.000%
C	NP	NR3	L	\$0	0.000%
<u>CCC</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$0</u>	<u>0.000%</u>
<u>AA</u>	<u>NP</u>	<u>No</u>	<u>L</u>	<u>\$0</u>	<u>0.000%</u>
<u>EEE</u>	<u>NP</u>	<u>R2</u>	<u>L</u>	<u>\$0</u>	<u>0.000%</u>
S	NP	R1	L	\$0	0.000%
<u>Y</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$0</u>	<u>0.000%</u>
DDD	NP	R1	S	\$0	0.000%
MMM	NP	NR6	S	\$0	0.000%
HHH	NP	No	S	\$0	0.000%
III	NP	No	S	\$0	0.000%
JJJ	NP	No	M	\$0	0.000%

Bold indicates a hospital responding to the questionnaire.

Underlined bold indicates a hospital consenting to a personal interview.

**APPENDIX 4-2: Health Promotion:
Community Programs and Services + Health Education Expenses:
2005**

<u>Hospital Designation</u>	<u>2005 Owner- ship</u>	<u>2005 System?</u>	<u>Peer Group</u>	<u>\$Total Com Progr and Srv +Hlth Ed Expenses</u>	<u>% TOTAL HP/Oper Exp</u>
A	NP	NR3	L	\$59,441,297	21.568%
B	NP	NR3	L	\$36,580,002	12.781%
C	NP	NR3	L	\$11,482,069	10.975%
X	NP	NR2	L	\$10,844,880	0.732%
D	NP	R2	L	\$6,906,217	3.922%
H	NP	No	L	\$4,513,532	1.869%
U	NP	NR1	L	\$3,352,049	0.790%
V	NP	R2	L	\$3,046,770	0.748%
T	NP	No	L	\$2,667,326	0.830%
M	NP	No	L	\$2,463,933	1.094%
S	NP	R1	L	\$2,436,247	0.890%
W	NP	No	L	\$1,960,077	0.745%
O	NP	R3	L	\$1,854,323	1.050%
AA	NP	No	L	\$1,581,317	0.528%
K	NP	R2	L	\$1,572,114	1.178%
SS	NP	R1	L	\$1,419,102	0.233%
E	NP	No	S	\$1,399,757	3.271%
J	NP	R2	M	\$1,215,384	1.225%
LL	NP	No	L	\$1,062,242	0.340%
G	NP	No	M	\$1,036,872	2.430%
N	NP	R4	M	\$893,619	1.051%
KK	NP	NR6	L	\$884,835	0.342%
Z	NP	NR2	M	\$696,097	0.590%
DD	NP	NR2	M	\$543,532	0.435%
JJ	NP	R1	M	\$527,396	0.361%
F	NP	NR4	S	\$506,793	2.821%
I	NP	No	S	\$461,554	1.471%
L	NP	R3	M	\$441,671	1.138%
GG	NP	NR3	L	\$401,370	0.395%
EE	NP	R1	M	\$396,613	0.414%
AAA	NP	NR5	L	\$391,221	0.148%
R	NP	R2	M	\$367,416	0.974%
BB	NP	R1	M	\$366,990	0.479%
Q	NP	NR1	M	\$338,245	1.019%
XX	NP	No	M	\$325,489	0.188%
RR	NP	R2	M	\$323,564	0.239%
P	NP	R1	M	\$265,615	1.044%
WW	NP	NR5	M	\$223,839	0.192%

<u>Hospital Designation</u>	<u>2005 Ownership</u>	<u>2005 System?</u>	<u>Peer Group</u>	<u>\$Total Com Progr and Srv +Hlth Ed Expenses</u>	<u>% TOTAL HP/Oper Exp</u>
MM	NP	No	M	\$200,945	0.335%
ZZ	NP	R2	M	\$161,531	0.150%
QQ	NP	R3	M	\$150,269	0.248%
<u>FF</u>	<u>NP</u>	<u>NR1</u>	<u>S</u>	<u>\$122,454</u>	<u>0.397%</u>
OO	NP	NR2	S	\$122,235	0.301%
PP	NP	R2	M	\$118,453	0.267%
UU	NP	No	M	\$111,552	0.208%
<u>Y</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$96,705</u>	<u>0.640%</u>
<u>II</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$94,160</u>	<u>0.367%</u>
HH	NP	R1	S	\$66,964	0.391%
EEE	NP	R2	L	\$62,500	0.045%
<u>VV</u>	<u>NP</u>	<u>NR1</u>	<u>M</u>	<u>\$53,876</u>	<u>0.200%</u>
CC	NP	No	S	\$42,231	0.475%
<u>NN</u>	<u>NP</u>	<u>NR1</u>	<u>S</u>	<u>\$37,045</u>	<u>0.327%</u>
BBB	NP	No	M	\$27,349	0.137%
<u>CCC</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$18,095</u>	<u>0.065%</u>
DDD	NP	R1	S	\$8,473	0.054%
<u>GGG</u>	<u>NP</u>	<u>No</u>	<u>S</u>	<u>\$501</u>	<u>0.006%</u>
<u>KKK</u>	<u>NP</u>	<u>R1</u>	<u>S</u>	<u>\$0</u>	<u>0.000%</u>
LLL	NP	NR3	M	\$0	0.000%
MMM	NP	NR6	S	\$0	0.000%
HHH	NP	No	S	\$0	0.000%
III	NP	No	S	\$0	0.000%
JJJ	NP	No	M	\$0	0.000%

Bold indicates a hospital responding to the questionnaire.

Underlined bold indicates a hospital consenting to a personal interview.

APPENDIX 4-3: Responses to Questionnaires – By Hospital Designations

<u>Hospital Designation</u>	<u>2005 Ownership</u>	<u>2005 System?</u>	<u>Peer Group</u>	<u>Hospital Designation</u>	<u>2005 Ownership</u>	<u>2005 System?</u>	<u>Peer Group</u>
<u>INTERVIEWS</u>				<u>NO INTERVIEWS</u>			
AA	NP	No	L	E	NP	No	S
BB	NP	R1	M	EEE	NP	R2	L
CCC	NP	R1	S	FFF	County	No	S
EE	NP	R1	M	HH	NP	R1	S
F	NP	NR4	S	MM	NP	No	M
FF	NP	NR1	S	N	NP	R4	M
G	NP	No	M	Q	NP	NR1	M
GGG	NP	No	S	T	NP	No	L
I	NP	No	S	TT	County	No	S
II	NP	R1	S	UU	NP	No	M
JJ	NP	R1	M	W	NP	No	L
KKK	NP	R1	S	X	NP	NR2	L
M	NP	No	L	No ISDH	County	No	M
NN	NP	NR1	S	No ISDH	County	No	S
P	NP	R1	M	No ISDH	County	No	M
SS	NP	R1	L	No ISDH	County	R5	M
U	NP	NR1	L	No ISDH	County	R5	S
V	NP	R2	L	No ISDH	City-Cty	No	S
VV	NP	NR1	M	No ISDH	County	No	S
WW	NP	NR5	M	No ISDH	County	No	S
XX	NP	No	M	No ISDH	County	No	M
Y	NP	R1	S	No ISDH	County	No	S
YY	County	No	L				

**APPENDIX 4-4: Responses to Questionnaires – Health Education
Administrative, Department Director, Foundation or Staff Decisions**

<u>Hospital</u>	<u>2005</u>	<u>2005</u>	<u>Peer</u>	<u>Direction</u> <u>Admin.</u> <u>Dept</u>	<u>Hospital</u>	<u>2005</u>	<u>2005</u>	<u>Peer</u>	<u>Direction</u> <u>Admin.</u> <u>Dept,</u> <u>Fdn.</u> <u>Or Staff?</u>
<u>Desig.</u>	<u>Own.</u>	<u>System?</u>	<u>Group</u>	<u>Fdn.</u> <u>Or Staff?</u>	<u>Desig.</u>	<u>Own.</u>	<u>Syste</u> <u>m?</u>	<u>Group</u>	
INTERVIEWS					NO Interviews				
AA	NP	No	L	A	YY	Cnty	No	L	S
BB	NP	R1	M	S	E	NP	No	S	D
CCC	NP	R1	S	S	EEE	NP	R2	L	D
EE	NP	R1	M	S	FFF	County	No	S	D
F	NP	NR4	S	D	HH	NP	R1	S	S
FF	NP	NR1	S	F	MM	NP	No	M	S
G	NP	No	M	D	N	NP	R4	M	D
GGG	NP	No	S	A	Q	NP	NR1	M	F
I	NP	No	S	D	T	NP	No	L	D
II	NP	R1	S	S	TT	County	No	S	A
JJ	NP	R1	S	S	UU	NP	No	M	D
KKK	NP	R1	S	D	W	NP	No	L	S
M	NP	No	L	S	No ISDH	County	No	M	S
NN	NP	NR1	S	F	No ISDH	County	No	S	D
P	NP	R1	M	S	No ISDH	County	No	M	D
SS	NP	R1	L	S	No ISDH	County	R5	M	D
U	NP	NR1	L	F	No ISDH	County	R5	S	D
V	NP	R2	L	A	No ISDH	City-Cty	No	S	S
VV	NP	NR1	M	F	No ISDH	County	No	S	D
WW	NP	NR5	M	D	No ISDH	County	No	S	D
X	NP	NR2	L	D	No ISDH	County	No	M	S
XX	NP	No	M	D	No ISDH	County	No	S	S
Y	NP	R1	S	D					

Appendix 4-5: Questionnaire and Cover Letter

Community Benefit Representative
XYZ Hospital, City, IN - Zip

Dear Ms/Mr. _____:

I would greatly appreciate your help! I am trying to verify the figures and process reported to and by the Indiana State Department of Health regarding hospital community benefits in Indiana. I am conducting a research project as part of a program with INDIANA UNIVERSITY and THE CENTER ON PHILANTHROPY. The project is to study the health promotion and donation programs Indiana hospitals provide for the benefit of their communities.

Part of the purpose of the study is to better clarify the benefits Indiana hospitals provide through community wellness and health education programs – and the process hospitals use to make these decisions. This is part of a larger research project evaluating the extent that Indiana hospitals give back to their communities.

There is a second part of the questionnaire that also seeks additional information on the category of “donations” – funds identified as given by the hospital to other causes in the community. Would you mind taking a couple of minutes to fill out the enclosed questionnaire? Because the study focuses on Indiana hospitals, your assistance is critical for the success of this project!

The questionnaire should take less than ten minutes to complete, and all responses will be kept confidential. I will be happy to return to you a summary of all the completed responses for your own information. THANK YOU! Your involvement is greatly appreciated.

Sincerely,

Al Lyons
PhD Candidate, Center on Philanthropy at Indiana University

P.S.: PLEASE NOTE: All answers remain strictly confidential. Specific information shared will not be reported to any others – either within the hospital, the state hospital system, or any governmental entities. Results will be assembled in aggregate summaries and information conveyed through papers or reports based on this study will be presented in a way that readers will not be able to connect information with specific hospitals nor infer anything specific about your hospital.

PLEASE RETURN TO:

Al Lyons, 9616 Harbour Pointe, Bloomington, Indiana 47401, 812-824-7082,
allyons@sopris.net

Indiana Community Benefit Questionnaire

Hospital Name _____
City _____, Indiana
Report for the Year 2005 Fiscal Year Period:

Community Benefit – Health Promotion Programs:

The 2005 Indiana Hospital Fiscal Report
<http://www.in.gov/isdh/regsvcs/acc/fiscal05/002408.htm> states _____ Hospital_ had the following expenditures for **Costs of Subsidized Community Benefits:**

Estimated Incoming Revenue- \$ X

Estimated Outgoing Expenses- \$ X

Unreimbursed Costs by Hospital- \$ X

1. Who in the hospital is most responsible for reporting those figures?
 CEO
 Other Administration
 Department Head
 Support Staff
 Other (please specify):
 2. Which department is most responsible for managing health promotion programs and budget?
 Administration
 Public Relations/Marketing
 Health Education
 Fund Development/Foundation
 Other (please specify):
 3. Are the above programs determined and operated by more than one department or entity?
 Yes
 No
- If the answer to #3 is "Yes", how many departments or entities offer health promotion programs?
 Two
 Three
 Four
 Five or more
• Which ones?

Do you have any other comments that might help clarify any of the above?

Appendix 4-6: Responses to Health Promotion Questionnaire #3

Are the above programs determined and operated by more than one department or entity? Which ones?

- Community Education, Indiana Poison Center, Healthnet, Women's Services, Medical Education
- Physical Therapy, Dietary Education
- Individual departments are responsible; No centralized location (4 responses, by multiple hospitals in one system)
- Numerous departments, with six programs listed as examples
- Occupational health, Outpatient Physician Clinic staff, Infection Control Nurse, Imaging Dept., Lab Dept., PT/OT Dept., Nursing Administration, OB Staff
- Resource Center (focused on community), Wellness (focused on employees), Comp Center (focused on businesses) – there is some overlap
- PR/Community Education
- Health Ed, Sports Medicine, Women's Center, Family Medicine Center
- Health Education and Marketing
- Marketing/Public Relations, Community Wellness, 3 Grant Programs, Women's Services, Oncology Services, Pediatric Services, EMS
- Education, Lab, Radiology, Oncology Services, Business Development – all working together
- Clinical departments contribute to Community Health Promotion programs in the form of "Health Fairs"
- Foundation, Obstetrics, Marketing, EMS/Ambulance
- Health Education, Nursing, Lab, Radiology, Public Relations and other Ancillary Services
- Marketing, Community Outreach, Family Medicine Center, Center for Family Practices, Nappanee Family Medicine
- Various departments such as Community Health, Primary Care Clinic, Diabetes Center, Mental Health, Nursing, etc.

**Appendix 4-7: Responses to Health Promotion Questionnaire –
“Do you have any other comments that help clarify any of the
above?”**

- “How the summary of Community Benefits table was calculated is unknown to me, it does not match the report I submitted. However, it could reflect data submitted by our Finance Department.”
- “Most marketing positions also have other job responsibilities, like Human Resources”
- “Cost of programs reported does not include cost of human resources involved in the programs. Only the non-salary expenses were reported”
- “One department oversees the program, but every department is responsible to support CB efforts. For example: Radiology does mammograms, Community Relations does donations, and EMS does the emergency services”
- “We offer a wide variety of community health education programs and training programs including smoking cessation, Safe Sitter babysitting training, free prenatal and child birth classes, free well baby checkups (home visit), health fairs, health screenings, plus we support other agencies who share in our mission by donating free office and meeting space”
- “Our department that offers health education has been combined with marketing, giving the dept a title of Community Health Relations. The two departments that were combined were Marketing and Community Health.”
- Many departments run health and wellness programs. All report activities to Marketing, which compiles all information to submit in Community Benefit Report to ISDH. This info is then combined with financial info in Accounting, and submitted.”
- Reporting of the above costs of subsidized Community Benefits should have been as follows:
 - Incoming Revenue - \$ 85,696
 - Outgoing Expense - \$ 904,964
 - Unreimbursed Costs by Hospital - (\$819,268)
 - Note: ISDH reported all as “\$0”

CHAPTER FIVE: DONATIONS AND INDIANA HOSPITALS

This chapter continues the exploration of available data from Indiana hospitals and their activities related to community health education and donations. This chapter focuses on the area of donations, building on the analysis of health education expenditures in the preceding chapter. It investigates one hypothesis of this paper: *Donation programs are either motivated by Political considerations and are located in a separate department or by Ethical/Altruistic motivations so are Leadership Directed and located at the hospital leadership level.*

Chapter Five uses the same organizational framework as developed in Chapter Four to address the question: “How and why do Indiana nonprofit hospitals make financial contributions?” It presents a similar analysis of reports and surveys to explore how individual hospitals determine and disburse donations to their community. It also notes how these donations relate to efforts by nonprofit hospitals to attract contributions from their communities.

