Access to capital for rural hospitals

Authors: Britton Herbert, Lauren LaPine-Ray, Mat Slaybaugh

Introduction

The United States continues to face challenges in health care access across the country. This is most notable in rural areas where residents access care via small or rural hospitals. Nearly 432 rural hospitals in the United States are at risk of closure, with 50 percent of rural hospitals operating with negative margins.[i] Rural hospitals provide critical services to people living in areas with lower median household incomes, higher rates of chronic disease, and more prevalent transportation shortages.[ii]

While rural hospitals are key to community health and vitality, they also are at a unique disadvantage compared to larger health systems and governmental agencies in their ability to access capital for critical infrastructure improvements and investments. Rural hospitals are anchor institutions in communities and as such need access to flexible funding to maintain service lines and to ensure access to critical health services. Rural hospitals need access to capital for a variety of reasons including:

- Hospital infrastructure is expensive to maintain and medical innovation advances at a rapid pace requiring plant updates.
- As rural demographics change, there is a need for construction/renovation to ensure hospitals are meeting the needs of patients, such as cancer care, infusion, and radiology.
- The cost of materials and labor for hospital construction continues to increase, putting already stretched rural hospitals at a disadvantage to begin new construction.
- Rural hospitals have limited administrative staff and rarely have funds to support a grant writer, hindering their ability to apply for state and federal grants. While United States Department of Agriculture (USDA) Rural Development grants are available, many rural hospitals lack the internal capacity to submit competitive applications.
- Rural health facilities often have insufficient funding, infrastructure, resources, and personnel to successfully achieve the level of cybersecurity needed to protect patient information.

To address these problems and maintain financial viability, rural hospitals need access to capital. Because rural hospitals across the United States are experiencing similar challenges, a federal solution via an act of Congress is necessary. The last time the federal government provided this type of lifeline for rural hospitals was in 1946 when Congress passed the Hill-Burton Act, which gave hospitals, nursing homes, and other health facilities grants and loans for hospital construction and modernization.[iii] In exchange for federal funds, hospitals agreed to provide a reasonable volume of services to people unable to pay for services, and the hospital was required to make their services available to surrounding communities. As health care facilities were concentrated in urban areas, nearly 40 percent of counties at that time did not have a hospital. With a two-to-one match of federal dollars to non-federal funds, this program provided a cash infusion for state planning and new facility construction to increase the number of hospital beds available in underserved areas. Within 30 years of being signed, nearly one-third of hospitals across the country had been constructed in part using Hill-Burton funds, and by the end of the century more than 4,000 communities had benefited from new health care entities.

Core principles of the Hill-Burton Act have been carried out through subsequent legislation. A federal/state match requirement stretches the reach of federal funding and can be seen in many programs today, such as the State Office of Rural Health grant and the structure of Medicaid funding. The requirements for nonprofit facilities to demonstrate community benefit through community health needs assessments still exist today. Designing a similar opportunity for rural hospitals to again access to capital for critical infrastructure improvements will strengthen rural communities, maintain critical access to health care services, and foster healthy and vibrant communities across the country. Further details on how Congress could craft new legislation to support these efforts are outlined in this policy paper.

Analysis

Rural hospitals struggle with aging facilities, but data capturing the age of rural hospitals at a national level does not exist. Many rural hospitals were constructed with funding through the Hill-Burton Act, with rural counties having seen an increase of 1.5 beds per 1,000 residents during that period.[iv,v] Those hospital buildings are now 50 to 77 years old. Currently the most widely used measure for hospital facilities is "average age of plant." However, this is not a direct measure of physical age but a financial ratio that factors in ongoing facility investments and depreciation. In 2021, approximately one-third of rural hospitals had an average age of plant of 15 years or greater.[vi,vii] Data on the median average age of plant demonstrates a steady upward trend. These trends are both a result of financial strain and a continued driver of financial strain.

Aging plants increase the financial burden of rural hospitals. It's been estimated that waiting to replace equipment or facilities until failure can end up costing the expense of the replacement squared.[viii] As an example, a $500 replacement item could end up costing $250,000 if delayed to the point of failure.[ix] Research from the National Rural Health Resource Center identified the average age of plant as a good indicator of distress.[x] The research showed that newer facilities have a positive effect on financial performance.

Age of plant not only impacts hospital finances. It should also be considered when assessing a hospital's ability to provide quality care. A study comparing average age of plant to key quality indicators found that hospitals with the newest facilities had a total performance score 2.35 points higher than hospitals with the oldest facilities.[iii] The study concluded that there is an inverse relationship between age of plant and quality.[xi,xii] Further, the struggles hospitals experience investing in their physical plants are the same they face with technology updates and cybersecurity. This puts them at increased risk for cyberattacks as well as further behind the ball on care quality.

