Accessing Funding for Capital Projects in Rural Healthcare

Policy Paper June 2025

Overview

America's rural healthcare system faces growing challenges in accessing capital funding for essential infrastructure projects. While historical programs like the Hill-Burton Act demonstrated the transformative power of federal investment—establishing nearly one-third of the nation's hospitals by 1975—today's rural healthcare facilities struggle to navigate increasingly complex financing pathways. As they juggle operational pressures with long-term capital needs, access to capital funding is critical to sustaining healthcare services in rural communities.

Summary of Key Findings

- Rural providers have multiple challenges and sources to access capital including federal, private, and state programs.
- United States Department of Agriculture (USDA) Community Facilities (CF) Program delivered over $8 billion in healthcare funding (2012–2023), with hospital projects averaging five times more funding than non-hospital projects.
- Technical assistance and lender experience are critical to securing and managing complex capital projects.
- Housing and Urban Development (HUD) 242 supports large-scale rural hospital projects, yet only funds a few rural projects per year due to criteria and capacity limits.
- New Markets Tax Credits (NMTCs) are underutilized in rural healthcare, with only 34 projects over 20 years—mostly for community health centers.
- Pre-development support and blended financing strategies are key enablers of success yet remain limited or inconsistent across rural regions.
- State investments are increasing and vary widely, with programs in over 25 states providing targeted rural infrastructure funding.

Introduction

As rural America faces mounting healthcare challenges, a critical paradox persists: while funding programs exist to support rural healthcare capital projects, the communities most in need often cannot access them. Maintaining the infrastructure required to deliver care is foundational, yet this persistent funding-access divide threatens the stability of rural healthcare nationwide and reveals a key vulnerability in the nation's healthcare strategy. Understanding both the root causes and the real-world impacts of this disconnect—along with evaluating the effectiveness of existing programs—is essential to strengthening the long-term sustainability of rural healthcare delivery.

The Center for Community Investment (CCI) describes capital in community investment projects as needing to 'flow uphill'—highlighting how these initiatives often fall outside typical commercial lending pathways and require intentional strategies to attract and align funding. This is especially true in healthcare, where the complexity of planning, regulatory requirements, and stakeholder coordination further limits access to conventional capital. At the same time, rural health executives are often operating in crisis mode, facing chronic funding uncertainty and limited capacity—leaving little time or bandwidth to navigate lengthy and fragmented financing processes. Decades of limited funding in rural health have compounded this challenge, creating the added expectation of meeting modern care demands within facilities that lack adequate space, face mounting maintenance costs, and rely on outdated equipment—conditions that inadvertently limit their potential impact and contribute to a self-perpetuating cycle of disinvestment.

This paper aims to provide information and inspire action, whether by enhancing current programs, removing challenges, directing more capital to rural healthcare, or exploring new solutions. Rather than prescribing a single path, it offers a foundation for a variety of stakeholders to build upon, driving change from multiple directions.

Rural Healthcare Capital Access

The Hill-Burton Act of 1946 significantly expanded healthcare access across the United States, particularly in rural areas where nearly 40% of counties previously lacked hospitals. Federal investments through this program supported the

construction of approximately one-third of all U.S. hospitals by 1975, including clinics, rehabilitation centers, and long-term care facilities. These institutions became vital economic anchors in their communities, ultimately supporting one in nine jobs nationwide (1,2).

As Hill-Burton funding declined, rural healthcare facilities increasingly depended on new sources of capital. However, policy changes in the early 1980s—including the introduction of prospective payment systems—shifted reimbursements to flat-rate payments. This model disproportionately affected low-volume rural providers, leaving them consistently underfunded and compounding the difficulty of accessing capital for facility maintenance and modernization (3).

Capital investment is critical to delivering high-quality care, but it is costly and complex. Healthcare infrastructure and equipment require long-term, upfront investments, and are accompanied by ongoing regulatory, compliance, and maintenance expenses. These challenges were further magnified by sharp increases in construction costs: since 2012, healthcare construction costs have risen over 64%, with a 17% spike in 2022 alone—excluding pandemic-related anomalies. This surge reset the baseline for capital investments, eroding the real value of capital budgets and compounding the funding gap with each year of deferred reinvestment (19) (Figure 1).

Figure 1

Annual Increase in Prices for Healthcare Construction by Year

YEAR	PRODUCER PRICE INDEX VALUE	EQUIVALENT PROJECT COST ($M)	COMPOUND ANNUAL GRWOTH RATE (%)
2012	100.0	$10.00M	-
2015	102.0	$10.20M	0.66%
2020	110.0	$11.00M	1.52%
2022	150.0	$15.00M	16.77%
2025	164.3	$16.43M	3.08%

These financial pressures, along with the capital-intensive nature of healthcare delivery, contributed to a wave of industry consolidation. To gain efficiencies of scale, larger health systems expanded into rural areas. Many rural providers chose to affiliate with these systems, often influenced by the promise of greater capital investment and financial stability.

