

Banks and Nonprofit Hospitals: Partners in Community Development?

How Banks and Nonprofit Hospitals Can Collaborate on Community Building and Health Outcome Improvement: Exploring the Nexus between the Community Reinvestment Act (CRA) and the Affordable Care Act (ACA)

by Steven Kuehl

Introduction

Though often located in the same neighborhoods, banks and nonprofit hospitals typically conduct their community involvement activities independent of one another. Banks support their communities through the prudent allocation of credit and financial services to help grow the local economy. Nonprofit hospitals provide services that promote individual and community health. The Federal Reserve Bank of Chicago has been convening conversations between the public health and banking professionals for more than five years. This article furthers that conversation by providing background on the regulatory environments of banks and nonprofit hospitals regarding their mandated community involvement, with the goal of highlighting potential synergies. By pooling financing, expertise, experience, data, and other resources, banks and nonprofit hospitals can meet their respective regulatory mandates while capturing efficiencies to better manage costs, mitigate risks, and potentially increase impact on local communities.

The Affordable Care Act (ACA), passed in 2010, ushered in sweeping changes to the American health care system by increasing the share of the U.S. population with health insurance. This article focuses on the ACA's impact on nonprofit hospitals. Traditionally, nonprofit hospitals have maintained their nonprofit status by providing 'charity care,'

that is, providing care to uninsured patients. With the reduction in the number of uninsured patients, nonprofit hospitals must conduct (among other things, explained in greater detail later in this article) a Community Health Needs Assessment (CHNA) every three years in order to maintain their nonprofit status.

In 1977, Congress passed the Community Reinvestment Act (CRA) to encourage depository institutions (banks) to meet the credit needs of the communities in which they operate, including low- and moderate-income (LMI) neighborhoods, consistent with safe and sound banking operations.¹ Banks are subject to laws such as the CRA, in return for the privilege of deposit insurance protection and access to the Federal Reserve's discount window.²

To assess compliance with the CRA, banks are evaluated by CRA examiners on a regular schedule. The results of these examinations are public. Although the underlying legislation has not changed, updated interpretive guidance is provided to ensure the Act responds to emerging issues and contextual changes. The most recent updated guidance, released in 2016, and commonly referred to as the "Q&As," included, for the first time, an explicit reference to health and health-care-related activities.

Although drafted separately, at different times, motivated by different conditions, and addressed to distinctly different institutions, the CHNA requirement under the ACA and the assessment framework applied by the CRA bear remarkable similarities that, if leveraged appropriately, hold the potential to underpin strategic, mutually beneficial partnerships that are both compliant with applicable regulations and create local economic impact. These could range from operating lines of credit that bridge the period between provision of care and reimbursement by federal and state transfer programs, to financing facility renovations and improvements that create jobs and expand services – an especially critical need in economically struggling rural areas.

With that in mind, this article provides:

1. Baseline information about the Community Reinvestment Act for health care professionals, including the 2016 CRA Q&A additions.
2. Baseline information about the ACA Community Health Needs Assessment for financial institution professionals.
3. Examples drawn from CRA performance evaluations where banks have engaged in CRA activities with a health component.
4. Suggestions for best practices around bank/nonprofit hospital collaboration.

Overview of the Community Reinvestment Act

In 2016, updated guidance in the form of the “Interagency Questions and Answers Regarding Community Reinvestment” (Q&As) were released by the federal banking regulators.³ The Q&As clarified that the definition of “community development” can include activities that, among other things, promote community- or tribal-based child care, educational, health, social services, or workforce development or job training programs targeted to low- or moderate-income persons, affordable housing for low- or moderate-income individuals, and activities that revitalize or stabilize low- or moderate-income areas, designated disaster areas, or underserved or distressed nonmetropolitan middle-income geographies.⁴

This update built on almost 40 years of examination practice and reflects ongoing efforts to adapt this important legislation to changes within the financial services industry. What follows is a high-level summary of how the CRA impacts banks. The intent is to help those unfamiliar with the CRA understand some of its nuances across institutions of different asset sizes. CRA officers at local banking institutions can provide additional insights. Exploratory conversations are encouraged early in any project planning process.

Some basics that apply to all CRA-regulated banks

1. A bank must define an assessment area

To comply with the CRA, a bank must define its geographic assessment area, which is essentially where it conducts the majority of its business activities. In general, an assessment area refers to the political subdivisions where the bank has its main office, its branches, and its deposit-taking automatic teller machines (ATMs), as well as the surrounding geographies in which the bank has originated or purchased a substantial portion of its loans.⁵ Further, an assessment area may not arbitrarily exclude low- or moderate-income areas nor reflect illegal discrimination, among other provisions. A bank may have more than one assessment area.⁶

2. CRA ratings

Examiners assign one of the following ratings of performance: Outstanding, Satisfactory, Needs to Improve, or Substantial Noncompliance. Evidence of discriminatory or illegal credit practices will have a negative effect on examiners’ evaluation of a bank’s performance and could lower its overall rating.