Multiple factors contribute to hospitals' inability to make necessary updates to their facilities. First is financial strain. With negative operating margins, it is difficult for hospitals to access capital through traditional funding mechanisms. The other major contributor is rising construction costs. In the 2024 hospital construction survey, Health Facilities Management reports that more than half of health care professionals surveyed had experienced cost increases of 76 to 100 percent since 2021.[xiii,xiv] The total cost to build a hospital in 2025 is estimated between $87 million to $203 million[xv]. This escalation in price makes accessing capital funding almost unattainable for many rural hospitals.

Capital funding sources

Maintaining aging rural facilities and building replacement facilities requires access to a significant degree of capital. Rural hospitals can procure new capital through multiple avenues, all with associated pros and cons. The following is a brief analysis of a few of the most common types of capital used for health care projects.

Loans: The most common source of capital funding comes in the form of loans with the primary source being the USDA Community Facility programs.[xvi] These funds have a significant upfront investment in time to complete the paperwork to secure a loan but are low maintenance once approved. The initial burden is great enough to turn some small organizations away from applying. Community development financial institutions are another source of loans more appropriate for small health care entities.

Grants: State and federal bodies can offer grants and cooperative agreements for funding. These sources frequently disallow use on the purchase or improvement of real property or set forth a hard cap on purchase price. For example, the Small, Rural Hospital Improvement Program COVID-19 funds were provided during the pandemic toward infection prevention and control activities.[xii]

Congressionally directed: Funding can be made available through federal and/or state appropriations frequently referred to as "earmarks." These typically aid multiple facilities on a one-time basis specific to a particular state or congressional district. Funding targets a specific need identified by the legislature and funding is provided to address that need.

Tax levies: One-third of rural hospitals are government owned.[xvii] This provides an opportunity to coordinate tax levies to support capital improvement projects. While levies can be useful in covering the entirety of needed capital, they are not a guaranteed method of funding. This approach requires significant community buy-in and a tax base within the community able to provide this financial support.

Philanthropy: Health care organizations can benefit from gifts from individual donors or foundations, especially the 58 percent of rural hospitals that are nonprofit. [xviii] These donations can be directed toward specific purposes or tailored to the organization's needs. Gaining the attention of individual donors can be difficult, and the presence of a foundation investing in a specific area is not a guarantee. The amount provided tends to be smaller than necessary for large-scale capital projects and is more in line with equipment purchases or programmatic seed money.

Policy recommendations

NRHA's current policy priorities – investing in a strong safety net and building rural health opportunities – emphasize the importance of access to capital for rural providers. With half of rural hospitals operating with negative margins, it is only through accessible capital that facilities can be maintained and improved.[v,vi,xii] Without this access to capital, health care facilities will close, resulting in medical deserts and removing timely access to care.

- **Enhance USDA Rural Development Community Facilities direct loans.** These loans are a staple for hospital infrastructure projects. The program could be more supportive of rural health care facilities in two ways:

- Allow 100 percent coverage of projects through use of funds rather than the current 75 percent rate.
- Set the interest rate at 0 percent rather than the fluid rate currently set by USDA.

- **Create an infrastructure project technical assistance center.** The capital required for a project is spread across more areas than solely materials and work hours, including project design, engineering reviews, and project management expenses.

- **Support REH conversion infrastructure changes.** Hospitals converting to the Rural Emergency Hospital model are often Hill Burton Act facilities designed and opened in a different health care landscape. These aged facilities are frequently not designed with an outpatient/emergency department focus but rather inpatient. When a facility converts to an REH, it should receive a one-time infrastructure payment to support facility redesign and update existing core systems.

Recommended actions

Enhance USDA Rural Development Community Facilities direct loans

- *Amend loan coverage policy*: Advocate for legislative or regulatory changes to allow 100 percent project cost coverage under the Community Facilities Direct Loan Program, eliminating the current 75 percent cap. Rural hospitals often lack access to matching funds or alternative financing sources, making full coverage essential for project viability.
- *Set fixed 0 percent interest rate for health care projects:* Propose a policy change to establish a 0 percent interest rate for rural health care infrastructure loans. This would reduce long-term financial burdens on rural hospitals and align with federal goals of improving rural health equity.

