

Examining the Relationship between Community Orientation and Hospital Financial Performance

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A community orientation strategy may be a socially responsible way for hospitals to simultaneously improve financial performance and community health, in accordance with the Affordable Care Act. Using data from the AHA Annual Survey, AHRF, and CMS Cost Reports, this study examined the association between hospital community orientation and three measures of financial performance, and whether that relationship differs for some types of hospitals. The analysis revealed that hospital community orientation was positively associated with total margin and that not-for-profit hospitals engaging in higher levels of community orientation experienced lower operating margins, on average, relative to for-profit hospitals.

INTRODUCTION

The responsibility for managing and improving community health continues to be a priority for hospitals as the focus on prevention and population-based healthcare is at the forefront of the recent health reform (AHA, 2012). Community orientation – defined as the “generation, dissemination, and utilization of community intelligence to address current and future health needs” (Proenca, 1998, p. 29) - is one way that hospitals may meet this responsibility (Alexander, Weiner, & Succi, 2000; Lee, Chen, & Weiner, 2004). It is unknown, however, whether engaging in these activities comes at the expense of a hospital’s financial performance. Some research suggests that financial benefits may accrue to

organizations that are more responsive to the needs of their stakeholders (Donaldson & Preston, 1995). For example, in the context of this study, hospitals that provide customized services based on a robust community orientation strategy may find that they are able to increase their market share by directly appealing to the health needs of the community. Alternatively, the costs associated with providing these services may have no or even a negative impact on financial performance. For example, engaging in these activities could result in a loss of revenue because of foregone admissions due to healthier community residents.

The purpose of this paper was to investigate these possibilities by examining whether community orientation is associated with hospital financial performance. The study contributes to existing research in this area of literature by using longitudinal data to assess the future financial impact of engaging in community-oriented activities. Study findings have important implications for hospital administrators that are learning how to meet the improved quality demands of the Affordable Care Act (ACA), while maintaining economic viability.

CONCEPTUAL FRAMEWORK

Hospitals are increasingly concerned with maintaining positive financial performance due to changes in the reimbursement structure of the U.S. healthcare system. The transition from fee-for-service to value-based reimbursement has been of the utmost importance to hospital administrators in pursuit of strategies to maintain quality and financial outcomes. These strategies often involve responding to the needs and concerns of stakeholders (Kumar, Subramanian, & Yauger, 1998).

Stakeholder theory involves the management of various stakeholder interests (Freeman, 1984), which is important given their influence on organizational performance (Becker & Potter, 2002; Donaldson & Preston, 1995) that may assist or hinder organizational success (Philips, Freeman, & Wicks, 2003). For hospitals, stakeholders may be internal, including upper-management and physicians (Fottler, Blair, Whitehead, Laus, & Savage, 1989) or external (i.e., schools, employers, government). External stakeholders, in particular, may be more difficult to manage given the large number and different types of stakeholders, as well as the absence of direct control over these stakeholders (Olden, 2003). We submit that hospitals that have a more robust community orientation strategy will be more likely to understand the needs of these external stakeholders, and consequently, will be better positioned to “manage” them.

Research related to corporate social responsibility (CSR) provides additional reasons to believe that community orientation may be associated with financial performance. In general, research has found that CSR – defined as those organizational actions focused on enhancing social welfare (Barnett, 2007) - is positively related to firm financial performance (Cochran & Wood, 1984; Simpson & Kohers, 2002). This is because engaging in activities consistent with CSR values improves an organization’s relationship with key stakeholders (McGuire, Sundgren, & Schneeweis, 1988). For example, an organization’s efforts to engage in CSR builds trust with stakeholders, which decreases transaction costs and positively impacts financial profitability (Barnett, 2007). Likewise, efforts to engage in CSR may engender loyalty among stakeholders (e.g., vendors, patients), which may reduce transaction costs required to seek out new partners and patients. We submit that community orientation is comparable to CSR as it also entails being responsive to social welfare in the form of addressing the health needs of the surrounding community (Proenca, 1998; Lee et al., 2004).