Following an introduction outlining the factors relating to hospital donations, Chapter Five first evaluates the donations data collected by the Indiana State Department of Health (ISDH) to determine what this data might reveal about the reporting of this area by Indiana hospitals. The second part of this chapter compares IRS data with the ISDH data to determine the comparability of the two reporting documents. Part three of the chapter reports the results of two surveys

of individual Indiana hospitals that explore the specific processes involved with developing and presenting health education programs. The information gained from the statistical analysis and the surveys is then applied to the hypothesis that *Donation programs are either located in a separate department or at the hospital leadership level*. If true, this effectively separates donations from the health education programs that are embedded in the organization either at the management or stakeholder levels.

Introduction

Nonprofit Hospitals and Motivations for Donations: According to earlier explanations of organizational philanthropic motivations, donations fulfill either Young and Burlingame's Political model for philanthropy, providing the hospital with community influence and participation – or their Ethical/Altruistic motivations, expressing values of the organization's leadership. These motivations contrast with Health Education programs that seem to be primarily driven by Stakeholder Discretion as well as by Departmental/Management motivations. These motivations are outlined in Table 5A.

Table 5A: The Nonprofit Philanthropy Models

Nonprofit Philanthropy Model	External Mandate	Management Function	Leadership Directed (CEO or Board) [ETHICAL/ALTRUISTIC]	Separate Organizational Function [POLITICAL]	Stakeholder Discretion
Corporate Motivation (from Young and Burlingame)	To comply with External Criteria	To ensure and/or increase firm profitability	To meet community and social responsibility	To strengthen economic and community power	To satisfy multiple constituencies
Corporate Structure	Imitative of Mandates	Embedded in Dep't and Manager Hierarchy	Practices at Leadership Level	Separate foundation or identified and publicly-visible department	Dispersed throughout organization

It is theorized that decisions and actions regarding donations would be centered at the hospital leadership level, primarily driven by Ethical/Altruistic motives.

Conversely if donations fulfill a Political model for giving, a motivation is to provide the hospital with community influence and participation. This political benefit could be strengthened if the donation function is decoupled from the delivery of healthcare itself and located in a separate department of the hospital or even in a separate foundation. In both motivations, donations become decoupled from operations.

One reason for this decoupling is that nonprofit hospitals¹ may seek contributions from their constituency as well as make donations to other organizations. If either or both giving processes are placed into a separate foundation or other entity, this can effectively separate these two aspects of the donation process

¹ As will be shown later in this chapter, for-profit hospitals also may receive donations. However, it is not clear how proactively they seek such contributions.

from operations. A consequence of this decoupling is that it can be difficult to accurately compare both incoming and outgoing donations with related health care activities. These complications can be increased in situations where single fund development departments serve multiple facilities especially for systems with a single foundation that serves individual hospitals or groups of hospitals. Such foundations are generally treated as separate organizational entities, meaning their income and expense figures may not be captured in hospital reports. The new Schedule H forms are not expected to address this problem in the future, as the category of donations is treated in a very general manner and allows individual hospitals to self-interpret what exactly they count and report on those forms. The focus of policy on charity care and the lack of attention to other community benefit figures mean that other philanthropic behavior of nonprofit hospitals is potentially being undercounted or even overlooked. It also leads to difficulties for comparisons between hospitals or to pre-determined standards.

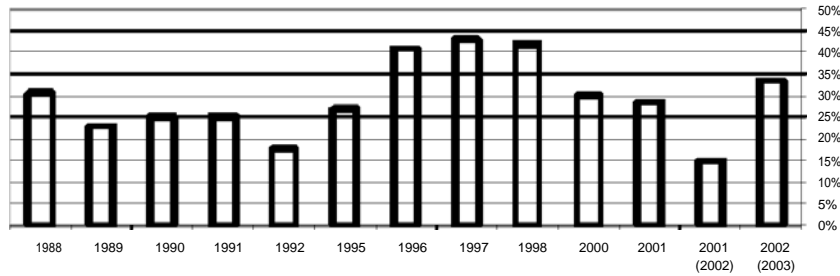
One additional complication of identifying donations to the community as opposed to those from the community is that while a hospital's net donation to the community might be considered as part of "community benefit" (as it is in the ISDH Reports as well as the IRS Schedule H), donative theorists might conversely theorize that it is the donations from the community that indicate an organization's worthiness for tax exemption. One example of this apparent contradiction is in the articles arguing both of these points by John D. Colombo (Colombo 2005, Hall and Colombo 1991a and 1991b). By subtracting incoming

contributions from outgoing donations, policies have the effect of diminishing the relative level of the both types of donations

The Use of Donations by Hospitals: As stated in the Introduction to this paper, the Association for Healthcare Philanthropy (AHP) reported that healthcare facilities generated over \$7 billion in contributions in 2005 – or approximately 2% of all giving in the country.² About one-third of the money that was raised by nonprofit hospitals in 2002 was used for projects involving community benefit, a trend that has been relatively consistent going back to 1988. Chart 5-A shows the total percentage of funds contributed to nonprofit hospitals in the United States between 1998 and 2003 that went to support community benefit-related programs and projects, including Research and Teaching as well as support for Hospice.

² *HFMA News*, (2006). The figure of total giving also includes proceeds from investments, pledges and planned gift expectations, making it not an exact match to the *Giving USA* figures.

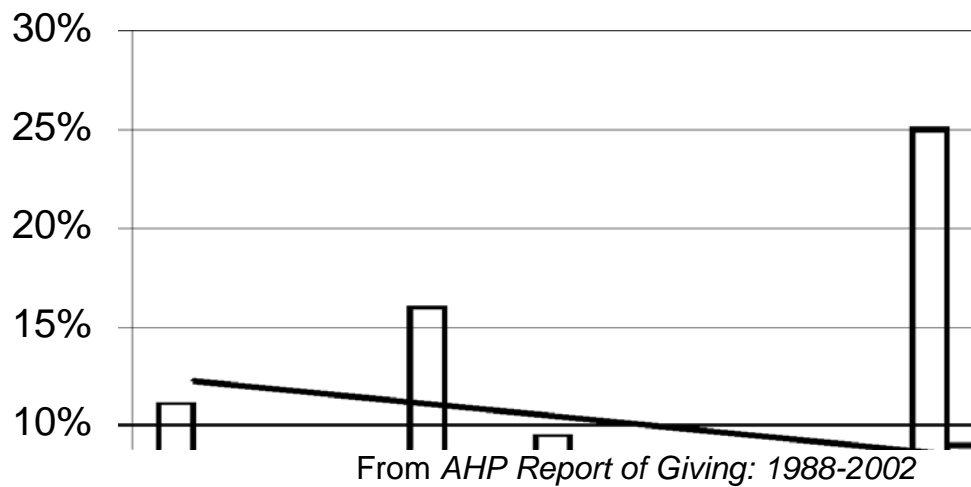
Chart 5-A: Total Percentage of Contributions used for Community Benefit-Related Purposes by US Nonprofit Hospitals – 1988-2002



From *AHP Report of Giving: 1988-2002*

While this AHP Report on Giving does not identify health education per se as a category, it does differentiate Charity Care as well as Community Benefit (separately from Education³ and Hospice). Chart 5-B shows the relative percentage of these uses.

Chart 5-B: Total Percentage of Contributions used for Charity Care and Community Benefit Purposes by US Nonprofit Hospitals – 1988-2002



³ "Education" may include professional education or community health education programs. The AHP survey does not specifically define the term.

The figures and results from this survey suffer from the weaknesses of any self-reported survey. The fluctuations not only are due to individual hospitals reporting different uses differently but also to inconsistencies in which hospitals reported from year to year.⁴ However, the figures do indicate that not only is community benefit one of the major uses of contributions by hospitals (along with operations and construction, and purchasing new equipment) but that there may also be a slight rise in the percentage of funds raised for community outreach programs and a slight decline in the amount given for charity care as Chart 5-A shows (AHP 1908-2002).

ISDH Data on Donations

The first step in trying to identify the donative behavior of Indiana hospitals is to investigate the donation information shared in the ISDH reports.

Donations are the third category reported on Statement Three, for all hospitals in Indiana. The 2005 ISDH Fiscal Reports noted that all hospitals in Indiana had the following donation information, as indicated on Table 5B:

⁴ It should be pointed out that in four years the results of this survey were not reported due to low response rates and that the final two years were figured on a fiscal rather than calendar year basis – showing further difficulties with self-reported data.

Table 5B: Donations by Indiana Hospitals

	Donations Received	Donations Outgoing	Net Donations	Ratio: Net Donations/ Donat. Out
<u>For- Profit</u> ⁵	\$205,518	\$945,484	\$739,966	78.26%
<u>Public</u>	\$10,975,284	\$9,133,776	\$(1,841,508)	(20.38%)
<u>Nonprofit</u>	\$ 9,984,376	\$12,871,139	\$2,886,763	22.43%
<u>TOTAL</u>	<u>\$21,165,178</u>	<u>\$22,950,399</u>	<u>\$1,785,221</u>	<u>7.78%</u>

The final Net Donation figure (TOTAL: \$1,785,221) is considered to be the actual donations from the hospital that are counted as part of their community benefit expenditure for the year. From the final ratio it is also seen that while hospitals reported more than \$22 million in donations to others, less than 10% of those were considered to be net donations and qualified as community benefit expenses. Even for nonprofit hospitals, only a little over one of every five donated dollars are considered to be community benefit.⁶ Table 5C shows a comparison of the donations by system affiliation.

⁵ There could be a question why or how for-profit hospitals might receive and report donations. Some of this could be income they receive through a nonprofit foundation affiliated with the hospital. However, not all for-profit hospitals that report incoming donations also have a nonprofit foundation. Another situation could be that individuals make contributions to the hospital because they are a hospital, with no consideration of the ownership. The latter scenario could particularly apply to hospitals that historically have been community public hospitals and in that role have sought and received donated community support, but have recently been bought by a for-profit chain. As the ISDH data does not indicate source of donations – and there are no IRS 990 forms to investigate these sources further – the exact motivations or sources involved can only remain speculative.

⁶ There is a question that is raised by only counting “net donations” as community benefit rather than “Donations Outgoing.” The ethics for a hospital to use income from one source – given for a particular implicit or explicit purpose – to offset expenditure to an unrelated purpose could be questioned. For example: in terms of health education, it is understandable that a health education class might charge a fee to attend, but the fee does not cover the costs of offering the class. The net expense would be the actual cost to the hospital of providing the service. But a contribution made to a hospital also may have nothing to do with a different donation made from the hospital. There is no stipulation that the hospital must make a subsequent donation because it received the first contribution.

**Table 5C: 2005 Net Donation (Outgoing) as % Operating Expenses⁷
 – Indiana Hospitals: By Ownership and System⁸**

	<u>System</u>	<u>Independent</u>	<u>TOTAL</u>
Nonprofit	.0830%	(.0769%)	0.04%
For-profit	0.11%	N/A	0.11%
Public	(.1170%)	(.0759%)	(0.08%)
<u>TOTAL</u>	<u>.0793%</u>	<u>(.076%)</u>	<u>.0216%</u>

The table leads to the conclusion that there is a significant difference between Net Donations made by system-affiliated hospitals and hospitals not associated with a system. Hospitals that are part of a system give a higher level of donations than they receive, while conversely independent hospitals receive more contributions than they give.

Whether there is a difference based on religious affiliation is noted in Table 5D:

Table 5D: Indiana Hospital Donations: Differentiated by Religious Affiliation As a % Operating Expenses

	\$ Donat. Rec'd	\$ Donat. Outgoing	\$ NET Donat.	% Donat Rec'd	% Donat. Outgoing	% NET Donat.
Religiously Affiliated	\$ 3,667,868	\$3,800,697	\$853,078	0.1250%	0.1295%	0.0291%
(NP) Non-Religiously Affiliated	\$17,497,310	\$19,149,702	\$1,650,392	0.2018%	0.2209%	0.0190%

When net donations are compared as a percentage of operating expenses, religious hospitals (.029%) appear to give a higher percentage of net donations

⁷ The ratios are computed by dividing the total operating expense by the total donations from all hospitals, from the different categories. This provides a comparison of the total ownership categories of hospitals in Indiana, rather than comparing a typical hospital (median).

⁸ It should be emphasized that the figures measure donations made by the hospital to other entities. A *positive* figure indicates that more donations made by the hospital than were received by the hospital from other contributions.

than non-religious (nonprofit) hospitals (.019%).⁹ However, both are far below the level of for-profit hospitals (.11%, as noted on Table 5C). One further comparison of religious vs. non-religious hospitals is the percentage of Net Donations compared to Outgoing Donations:

***Ratio of Net Donations:
Net Donations as a percentage of Outgoing (Gross) Donations***

- For Religiously affiliated Hospitals: 22.4%
- For Nonprofit Non-Religiously affiliated Hospitals: 8.6%

When the comparison is extended to a percentage of outgoing donations, the difference between religious and non-religious hospitals is even greater (22.4% for religious vs. 8.6% for non-religious). While these figures could be used to conclude that religious hospitals are more philanthropic than non-religious hospitals, the above data does not answer the question of whether the hospital foundation is included in either of the donation figures (i.e. received or outgoing).

In addition, since the net donation is considered to be part of the hospital's community benefit commitment, so there could be a perceived incentive (created by the community benefit standards) to count as much as possible as donations to others and to record as little as possible as income from others. It could also be concluded that for-profit hospitals are more philanthropic than both, as for-

⁹ It should be noted that the total religious percentage of .029% when added to the nonreligious percentage of .019 % is .048% - and seems to exceed the .04% total for all nonprofit hospitals in the final column of Table 3-21. This is due to rounding as well as the greater number of nonreligious hospitals.

profit hospitals far exceed this ratio at 78.2% (see above, Table 5B). But the latter conclusion could also be skewed due to for-profit hospitals not (generally) seeking incoming donations (although they do report receiving some level of contributions). These uncertainties emphasize some of the difficulties in properly evaluating hospital donation activity.

To better assess the donation behavior of Indiana hospitals, there is an opportunity to evaluate the validity of the donations figures shared by Indiana hospitals on the ISDH Fiscal Report as compared to figures recorded on the hospital's IRS Form 990. IRS reports identify both contributions from others as well as donations by the hospitals to other organizations. One further caveat is that on the ISDH report, any contributions that are restricted for specific purposes do not need to be counted – only those contributions that are unrestricted. This practice of differentiating restricted donations from unrestricted donations (which need not be documented on the ISDH Report – and is not a distinction that is made either on the current IRS Form 990 or on the new Schedule H report by the IRS), can lead to further discrepancies in the figures reported as contributions coming to the organization.