This paper provides a historical overview of major capital funding programs and analyzes the persistent

challenges that prevent rural healthcare providers from converting available funding into usable capital—undermining sustainability in rural health systems. Despite the existence of federal and state programs, significant gaps remain in translating available funding into accessible capital at the local level (4,5, 18).

Methods

This paper employed a mixed-methods approach, combining data analysis with in-depth stakeholder interviews to examine the challenges of capital access in rural healthcare.

The methodology included a systematic review of federal funding programs through September 2024, alongside key informant interviews with rural healthcare administrators, financial experts, and program officials. Interview participants were selected to reflect a range of geographic regions, organization types, and facility sizes and the interviews helped validate quantitative findings and added crucial contextual insight.

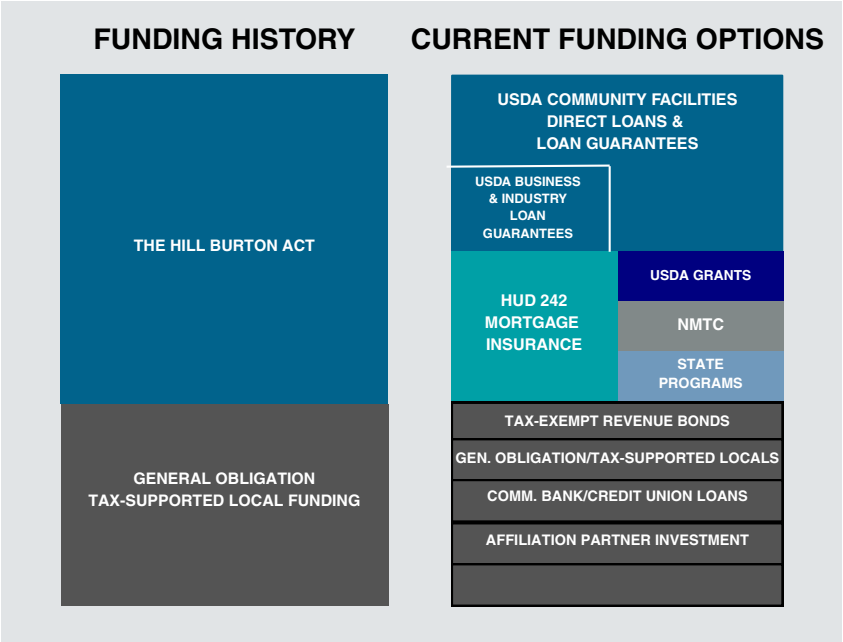
Data collection and analysis focused on both funding distribution patterns and the lived experiences of Critical Access Hospitals and other rural facilities.

Sources of Financing

One of the most consistent themes emerging from interviews and data analysis is that there is no single 'silver bullet' for financing healthcare infrastructure in rural communities. Stakeholders frequently emphasize the need to blend multiple funding sources for a single project, noting that each community's "financing recipe" varies based on local context, timing, and specific project needs.

Figure 2

Rural Healthcare Capital Project Funding Allotment



Reflected in Figure 2 the following section provides an overview of each primary capital source available to rural healthcare providers—highlighting their strengths, limitations, and real-world usage to inform more effective financing strategies.

Internal Reserves and Board-Designated Capital Funds

Many rural healthcare organizations adopt conservative financial strategies, focusing on preserving limited resources rather than taking on long-term debt and using a "pay-as-you-go" approach using reserves and capital accumulated over time.

This is often reflected in the goal of funding a reserve account annually to offset the annual cost of depreciated assets. While some successfully build internal reserves or board-designated capital funds to meet the replenishment goal—often reinvesting proceeds from service expansions—this remains an aspirational goal for most. Over time, this creates a ripple effect as the cost of overdue renovations becomes prohibitive, service capacity declines, operational strain increases, and financial vulnerability deepens (6,7).

This underscores the importance of:

- Board and executive education on sustainable capital management,
- Continued technical assistance for operational planning,
- Expanded support and funding for pre-development planning, and
- Design strategies to minimize infrastructure costs through efficient space use.

State Appropriations and Capital Funding

Since 2015, over 25 states have launched targeted programs to support rural healthcare infrastructure, using state-level funding sources independent of federal stimulus or pass-through grants. This analysis intentionally excludes programs focused on electronic health records (EHR) or other digital systems to focus exclusively on physical infrastructure investments such as construction, renovation, HVAC upgrades, and modernization. The programs identified span competitive grants, low-interest loan funds, and one-time capital level funding sources independent of federal stimulus or pass-through grants.