In sum, based on the aforementioned research and arguments, we believe that higher levels of community orientation will be associated with better financial performance. We posit, however, that the financial benefits of investing in community orientation will not be observed immediately, but rather will lag these efforts. This is because of the time it takes to witness uptake with any new health programs or services and possibly procure any benefits. Therefore, it is hypothesized that:

H1a: Community orientation is positively associated with return on assets.

H1b: Community orientation is positively associated with operating margin.

H1c: Community orientation is positively associated with total margin.

The Moderating Influence of Ownership Status

Another consideration is the conditions that may accentuate or attenuate the influence of community orientation and financial performance. In this study, we specifically focus on whether community orientation may have differing effects on financial performance as a result of hospital ownership status. In general, research indicates that for-profit hospitals are more efficient, but at the expense of vulnerable populations (Becker & Potter, 2002). One potential reason for this pattern is that for-profit hospitals do not partake in activities that do not generate a substantial profit or return on the investment, or at least not as much as their not-for-profit counterparts (Proenca, Rosko, & Zinn, 2000). In contrast, not-for-profit hospitals have a mission focused on helping vulnerable populations and may be more likely to engage in community orientation activities to achieve their mission. We expect the relationship between community orientation and financial performance to differ by profit status due to different norms and expectations applied to these hospitals by stakeholders. Specifically, we believe that stakeholders have a greater expectation of not-for-profit hospitals to provide these services due to their mission and regulatory requirements associated with their not-for-profit status. To the extent these services have not been as readily provided by for-profit hospitals, a more robust community orientation strategy may result in even better financial performance, relative to not-for-profit hospitals. Under the premise that the relationship between community orientation and financial performance will be moderated by hospital ownership, this study will test the following hypotheses:

H2a: The positive relationship between community orientation and return on assets will be stronger for not-for-profit hospitals relative to for-profit hospitals.

H2b: The positive relationship between community orientation and operating margin will be stronger for not-for-profit hospitals relative to for-profit hospitals.

H2c: The positive relationship between community orientation and total margin will be stronger for not-for-profit hospitals relative to for-profit hospitals.

METHODS

Data Sources

This study used data from the American Hospital Association (AHA) Annual Survey, Area Health Resources Files (AHRF), and CMS Cost Reports from 2007 to 2010. The AHA Annual Survey provided information on hospital community orientation, as well as several organizational characteristics that serve as control variables in the study. AHRF provided information regarding the communities where hospitals were located (e.g., urban or rural). CMS Cost Reports provided information regarding financial performance.

Operationalization of Variables

Dependent Variables

Financial performance was measured with three financial ratios: return on assets (ROA), total margin, and operating margin. ROA represents hospital earnings relative to the invested capital. ROA is often compared to return on investment, although the latter is often in reference to one particular project (Burkhardt & Wheeler, 2013). ROA was calculated as:

$$ROA = \frac{\text{Net Income}}{\text{Total Assets}} \quad (1)$$

Operating margin considers only the revenue obtained from the hospital's operations and is most commonly used to assess hospital financial performance. Operating margin was calculated as:

$$\text{Operating Margin} = \frac{\text{Net Operating Income}}{\text{Total Operating Revenue}} \quad (2)$$

Total margin considers all hospital revenue and expenses and is calculated using the following formula:

$$\text{Total Margin} = \frac{\text{Net Income}}{\text{Total Operating Revenue}} \quad (3)$$

Independent Variables

Community orientation was a continuous variable measured as the summated score of a 13-question scale from the AHA Annual Survey (See Table 1). The items were dichotomous and hospitals that answered "yes" were given a score of 1 for each question and all others were given a score of 0. Therefore, hospitals' degree of community orientation ranged from 0, representing hospitals that do not provide any community-oriented activities, to 13 representing hospitals that provide all of the community-oriented activities. Hospital ownership was a dichotomous variable with 0 representing for-profit hospitals and 1 representing not-for-profit hospitals.