Comparing the ISDH Fiscal Report to the IRS Form 990: There is not (currently) a simple way to compare both the outgoing and incoming donations – as well as the net donations – using the IRS Form 990. However this form in its current structure can reveal quite a bit of information about both donations received by

an organization as well as given from that organization. To gain the best picture, it's important to also include the figures from hospital foundations. 89 of the 107 hospitals in Indiana have foundations (83%): there are 39 nonprofit hospital foundations (representing 56 hospitals, through system relationships), 31 public hospital foundations, and 2 for-profit hospital foundations. All of these file the IRS Form 990 as well as include their donation activity on the ISDH fiscal reports.

The discrepancy between the incoming donations figure on the ISDH Report and the IRS 990 as reported by hospitals is significant. If income from hospital foundations is also added there becomes even more of a gap. Table 5E shows how the ISDH Incoming donations figures for 2005¹⁰ compared to the IRS 990 figure – both for nonprofit hospitals as well as for affiliated foundations of those hospitals.

¹⁰ It should be acknowledged that the figures used for this comparison are from 2005, as opposed to the previous ISDH information that was from reports identified as 2004. This is due to the variability of hospitals that report their financial information on a fiscal year that is different than a calendar year. The IRS Form 990 notes an organization's fiscal year (meaning that for some hospitals a 2005 return may actually include 3 months, 6 months, or even 9 months of 2004 data) while the ISDH data makes no such distinction. This variability also lends confusion as to which year is actually being compared, one other factor that complicates comparative reports.

The more recent figures were also easier to verify in the questionnaires and interviews. After the author compared IRS data and ISDH data from both 2004 and 2005, the data from 2005 IRS returns seemed to compare more favorably with the ISDH reports from 2005. A decision was made to use the more comparable information (i.e. the 2005 IRS data as well as the ISDH 2005 reports) for this section's comparison between IRS and ISDH data.

Since the data being compared in this section is not tied to figures in the previous section, this change should not affect any of the conclusions reached in this section.

**Table 5E: Comparison of ISDH Contributions and IRS 990 Contributions
2005: Indiana Nonprofit Hospitals and Hospital Foundations (Total)¹¹**

	2005 ISDH Fiscal Report (Gross)	2005 Hospitals: IRS 990	Additional Donations Reported by Hospital Foundations in 2005: IRS 990	TOTAL IRS Donations: Hospitals PLUS Foundations
Direct Public Support	\$7,485,875	\$17,819,146	\$27,201,072	\$52,506,093
Indirect Public Support		\$60,586,561	\$28,064,707	\$88,651,268
Government Grants		\$14,156,225	\$3,862,618	\$18,018,843
TOTAL CONTRIBUTIONS (from others)	\$7,485,875	\$89,109,828	\$55,921,049	\$152,516,752

It's evident that there is a significant discrepancy. "Direct Public Support" reported only by the hospital on the IRS form records more than twice the amount of contributions as is reported on the ISDH fiscal report. If the results from separate hospital foundations are also included, the level of "Direct Public Support" reports six times the amount of contributions than reported on the ISDH fiscal reports. If government grants are added in – as well as "Indirect Public Support" – the amount of contributions to Indiana hospitals as reported to the IRS is nearly twenty times the level reported on the ISDH forms.

For the purposes of comparison, this paper focuses on the category "Direct Public Support", seeking to identify private community contributions (which includes private foundation and corporate grants), rather than government

¹¹ Only 26 of the 57 nonprofit hospitals identify income from donations on the 2005 ISDH report. 32 nonprofit hospitals report donations on the 2005 IRS Form 990. The figures in Table 5-5 include all of the hospitals reporting information under each report.

support. This can lead to a further complication, as it is not designated on the ISDH reports whether United Way support (which is generally recorded on the IRS forms as “Indirect Support”) or government grants can be counted as donations – although the wording implies that donations “mean” only “direct” public contributions. But these are not defined criteria. Also, the category “Indirect Public Support” may include inter-organizational transfers of funds between a hospital and a related foundation, rather than being an external donation of additional support.¹² While there is a possibility of donations being double-counted with a contribution being recorded at one entity (i.e. a hospital's foundation) and then being transferred to another entity (i.e. the hospital) and then being also recorded as a contribution to that organization, there is limited ability to track each donation and identify that situation. There are various loopholes in most reporting systems and the IRS Form 990 is no exception. However as was pointed out earlier in this dissertation, the Form 990 is as reliable a data source as we currently have available and the steps the IRS has taken to strengthen the form should strengthen this validity even more. Nevertheless, identifying any organization that intentionally or unintentionally misreports data can be difficult to assess.¹³ Comparing yearly reports may also complicate the tracking of transfers between organizations as donations received in one year may be transferred in another year. This is especially true in the case of multi-year campaigns or transfers from a foundation's endowment to a

¹² As indirect Public Support also includes gifts from United Way, excluding that figure could diminish the true extent of public support for a hospital.

¹³ One example of this difficulty with self-reporting is outlined in a 2002 report in the *Chronicle of Philanthropy* found that nearly 1/3 of the nonprofit organizations that reported more than \$1 million in contributions also reported \$0 in fundraising costs.

hospital that may occur only during major building programs. Donations received over two, three, or more years may be transferred in a lump sum in a single future year. Such situations are but a few examples of challenges that arise in evaluating donations to (and from) hospitals.

Another complication is that not all nonprofit hospitals in Indiana file an IRS Form 990. Several hospitals may be included in one system's filing – or while individual hospitals in a system may file separately there may be a single foundation for multiple system hospitals. Table 5F compares the ISDH and the IRS incoming contributions for individual nonprofit hospitals.

Table 5F: Comparison of donations received by Indiana nonprofit hospitals (2005 Reports of 2004 Data)

% IRS 990 Direct Contribution / ISDH Donations	% IRS 990 TOTAL Contribution / ISDH Donations	% IRS 990 Direct Contribution / ISDH Donations	% IRS 990 TOTAL Contribution / ISDH Donations
4059%	5567%	98%	98%
3391%	5229%	87%	213%
1623%	1623%	69%	100%
1376%	2280%	21%	1174%
434%	454%	20%	100%
420%	647%	17%	374%
310%	310%	10%	237%
288%	288%	9%	175%
274%	1562%	5%	105%
203%	659%	0%	663%
101%	107%	0%	453%
100%	113%	0%	423%
100%	100%	0%	211%

Bold = Comparable Figures (i.e. within 15%)

It should be noted that only 26 of the 57 nonprofit hospitals in Indiana claim any net donations on the ISDH report, so the table lists only those 26 hospitals.¹⁴

Only 22 of the nonprofit hospitals identify contributions received on both the IRS and the ISDH reports. The average ratio of IRS 990 Direct Contributions to ISDH Contributions is 501%; however, the median is 100% - that could indicate the two forms for a “typical” hospital agree. The average ratio of IRS 990 Total Contributions to ISDH Contributions is 895%; the median is 310%. When only public donations are compared, only five hospitals have comparable figures on their ISDH and IRS reports (identified as Direct Public Support). If Total Contributions from the IRS Form 990 are compared, seven hospitals have comparable figures. Four of these hospitals have comparable ratios for both figures, indicating they probably do not receive much Indirect Support or Government Grants.

If the actual incoming contribution figures are used from only those nonprofit hospitals that recorded contributions on BOTH the IRS and the ISDH Report, the discrepancy is even more pronounced, as Table 5G shows.

¹⁴ It should also be noted that only 32 of the 57 nonprofit hospitals report donations on the IRS Form 990.

**Table 5G: Comparison of ISDH Contributions and IRS 990
Contributions 2005: Indiana Nonprofit Hospitals
(Those indicating figures on BOTH reports)**

	2005 ISDH Fiscal Report	2005 Hospitals: IRS 990	% of Difference: ISDH/IRS
<u>Direct Public Support</u>	\$4,920,479	\$12,751,637	39%
TOTAL CONTRIBUTIONS (from others)	\$4,920,479	\$74,810,227	7%

The donations reported on the ISDH reports are less than half of those reported on the IRS form 990 (39%). One possible conclusion could be that approximately 61% of private donations received by Indiana hospitals are restricted and therefore don't need to be included in the ISDH Fiscal Report. Another conclusion could be that the two reports are filled out differently with different figures. There is currently no way to specifically define why and how the differences arise. Appendix 5-1 shows actual figures for all nonprofit hospitals in Indiana, as reported in 2005, and illustrates the discrepancies found between the two reports.

In comparison, many of the public hospitals do file a Form 990 and have comparable donations (and other financial) information available. Also the foundations associated with 31 public hospitals, as well as the two foundations affiliated with for-profit hospitals, are required to file a Form 990. Therefore much Form 990 information is available on public and for-profit hospitals and their

related foundations. Table 5H summarizes the available information for 2005 of public and for-profit hospitals from IRS Forms 990.

Table 5H: Public Hospitals and Foundations: Available IRS 990 Information

	All Public Hospital Foundation 990s	Public Hospitals with 990s (AND also have foundations)	Public Hospitals with 990s – BUT NO Foundation	TOTAL: Public Hospitals and Foundations	For Profit Hospital Foundations
Direct Public Support	\$7,446,996	\$3,502,071	\$3,918,066	\$14,867,133	\$172,256
Indirect Public Support	\$50,897	\$239,091	\$50,897	\$340,885	\$5,500
Government Grants	\$144,475	\$11,810,439	\$69,475	\$12,024,389	\$88,590
TOTAL CONTRIBUTIONS (from others)	\$7,724,259	\$15,551,601	\$4,111,946	\$27,387,806	\$266,346
ISDH		\$542,929			

The figures in Table 5H show that public hospitals receive significant direct support, although the 31 public hospitals and their foundations received approximately one-third of what was received by the 32 nonprofit hospitals and their foundations - \$14,867,133 for public hospitals compare to \$45,020,218 for nonprofit hospitals (according to the IRS Form 990 figures).

Outgoing Donations to Others

Similar discrepancies are found when trying to verify donations made by hospitals to other organizations in the community. Foundations and other affiliates can compound the confusion, since inter-organizational transfers of

funds may be categorized as contributions or may be recorded elsewhere on the balance sheets.

The first comparison could be of the ISDH data with the IRS data. However as the chart included in Appendix 5-1 shows, there is a very weak correlation of reported grants from the IRS Form 990 with either the gross or net outgoing donations (to others) as reported on the ISDH reports.¹⁵ Part of this may be due to only including hospital information and not that of the hospital foundation or other affiliates. Or it could be due to variability of reporting criteria for the two forms. Regardless, because of the wide discrepancy and the lack of detail available on the ISDH Reports, the data used for the remainder of this analysis will be taken solely from the IRS Form 990.

Outgoing Contributions to Others: Specific Information from the IRS Form 990

It is possible to gain a more complete understanding of the exact nature of these donations through details and supplements to the IRS Form 990s. The following section details findings from a review of all hospital and hospital foundation 990s from the state of Indiana for the fiscal year 2005. Table 5I shows the grants made as identified on the IRS Form 990 (as indicated on Part II, line 22 on the second page of the IRS Form 990).

¹⁵ The IRS Form 990 records the Gross donations to an organization. However the new Schedule H asks for net donations as well as gross to determine how much of the donation is counted as "community benefit." This is similar to the ISDH format.

Table 5I: Grants and Donations Made: Hospitals and Foundations Together

	Total Dollars "Contributed"
<u>PUBLIC Hospitals</u>	
<u>Fdn Only</u> (11 hospitals)	\$ 4,953,696
<u>Hosp and Fdn</u> (9 hospitals)	\$ 1,611,232
- Hospital	\$162,975
- Foundation	\$1,498,257
<u>Public Total</u> (20 hospitals)	\$ 6,546,928
<u>FOR-PROFIT Hospitals</u> ¹⁶	
<u>Foundation</u> (2 hosp)	
<u>FP Total</u>	\$ 1,017,255
<u>NON-PROFIT Hospitals</u>	
<u>Hosp only</u> (NOT part of a system)	\$ 1,948,698
<u>Hosp and Fdn</u> (NOT part of a system)	\$10,289,343
- Hospital	\$3,960,420
- Foundation	\$6,328,923
<u>NP SubTotal</u> (NOT part of a system)	\$12,238,041
[All NP Hosp Only]	[\$5,909,118]
NP Systems	\$216,610,651
- Hosp	\$115,677,668
- Fdn	\$100,932,983
<u>Non-Profit TOTAL</u>	<u>\$228,848,692</u>
<u>ALL TOTAL</u>	<u>\$236,480,875</u>

As can be seen, according to the IRS form 990 a majority of the donations made by Indiana hospitals (91%) came from nonprofit hospitals and foundations affiliated with systems. Looking at all nonprofit hospitals approximately 52% of the nonprofit total donations were from hospitals and 48% from their foundations. Table 5J shows that when public and for-profit hospitals are included, there is a

¹⁶ Since For-Profit hospitals do not file 990 forms with the IRS – nor are there corporate tax returns publicly available – so they are not included in this comparison. However for-profit hospitals in Indiana reported on the ISDH fiscal reports \$945,489 in donations, which would double the for profit totals on the table if they added in.

distinctly even split between hospital foundations and hospitals in making donations.

**Table 5J:
Grants and Donations Made: Hospitals and Foundations - Separate**

	Total Dollars "Contributed"
<u>FOUNDATIONS</u>	
Public – No Hosp 990	\$4,953,696
Public – with Hosp 990	\$1,498,257
For-Profit	\$1,017,255
Nonprofit - Non-system	\$6,328,923
Nonprofit - System	\$100,932,983
<u>TOTAL - FOUNDATIONS</u>	\$114,731,114
<u>HOSPITALS</u>	
Public – with Fdn 990	\$162,975
Nonprofit – No Fdn	\$1,948,698
NP – with Fdn (Non-system)	\$3,960,420
Nonprofit – with Fdn (System)	\$115,677,668
<u>TOTAL - HOSPITALS</u>	\$121,749,761
<u>TOTAL – ALL HOSPITALS and FOUNDATIONS</u>	<u>\$236,480,875</u>

When all types of hospitals are included (public and foundations associated with for-profit hospital as well as nonprofit), 51% of the contributions come from the hospitals while 49% from the foundations. This shows that if only hospital donations are included in donation figures, the amount donated will be only about half of the actual figure that hospitals are responsible for.

There is a further question about these donations and that is the extent they reflect and support external community needs and the extent they are simply internal transfers or support other interests of the hospitals. This information can be separated into the primary purposes of the donations, separated into

categories of: 1) self-benefit and internal use; 2) self-benefit but for community benefit programs; and donations to others in the community for 3) education and scholarships; 4) health care needs (provided by others); and for 5) other community non-healthcare organizations and needs (see Table 5K).