Eligible recipients include critical access hospitals (CAHs), rural emergency hospitals (REHs), federally qualified health centers (FQHCs), rural health clinics (RHCs), and local health

systems aiming to maintain or expand rural access to care. Funding mechanisms vary and include general fund appropriations, bond-backed capital budgets, and state surplus allocations. About half of the programs are designed as one-time investments or structured as recurring or revolving funds.

Notable examples include Minnesota's long-running Rural Hospital Capital Improvement Program, New York's Rural Transformation Grants, and Texas' facility modernization and technical assistance programs. Several programs —such as those in North Carolina, Kentucky, South Carolina, and Illinois— explicitly encouraged system affiliation or consolidation in the capital distribution process.

Funding levels ranged from $3 million to $60 million, reflecting a wide range of state investment. Together, these programs represent a substantial, albeit uneven, effort by states to address infrastructure challenges in rural healthcare systems through policy-driven public finance strategies.

Seeking Capital Through Regional System Affiliation

Affiliations between rural healthcare facilities and regional health systems have grown steadily in recent years, largely driven by the need for improved access to capital, economies of scale, and enhanced administrative and clinical support. As of 2018, approximately 43% of CAHs were affiliated with larger health systems. These partnerships can provide rural facilities with financial and operational resources that are often out of reach for independent organizations.

While comprehensive national data on post-affiliation capital investment is limited, available research suggests that system affiliation often facilitates increased investment in rural infrastructure, including facility upgrades and equipment modernization (13). Regional systems may also provide technical assistance and capacity to support long-term capital planning and access to financing tools unavailable to standalone providers.

Tax-Exempt Bonds

Affiliation with regional health systems can also create pathways for rural providers to access the tax-exempt municipal bond market, which remains a critical source of long-term capital for nonprofit healthcare infrastructure. Many rural healthcare organizations issue revenue bonds, often in partnership

with local municipalities as conduits, but those bonds are repaid from projected operating revenues rather than a dedicated tax base. However, rural providers often face structural barriers in the bond market: limited-service volumes, geographic isolation, and financial instability frequently result in non-rated or sub-investment-grade (i.e., "junk") bond classifications, increasing borrowing costs or limiting market access.

In response, independent rural hospitals and health centers have turned to federal credit enhancement programs, such as HUD 242 mortgage insurance and USDA Community Facilities loan and guarantee programs, to lower the cost of capital and improve creditworthiness. These financing programs—alongside supporting grants and technical assistance—have become essential tools for rural providers seeking to maintain independence while funding large-scale infrastructure projects that are often unattainable through private bond markets alone.

Foundations and Other Grants

A broad range of philanthropic and quasi-public entities provide support or rural healthcare infrastructure projects. These organizations provide some direct capital funding and more importantly, access to pre-development resources, planning assistance, and strategic guidance essential for rural providers seeking to undertake facility investments. The ability to access early-stage support—such as feasibility assessments, capital planning, and stakeholder alignment—is often a key determinant of success in securing full project financing.

Community foundations and regional foundations offer small grants and technical support for early planning, especially for renovations or facility improvements that benefit local service delivery. These foundations may also play a convening role, aligning donors, civic leaders, and nonprofit stakeholders to support locally relevant capital projects. Family foundations, while varied in structure, often provide early-phase funding and may support planning, site acquisition, or feasibility work based on personal or geographic alignment.

Health conversion foundations and Community Development Financial Institutions (CDFIs) are among the most consistent sources of pre-development support, offering financial modeling, bridge loans, and technical assistance tailored

to rural and safety-net providers. Organizations like Capital Link, Primary Care Development Corporation, and LISC serve as intermediaries with specialized expertise in health facility development, often working alongside FQHCs, CAHs, and behavioral health providers. National organizations such as the CCI also provide structured frameworks and coaching to help rural coalitions align stakeholders, identify capital gaps, and mobilize investment through initiatives like CCI's Accelerating Investments for Healthy Communities.

State and regional entities—including economic development authorities and regional commissions—may provide infrastructure planning grants, site readiness funding, or matching funds tied to workforce or regional resilience outcomes. Corporate foundations may support discrete pre-development activities, especially when linked to community benefit or workforce priorities. Finally, faith-based funders may provide support for facilities planning within the context of human services, health ministries, or affordable housing.

Together, these partners form a multi-layered infrastructure of support—one in which pre-development assistance is increasingly critical to overcoming structural barriers in rural health facility financing.

Fundraising

Capital campaigns remain a key funding strategy for rural healthcare infrastructure projects, offering both financial resources and a platform for community engagement. Stakeholders emphasize that a compelling case for support, grounded in clear connections between the proposed investment and measurable improvements in community health, is essential for success. Campaigns are typically structured in phases, beginning with a quiet phase during which the majority of funds are secured from lead donors, foundations, or anchor institutions before a broader public launch.