TABLE 1
COMMUNITY ORIENTATION SCALE

Scale Items – AHA Annual Survey 2007-2010

1. Does your hospital's mission statement include a focus on community benefit?
2. Does your hospital have a long term plan for improving the health of its community?
3. Does your hospital have a specific budget for its community benefit activities?
4. Does your hospital have dedicated staff to manage community benefit activities?
5. Does your hospital provide support for community building activities (e.g. economic development, housing, environmental improvements, coalition building)?
6. Does your hospital make financial contributions (grants, donations, scholarships), provide in-kind support or participate in fundraising for community programs not directly affiliated with the hospital?
7. Does your hospital partner with your local school system to offer health or wellness programs to help your community?
8. Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community?
9. Does your hospital use health status indicators (such as rates of health problems or surveys of self-reported health for defined populations) to design new services or modify existing services?
10. Does your hospital work with other local providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community?
11. If yes, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community?
12. Does your hospital work with other providers to collect, track and communicate clinical and health information across cooperating organizations?
13. Does your hospital either by itself or in conjunction with others disseminate reports to the community on the quality and costs of health care services?

Control Variables

Several control variables were included in the model that previous studies have found to be correlated with hospital financial performance (Bazzoli, Chan, Shortell, & D'Aunno, 2000; Zhao et al., 2008) and community orientation (Proenca et al., 2000). System affiliation and network affiliation were represented as binary variables. Hospital size was measured by the number of staffed hospital beds. Market competition was measured by the Herfindahl-Hirschman Index and was a continuous variable ranging from 0 to 1, or high concentration to low concentration, respectively. Hospital location was dichotomous with 0 representing rural hospitals and 1 representing urban hospitals. Lastly, teaching affiliation was also dichotomous where 0 denoted hospitals that were not designated as a teaching facility and 1 represented hospitals that are Members of the Council of Teaching Hospitals.

Analysis

The analytic sample included 6,936 hospital-year observations with 1,734 unique hospitals across the four years of the study. Descriptive statistics, bivariate correlations and additional tests were conducted to identify any instances of multicollinearity between the study variables. Tolerance levels and variance inflation factors met the accepted threshold criteria, indicating that multicollinearity was not a problem in the analysis. Given the dichotomous nature of the items within the community orientation scale, the Kuder-Richardson Formula 20 (KR-20) was deemed most appropriate to test the reliability of the scale (Kuder & Richardson, 1937). KR-20 estimates showed that all of the items were internally consistent (KR-20: 0.82) and satisfied the generally accepted threshold for empirical data.

Multivariate regression models with random hospital effects were performed to test the study hypotheses. A lagged variable of one year was created for community orientation to account for the likelihood that it may take additional time for a change in community orientation to result in a positive change in hospital financial performance (Proenca et al., 2000). For the second set of hypotheses, an interaction term was constructed by multiplying community orientation with the ownership dummy variable. The statistical significance of the interaction term was determined using an F-test of the change in the coefficient of determination (i.e., R-squared). The community orientation variable used to calculate the interaction term was mean-centered to facilitate interpretation. Separate regression models were used for the three measures of hospital financial performance.

RESULTS

Descriptive Statistics

The study sample was reduced to only those hospitals which had observations in each year of the study (2007-2010), as well as those hospitals that had complete information for the measures of financial performance and community orientation. As shown in Table 2, the entire sample consisted of 6,936 hospital-year observations. The hospitals provided an average of 11 community orientation activities, approximately, and were predominantly not-for-profit (87.1%). More than half of the hospitals were affiliated with a multi-hospital system (64.1%), while 42.9 percent were members of a network. The average hospital had 209 beds setup and staffed for use. Market competition had an average index of .68. A majority of the hospitals were located in urban areas (95.3%) and were not teaching facilities (91.5%). The larger number of urban hospitals and non-teaching facilities is attributed to the data management process in which the analytic sample was limited to those hospitals with complete information for the items in the community orientation scale, as well as the financial performance measures. In terms of financial performance, the average ROA was 4.9 percent, operating margin was 0.1 percent, and total margin was 3.9 percent.