Table 5K: Use of Grants Made by Indiana Hospitals

<u>A</u> <u>Self-Use:</u> Internal Transfer s	<u>B</u> <u>Self-Use:</u> Community Benefit	<u>C</u> <u>Self/Comm:</u> Education/ Scholarships	<u>D</u> <u>Community</u> Health Organiza- tions	<u>E</u> <u>Community</u> Non-Health Organiza- tions	TOTAL
\$186,271,594	\$37,619,651	\$2,382,951	\$5,990,783	\$3,614,013	\$235,878,992

When these uses are separated, it can be seen that approximately 80% of the donations indicated on the IRS Form 990 could be considered internal transfers and use. This does not mean that the donations are being recorded fraudulently. Many of these transfers are donations made for specific purposes to a foundation for use by the hospital (such as for construction or equipment payments). However it should be cautioned that this distinction is not effectively differentiated in either the current or revised IRS Form 990s.¹⁷

To better understand the donation behavior of specific nonprofit hospitals, donation activity was included in the survey of Indiana hospitals outlined in Chapter Four.

¹⁷ Information on Table 5-8 is taken from Appendix 5-4, which details the specific programs and project reported by individual Indiana hospitals and hospital foundations under "Grants and Allocations" on the 2005 IRS Form 990s.

Questionnaires about Donations

In the questionnaire sent out in 2008 to Indiana hospitals¹⁸ a page was included for feedback on the donations programs of the individual hospitals (see Appendix 5-2). This part of the questionnaire had four questions regarding reporting and management functions. These questions were designed to gain information about where in the organization where decisions were made about contributions as well as how the contributions were managed and reported. The first question was intended to locate the level of the organization for contribution decisions. The second question was to identify the reporting process within the hospital. One purpose for this question is to determine if the person(s) responsible for reporting contributions was the same as those responsible for the decisions to make the contributions, to manage the contribution process, or to report the level of donation activity. The third question was to determine which specific department was responsible for managing the donations processes and whether the management was focused at the same organizational level as the decision-making process. It also asked if the management of contributions was in a single department of the hospital. The fourth question sought to identify the organizations and the specific causes supported by the hospital's donations.

There are two complications and potential misunderstandings that could arise from these questions. The first is that the information being tested is from the hospital not from a hospital foundation. The second is that the process of making donations may differ from the process of accepting or encouraging donations.

¹⁸ For specific details of the survey process, see Chapter Four.

Both of these questions were the focus of the follow-up interviews. The responses below were focused solely on the hospital and on the process of making contributions from the hospital.

Response from Questionnaires

Three hospitals (of the 42 who actually returned questionnaires) did not fill out this page; their donation information was “\$0” and they marked the question as “Not Applicable”. For the others (33 individual responses representing 50 hospitals), the results of the donations¹⁹ portion of the surveys are as shown in Exhibit 5-1:²⁰

¹⁹ The results from the first page of the questionnaire addressing health promotion programs are covered in Chapter Five.

²⁰ To avoid possibly skewing the results, only the actual responses from the returned 39 questionnaires are shared. Even though community benefit programs for multiple hospitals may be coordinated by one individual it doesn't mean the decision process is always the same for all affiliated institutions. However some results will add up to more than 40 because of input that was shared in personal interviews when it was indicated that a response represented a single process that covered more than one of the affiliated hospitals.

In a few cases, a response may not have been given, leading to response rates less than the total.

Exhibit 5-1: Donations – Revenue Received and Payments Made

1. Who in the hospital is most responsible for determining that expense?²¹

<u>Item</u> <u>Response</u>	<u>Survey</u> <u>Response</u>	
<u>13</u>	<u>10</u>	CEO
<u>2</u>	<u>2</u>	Other Administration (no title)
<u>5</u>	<u>5</u>	CFO
<u>2</u>	<u>2</u>	Vice President for Community Relations
<u>7</u>	<u>2</u>	Other (please specify): Administrative Grant Making Committee Controller
<u>10</u>	<u>7</u>	Department Head
<u>4</u>	<u>2</u>	Support Staff
<u>6</u>	<u>2</u>	Other (please specify): Hospital Board of Directors has set a policy for expenditure of 10% of net revenue – 5 item; 1 survey response Community Benefit Committee of the Board of Directors – 1 item; 1 survey response

2. Who in the hospital is most responsible for reporting the above figure?²²

<u>Item</u> <u>Response</u>	<u>Survey</u> <u>Response</u>	
<u>6</u>	<u>3</u>	CEO
<u>16</u>	<u>13</u>	Other Administration(8 item and 8 survey responses noted “CFO” as responsible)
<u>17</u>	<u>12</u>	Department Head
<u>7</u>	<u>5</u>	Support Staff
<u>6</u>	<u>2</u>	Other (please specify): Community Development staff and Finance – 6 items; 2 survey responses

²¹ 1 hospital did not check this category, so for both response rates are lower by one. The hospital that did not respond noted that only a special event was held and the only expenses and income for the program were expenses and income from that event.

²² 2 hospitals indicated that both an “Administrative” (CFO) and a “Department Head” were jointly responsible for reporting. This means 52 item responses and 35 survey responses were recorded.

3. Which department is most responsible for managing the donation program and budget?

<u>Item</u> <u>Response</u>	<u>Survey</u> <u>Response</u>	
10	10	Administration
16	12	Public Relations/Marketing
1	1	Health Education
6	1	Fund Development/Foundation
0	0	Human Resources
18	9	Other (please specify):
		General Accounting - 3 items; 1 survey
		Community Development
		– 6 items; 2 surveys
		Community Benefits – 1 item; 1 survey
		Each Department handles their own
		donations – 2 item; 2 surveys
		Finance, Community Relations, and
		Education – 1 item; 1 survey
		Health Promotions and Community
		Relations – 5 items; 2 surveys

The responses fall within three broad categories. The first approach (*grant-making process*) is a formal policy and leadership process for determining and distributing grants. In this situation the hospital acts similar to a grant-making foundation, supporting community projects and organizations that fall within given criteria. This type of orientation reflects the Political model or the Leadership/Ethical model of contributions. The difference is whether the Board or Administration determines the actual contributions or if these decisions are carried out by a different segment of the hospital or a separate hospital Foundation. The second type (*marketing process*) is primarily an administrative process that is handled at a mid-administrative or departmental level. These donations reflect a marketing orientation and a Marketing or Management model for contributions and is undertaken primarily to increase profitability. The third

category (*informal process*) indicates that recommendations come from staff with approval by administration. In these cases the amounts of the contributions are relatively small and tend to support ongoing relationships with various related organizations. This category would correspond to the Stakeholder model and be a similar process and motivation as was found in Health Education programs (Chapter Four). The questionnaires and interviews are evaluated in relation to these three processes.

1. *Who in the hospital is most responsible for determining that expense?*

The responding nonprofit hospitals indicated that the process for determining donations is much more strongly led by top administration and/or the board of directors than was the case for Health Promotion expense. Two responses indicated they had internal grant making committees of top administration and two others that a committee of the board determines donation policies and reviews disbursements. One respondent indicated the hospital board has implemented a “tithing” policy: 10% of the net revenue (calculated on the previous year’s finances) is placed into a community benefit fund to be disbursed for community health initiatives and programs. Other responses ranged from the department head or vice-president of marketing or community relations had this approval responsibility (3 responses) and one identified the Controller as responsible (probably referring to the reporting rather than the decision process). One response stated: “Others recommend – CEO OKs.” A primary objective of

the personal interviews is to further clarify the organizational location of these processes and levels.

2. Who in the hospital is most responsible for reporting the above figure?

The reporting process was primarily located at the mid-administrative level, similar to the health education process. When specified, the primary department responsible was finance, with public relations or community development as a second designation. In almost every case the reporting process was the same for contributions as it was for health education.

3. Which department is most responsible for managing the donation program and budget?

These responses were more varied, with a split between administration responsible for managing the program (possibly reflecting a grant-making orientation) and public relations or marketing (possibly reflecting the hospitals with a marketing-orientation). Four respondents specified multiple departments managed the funds, with Community Benefits and/or Public Relations as one of them. The hospital foundation was identified by two respondents as responsible for administering outgoing donations as well as encouraging donations to the organization. One respondent indicated that "Administration also has 'Donation Funds,' " suggesting that an alternative informal approach is used by leadership to make contributions to causes as opportunities arise. This is one area that was further explored in the personal interviews.

4. *Which organizations received those donations and for what purposes?*

Responses to this question were extensive and varied (see Appendix 5-3). Most respondents emphasized that there were numerous organizations supported in various ways. Details of these organizational donations are an aspect to investigate further in the interviews.

Conclusions from the Questionnaires

The questionnaires indicate that donations by many nonprofit hospitals are a broad effort, especially in terms of the numbers of organizations supported. It also seems to be a formal process in several hospitals, with the implication that making community donations is an important part of a hospital's external relationship effort. This role seems to range from informal support for community partners to almost a formal community grant-making position. The role of donations as a form of marketing is one that is not only implicit (as in any corporate donation) but also acknowledged by the prevalence of community relations and marketing departments in the decision and management process.

The management of the programs (Question #3) as well as the decision-making processes (Question #1) actually fall fairly equally between the three broad categories, indicating that different hospitals make contributions for different motivations. Ten survey respondents indicated that the CEO managed the program as well as made the donation decisions. This corresponds to the first approach (*grant-making process*) and reflects the Leadership/Ethical model of

contributions. However if the actual contributions were carried out by a different segment of the hospital than administration, it could confirm the Political model for these organizations. In almost all the cases this seemed to be the situation and is an area to more specifically explore in the interviews.

For the remainder of the hospitals the decision-making process was somewhat scattered at various levels throughout the hospital leading to a possible conclusion that either contributions were part of the formal management structure or were more informally organized on a stakeholder level. The management of these programs fell equally into two distinct areas. One area reflected the second type (*marketing process*) and seemed to indicate that making contributions was primarily an administrative process that is handled at a mid-administrative or departmental level. Twelve individuals surveyed from 16 hospitals indicated this level of program management. These could reflect a Marketing or Management model for contributions that is undertaken primarily to increase profitability or otherwise support the healthcare provision from the hospital. The second area reflected the third category (*informal process*) and corresponds to the Stakeholder model. Nine respondents representing eighteen hospitals indicated the “other” category that primarily reflected this variability. Eight of the eighteen hospitals indicated one or more departments actually carried out the programs, again reinforcing the stakeholder orientation.

To further explore the donation process at individual hospitals telephone or personal interviews with self-selected survey respondents were conducted. These interviews were done with the same individuals, at the same time, and fit the same criteria as were outlined in Chapter Four. This portion of the personal interviews had four key objectives related to these initial responses about donations. The first objective is to determine the validity of the ISDH donation figure from the Hospital Fiscal reports. The second is to verify the process the hospital uses to allocate donations. The third objective is to define the role the hospital's foundation or fundraising program plays in this process – both in terms of soliciting contributions as well as in making donations. The fourth priority is to discover the policies that determine the types of organizations supported. The interviews addressed the two potential complications of whether the information being tested is from the hospital or from the foundation; and whether the process of making donations differs from seeking donations.

Personal Interviews

The personal interviews tended to reinforce the questionnaire responses as well as present an even more complex organizational process revolving around donations. The most common response to the first question (regarding the validity of the donation figure as reported by the ISDH report) was that the donation figure from the ISDH report did not match the figures they had. In most cases it was low – and a majority of responses indicated they did not know where

that figure might have come from. These responses suggest those who report the results of the programs and those who are responsible for determining and managing the programs could be separated and the processes de-coupled. In all cases they said the donation figure was from the hospital not the foundation – although nearly half expressed the feeling that the income was probably reported by the foundation. In no cases did they know this for sure.

Two conversations show the potential complexity involved with these donations. One respondent stated that they felt the income figure was from a county tobacco grant, and that the donations from the hospital were most probably for community fundraising events (such as sponsoring charity auctions or races) or marketing expense for advertising. Another noted that the net donations was “\$0” since the income is a transfer from hospital’s foundation, but the donations were an expense determined by the hospital’s board of directors – essentially using the hospital as a pass-through.

The second objective was to identify the process the hospital uses to allocate donations. Responses tended to group themselves according to the three levels noted earlier. Three smaller hospitals identified a more *informal process*, allowing department managers to make small donations as needed out of their budget or to make recommendations to administration for approval on a case-by-case basis. Four other hospitals (tending to be medium sized or independent facilities) indicated a *marketing approach*, with requests either going directly to a

community relations department as part of their budget or coming to the marketing department from administration. One respondent indicated the marketing budget for community sponsorships was a total of \$10,000 per year.

The prevalent *grant-making* responses were from the larger hospitals and system-related institutions that showed various levels of organizational sophistication. Two indicated they had formal tithing programs where 10% of the net revenue each year was given to community programs. In one hospital this was accomplished by giving the funds to the hospital's foundation to distribute; in the other hospital the community health education department administered the funds. The former (foundation-administered) program has been in place for ten years and until 2007 accepted community requests. In 2007 they discontinued this program and use the funding to initiate and operate their own outreach programs. The latter (internally-administered) program has an external application process that works like most any grant-making foundation. They have broad criteria for the grants, supporting projects that address "the needs of underserved populations, emphasizing sustainability for existing and pilot social service programs with measurable outcomes."

Two other system hospitals indicated a multi-level approach to donations. One has an administrative committee that screens community requests (via a formal grant application) and allocates an annual \$150,000 donation budget. They have broad criteria for projects ("of benefit to the greater community") and last year

received about \$1 million in requests. This same hospital has a budgeted allocation in the marketing department for event sponsorships that can be applied for by employee staff. Major requests for capital campaign support or other large community projects goes to the president's office and are allocated by board approval. A second system hospital has a similar sponsorship fund in the marketing department, with a "discretionary" fund administered by the administrator for any requests over \$10,000. Their primary donation determinations are by board committee that allocates a budgeted amount of donations every quarter (applied for by community request) and makes special larger grants on a yearly basis.

One large hospital has a "corporate contributions committee" under the health promotion director that reviews applications and allocates about \$150,000 per year to area organizations. The criteria for grants emphasize projects for improved health, youth, and diversity but also may provide general support to any community organization. Another large hospital has a grant request form and stresses projects that address community health needs, but also will fund any "strong organization that provides significant services to the community".

The third objective of the interviews was to define the role the hospital's foundation or fundraising program plays in this process – both in terms of soliciting contributions as well as in making donations. A majority of the responses indicated that the hospital's fundraising efforts were essentially

separate from their donation program. One stated that the health promotion program of the hospital received a yearly grant from their hospital's foundation, and another mentioned their foundation had a separate process for providing support to community organizations. Most respondents indicated their foundation was a separate program specifically to generate support for the hospital – and that the processes of encouraging contributions from the community and giving donations to the community were separate. Three smaller hospitals indicated there was no foundation or fundraising program and that any incoming contributions were either from unsolicited bequests or gifts through their hospice program, from grants, or from an annual fundraising event.

The fourth priority was to discover the policies that determine the types of organizations supported. As mentioned above, most organizations have broad flexibility to respond to a variety of community needs – but most indicated a preference for health-related organizations and projects. One small hospital noted their contribution was in-kind, donating 5,000 square feet of space for community use, which they valued at \$2,000 per month.