Effective campaigns incorporate high-visibility leadership committees, strategic donor segmentation, and carefully timed communications to maintain momentum. Tailored engagement strategies—including personal outreach, storytelling, and ongoing transparency—are critical to sustaining credibility and broad-based donor commitment throughout the campaign.

Campaign goals vary based on organizational size and project scope. For example, rural health centers often

set fundraising targets between $500,000 and $3 million, while CAHs may pursue capital campaign goals ranging from $1 million to $5 million. (7, 10) Regardless of the scale, successful efforts are consistently anchored in pre-campaign planning, early major donor commitments, and a disciplined focus on articulating the link between infrastructure investment and improved rural healthcare outcomes.

USDA Grants

The USDA Community Facilities (CF) Program awarded approximately $500 million in healthcare grants between 2012 and 2023, reflecting 8.7% of all CF grants, and averaging between eight and $16 million annually. During this period, individual grant awards ranged from $64,000-$83,000, reflecting support for smaller needs but limited overall impact on larger scale projects.

Emergency grants during the public health emergency temporarily boosted funding levels, with healthcare projects accounting for 68% of total awards in 2022–2023 as Congress leveraged the USDA grant programs for distributing pandemic-related funding and preparedness and demonstrated an expanded potential role in distributing targeted funding to address rural community development needs (8).

In 2022, USDA launched a pilot technical assistance grant program in partnership with the National Rural Health Association (NRHA). Stakeholders recognized the program for its quick response times and the availability of prequalified technical advisors provided to hospitals who are recipients of USDA grants and loans, or who are pursuing that and seeking financial stability.

Commercial Bank, Credit Union, and CDFI Loans

Commercial banks and credit unions play a limited but important role in rural healthcare financing, primarily offering short- to medium-term loans, lines of credit, and accounts receivable financing. These instruments typically support working capital needs, equipment purchases, and minor facility upgrades. However, the ability of these institutions to underwrite larger capital investments is often constrained by their balance sheet size and lending limits—particularly in the smaller financial institutions that serve rural communities (17).

CDFIs have emerged as key partners in many types of rural

financing, offering more flexible terms and combining lending with technical assistance, but their involvement in healthcare projects has been limited to date. CDFIs may support predevelopment, bridge financing, or gap funding for projects not yet eligible for traditional or government-backed loans. Some also participate in NMTC transactions, helping to bring additional subsidy into rural capital stacks.

Despite their value, these sources are generally insufficient to meet long-term capital needs such as facility construction or major expansions on their own. High-cost infrastructure projects typically require access to federal credit enhancement programs —including HUD 242 mortgage insurance, USDA Community Facilities loans, or the tax-exempt bond market —to achieve viable financing structures. While no public database currently tracks rural healthcare lending by commercial banks or credit unions, available evidence suggests that uninsured lending capacity remains limited in most rural markets without the presence of external guarantees or public credit support. (10, 11, 12).

Federal Loan and Guarantee Programs to Provide Access to Capital

The three most significant financing programs for rural healthcare capital projects are–in order of total funding– USDA CF loans and loan guarantees, HUD 242 Mortgage Insurance Program, USDA Business and Industry (B&I) guaranteed loans. Other tools— such as the New Markets Tax Credit NMTC program, established in 2000— have been used in limited healthcare transactions and remain largely underutilized in rural settings (9, 14, 15, 16, 17).

USDA Community Facilities Loans

USDA programs have become key sources of healthcare infrastructure financing in rural communities, offering both direct loans and loan guarantees to support facility development.