TABLE 2
VARIABLE DESCRIPTIVE STATISTICS

Variable	Mean/ Frequency (n)	s.d.	Source
Dependent Variables			
Return-on-Assets (ROA)	.049	.300	CMS Cost Reports
Operating Margin	.001	.215	CMS Cost Reports
Total Margin	.039	.206	CMS Cost Reports
Independent Variables			
Community Orientation	10.71	2.684	AHA
Hospital Ownership			AHA
Not-for-profit	87.10% (6,043)	--	
For-profit	12.90% (893)	--	
Community Orientation x Ownership	9.51	4.35	
Control Variables			
System Affiliation			AHA
Non-member of system	35.9% (2,488)	--	
Member of system	64.1% (4,448)	--	
Network Affiliation			AHA
Non-member of a network	55.6% (3,856)	--	
Member of network	42.9% (2,975)	--	
Hospital size (No. of beds setup and staffed)	209	213	AHA
Market competition (range 0 to1)	.68	.35	
Location			AHRF
Rural	4.7% (324)	--	
Urban	95.3% (6,612)	--	
Member of Council of Teaching Hospitals			AHA
No	91.5% (6,344)	--	
Yes	8.5% (592)	--	

Multivariate Analysis

After lagging community orientation by one year, there were missing observations for the first year (i.e., 2007) of hospital groupings by Medicare provider number, as observations for 2007 were systematically dropped from the analysis. In addition, there were missing observations for several control variables, which resulted in a smaller sample size for the regression. Most missing data was related to network affiliation. Consequently, the final analytic sample for the regression analysis included 5,124 hospital-year observations.

Results for Main and Interaction Effects

Community orientation was not significantly associated with ROA ($B = -0.002$, $p = 0.127$) or operating margin ($B = 0.001$, $p = 0.202$; Table 3). Thus, there was no support for hypotheses 1a and 1b. Hypothesis 1c, however, was supported with the analysis indicating that community orientation was positively associated with hospital total margin ($B = 0.002$, $p = 0.020$).

Although not hypothesized, but pertinent to the interaction effect, hospital ownership was associated with financial performance for each of the three measures. Not-for-profit hospitals were negatively related to hospital ROA ($B = -0.0811$, $p < 0.0001$), operating margin ($B = -0.055$, $p < 0.0001$), and total margin ($B = -0.020$, $p = 0.007$), when compared to for-profit hospitals. The results for the interaction effect shown in Table 4 revealed that Hypothesis 2a was not supported, as the interaction between community orientation and ownership status was not significantly associated with ROA. Although the relationship tested was statistically significant, Hypothesis 2b was not supported as the interaction term for

community orientation and not-for-profit hospitals was negatively related to hospital operating margin ($B = -0.005$, $p = 0.037$), which was contrary to the positive relationship that was hypothesized. There was no support for Hypothesis 2c, as the interaction between community orientation and hospital ownership was not significantly associated with total margin.

TABLE 3
RESULTS OF MULTIVARIATE REGRESSION MODELS
WITHOUT INTERACTION EFFECT

Variable	Return On Assets			Operating Margin			Total Margin		
	B	SE	Sig.	B	SE	Sig.	B	SE	Sig.
<i>Intercept</i>	0.073	0.023	0.002	-0.074	0.019	0.0001	-0.011	0.016	0.494
System Membership	0.027	0.007	0.0003	0.024	0.006	<.0001	0.017	0.005	0.001
Network Membership	0.011	0.007	0.108	0.010	0.006	0.072	0.009	0.005	0.049
Hospital Size	0.0001	0.00002	0.008	0.00002	0.00002	0.323	0.00004	0.00002	0.017
Market Competition	0.005	0.012	0.649	0.011	0.009	0.262	-0.001	0.008	0.909
Rural/Urban	0.037	0.016	0.024	0.084	0.014	<.0001	0.031	0.012	0.008
Teaching Affiliation	-0.008	0.015	0.588	-0.018	0.012	0.138	-0.011	0.011	0.281
Community Orientation (Lag)	-0.002	0.001	0.127	0.001	0.001	0.202	0.002	0.001	0.020
Ownership	-0.0811	0.011	<.0001	-0.055	0.009	<.0001	-0.020	0.008	0.007