As stated earlier, the interviews also addressed the two potential complications identified earlier in the chapter: whether the information being tested is from the hospital or from the foundation; and whether the process of making donations differs from the process of accepting or encouraging donations. In only one case

was the foundation mentioned as being central to the donation process.²³ In all other responses the donation information was from the hospital not the foundation. Investigating the second complication found only three institutions had a link between accepting contributions and making donations (and one of those was the formal foundation and outreach structure indicated in footnote #190). In the other two cases the funding activity was fairly low and involved a single event or program where the proceeds went to a predefined cause. In all other cases the process of making donations was separate from the process of encouraging contributions from the public.

Analysis of Responses – Location of Donations: The primary purpose of the questionnaires and the interviews was to identify where in the organization the decision process regarding donations was primarily located. To evaluate this requires two stages. The first is to look at the correspondence between the distribution of donations from the organization only. The second is to look at the “donation process” *in toto*: i.e. both the distribution and the receiving of donations.

The first stage – decisions to donate – are scattered among various locales and the three broad categories of processes defined earlier. These categories are: the *grant-making process* (a formal policy that reflects the Political model of

²³ In that instance the health system had been structured so that all donations and outreach programs from all the hospitals in the systems were managed by that foundation. In addition the hospital tithed a defined percentage of their annual net revenue to the foundation for conducting outreach programs.

contributions, although there could also be an indication of the Leadership/Ethical model); the *marketing process* (an administrative process at a departmental level, reflecting a Marketing or Management model); and an *informal process* (from staff with approval by administration, corresponding to the Stakeholder model). Table 5L summarizes those decision processes:

Table 5L: Location of Decisions to Make Donations to Others

<i>Grant-Making Process: Administration – Ethical/Altruistic</i>	<i>Grant-Making Process: Foundation – Political</i>	<i>Management Process: Departmental</i>	<i>Informal Process: Stakeholder</i>
14	20	5	3

As indicated above, the overwhelming majority of hospitals treated donations as a grant-making process, with nearly 50% primarily positioning donations as a Political motivation (i.e. in a separate organization) but with also with 1/3 positioned as potentially an Administrative location (or Ethical/Altruistic motivation). This suggests that donations are treated by the hospitals primarily as providing support for causes either that leadership believes in or that will help provide political influence for the hospital within the community. Two caveats should be emphasized. The first is for many hospitals smaller donations can be made from staff levels, reflecting a Stakeholder Model. The second is that donations are found in a mix of locations even in hospitals with a more centralized donation function, meaning that it can be misleading to assign this function to a single location for any hospital. However the locations indicated in

Table 5L reflect the principle organizational location for the donation-making process.

The second stage for analysis of this process – to determine the primary location of both distribution and solicitation of donations – involves making a subjective determination of the primary location for the principle donation activities for each hospital. This analysis is in two parts. The first is to determine where decisions regarding donations are located and the second is to identify whether the donation program decisions process was located in the same place as the health education program decisions. Table 5M summarizes those factors (see Appendix 5-5 for a breakdown by hospital):

Table 5M: Primary Location of ALL Donation Decisions and Operations – Distribution AND Solicitation

Donation Decision: Administration	Donation Decision: Department	Donation Decision: Staff	Donation Decision: Foundation	Is Donation Decision in Same Location as Health Education?
16	8	0	18	No –28; Yes - 14

Out of 42 hospitals²⁴ represented in the surveys, 18 (42%) indicated that the primary decision level was in a Foundation (or a separate department), 16 (38%) that it was in Administration, and 8 (19%) at a Department level. 28 of the 42 hospitals (66%) indicated that donation decisions were located in a different level of the hospital’s organizational structure than health education programs. Of the 14 hospitals that indicated the same organizational level handled both health

²⁴ 3 of the 45 hospitals surveyed indicated they did not have a donation program.

education and donations, 5 noted that location was the Foundation (all from the same system). This indicates that even though the decisions at these five hospitals are made at the same organizational level, both programs (health education and donations) are separated from the healthcare operations of the hospital. Only 9 of the 45 hospitals surveyed (20%) had decisions made within the same organizational level within the primary healthcare structure – and 6 of these were at the department level (13%). The other three had both decisions made at the administrative or leadership level.

These results tend to confirm the two hypotheses regarding donation decisions, although there is a fairly even split between whether donations are at the Leadership level (indicating an Ethical/Altruistic motivation) or at the Foundation level (indicating a Political motivation). It should also be noted that of the hospitals indicating donations were at the Leadership level, over half (9 out of the 16) were smaller, independent hospitals. The others were associated with one Catholic system or with a Jewish hospital system.

Conclusions

It is hypothesized that the donation process would be largely decoupled from the central operations of the hospital in order to best fulfill the anticipated role of community influence presented by the Political or Ethical model of contributions. To aid this decoupling, the donation process is expected to be located in a separate department or foundation. The types of causes supported would be

selected to secure a maximum level of community influence and visibility for the hospital.

There were four specific hypotheses presented at the beginning of the chapter. The first was that donations fulfill either the Political model for giving or the Ethical/Altruistic model. The Political model provides the hospital with community influence and participation. In the hospital donations will be found in different parts of the hospital's organizational structure than their healthcare operational or health education programs, allowing for both the maximum community political benefit as well as decoupling the donation process from operations. This hypothesis was both confirmed and expanded. The primary location of donation decisions was fairly evenly split between administrative level (indicating an Ethical/Altruistic motivation) and a Foundation location (indicating a Political motivation). The fact that over 2/3 of the hospitals located donations in a different level than health education indicates a decoupling that hospitals practice in terms of these two elements of philanthropic behavior. Such decoupling helps remove donations from healthcare decisions, which may be advantageous in terms of positioning the hospitals in the community but could be detrimental in terms of conveying to a community the extent of their philanthropic benefit.

This decoupling was further confirmed in that for every hospital that had a formal fundraising program (except one), the donation process was separate from the fundraising process. The one exception had the entire outreach activities for all

system hospitals located formally within the foundation. For over 40% of the hospitals surveyed the Political model seemed to hold; but for a comparable number of the hospitals a Leadership model seemed to be the primary motivation. This suggests that hospitals make donation decisions based upon two possible motivations: the ethical values of the leadership or to seek community influence. It is possible that both of these motivations could be influencing donation decisions, but to isolate one or the other without further investigation can be difficult. And a single general statement about any one motivation is probably misleading.

A second hypothesis was that because of the complexities of the hospital organizational structures, efforts to accurately count and compare incoming and outgoing donations are extremely difficult to extract. The processes in individual hospitals found through the surveys and interviews not only confirmed this complexity but also indicated that it actually is more involved and scattered than might have been anticipated. This relates to the underlying concern about the comparability of various regulatory reports. One aspect that the interviews noted is that hospitals (at least those interviewed) are extremely aware of the need to document their activities and strive to accurately convey their activities. However different management approaches and the variable nature and role that donations can play make the processes for determining and reporting that activity inconsistent.

Chapter Six summarizes results from the surveys in both Chapter Four and Chapter Five and draws some further conclusions from this thesis.

**APPENDIX 5-1: Comparison of Actual Donations Received, as Reported by
Indiana Nonprofit Hospitals – ISDH and IRS Reports (2005)**

ISDH Donations Est.	IRS 990	IRS 990
Incoming Revenue from Others	Direct Public Support	Total Contributions
\$4,685	\$158,878	\$244,960
\$953,988	No IRS Report	
\$129,063	No IRS Report	
\$72,000	\$0	\$43,150,641
\$0	\$4,446	\$120,349
\$346,585	\$0	\$0
\$348,776	\$73,537	\$4,093,024
\$101,486	None reported	None reported
\$252,876	\$10,264,519	\$14,077,410
\$44,625	None reported	None reported
\$166,197	\$143,970	\$354,793
\$18,425	None reported	None reported
\$370,678	No IRS Report	
\$0	\$0	\$4,459,508
\$0	\$0	\$280,603
\$26,997	None reported	None reported
\$0	\$3,000	\$157,482
\$6,152	None reported	None reported
\$706,654	\$117,941	\$2,640,184
\$65,539	No IRS Report	
\$0	\$0	\$75,500
\$21,958	None reported	None reported
\$0	\$38,060	\$368,673
\$68,603	\$68,603	\$68,603
\$0	\$0	\$2,505,077
\$265,335	\$25,590	\$629,738
\$93,472	\$0	\$619,453
\$42,900	\$132,970	\$132,970
\$0	None reported	None reported
\$0	None reported	None reported
\$0	\$865,956	\$1,512,228
\$803,909	\$809,836	\$856,710
\$0	None reported	None reported
\$0	\$7,778	\$2,625,992
\$0	\$0	\$159,133
\$1,667	\$1,667	\$1,886
\$332,338	\$15,339	\$347,674
\$0	\$0	\$125,367

Appendix 5-2: Donations – Revenue Received and Payments Made

The 2005 Indiana Hospital Fiscal Report (**Statement Three: Unique Specialized Hospital Funds**) states _____ Hospital made the following donation for the benefit of the community:

TOTAL NET DONATIONS (From the Hospital – To Others)	-	\$X
Estimated Incoming Revenue from Others	-	\$X
Estimated Outgoing Expenses to Others	-	\$X
Net Dollar Gain or Loss after Adjustment	-	\$X

1. Who in the hospital is most responsible for determining that expense?
____ CEO
____ Other Administration
- ____ CFO
- ____ Vice President for _____ (please specify):
- ____ Other (please specify):
____ Department Head
____ Support Staff
____ Other (please specify):
- Are others also involved with that decision? (and if so, who?)
2. Who in the hospital is most responsible for reporting the above figure?
____ CEO
____ Other Administration
____ Department Head
____ Support Staff
____ Other (please specify):
3. Which department is most responsible for managing the donation program and budget?
____ Administration
____ Public Relations/Marketing
____ Health Education
____ Fund Development/Foundation
____ Human Resources
____ Other (please specify):
4. Which organizations received those donations and for what purposes?

Do you have any other comments that help clarify any of the above?

Thank you for taking the time to help with this study! Would you be willing to participate in a follow-up telephone conversation (approximately fifteen minutes) to discuss the above in more detail? ____ Yes ____ No

Please return to Al Lyons: allyons@iupui.edu

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Appendix 5-3: Responses to Question #4

Which organizations received those donations and for what purposes?

- a. Too many to list, typically agencies related to health services (American Heart Assoc, diabetes, cancer, etc.) also youth agencies, government agencies, Minority Health groups, and Health disparity groups
- b. A wide variety of community organizations, for event sponsorship
- c. Area nursing program
- d. Organizations in the area who request assistance
- e. There are multiple organizations who receive donations with significant support provided to nonprofit organizations who partner with the hospital to improve the health of the community – our mission. Examples: Matthew 25 Health and Dental Clinic – provides medical and dental care to low income and uninsured patients receives significant support from the hospital in the form of operating funds, in-kind lab processing, in-kind diagnostic services, to Matthew 25 patients and program support
- f. Schools – health and wellness initiatives, local organizations and national organizations such as American Heart and American Cancer.
- g. We are a small Critical Access Hospital with limited resources. We donate meeting and office space to several community service agencies. Some agencies utilize permanent office and meeting space while other organizations use space on a more limited basis. A pregnancy testing and care agency has a permanent office as does a marriage and family mentoring program. Our county older adult services provide Medicare Part D counseling and medication assistance services two days per week. An agency provides free tax preparation for low income residents during tax season. The County Health Department uses hospital space to administer free childhood immunizations one day per month. A weight loss group uses hospital space one night per week. All of the above space is donated on a gratis basis to the organizations listed. The hospital also provides housekeeping and pays all utility costs. This has been an innovative way to bring needed social services to our community.

- h. Various organizations receive these funds for the purpose of purchasing healthcare products for the operation of the hospital
- i. There are multiple health related organizations that receive donations. Uses range from direct health services to promotion and research
- j. Too lengthy to list – we mostly donate to organizations supporting health education or children’s initiatives
- k. Donations recorded here were mainly for the state bio-terrorism grant and expenses were related to the use of those funds
- l. Hospital foundation – community projects; local HS Sports
- m. Local high schools, physicals for sports, money collected donated to schools, Boys and Girls Club, youth activities, public relations and community improvements
- n. The hospital receives the above donations from the annual ball committee and foundation to purchase an identified piece of equipment for the hospital
 - i. There are no expenses for the hospital to receive these donations, the money that is received is the proceeds from the ball
- o. Wide variety – details attached to CB report
- p. Various nonprofit agencies; purpose is to give to the community
- q. SOAR Literacy program, schools, other nonprofits
- r. Multiple nonprofit organizations such as Boys and Girls Club, etc.
- s. County organizations; patients unable to pay
- t. Miscellaneous
- u. American Red Cross, American Cancer Society, American heart Assoc, March of Dimes, Purdue University School of Nursing, etc.
- v. Donations can be solicited and granted by any department in the hospital

Appendix 5-4:
DONATIONS GIVEN by INDIANA HOSPITALS and FOUNDATIONS: 2005
From 2005 IRS Form 990

HOSPITAL FOUNDATION ONLY: PUBLIC HOSPITALS No Hospital 990

	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
	Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs
<i>Hospital #1</i> ²⁵					
o Gave \$19,964					
▪ Hosp for Equip:	\$18,464				
▪ 1 st Baptist Church;				\$1,500	
• Foreign Health mission					
<i>Hospital #2</i>					
o Grants and Allocations: \$168,524				\$168,524	
<i>Hospital #3</i>					
o Grants and Allocations: \$158,770					
▪ Hosp Equip	\$105,542				
▪ Safe Kids			\$4,309		
▪ Scholarships				\$1,075	
▪ Prof Ed and PR, Health Promo				\$27,844	
<i>Hospital #4</i>					
o Grants and Allocations: \$27,072					
▪ Hosp Equip	\$26,572				
▪ Comm Fdn					\$500
<i>Hospital #5</i>					
o Grants and Allocations: \$2,010,277					
▪ Hosp PR and Mktng	\$365,858				
▪ Scholarships			\$209,190		
▪ LifeLine and Assist Living				\$1,435,229	
o Grants and Allocations: \$191,909 (Add'l?)					
▪ Scholarships			\$106,909		
▪ Hospital	\$85,000				
<i>Hospital #6</i>					
o Grants and Allocations: \$41,204					
▪ Hosp Master Plan	\$41,402				
<i>Hospital #7</i>					
o Grants and Allocations: \$1,114,482					
▪ To hospital	\$60,738				
▪ To hospital	\$289,003				
▪ Hospice		\$267,655			
▪ To clinic		\$359,094			
▪ Healthy Communities				\$120,002	
▪ Adult Day Care				\$6,490	
▪ Scholarships		\$11,500			
o Total: \$ 1,201,694					
▪ To Hospital	\$844,332				
▪ To Clinic(add'l?)					\$357,362

²⁵ The numbers of the hospitals are assigned at random and are included for the sake of convenience. They are not correlated to any criteria except for the category under which they are listed.