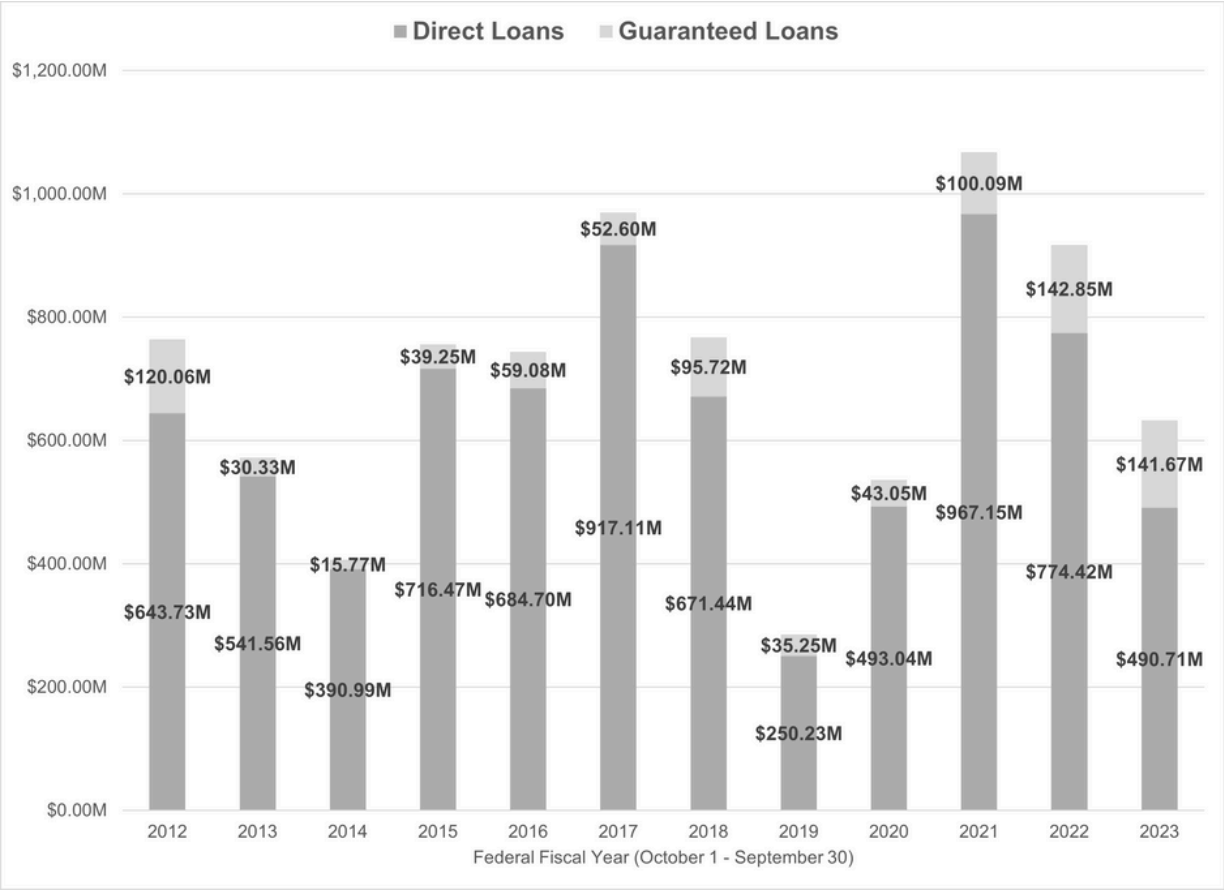
As illustrated in Figure 3, between 2012 and 2023, healthcare and social assistance projects received 48% of all USDA CF funding, totaling over $8 billion, with an average annual investment of $701.4 million.

The CF Direct Loan Program serves communities with populations of

Figure 3

USDA Community Facilities Direct and Guaranteed Loans

Healthcare and Social Assistance Projects



20,000 or fewer, while the Guaranteed Loan Program extends eligibility to areas with up to 50,000 residents. Eligible borrowers include public bodies, community-based nonprofits, and federally recognized tribes that demonstrate financial need.

Over the 12-year period, the average healthcare project size was $11 million. However, hospital-based projects averaged $19 million, compared to $3.7 million for other healthcare projects—a fivefold difference. This disparity highlights the added complexity and scale of underwriting large hospital projects within the sector (20).

An analysis of program awards from 2012 to 2023 revealed a hybrid public-private funding structure (Figure 3), with USDA leveraging $7.5 billion in direct loans and $875 million in guaranteed loans issued by private lenders—representing 10% of overall healthcare financing. Program staff identified the presence of dedicated USDA national office healthcare

experts and partnerships with guaranteed lenders as key to managing the complexity of healthcare loan transactions.

Despite accounting for a smaller portion of total healthcare funding, guaranteed loans are playing an increasingly strategic role. These loans represented 58% of all guaranteed loan activity across the CF program.

As shown in Figures 4 and 5, healthcare-related guaranteed lending has increased steadily since 2019, reaching a record high of 93% of all guaranteed loans in FY2023.

Between 2012 and 2023, 92 lenders participated in healthcare guaranteed lending. However, 93% made only one or two loans, with an average loan size of $5.1 million. By contrast, the six lenders who made three or more loans had an average loan size of $13.8 million—2.7 times larger than infrequent lenders.

This points to a growing concentration of guaranteed lending among a small group of experienced institutions. In fact, the top five lenders accounted for an increasing share of all healthcare guaranteed loans—52% in 2022, 61% in 2023, and 83% in 2024.