TABLE 4
RESULTS OF MULTIVARIATE REGRESSION MODELS
WITH INTERACTION EFFECT

Variable	Return On Assets			Operating Margin			Total Margin		
	B	SE	Sig.	B	SE	Sig.	B	SE	Sig.
<i>Intercept</i>	0.102	0.033	0.002	-0.111	0.026	<.0001	-0.035	0.023	0.121
System Membership	0.027	0.007	0.0003	0.024	0.006	<.0001	0.017	0.005	0.001
Network Membership	0.011	0.007	0.110	0.010	0.006	0.070	0.010	0.005	0.048
Hospital Size	0.00006	0.00002	0.007	0.00002	0.00002	0.330	0.00004	0.00001	0.018
Market Competition	0.007	0.012	0.575	0.009	0.009	0.341	-0.002	0.008	0.806
Rural/Urban	0.037	0.016	0.026	0.085	0.014	<.0001	0.031	0.012	0.007
Teaching Affiliation	-0.009	0.015	0.567	-0.018	0.012	0.150	-0.011	0.010	0.298
Community Orientation (Lag)	-0.005	0.003	0.069	0.005	0.002	0.014	0.005	0.002	0.015
Ownership	-0.077	0.011	<.0001	-0.060	0.009	<.0001	-0.024	0.008	0.003
Interaction Effect	0.004	0.003	0.213	-0.005	0.002	0.037	-0.003	0.002	0.131

Results for Control Variables

System affiliated hospitals were positively related to ROA ($B = 0.027$, $p = 0.0003$), operating margin ($B = 0.024$, $p < 0.0001$), and total margin ($B = 0.017$, $p = 0.001$). Network-affiliated hospitals were significantly associated with total margin only ($B = .009$, $p = .049$). Hospital size was positively associated with ROA ($B = 0.00001$, $p = 0.008$) and total margin ($B = 0.00004$, $p = 0.017$), but was not significantly associated with operating margin. Market competition was not associated with any of the measures of financial performance. Urban hospitals were associated with each measure of financial performance: ROA ($B = 0.037$, $p = 0.024$), operating margin ($B = 0.084$, $p < 0.0001$) and total margin (B

= 0.031, $p = 0.008$). Lastly, teaching hospitals were not associated with any measure of financial performance.

DISCUSSION

Hospital community-oriented activities may influence financial performance, yet little research has examined this possibility. This study addressed this gap by examining the relationship between hospital community orientation and three measures of financial performance. The study found that community orientation was associated with total margin, but contrary to previous research (McGuire et al., 1988), community orientation was not associated with hospital ROA nor operating margin. The significant relationship does suggest that the more community-oriented activities provided by the hospital in the previous year, the greater the increase in total margin during the following year. This may be attributed to a decrease in expenses associated with an increased emphasis on the activities affiliated with community orientation strategy and potential improvement in the health of the local population.

Not-for-profit hospitals were negatively related to each of the three measures of financial performance, when compared to for-profit hospitals. These results may be explained by the mission of not-for-profit hospitals and the tradeoff between charity care and hospital profitability. These findings are consistent with other studies that have found that for-profit hospitals reported higher revenue and profits than not-for-profit hospitals (Shen, Eggleston, Lau, & Schmid, 2007).

In addition, hospital community orientation had a negative relationship with the operating margin in not-for-profit hospitals compared to for-profit hospitals. However, the interaction term between community orientation and ownership was not associated with ROA and total margin. Examining the results of the research model further revealed that, essentially, not-for-profit hospitals perform no better or worse by providing community orientation activities in terms of their operating margin. Yet, for-profit hospitals may experience a slight increase in operating margin with each additional community-oriented activity provided. Participating in more community-oriented activities that respond to stakeholder needs and increase the hospital's exposure within the community may also increase the hospital's revenue. The lack of large financial gains may be better explained from the notion that financial benefits are not the primary goal of the community orientation strategy. Although improving financial performance may be an additional benefit, community orientation is a philanthropic and collaborative approach to improving community health. If hospitals understand that the goal of community orientation is to improve health, then it may be the case that hospitals are not utilizing this strategy as a means of seeking additional profit. In general, despite different underlying business models, values, and motivations, the relationship between community orientation and financial performance is consistent across for-profit and not-for-profit hospitals.