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- <u>Benefit CB</u>	Self: <u>CB</u>	Educ/ <u>Scholarships</u>	Community <u>Health</u>	Gen'l NP <u>Programs</u>

Hospital #8

- Grants and Allocations: \$21,102 [Last hosp 990 – 2004]
 - To hospital \$21,102
 - Scholarships \$7,000

Hospitals #9-11

- No Grants and Allocations: (3 Hospitals)

PUBLIC Independent Hospitals: HOSPITAL and FOUNDATION 990:

Hospital #41

- HOSPITAL: No Grants Noted
- FOUNDATION: Grants and Allocations: \$15,960
 - Scholarships (Prof Loans) \$15,500
 - To Hospital \$460

Hospital #42

- HOSPITAL: No Grants Noted
 - Community Wellness \$162,975
- FOUNDATION: Grants and Allocations: \$94,473
 - Undesignated \$96,506
- Incl. Ambulance: \$87,450
 - Adds other expenses such as patient newspapers
 - "Contributions" Expense of \$157

Hospital #43

- HOSPITAL: No Grants noted
- FOUNDATION: Grants and Allocations: \$36,205
 - Equip for Hosp \$25,830
 - Equip for Community \$4,175
 - Donations to Comm. NP \$6,200

Hospital #44

- HOSPITAL: No Grants noted
- FOUNDATION: Grants and Allocations: \$265,815
 - Scholarships/Ed \$25,045
 - "Healthier Communities Program" \$336,470
 - Add'l \$90,132 in other expenses (incl some wellness programs)

Hospital #45

- HOSPITAL: No Grants noted
- FOUNDATION: Grants and Allocations: \$34,142
 - Total Exp \$93,998
 - To Hospital \$24,835
 - Scholarships \$36,947
 - To local charities \$9,307
 - Community Trail Project \$22,909

Hospital #46

- HOSPITAL: No Grants noted
- FOUNDATION: Grants and Allocations: \$288,337
 - All to hospital \$288,337

Hospital #47

- HOSPITAL: Grants and Allocations: \$2,376,149
 - Incl CC and all other CB?
- FOUNDATION: Grants and Allocations: \$155,226
 - To Hosp for equip \$155,226

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Hospital #48

- HOSPITAL: No grants noted
 - \$836,067 for Community Educ, incl
 - Prof Educ \$35,085
 - Patient Educ \$526,125
 - Comm Educ \$171,066
 - Comm Prog \$103,791
- FOUNDATION: Grants and Allocations: \$280,360
 - To Hospital \$200,788
 - Scholarships \$31,572
 - Comm Prog (Fam Hlth Ctr) \$50,000

Hospital #49

- HOSPITAL: No grants noted
 - No 990 for 2005 (2004 only)
- FOUNDATION: Grants and Allocations: \$175,905
 - Hospital \$134,050
 - Scholarships \$8,000
 - Clinic and Parish Nurse \$15,600
 - Community Orgs \$10,500
 - Total transferred: \$391,886
 - Incl promo expenses

HOSPITAL FOUNDATION ONLY
FOR-PROFIT HOSPITAL FOUNDATIONS

Hospital #12

- Capital Contribution to Fdn: \$11,002,575
- Chaplain program: \$20,205

Hospital #13

- Grants and Allocations: \$997,050 (Total: \$1,112,677)
 - Education \$33,708
 - Comm Hlth \$607,319
 - Comm NP \$356,023
- Indirect Contribution Received: \$5,500

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Nonprofit HOSPITAL 990 ONLY – No Foundation 990:

Hospital #14

- o Grants and Allocations: \$3,750 – No Info

Hospital #15

- o HOSPITAL: No Grants noted
- o CB REPORT:
 - Subsidized Services \$12,772,126 (NET: \$2,350,142)
 - Non-duplicated Services \$4,529
 - Education (Prof and Student) \$957,188
 - HC Related Programs \$89,921 (NET: \$81,781)
 - Wellness and Health Ed
 - Total: \$323,055 – NET: \$312,655
 - Donations to Orgs (\$110,150) \$32,200 \$77,950
 - In-Kind Donations and Services \$96,077 \$122,795 \$739,565
 - Total: \$958,437 – NET: \$923,641
- o (NOTE: No Fdn 990) in Supplement: "FOUNDATION to Hosp: \$1,094,498"

Hospital #16

- o Grants and Allocations: \$10,000
 - Scholarships \$10,000

Hospital #17

- o Grants and Allocations: \$9,000
 - Not Specified \$9,000

Hospitals #18-21

- o No Grants Noted – 4 Hospitals

NONPROFIT Hospitals: HOSPITAL and FOUNDATION 990:

Hospital #22

- o HOSPITAL: No Grants Noted
 - Tithing Program (\$2.5 Mill) \$2.5 Million
 - \$1,211,405 in Indirect contrib. Received (from Fdn???)
- o FOUNDATION: Grants and Allocations: \$1,286,120
 - To Hospital \$1,251,428
 - Scholarships \$35,692
- o "Contribution from parent co: \$4,086,251"
 - Listed on 990 as "Indirect Public Support"

Hospital #23

- o HOSPITAL: No Grants noted
- o FOUNDATION: Grants and Allocations: \$55,365
 - Equip and Renovation \$55,365
 - Total transferred to hospital: \$69,207 (incl. Reimb for Exec Dir salary)

Hospital #24

- o HOSPITAL: Grants and Allocations: \$158,933
 - CB REPORT:
 - Scholarship \$250
 - Comm Hlth Prog \$127,108
 - Comm NP \$31,575
- o FOUNDATION: Grants and Allocations: \$165,431
 - To Hosp for equipment \$165,431

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Hospital #25

- HOSPITAL: No Grants noted
 - \$433,331 in Indirect contrib. Received (from Fdn???)
- FOUNDATION: Grants and Allocations: \$325,227
 - For Capital and Operations- \$325,227
 - \$521,964 in Total to Hospital, incl. Operating expenses forgiven by hospital

Hospital #26

- HOSPITAL: Grants and Allocations: \$145,713
 - To St Anthony (rival Hosp) \$110,000
 - Scholarships \$35,713
- [NOTE Incl Aux, Hosp and Fdn – TOTAL: \$2,488,044]
 - Comm Prev and Well \$945,421
 - School-based Prog \$41,651
 - Spirit Care \$8,928
 - Med Res \$82,076
 - Educ \$293,255
- FOUNDATION: Grants and Allocations: \$201,813
 - To Hosp \$172,100
 - Hosp: Community Wellness \$27,469
 - Scholarships \$18,500

Hospital #27

- HOSPITAL: No Grants noted
 - \$152,970 as "Indirect Contrib Received (from Fdn)
- FOUNDATION: Grants and Allocations: \$152,970
 - Transferred to hospital - \$152,970
 - Total of \$200,773 transferred to hospital, incl expenses

Hospital #28

- HOSPITAL: Grants and Allocations: \$23,255
 - Comm Hlth Prog \$5,887
 - Comm NP \$17,368
- FOUNDATION: Total; \$195,962
 - Grants and Allocations: \$34,875
 - Hospital - \$31,875
 - Scholarships \$3,000
- Support Phys Office – underserved area - \$161,087

Hospital #29

- HOSPITAL: Grants and Allocations: \$167,080
 - \$332,335 in Indirect Contrib Received (from Fdn)
- FOUNDATION: Grants and Allocations: \$332,338
 - Capital and Operations - \$332,338

Hospital #30

- HOSPITAL: Grants and Allocations: \$208,424
 - To Parent System - \$208,424
- FOUNDATION: Grants and Allocations: \$878,411 (Total \$1,208,004)
 - Hospital grants \$767,909
 - Scholarship \$25,000
 - Comm Hlth prog \$49,502

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Hospital #31

- HOSPITAL: No Grants noted
 - \$1,421,877 in Indirect Contrib
- FOUNDATION: Grants and Allocations: \$395,831
 - Scholarships \$22,125
 - To hospital and clinic \$373,706
 - To clinic in other city \$25,000
 - To various FR causes \$930

Hospital #32

- HOSPITAL: Grants and Allocations: \$316,950
 - To affiliates \$133,784
 - Health Initiatives \$187,666
 - Scholarships \$650
 - Comm Hlth Prog \$85,400
 - Comm NP \$41,532
 - Non-Defined Donations: \$60,084
- FOUNDATION: No grants noted

Hospital #33

- HOSPITAL: No grants noted
- FOUNDATION: Grants and Allocations: \$1,239,440
 - Scholarships \$34,500
 - Partners for Community Impact \$10,150
 - To Hospital \$1,199,290

Hospital #34

- HOSPITAL: No grants noted
- FOUNDATION: Grants and Allocations: \$74,600
 - To hospital \$42,900
 - Other orgs \$31,700

Hospital #35

- HOSPITAL: No grants noted
 - \$32,226 in Indirect contrib. Received
- FOUNDATION: Grants and Allocations: \$3,351
 - To hospital \$3,351

Hospital #36

- HOSPITAL: No grants noted
 - \$236,257 in Indirect contrib. Received
 - CB Expense: \$588,638
- FOUNDATION: Grants and Allocations: \$353,285
 - Hosp Equip \$148,000
 - Hospice \$53,607
 - Scholarships and Ed \$103,391
 - LifeLine \$48,020
 - Other \$267

Hospital #37

- HOSPITAL: No grants noted
 - \$99,108 in Indirect contrib. Received
- FOUNDATION: Grants and Allocations: \$753,720
 - To hospital \$753,720

Nonprofit SYSTEM "A" HOSPITALS and FOUNDATIONS

Hospital #50

- HOSPITAL
 - No Grants Noted

Hospital #51

- HOSPITAL
 - No Grants Noted
 - \$60,321 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$104,359 (incl \$43,329 in grants)
 - To hospital \$43,329
 - Transferred \$64,693 to hospital for expenses

Hospital #52

- HOSPITAL
 - No Grants Noted
 - \$9,833 in Indirect Contrib Received

Hospital #53

- HOSPITAL
 - No Grants Noted
- FOUNDATION
 - No Grants Noted

Hospital #54

- HOSPITAL – 2006 ONLY (no 990 for 2005)
 - No Grants Noted
 - Net expense CB programs: \$213,755
 - \$17,367 in Indirect Contrib Received

Hospital #55

- HOSPITAL
 - No Grants Noted
 - \$8,000 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$37,105
 - To hospital \$8,000
 - Clinic \$24,000
 - Nurse Educ \$3,325
 - Sr resource Ctr \$1,870

Hospital #56

- HOSPITAL
 - No Grants Noted
 - \$219 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$24,256 (\$13,917 in Grants)
 - Scholarships \$13,750
 - To hospital \$167

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self- CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Hospital #57

- HOSPITAL
 - No Grants Noted
- FOUNDATION
 - Grants and Allocations: \$119,637
 - To hospital \$119,637

Hospital #58

- HOSPITAL
 - Grants and Allocations: \$985,700
 - \$4,459,908 in Indirect Contrib Received (from Fdn)
- FOUNDATION
 - Grants and Allocations: \$5,797,257 (incl Grants of \$4,598,968)
 - To Hosp #58 \$4,459,908
 - To Hosp #54 \$ 5,083
 - To Clinic \$129,179
 - To Ped Rehab \$ 4,798
 - Current Year Operating Exp transferred from Hospital: \$916,141

Nonprofit SYSTEM "B" HOSPITALS and FOUNDATIONS

Hospital #59

- HOSPITAL
 - Grants and Allocations: \$412,008 (to Fdn for CB)
 - \$9,079 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$377,800 (incl \$370,752 in Grants)
 - University (Nursing Prog) \$104,957
 - For Clinic \$41,779
 - Cancer Serv of Allen Cty \$25,475
 - County Rescue \$25,475
 - Misc Programs (\$180,114)
 - \$438,036 in Indirect Contrib Received

Hospital #60

- HOSPITAL
 - No Grants Noted
 - \$1,064 in Indirect Contrib Received

Hospital #61

- HOSPITAL
 - Grants and Allocations: \$130,006
 - CB Funding (via Fdn) \$50,003
 - Hosp Funding (via Fdn) \$80,003
 - \$500 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$1,153,356 (incl \$1,135,561 in Grants)
 - Hosp Building \$1,058,148
 - Children's First Ctr \$6,043
 - Hospice \$42,623
 - Comm Hlth Prog \$46,542
 - \$171,290 in Indirect Contrib Received

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Hospital #62

- HOSPITAL
 - Grants and Allocations: \$5,129,846
 - To Health Sys \$5,022,846
 - Comm Prog
 - Comm Health Prog
 - \$255,482 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$133,923
 - Hospice \$61,141
 - Hosp CB Programs \$43,127
 - Scholarships \$11,250
 - Comm Hlth Prog

Hospital #63

- HOSPITAL
 - Grants and Allocations: \$370,010
 - Scholarships \$8,000
 - Fdn Expenses \$80,004
 - Comm Hlth Improv (via Fdn) \$282,006
 - Tithing Program
 - \$50,367 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$337,887 (incl \$331,315 in Grants)
 - Hosp Hlth Prog \$77,647
 - Hosp Prog \$37,306
 - Comm Hlth Prog \$13,646
 - YMCA Bldg \$171,788
 - Other Comm Prog \$ 37,500
 - \$362,010 in Indirect Contrib Received

Hospital #63

- HOSPITAL
 - Grants and Allocations: \$3,045,000
 - To Fdn: Comm Hlth Improve \$3,045,000
 - \$3,042,420 in Indirect Contrib Received
- FOUNDATION
 - Grants and Allocations: \$5,097,891 (incl 4,934,664 in Grants)
 - \$3,205,825 in Indirect Contrib Received
- Outreach Prog – by Hosp \$3,112,242
- Comm Hlth Prog \$1,433,381
- Community NP \$380,041

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit CB	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Nonprofit SYSTEM "C" HOSPITALS and FOUNDATIONS

Hospital #64

- FOUNDATION: Indirect Contributions Received: \$16,476,209
 - o From Hospital
- Grants and Allocations: \$44,206,544 (Total: \$47,035,439)
 - o Cash: \$1,040,000
 - Perf Arts Ctr and Arts Fdn \$1,040,000
 - o Non-Cash: \$43,166,544
 - Perf Arts Ctr \$1,822
 - Hosp #65 \$ 86,082
 - Hosp #66 \$43,078,640

Hospital #65

- HOSPITAL: Indirect Contributions Received: \$86,082
- No Grants Noted
- Allocation from Fdn: \$6,087,881

Hospital #66

- HOSPITAL: Indirect Contributions Received: \$43,150,641 (from Fdn)
- No Grants Noted

Hospital #67

- HOSPITAL: Indirect Contributions Received: \$27,059
- Grants and Allocations: \$16,583,268
 - o Support to Parent: \$16,503,268
 - o Arts Fdn \$80,000

Nonprofit SYSTEM "D" HOSPITALS and FOUNDATIONS

Hospital #68

- HOSPITAL
 - o No Grants Noted
- FOUNDATION
 - o Grants and Allocations: \$275,000 (Total: \$442,589)
 - Bioterrorism Grant pass-through \$60,154
 - Scholarships \$16,271
 - Various Programs \$199,352

Hospital #69

- HOSPITAL
 - o No Grants Noted
 - o Indirect Contribution Received: \$210,823
- FOUNDATION
 - o Grants and Allocations: \$949,440 (Total: \$1,765,687)
 - Various dept's \$1,765,687