Figure 4

USDA Healthcare Guaranteed Loans as a Percent of All Guaranteed Loans

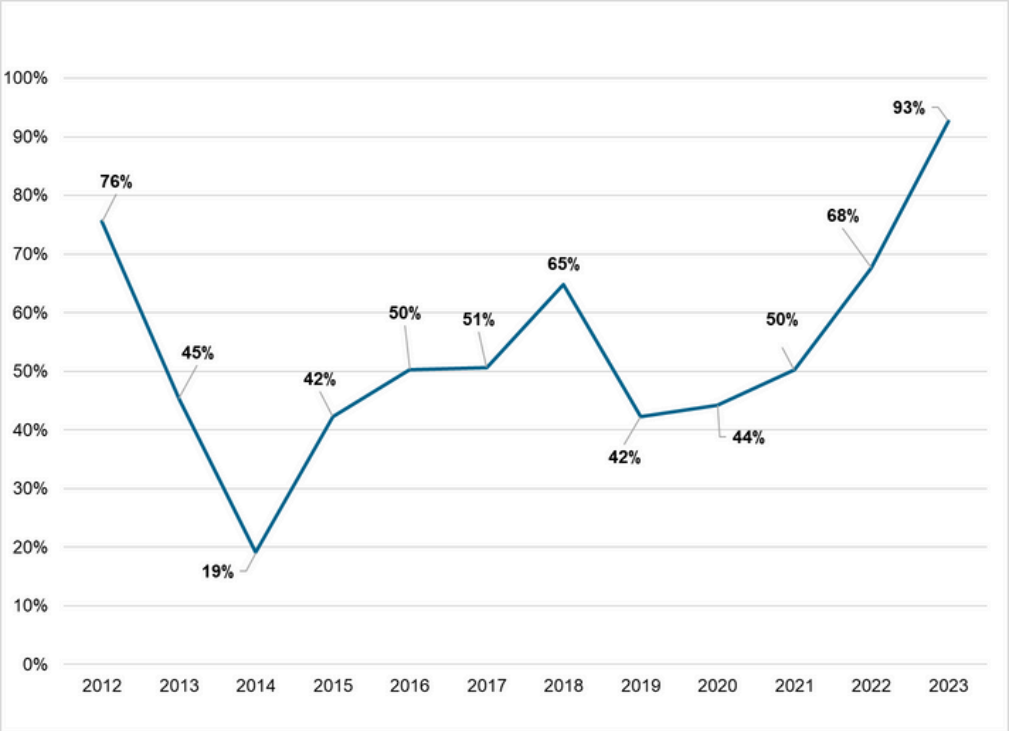
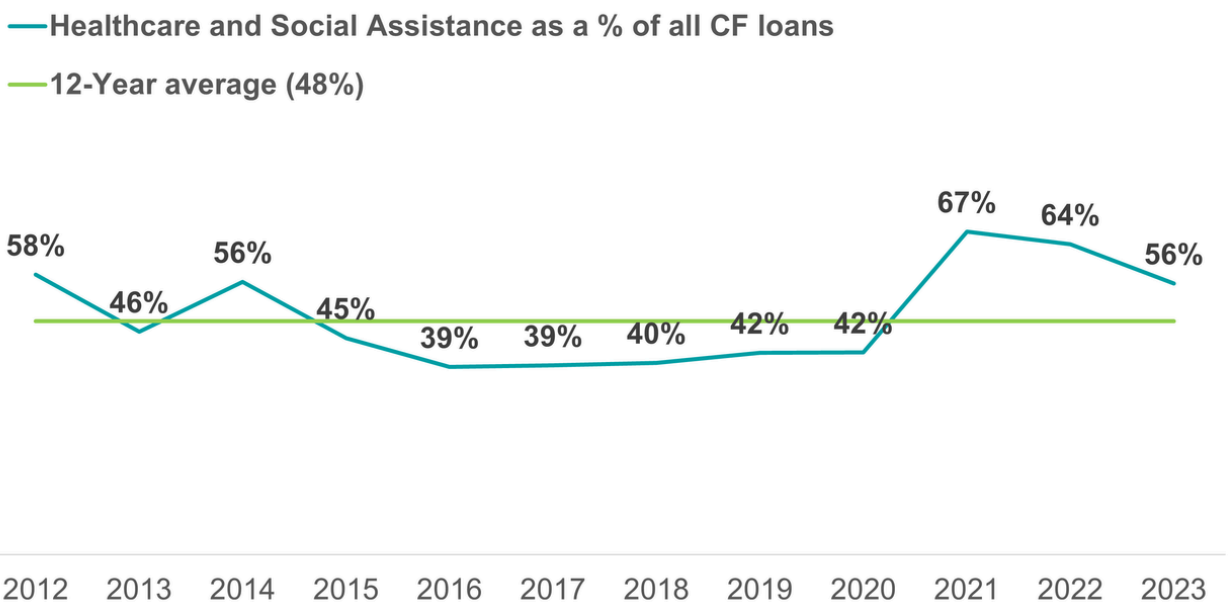


Figure 5

Healthcare as a Percentage of Total Community Facilities (CF) Direct and Guaranteed Loans by Year FY 2012 - FY 2023



This trend suggests that specialized expertise and repeated engagement are becoming critical to successfully financing rural healthcare projects. These top lenders have developed strategic partnerships with USDA, helping scale lending capacity and address project complexity.