Create an infrastructure project technical assistance center

- *Establish a federally funded technical assistance center:* Recommend the creation of a dedicated center within USDA or the US Department of Health and Human Services (HHS) to provide technical assistance for rural health infrastructure projects. Services could include:
  - Project design and engineering consultation
  - Environmental and regulatory compliance support
  - Grant and loan application assistance
  - Project management training
- *Secure dedicated funding:* Advocate for a discrete funding stream (through the HHS Health Resources and Services Administration (HRSA) or USDA, for example) to support the center's operations and ensure accessibility for small and under-resourced facilities.

Support REH conversion infrastructure changes

- *One-time infrastructure payment for REH conversions: Propose* a federal grant program to provide one-time payments to facilities converting to the REH model. Eligible uses include:
  - Redesign of inpatient-focused layouts to outpatient/emergency-centric models
  - Upgrades to HVAC, electrical, and IT systems
  - Renovation of emergency departments and outpatient service areas
  - Incorporate into existing REH support programs

- *Integrate infrastructure support* into existing REH transition assistance programs administered by CMS or HRSA.

Conclusion

Rural hospitals are dealing with aging facilities, but the full extent and impact of this is difficult to understand due to limited data. Research has shown a positive correlation between age of plant and financial stress, as well as a negative correlation between age of plant and quality of care[iii,x]. These factors highlight the importance of making key infrastructure updates. Unfortunately, access to capital for plant improvements is limited, with facilities in greatest need facing the most barriers. Policy changes are needed to create resources to help rural hospitals curb this trend.

References

[i] A closer look at U.S. health care infrastructure. www.hfmmagazine.com. https://www.hfmmagazine.com/articles/3239-a-closer-look-at-infrastructure

[ii] Albert Henry, T. (2024, June 6). AMA outlines 5 keys to fixing America's rural health crisis. American Medical Association. https://www.ama-assn.org/delivering-care/population-care/ama-outlines-5-keys-fixing-america-s-rural-health-crisis

[iii] Beauvais B., Richter J.P., Kim F.S., Palmer E.L., Spear B.L., & Turner R.C. (2021). A reason to renovate: The association between hospital age of plant and value-based purchasing performance. Health Care Management Review, 46(1), 66–74. https://doi.org/10.1097/HMR.0000000000000227

[iv] Center for Healthcare Quality and Payment Reform. (2024). Hospitals at risk for closure, state-by-state. Pennsylvania Office of Rural Health. https://www.porh.psu.edu/hospitals-at-risk-for-closure-state-by-state/

[v] Health Resources and Services Administration. (n.d.). Hill-Burton free and reduced-cost health care. U.S. Department of Health and Human Services. https://www.hrsa.gov/get-health-care/affordable/hill-burton

[vi] KFF. (2023). Hospital beds per 1,000 population by ownership type. KFF State Health Facts. https://www.kff.org/other/state-indicator/beds-by-ownership/

[vii] Kelly, S. (2022, September 12). Rural hospitals face 'precarious' outlook as expenses climb, AHA says. Healthcare Dive. https://www.healthcaredive.com/news/rural-hospitals-american-hospital-association-closures/631582/

[viii] Levinson, Z., Hulver, S., Godwin, J., & Neuman, T. (2025, February 19). Key facts about hospitals. KFF. https://www.kff.org/key-facts-about-hospitals/

[ix] Optum. Almanac of Hospital Financial and Operating Indicators, 2005–2017; CHIPS, The Almanac of Hospital and Financial Operating Indicators, 1994 and 1996–97.

[x] Rural Health Information Hub. (n.d.). Capital funding for rural healthcare overview. https://www.ruralhealthinfo.org/topics/capital-funding

[xi] ibid

[xii] Social Security Administration. (n.d.). The Hospital Survey and Construction Act. Social Security Bulletin. https://www.ssa.gov/OP_Home/ssact/title18/1864.htm

[xiii] 2024 Hospital Construction Survey results | Health Facilities Management. www.hfmmagazine.com. https://www.hfmmagazine.com/articles/4944-2024-hospital-construction-survey-results

[xiv] Fact Sheet: Federal Investment Needed to Keep Hospitals' Physical Infrastructure Ready to Meet Health Care Needs | AHA. www.aha.org. https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-federal-investment-needed-keep-hospitals-physical-infrastructure

[xv] ibid

[xvi] Social Security Administration. (n.d.). The Hospital Survey and Construction Act. Social Security Bulletin. https://www.ssa.gov/OP_Home/ssact/title18/1864.htm

[xvii] KFF. (2023). Hospital beds per 1,000 population by ownership type. KFF State Health Facts. https://www.kff.org/other/state-indicator/beds-by-ownership/

[xviii] ibid