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
Self- Benefit	Self: CB	Educ/ Scholarships	Community Health	Gen'l NP Programs

Nonprofit SYSTEM "E" HOSPITALS and FOUNDATIONS

Hospital #70

- HOSPITAL: Grants and Allocations: \$90,285,786
 - o To affiliates \$89,657,684
 - Note: \$85,835,000 to a single affiliate
 - o Education \$3,320
 - o CB \$10,000
 - o Comm Hlth \$336,246
 - o Comm NP \$278,536
- "Contributions" (noted as a separate, undefined line item from above)
 - o \$1,845,891
- Indirect Contributions Received: \$1,339,099
- Related FOUNDATION: Grants and Allocations: \$12,306,352 (Total: \$12,461,569)
 - o Paid to Hospital \$12,461,569
- Related FOUNDATION:
 - o To Hospital: \$26,699,931- \$26,699,931
- Related FOUNDATION: Grants and Allocations: \$1,542,106
 - o To Hospital: \$1,542,106

Nonprofit SYSTEM "F" HOSPITALS and FOUNDATIONS

Hospital #38

- FOUNDATION
 - o Grants and Allocations: \$2,416,849
 - Hospital #40 \$529,048
 - Hospital #40 \$605,480
 - Hospital #39 \$593,728
 - Hospital #39a \$111,685
 - Comm Hlth \$211,832
 - Comm NP \$248,074
 - o Indirect Contribution Received: \$197,628

Hospital #39

- HOSPITAL
 - o No Grants Noted
 - o Indirect Contribution Received: \$133,430
 - Contributions for the poor: \$23,596
 - Contributions for the community: \$228,358

Hospital #40

- HOSPITAL
 - o No Grants Noted
 - o Indirect Contribution Received: \$265,335
 - Contributions noted as given, undefined: \$708,862

APPENDIX 5-5:
Responses to Questionnaires – Health Education AND Donations
Administrative, Department Director, Foundation or Staff Decisions

Hospital <u>Desig.</u>	2005 <u>Own.</u>	2005 <u>System?</u> ²⁶	Peer <u>Group</u>	HEALTH	DONATIONS
				EDUCATION	EDUCATION
				Direction	Direction
				Admin, Dept,	Admin, Dept,
				<u>Fdn,</u>	<u>Fdn,</u>
				<u>Or Staff?</u>	<u>Or Staff</u>
<u>INTERVIEWS</u>					
AA	NP	No	L	A	A
BB	NP	R1	M	S	F
ccc NP		R1	S	S	F
EE	NP	R1	M	S	F
F	NP	NR4	S	D	D
FF	NP	NR1	S	F	F
G	NP	No	M	D	D
GGG	NP	No	S	A	A
I	NP	No	S	D	S
II	NP	R1	S	S	F
JJ	NP	R1	S	S	F
KKK	NP	R1	S	D	F
M	NP	No	L	S	F
NN	NP	NR1	S	F	F
P	NP	R1	M	S	F
SS	NP	R1	L	S	F
U	NP	NR1	L	F	F
V	NP	R2	L	A	A
VV	NP	NR1	M	F	F
WW	NP	NR5	M	D	A
X	NP	NR2	L	D	D
XX	NP	No	M	D	F
Y	NP	R1	S	D	F

²⁶ System designations are the same as noted in Chapter Four. System Designations are: R = Religious System; NR = Nonreligious Systems; No = No System. The numbers correspond to common systems (e.g. R1 = all hospitals part of the same Religious System #1; R2 = all hospitals part of Religious System #2; and so on).

<u>Hospital</u> <u>Desig.</u>	<u>2005</u> <u>Own.</u>	<u>2005</u> <u>System?</u>	<u>Peer</u> <u>Group</u>	HEALTH DONATIONS	
				EDUCATION	
				<u>Direction</u> <u>Admin, Dept,</u>	<u>Direction</u> <u>Admin, Dept,</u>
				<u>Fdn,</u> <u>Or Staff?</u>	<u>Fdn,</u> <u>Or Staff</u>
<u>NO Interviews</u>					
YY	Cnty	No	L	S	F
E	NP	No	S	D	A
EEE	NP	R2	L	D	D
FFF	County	No	S	D	None
HH	NP	R1	S	S	F
MM	NP	No	M	S	D
N	NP	R4	M	D	A
Q	NP	NR1	M	F	F
T	NP	No	L	D	A
TT	County	No	S	A	A
UU	NP	No	M	D	A
W	NP	No	L	S	D
No ISDH	County	No	M	S	A
No ISDH	County	No	S	D	D
No ISDH	County	No	M	D	None
No ISDH	County	R5	M	D	A
No ISDH	County	R5	S	D	A
No ISDH	City-Cty	No	S	S	A
No ISDH	County	No	S	D	D
No ISDH	County	No	S	D	A
No ISDH	County	No	M	S	None
No ISDH	County	No	S	S	A

CHAPTER SIX: CONCLUSIONS AND OBSERVATIONS

Chapter Six concludes with a summary of the findings of the previous theoretical and empirical exploration on the philanthropic behavior of Indiana hospitals. It presents how these findings could be applicable for strengthening current policy, related to nonprofit organizations in general and nonprofit hospitals in particular. Following an update on recent legislative actions affecting health care and hospitals, the chapter summarizes the key points of the dissertation and how these illuminate the philanthropic behavior of Indiana hospitals. It then revisits the original questions posed in the thesis and identifies how the answers to these questions relate to some of the challenges faced by policymakers. Finally, conclusions are outlined showing how the findings from the thesis might be used to further public policy related to expand our understanding of nonprofit philanthropic behavior.

A Legislative Update on Hospital Community Benefit

In February 2009, the Internal Revenue Service (IRS) issued findings from a study of 500 nonprofit hospitals. One purpose of the study was to assess the extent of community benefit the hospitals offered the communities they served. The IRS reported that the hospitals provided an average of 7 percent uncompensated care, or a median of 4 percent. The next largest categories were medical education and training, research, and community programs. In the report the IRS noted the limitations: "For example, although the IRS designated

the general categories of activities that could be reported as community benefit for purposes of the study, determining what was treated as community benefit (for example, bad debt or Medicare shortfalls) and how to measure it (cost versus charges) was largely within the [hospitals'] discretion.”¹

The findings from the 2009 IRS study provide yet another example of the difficulties and variability of establishing standards based on “the application of imprecise legal standards to complex, varied, and evolving fact patterns.”² In a response to the report, Senator Charles E. Grassley, Republican from Iowa and the ranking Republican on the Senate Finance committee noted: “I’m disappointed that the IRS didn’t provide guidance to the hospitals on how to define community benefit and uncompensated care, so the numbers are likely to be overstated in some cases.”³

The IRS report and Grassley’s reply reflect the ambiguities that exist with current policy attempts to quantify the charitable behavior of nonprofit hospitals. As one example, the IRS report acknowledges that many hospitals may include bad debt as part of uncompensated care. Bad debt is a specific expense item that both

¹ Williams, Grant “IRS Releases Long-Awaited Report on Hospital Pay and Services,” *Chronicle of Philanthropy* (February 12, 2009), available at <http://philanthropy.com/news/updates/7118/irs-releases-long-awaited-report-on-hospital-pay-and-services>, (last accessed 6/24/2009) citing Internal Revenue Service, “IRS Nonprofit Hospital Study – Final Report” (2009) available at <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html> (last accessed 6/24/2009).

² Ibid.

³ “Grassley: IRS Non-profit Hospitals Study is Helpful, Treasury Should Look at Restoring Charity Care Standards” (February 12, 2009) available at http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=19329 (last accessed 6/24/2009).

Grassley and the Catholic Hospital Association have held should not be included as part of community benefit. However, the American Hospital Association standards do advocate the inclusion of bad debt in uncompensated care. As the report observes, how individual hospitals report this varies, grounding conclusions drawn from broad studies in uncertainty. From a different perspective, the effort to determine the value of these tax exemptions is also uncertain. In preparation for a May 12, 2009 Senate Finance Committee hearing, the Joint Committee on Taxation noted that while they computed the value of nonprofit hospital tax exemption in 2002 as being \$6.1 billion, because of imprecise reporting requirements, variations in depreciation recording, and a lack of definition of how relationships between various entities should be reported, the “value of tax exempt status for nonprofit hospitals is extremely difficult to quantify.”⁴

Grassley’s response was to question: “does it make sense to retain tax exemption for hospitals?”⁵ But the benefit of this response to society is dubious. As various commentators have observed, discontinuing tax exemption could simply prompt nonprofit hospitals to change financial processes to protect assets or encourage those hospitals to become for-profit.⁶

⁴ “Background Materials For Senate Committee On Finance Roundtable On Health Care Financing,” (JCX-27-09) Joint Committee on Taxation (May 8, 2009): 39-42 available at <http://www.jct.gov/publications.html?func=startdown&id=3557> (last accessed 6/24/2009).⁵ Williams, Grant “Sen. Grassley Raises Question About Tax Exemptions for Hospitals,” *Chronicle of Philanthropy* (May 13, 2009), available at <http://philanthropy.com/news/updates/8237/sen-grassley-raises-question-about-tax-exemptions-for-hospitals>, (last accessed 6/24/2009).

⁶ See for example: Meisel, Zachary F. and Jesse M. Pines, “Tax Break Under the Microscope,” *Slate Medical Examiner* (June 19, 2009) available at <http://www.slate.com/id/2220784> (last accessed 6/24/2009).

Whether the actual charitable behavior of nonprofit hospitals can be improved through such policy decisions is questionable.

Current community benefit reporting focuses on the level of Charity Care provided by nonprofit hospitals. Because of the level of uncertainty that surrounds the quantification of their activities – and because of the doubts surrounding the effectiveness of the standards to change actual organizational behavior – it could be that a broader approach might be warranted. This paper offers a perspective that this debate should be expanded to focus on criteria such as reporting the level of expenditures hospitals make to provide health promotion and donation programs for the benefit of their community. By reporting their philanthropic behavior, nonprofit hospitals could present a more realistic picture of their commitment to their communities than the current debate over uncertain levels of charity care and uncompensated care. It also could provide models that could encourage more of this type of behavior. It should also be acknowledged that the available data related to other areas of community benefit, as well as to charity care, is imprecise and not reliable for meaningful comparisons to independent standards or to other organizations.

The overall dissertation presents a theoretical justification for reporting on philanthropic behavior provided by nonprofit hospitals. It then shows how such behavior can be evaluated using data from Indiana hospital reports. This shows how current practices, guidelines, and reporting procedures provide variable and inconclusive results. The inconsistency that currently exists among

individual hospitals could be addressed through regulatory requirements that focus on documenting relevant types of procedures. However even as current regulatory reporting becomes more defined, they nevertheless fail to adequately address those inconsistencies.

A Summary of the Conclusions of the Dissertation

The dissertation defines four different organizational structures that correspond to the underlying primary motivations the organizational theory indicates as a rationale for philanthropic behavior by nonprofit organizations. Built on the philanthropic motivations of for-profit companies, these structures are termed the Management Function Model, the Leadership Directed Model, the Separate Organizational Model, and the Stakeholder Discretion Model. The Management Function Model identifies practices institutionalized into the formal mid-management levels of the organization and are embedded within the normal or existing organizational structures of the organization. The Leadership Directed Model includes practices controlled by the personal actions of organizational leadership, particularly of the board and/or Chief Executive Officer. A Separate Organizational Model identifies practices centralized into a discreet entity to gain maximum exposure for the behavior, yet separate from its primary mission. The Stakeholder Discretion Model refers to practices that arise at different levels in the organization as responses by various internal stakeholders to diverse external requests and situations.⁷ These four models are used to further identify

⁷ It should be noted that a fifth model is added: the External Mandate Model. This model hypothesizes that organizations within similar systems could resemble each other, due to

decisions located within different levels of the organization, allowing inferences to be made about the motivations of the organization to engage in philanthropic behavior based on the location of those practices. The dissertation further maintains that nonprofit hospitals are especially valid subjects for determining this type of organizational behavior, as the community benefit standards denoted by the Catholic Hospital Association include aspects of operations that reflect philanthropic behavior – especially health education and donation programs. The next step is to determine whether adequate information might be available to determine this type of organizational behavior.

The Indiana State Department of Health's (ISDH) Hospital Fiscal Reports database is evaluated to determine whether such information could be used for identifying levels and types of hospital community benefit. It notes that the ISDH process not only provides comprehensive information related to community benefit but that it also reflects a level of detail that is now required on the IRS new Schedule H form for all nonprofit hospitals in the United States. The dissertation finds that there are questions about the comparability and validity of many of the criteria reported. A corresponding concern is how accurately summary reports reflect the actual commitment and actions of the individual hospitals to meet the identified needs of its defined community. It is further acknowledged that while the IRS form seems to be more definitive in identifying

regulatory or systemic requirements. The primary application of this model is to provide a theoretical basis for system hospitals resembling other hospitals in the same system. Since this was not found to be the case – and because this model does not affect where decision in a single hospital might be located – only four models are used for the evaluation.

the donation information than the ISDH form, the ISDH database provides information on health promotion expenditures that the IRS form does not. Since the level of Health Education expenses is generally much more extensive than donations, this lack of detail on the IRS forms makes future efforts to improve the collection of such information even more significant.

An investigation of the detail of the ISDH reports concludes that while these reports may provide some useful information for individual hospitals, broader conclusions about the behavior of nonprofit hospitals or categories of hospitals as a group are limited. Averages, median figures, and summaries don't account for the variety of factors that are necessary to adequately evaluate these types of organizational behavior and motivations. This is even more difficult when investigating the behavior of Indiana nonprofit hospitals as reflected in the categories of community health education programs and donations.

To explore these two categories, the Community Health Education programs of Indiana nonprofit hospitals are first investigated in detail. The thesis finds that the processes that provide and report community health education/promotion programs are scattered throughout the organization. This decentralized decoupling suggests they are motivated by normative Stakeholder values reflecting professional standards not easily standardized within centralized reporting systems. While the general commitment to providing health education programs does seem to be a formal part of a large percentage of the responding

hospitals, the specific decisions of what programs are presented, which publics to address, and how the expenses and other details of the program operation are reported are primarily left to the individuals throughout the hospital hierarchy. This multi-level situation complicates the policy efforts that seek to standardize and compare different hospital programs.

The dissertation next investigates the donations made by Indiana nonprofit hospitals. This investigation confirms that the donation process was largely decoupled from the central operations of the hospital in order to best fulfill the anticipated role of community influence presented by the Political or Ethical model of contributions. The donation process was located either in a separate department or foundation (related to the Political model) or centralized at an administrative level (confirming the Ethical model). Furthermore, donations were found in different parts of the hospital's organizational structure than their healthcare operational or their health education programs, decoupling the donation process from operations as well as from the health education programs. While this decoupling helps remove donations from healthcare decisions, which may be advantageous in terms of positioning the hospitals in the community, it could be detrimental in terms of conveying to a community the full extent of their philanthropic benefit.