Lastly, there were varying results among the control variables. First, system-affiliated hospitals were positively related to each measure of financial performance. This finding is supported by previous research which has suggested that system-affiliated hospitals are able to increase their revenue and eliminate certain expenses that may be attributed to having the same leadership (Bazzoli et al., 2000). Having the same governance structure may mean that system-affiliated hospitals are better able to identify and manage the needs of stakeholders. However, hospitals affiliated with a network were associated with higher performance for only one of the three measures of financial performance (total margin). The weak support for this relationship may be explained by research that has found that the organizational structure of hospital networks and the particular measures chosen by researchers to test financial performance may contribute to the varying results for this relationship (Bazzoli et al., 2000; Clement et al., 1997). Regardless, given the number of missing observations for network affiliation, this finding should be interpreted with caution.

Consistent with previous research, hospital size was associated with two of the three measures of financial performance—ROA and total margin. One explanation for the nonsignificance with respect to operating margin is a potential nonlinear relationship; Kim and colleagues (1997) noted a curvilinear relationship between hospital bed size and hospital profitability. Additional research is needed to assess

this possibility. The results also indicated that urban hospitals were affiliated with financial performance. This finding may be due to the number of insured patients that access hospitals in metropolitan areas compared to rural areas that may have more uninsured patients and as a result will provide more charity care or incur greater amounts of bad debt. Contrary to prior studies (Clement et al. 1997), market competition and teaching affiliation were not associated with hospital financial performance. Therefore, these relationships may need to be evaluated again using a more diverse sample of hospitals.

On the whole, the results of this study suggest that hospital executives would benefit from pursuing a community orientation strategy. Either for achieving their mission or to experience some increase in revenue, community-oriented activities seem marginally beneficial to both not-for-profit and for-profit hospitals, respectively.

Limitations and Future Research

Given the varying results, there are several opportunities for future research to expand upon the findings of this study. Exploring the relationships in this study in post-ACA years was hindered by the transition of the community orientation scale to an open-ended, qualitative question, which may present an interesting challenge for researchers as it will require a mixed-methods approach to any study. Yet, it may provide more information about how involved hospitals are in providing community-oriented activities. Researchers may consider using more years of data to test a 3-year or 5-year lag effect to consider the long-term influence of community orientation on hospital financial performance. Community-oriented activities deal with multifaceted health and social issues, therefore, it may take a substantial amount of time for these activities to manifest in changes in hospital financial performance. Future research may also consider the perceptions of hospital community orientation from the local community, which may help identify opportunities to improve community orientation offerings and compensate for the fact that the study was based on self-reported data about the presence or absence of community-oriented activities that may not directly capture the degree to which these activities are being performed by the hospital.

Future research may consider the change in community orientation and the influence it has on the change in financial performance (Ruf, Muralidhar, Brown, Janney, & Paul, 2001). This type of analysis will also benefit from more years of data, which may see greater variation in community orientation within hospitals. Again, however, the limitation of accessing this same data via the AHA Annual Survey is noted and it will be necessary to acquire community-oriented activity information through another data source, such as the Internal Revenue Service or developing an entirely new community orientation scale. Lastly, future researchers examining the relationship between hospital community orientation and financial performance may want to consider the role of the chief executive officer and their inclination towards social responsibility that may reflect the hospital's level of CSR (Lerner & Fryxell, 1994; Pava & Krausz, 1996), or community orientation.

CONCLUSION

Community orientation allows hospitals to meet the needs of stakeholders within the community, especially patients. A robust community orientation strategy can assist hospitals in meeting their responsibility to improve community as well as individual health. However, whether this strategy is pursued at the expense of a hospital's bottom line has not received much attention within the literature. This study suggests that there is a positive relationship between community orientation and financial performance, although it is limited to certain aspects of financial performance. The study findings are informative for administrators who recognize the dual responsibilities to be responsive to community needs while remaining financially viable.

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