The development of lender expertise in supporting large scale investments is further supported by the data reflecting the average loan size for lenders outside the top five increased by 21%, from $5.6 million in 2012. In contrast, the top five lenders began with an average loan of $5 million in 2012, but grew to an average of $31.3 million in 2023—a sixfold increase over the same period.

Healthcare projects also attracted a larger share of USDA Guaranteed Loan capital than any other sector. In 2023, 22% of all healthcare-sector awards were guaranteed loans, while other industries received just 2%. Over the past 12 years, healthcare projects have accounted for an average of 58% of all guaranteed loans, with that share growing to 68% in 2022 and 93% in 2023.

HUD 242 Mortgage Insurance

Although originally developed to support urban hospital infrastructure, the HUD 242 Mortgage Insurance Program has also played a meaningful role in rural healthcare financing. Notably, it supported the first CAH replacement project in Del Norte, Colorado—a town of just 1,900 residents. As of the latest analysis, rural projects account for $1.5 billion, or 19%, of HUD's $7.8 billion total loan portfolio.

Rural mortgage sizes under the program vary, with an average loan of $46.2 million and a median of $29.4 million, reflecting a blend of moderate and large-scale infrastructure investments. On average, HUD 242 supports three to four hospital loans annually, with one to two loans made to rural hospitals each year. In some years, such as 2018, as many as six rural loans were approved, while in others, only one or two rural projects received financing. Urban hospitals consistently account for about two loans per year.

While rural hospitals represent a meaningful share—approximately one-third to one-half of annual loan volume—the overall number of loans issued each year remains limited. These figures underscore HUD 242's role as a highly selective but impactful tool for financing essential hospital infrastructure improvements in both rural and urban communities.

USDA Business Programs

In addition to supporting not-for-profit and public healthcare operations through the USDA CF program, USDA allocated an additional $1.1 billion to healthcare-sector projects via a separate program that functions similarly to CF loans but extends eligibility to private physician clinics and other for-profit rural health businesses. These guaranteed loans, made under the Business and Industry (B&I) Loan Program, have a distinct profile compared to CF loans. First, B&I loans are substantially smaller on average, typically ranging between $1 million and $2 million per project. Moreover, the targeted use of the program is evident in the most frequent borrower classification: the "All Other" subsector of Healthcare and Social Assistance. This reflects investment in services and entities outside the traditional scope of hospitals and clinics commonly supported by the CF program (21).

New Markets Tax Credits

Despite representing nearly 20% of the U.S. population, rural communities received only 15–20% of NMTC project allocations

between 2003 and 2022. Rural NMTC investments were not only less frequent, but also smaller in size, with average allocations ranging $1.5 million to $3 million lower than comparable urban projects. These disparities reflect persistent structural barriers, including smaller project scale, higher transaction costs, and limited access to the capital networks that typically drive NMTC financing (22).

This pattern of underrepresentation suggests that rural projects, even when fully eligible, face systemic disadvantages within competitive federal financing frameworks. The challenge is particularly pronounced for healthcare-related projects, which make up a very small share of rural NMTC activity. Across all rural counties designated as "fully" or "partially" eligible by the Federal Office of Rural Health Policy (FORHP), only 34 NMTC-financed healthcare projects were identified over a 20-year period. These projects occurred sporadically and typically represented less than 5% of rural NMTC investment activity in any given year.

Of the 34 identified projects, 25 (74%) were hospital-related, receiving approximately $427.6 million, or 83% of all rural healthcare NMTC funding. Primary care facilities, including FQHCs and RHCs, accounted for eight projects (24%), receiving $69.4 million (13.5%) in allocations. One additional project was unclassified. While annual rural healthcare allocations occasionally exceeded $17 million, the overall volume and frequency of funded projects remain low, especially relative to the level of unmet capital need in rural healthcare infrastructure.

Conclusion

The data presented in this analysis paint a detailed picture of the capital access landscape facing rural healthcare providers. While numerous financing tools exist—from federal loans and guarantees to state appropriations, foundation grants, and tax-exempt bonds—the pathway to securing and aligning these resources remains highly complex. Capital flows are unevenly distributed, often dependent on institutional capacity, technical assistance, and lender experience.