The Philanthropic Behavior of Indiana Hospitals –

A Compilation and a Perspective

The initial question posed by this dissertation is “Does nonprofit philanthropy exist?” If it does exist, this prompts a second question: “How much philanthropy does a nonprofit organization provide?” The findings of the dissertation show that nonprofit philanthropy does exist and for some hospitals is fairly significant. The question of “How much philanthropy does a nonprofit organization provide?” varies greatly for individual hospitals and differences in reporting and organizational structures make individual comparisons inconclusive. However, public policy seeks to draw broad conclusions about the relative value provided by nonprofit hospitals as a whole. By collectively examining the total nonprofit hospital sector in a given state (such as Indiana) we can see that the level of philanthropic behavior is significant, even acknowledging the limitations of individualized comparisons.

To illustrate this significance, Table 6A summarizes the total Health Promotion and Donation expense as reported by Indiana nonprofit hospitals for 2004.

Table 6A (Data is from Tables 4C and Table 5B): Health Promotion Expenses and Donations Indiana Nonprofit Community Hospitals –2004

	Total Expenditures by Indiana NP Hospitals	% of Operating Budgets
Health Promotion	\$166,686,707	1.98%
Gross Donations Made	\$12,871,139	.04%
TOTAL	\$179,557,846	2.02%

As Table 6A shows, in 2004 nonprofit hospitals in Indiana spent more than 2% of their operating budgets either on Health Promotion programs or in cash donations. A majority of this expenditure was provided by health promotion programs, a non-required in-kind donation of services for the benefit of their community.

To determine the significance of these figures, we could try to compare these efforts to for-profit contributions, using percentage of net pre-tax profit as a guideline. It might be conjectured that if nonprofit hospitals do have an intrinsic interest in their community their level of donations would exceed those of for-profit companies, even though there are no tax benefits to tax-exempt hospitals.⁸ According to the tax code, corporations may deduct contributions of up to 10% of their pre-tax profits from their income statement. Nationally, corporate contributions in the United States in 2006 were 0.8% of pre-tax profits (*Giving USA 2007*), far below that level. Table 6B shows how nonprofit hospital

⁸ Conversely, if Grassley's suggestion to remove tax exempt status from nonprofit hospitals does occur, such comparisons with for-profit hospitals could be very relevant.

philanthropic expenditures relate to their net revenues (total revenue less operating expenses), being figures that might be related to pre-tax profits:

Table 6B: Health Promotion Expenses and Donations for Indiana Nonprofit Community Hospitals – as a Percentage of Net Revenues: 2004

	Total Expenditures by Indiana NP Hospitals	Net Revenues PLUS Expenditures	% of Net Revenues
Health Promotion	\$166,686,707		23.7%
Gross Donations Made	\$12,871,139		1.8%
TOTAL	\$179,557,846	\$699,090,489	25.5%

In 2004, the nonprofit hospitals in Indiana in total realized \$519,532,643 in net revenue. If they had not spent an additional \$180 million on programs for health promotion and donations, Indiana nonprofit hospitals would have earned nearly \$700 million in “profits” (i.e. net revenue, or revenue over expenses). As the figures show, more than 25% of the net revenue earned by hospitals in Indiana in 2004 was returned directly to the community in services or donations. The rest of these “profits” were reinvested for future community health care needs. As one comparison, for-profit hospitals in Indiana during the same period made \$945,484 in gross donations⁹ – or .4% of their net (pre-tax) profits; nonprofit hospitals gave donations of over 4 times that amount, or 1.8% of their net profits. Indiana’s for-profit hospitals not only did not give as much of their net donations

⁹ Health Promotion program expenses are not able to be compared, as for-profit hospitals do not have to share that information.

in donations as nonprofit hospitals did, they were 50% lower than the average for all for-profit corporations.¹⁰

Final Observations

In June 2008, the Indiana State Department of Health began a process to redesign its website. As part of that redesign process, several sections have changed as well as a number of data sources. One of those sources that is no longer available is the Hospital Fiscal Report and accompanying Community Benefit information. Whether that information will be added at a later time or will no longer be offered is conjecture. If there has been a decision to no longer make that data public (which was part of a 1994 Indiana state legislative action), it may very well have been prompted by the pending initiation of the IRS revised Form 990 and accompanying Schedule H.

Drawing conclusions from this study of the data on Indiana hospitals – both from the ISDH and the IRS Form 990s – is difficult. There is an inconsistency between the two databases as well as within each of the datasets that makes any specific conclusions suspect. However there are several observations that the process can offer.

¹⁰ However it should be acknowledged that because of for-profit hospitals do not fully report health education expenses, these in-kind donations are not included in the for-profit hospital figures.

The IRS Form 990 and Databases:

1. The IRS Form 990 revision and Schedule H should help the consistency and (perhaps) reliability of information supplied by nonprofit hospitals. This will mean that there is an opportunity for more detailed evaluations and accountability in the future.
2. The fact that for-profit and (many) public hospitals don't have to file comparable information is a drawback for the understanding of our healthcare system. Until all hospitals are required to file comparable information, cross-sector comparisons and conclusions will undoubtedly be hampered.
3. Much information that would be helpful to have available, still won't be part of the reporting system, meaning that evaluations of the type of information investigated in much of this thesis will continue to be difficult.

On Hospital Community Benefit:

1. There seems to be very little correlation between the amount of Charity Care provided by a hospital and their commitment to philanthropic programs. However this may be a function of inadequate data rather than an actual indication of a trend or a body of practice.
2. Community Benefit seems to be most valuable as a political tool for government representatives and as a public relations tool for nonprofit hospitals. Public policy could be misreading an important aspect of community benefit – primarily health education programs – by

emphasizing charity care (which seems to be a function of location more than charitable intent or practice). If instead there was increased emphasis on health education programs, then they may be encouraging an area that actually can improve the health of Americans while being an area that hospitals can proactively address.

3. The hospital systems are increasingly making community benefit of all kinds a higher priority. But the survey shows that this is happening at different levels and at different rates of organization. This is even true for Catholic systems that might be expected to have a more coordinated approach to any area that their national association has been working with for nearly forty years.
4. The professional values and ethics of hospital employees seem to be driving much of the actions toward improved health education. This appears to be true even for those that may not be considered as “professional healthcare workers” – i.e. those who fill public relations and administrative positions.

On Community Health Education: Three conclusions related to health education programs are drawn from the ISDH Hospital Fiscal reports, a written questionnaire, and personal interviews.

1. The data that are currently shared regarding hospital community health education expenses are variable and uncertain. Furthermore, it is unlikely that the new IRS Form 900 and Schedule H will change this, as the

information on health education that is being collected is relatively undefined.

2. The IRS has accelerated the adoption of the CHA/VHA criteria for reporting community benefit, but has limited the details of the programs on the reports that will be made public. While this should mean a more consistent reporting process, the lack of details on community health education makes drawing specific conclusions about community health education programs problematic. This also leads to the conclusion that a charity care emphasis by policymakers may be at the expense of improved community health education.
3. The variety of internal processes within different organizational levels to determine and report community health education programs confirm the neo-institutional approaches that emphasize the decoupling of decision-making in nonprofit organizations. They also demonstrate the importance of professionalization as an impetus to legitimacy and to shape a standard organizational culture and ethics. The empowerment of departments and employees at the organizational grassroots or staff level becomes a primary way for a hospital to encourage the philanthropic behavior by those within the organization, at least in relation to health promotion programs. However this level of decoupling makes unified reporting more difficult.

On Donations:

1. Because of the complexities of the hospital organizational structures, efforts to accurately count and compare incoming and outgoing donations are extremely difficult to extract. The different management approaches and the variable nature and role that donations can play within the organization make the processes for determining and reporting that activity inconsistent. Any future efforts to more specifically capture and understand hospital donation activities – both in receiving and giving donations – needs to address the situation of multi-organizational locales for the donation function.
2. One additional complication of identifying donations to the community as opposed to those from the community is that while a hospital's net donation to the community might be considered as part of "community benefit" (as it is in the ISDH Reports as well as the IRS Schedule H), donative theorists might conversely theorize that it is the donations from the community that indicate an organization's worthiness for tax exemption. One example of this apparent contradiction is in the articles arguing both of these points by John D. Colombo (Colombo 2005, Hall and Colombo, 1991a and 1991b).

On the Philanthropic Behavior of Nonprofit Organizations and the Implications for Philanthropic Study: The study of the nonprofit sector has traditionally focused on nonprofit organizations as recipients of charity. A perspective that has been

relatively neglected is that of nonprofit organizations as both recipients and donors of charitable resources. Recognizing that nonprofit organizations play this dual role within our communities, positions them as more complex entities within our social sphere than simply falling within a distinct nonprofit sector role. This broader understanding further complicates the simple three sector designation of our society as is commonly portrayed. This can also call into question the significance that sector plays in determining an organization's behavior. The recent literature on social entrepreneurship has provided some indication of an organization being able to serve in multi-sector roles. But even this literature has focused more on the profit generating activities of nonprofit organizations while overlooking the for-profit-like donor behavior that this thesis examines.

As the field of philanthropic studies develops, one future direction for the field could include incorporating a much more extensive range of organizational behaviors than can be contained within simple single-sector considerations. This broader and more individualized view of organizations can deepen our understanding of the multiple factors that affect any organizational activity. At the same time, expanding the number and types of organizational considerations complicates regulatory policies that seek to standardize and categorize organizations that provide public benefits. It is also important for policymakers to realize that such standardization might serve to constrain the very public-serving behavior they seek to nurture.

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CURRICULUM VITAE

Alvin L. Lyons

Education:

Doctor of Philosophy: Philanthropic Studies, Indiana University, Indianapolis: 2009

Master of Arts: Philanthropic Studies, Indiana University, Indianapolis:

2003 Bachelor of Arts: Colorado College, Colorado Spring, Colorado: 1973

Employment: Current:

- The Johnson Center for Philanthropy at Grand Valley State University
 - o Director, Social Innovation and Nonprofit Leadership
- Grand Valley State University
 - o Visiting Professor, School of Public and Nonprofit Administration
- Adjunct Professor, School of Public and Environmental Affairs, Indiana University Purdue University Indianapolis

Employment: Recent:

- Associate Director, Social Entrepreneurship Certificate Program, Indiana University 2006-2008
- Adjunct Professor, School of Public and Environmental Affairs, Indiana University, Bloomington 2005-2008

Professional Experience:

President, Lyons Associates, Bloomington, Indiana: 2003-Current.

Senior Vice President and Director of Educational Services, Lyons Associates, Inc., Aspen, Colorado: 1973-2002.

Consulting supervisor for over 250 fund development programs of nonprofit organizations nation-wide, primarily hospitals - helping them generate more than \$250 million in contributions. These various programs were directed, on an ongoing basis, for periods from one year to over twenty years. (Specific references and contacts available upon request). The fund development structure focused on effectively organizing a strong on-going community network of over 100 volunteer leaders to conduct the fund development activities.

As director of educational services, developed and conducted more than 200 educational seminars, training over 3,000 development professionals and community leaders. AI created the educational programs and materials for seminars on all aspects of fund development, including annual giving, business relations, planned giving, special events, major gifts, foundation support, marketing and community service and public outreach programs. He also co-founded the Aspen Academy for Fund Development, a training program for development staff as well as being a frequent speaker for national, regional, and state programs of the Association for Healthcare Philanthropy, the Association of Fundraising Professionals, and the American College of Healthcare Executives.

In November 2007 he presented a week-long workshop on hospital fundraising at Swinburne University in Melbourne, Australia.

Founder and Producing Director, Aspen Stage, Aspen, Colorado: 1984-Present
Managing Director, Odyssey Theatre, Los Angeles, California: 1979-1980.
Al has managed non-profit professional theater companies in Los Angeles and Aspen, Colorado as well as founded and managed a non-profit semi-professional company in Aspen, Colorado. He has produced and directed more than 50 stage productions and produced and directed over 100 audio theater productions, ten of which have played nationally on public radio.

Volunteer Board Membership:

Current: Past President, Aspen Stage
Board Member, Grapevine Foundation, St Helena, California
(A nonprofit provider of ePhilanthropy services to other nonprofits)
Leadership Council Member, Expanded Learning Opportunities Network (ELO), Grand Rapids, Michigan
(A coalition of community stakeholders working for quality after school programs)

Past: Board Member, Middle Way House, Bloomington, Indiana
(Domestic violence shelter and support organization)
Founding Board Member, Parker Ivory Foundation, Indianapolis (Neighborhood development and minority job training programs)
Indiana Theater Association
Indiana University Friends of Music
(Support organization for the IU School of Music)
Sarabande Books, Louisville, Kentucky
(A nonprofit publisher of poetry and short fiction)
Aspen Council for the Arts
Aspen Community Theater
Los Angeles Olympic Arts Organizing Committee

Advisor to the Board: KAJX Aspen – Roaring Fork Public Radio

Publications:

Contributor:
“Notable American Philanthropists,” Robert M. Grimm, editor. Westport, Connecticut: Greenwood Press. 2002
“Philanthropy in America: A Comprehensive Historical Encyclopedia,” Dwight F. Burlingame, editor. Santa Barbara CA: ABCCLIO. 2004
“Grantwriting and Leadership in Working with Foundations and Government,” in (Kathryn Ann Agard, editor) *Leadership in Nonprofit Organizations*, SAGE Reference project (publication pending)
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Book Review:

“Generations of Giving: Leadership and Continuity in Family Foundation”
by Kelin E. Gersick; *The International Journal of Not-for-Profit Law*, Volume 7,
Issue 4, September 2005

Conference Presentations:

“Evaluating the Effectiveness of Hospital Fund Raising Programs,”
Association for the Research of Nonprofit Organizations and Voluntary Action
(ARNOVA), November 2004

“Hospitals for Rural Communities: The Commonwealth Fund and
Experimental Origins of Community Organizing and the Hill-Burton Act,”
ARNOVA, November 2005

“A Comparative Study of Nonprofit AIDS Organizations in Indiana,”
ARNOVA, November 2005

“What Does an Interdisciplinary PhD Program in Philanthropic Studies
Mean to Fund Raising?” Benchmark 3 Conference, March 2006

“Does the Study of the Arts Have a Role in Philanthropic Studies?”
Benchmark 3 Conference, March 2006

“The Principles And Practices of Hospital Fundraising: A Workshop for
Victoria Hospital Fundraisers, Board Members, and Administrators” Swinburne
University, Melbourne Australia, November 2007

“Moving Beyond Program Sustainability” Learn and Serve Grantee
Workshop, Michigan Campus Compact, Big Rapids MI, October 2008

“What Do Foundations Want? Encouraging Grants - for Operations and
Beyond” Arizona State University, 16th Annual Nonprofit Conference on
Sustainability Strategies, December 2008

“Is Social Entrepreneurship in the Future of Our Nonprofit?” Arizona
State University, 16th Annual Nonprofit Conference on Sustainability Strategies,
December 2008

“Major Gifts: Seeking Investments for Your Future” National Association of
Independent Schools Conference, Chicago IL, February 2009

“Governance Matters – Cultivating Scarce Resources,” International Soil
and Water Conservation Society Conference, July 11, 2009, Dearborn, Michigan

“What Do Foundations Want? Encouraging Grants - for Operations
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“Positioning Your Organization to Apply for Operating Support: Strategies
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Conference, September 17, Traverse City, Michigan

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