Notably, large-scale capital projects increasingly rely on blended financing strategies, with a growing concentration of expertise among a small group of lenders and intermediaries. Programs like USDA Community Facilities and HUD 242 have demonstrated significant impact but are limited in scope and

accessibility. Meanwhile, underutilized tools like the New Markets Tax Credit reveal structural barriers that persist even in designated eligible communities.

Trends show a growing reliance on partnerships, regional affiliations, and pre-development support to navigate this fragmented environment. The importance of early-stage technical assistance, consistent lender relationships, and internal readiness emerges repeatedly as a key determinant of success.

While rural healthcare capital needs are diverse and context-specific, the shared challenge remains consistent: converting available funding into accessible, deployable capital. This data offers a foundation for further coordination, collaboration, and targeted action by those seeking to strengthen the infrastructure that underpins rural health systems.

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for this Information Services to Rural Hospital Flexibility Project. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government.

Resources

1. Smith, K. (2023). A (Brief) History of Health Policy in the United States. Delaware Journal of Public Health, 9(5), 6–10.
2. Kodjak, A. (2016, October 2). A bygone era when bipartisanship led to health care transformation. NPR. https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation
3. Scarborough C. The legacy of Hill-Burton. Healthcare Ala. 1994 Jul-Aug;7(4):8-10, 27. PMID: 10137386.
4. McLaughlin N. Tough act to follow. Hill-Burton reshaped healthcare and showed what government can accomplish. Mod Healthcare. 2005 Aug 15;35(33):32. PMID: 16124732.
5. Henry J. Kaiser Family Foundation. (2023, June 15). A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies. https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/
6. Hawryluk, M. (2024, January 12). Rural hospitals face aging infrastructure amid financial issues. Modern Healthcare. Retrieved April 7, 2025.
7. Rural Health Information Hub. (2025, March 19). Capital funding for rural healthcare. https://www.ruralhealthinfo.org/topics/capital-funding.
8. U.S. Department of Agriculture. (n.d.). Community Facilities Direct Loan & Grant Program. USDA Rural Development. https://www.ruralhealthinfo.org/topics/capital-funding.
9. U.S. Department of Agriculture, Rural Development. (2023). Rural investments data [Database]. https://www.rd.usda.gov/rural-data-gateway/rural-investments/data
10. American Hospital Association. (2010, December). A guide to financing strategies for hospitals with special consideration for smaller hospitals.
11. Office of the Comptroller of the Currency. (2022, First Issue). Overview of community development financial institutions. Consumer Compliance Outlook.
12. United States Government Publishing Office. (n.d.). Part 242 [Regulation]. Electronic Code of Federal Regulations. https://www.ecfr.gov/current/title-24/subtitle-B/chapter-II/subchapter-B/part-242
13. O'Hanlon, C. E., Damberg, C., DeYoreo, M., Mahmud, A., & Timbie, J. (2019). Access, quality, and financial performance of rural hospitals following health system affiliation. Health Affairs, 38(12), 2095-2104.
14. Mauermann, C. Thornburg Investment Management. (2024, February 1). Under the microscope: Understanding hospital bonds and their growth. Thornburg.
15. Levitt, A. MunicipalBonds.com. (2023, September 19). Hospital-backed municipal bonds: Hidden opportunity. Municipal Bonds 101.
16. CDFI Fund. (2024). NMTC Public Data Release Summary FY 2003-FY 2022 [PDF]. U.S. Department of the Treasury. https://www.cdfifund.gov/sites/cdfi/files/2024-06/2024_NMTC_Public_Data_Release_Summary_FY-2003-FY_2022_approved_final.pdf

Resources

17. U.S. Department of the Treasury, Community Development Financial Institutions Fund. (2023). Annual Report to Congress [ACR-2023].
18. Leider, J. P., Meit, M., McCullough, J. M., Resnick, B., Alfonso, Y. N., & Bishai, D. (2020). The state of rural public health: Enduring needs in a new decade. American Journal of Public Health.
19. ShiftMed Team. (2024, October 30). Rural healthcare financial crisis: Strategic solutions for health system leaders. ShiftMed.
20. Rupasingha, A., & Cho, J. (2025, January 22). Federal assistance and rural hospital closings: The impact of the USDA community facilities program (ERR-344). U.S. Department of Agriculture, Economic Research Service. https://www.ers.usda.gov/publications/pub-details?pubid=110765
21. South Dakota Association of Healthcare Organizations. (2024, June 13). Understanding USDA funding options for rural healthcare facilities.
22.U.S. Department of the Treasury Community Development Financial Institutions Fund. (2024, June 24). New Markets Tax Credit (NMTC) Public Data Release FY 2003 to FY 2022 Summary Report. https://www.cdfifund.gov/sites/cdfi/files/2024-06/2024_NMTC_Public_Data_Release_Summary_FY-2003-FY_2022_approved_final.pdf