3. Penalties for noncompliance

A bank’s regulator evaluates the bank’s CRA record through periodic examinations or via a mandatory review whenever a bank applies to merge, acquire, or gain new powers. If a bank does not achieve at least a “Satisfactory” rating, the bank’s regulator could delay or deny its request to merge with another lender, open new branches, or expand its services, as a rating below this threshold indicates the bank is not effectively responding to community needs.⁷

4. CRA public disclosure

A bank's CRA performance evaluation is available to the public. The evaluation provides an opportunity to learn how an institution is addressing its community's needs.

Banks of different asset size are evaluated differently

Banks are evaluated under different CRA examination procedures based upon their asset-size classification.⁸ The asset-size threshold adjustments effective January 1, 2019, are as follows:

- Small bank – a bank that, as of December 31 in either of the prior two calendar years, had assets of less than \$1.284 billion.
- Intermediate small bank – a bank with assets of at least \$321 million as of December 31 in both of the prior two calendar years and less than \$1.284 billion as of December 31 in either of the prior two calendar years.
- Large bank – a bank with assets of at least \$1.284 billion as of December 31 in both of the prior two calendar years.

Small bank CRA performance

For a small bank, in addition to reviewing responses to any written CRA complaints, examiners will conduct a lending test that reviews:

- Average net loan (and leases) to total deposit ratio⁹
- Assessment area concentration¹⁰
- Borrower distribution (by income/revenue)¹¹
- Geographic distribution¹²

Intermediate small bank CRA performance

An intermediate small bank (ISB) will be reviewed on the same five performance criteria as a small bank. An ISB must also pass a community development test, which measures its responsiveness to community development needs (see sidebar) through the combination of loans, investments, and services, which are measured in number and amount, as applicable. The ISB must achieve at least a "satisfactory" rating on both the lending and community development tests to be rated "satisfactory" or better overall.

What is community development under the CRA?

Community development activities under the CRA include:¹³

- Supporting affordable housing targeted to LMI individuals/families (including multifamily rental housing).
- Targeting community services or retail banking services to LMI individuals/families (e.g., providing financial literacy services to LMI people; serving on the board of a community development corporation; offering individual development accounts [IDAs]; and free or low-cost banking products and services).
- Promoting economic development (e.g., financing businesses or farms that have gross annual revenues of \$1 million or less or that meet the size eligibility requirements of the Small Business Administration's [SBA] Small Business Development Center [SBDC] or Small Business Investment Company [SBIC] programs) and create, retain, or improve permanent jobs for LMI individuals or in LMI communities.¹⁴

Revitalizing or stabilizing:

- Low- or moderate-income census tracts (e.g., a loan for an anchor business in an LMI area [or nearby areas] that employs or serves area residents; a loan for a pharmacy that employs and serves area residents).
- Designated disaster areas (e.g., providing financing to help retain businesses that employ local residents, including LMI residents; provision of financing or other assistance for essential communitywide infrastructure, community services, and rebuilding needs).
- Distressed or underserved nonmetropolitan middle income census tracts (e.g., provision of financing or other assistance for a new or expanded hospital that serves the entire county, including LMI residents; an industrial park for businesses that employ LMI individuals; a renovated elementary school that serves children from the community, including children from LMI families).

Large bank CRA performance

A large bank is evaluated using three separate CRA tests:¹⁵

- Lending test – includes an analysis of the number and amount; geographic distribution; and borrower characteristics of the bank's home mortgage, small farm, and consumer loans (if applicable). The use of innovative and flexible lending practices in a safe and sound manner to address the credit needs of LMI individuals or geographies is a qualitative consideration when assessing the success and effectiveness of a large bank's lending. In addition, the bank's community development loans are evaluated based upon both the number and dollar amount as well as their complexity and innovativeness.¹⁶
- Investment test – evaluates a bank's record of helping to meet the credit needs of its assessment area(s) through qualified investments that benefit its assessment area(s) or a broader statewide or regional area that includes the bank's assessment area(s). Performance criteria includes the dollar amount and the innovativeness or complexity of qualified investments. It also includes the bank's responsiveness to community needs, and the degree to which the qualified investments are not routinely provided. Examples of qualified investments include grants, deposits, or shares in, or to, financial intermediaries (e.g., community development financial institutions [CDFIs], New Markets Tax Credit community development entities [NMTC CDEs], community development corporations [CDCs], minority- and/or woman-owned financial institutions, and community loan funds) that primarily lend in LMI areas or to LMI individuals in order to promote community development.
- Service test – analyzes both the availability and effectiveness of a bank's systems for delivering retail banking services and the extent and innovativeness of its community development services. Included in the evaluation of retail banking services are: the geographic distribution of bank branches; the institution's record regarding branch openings and closings; the availability and effectiveness of alternative systems for delivering retail banking services; and the range of services provided in LMI geographies and the degree to which services are tailored to meet the needs of those

areas. Included in the evaluation of community development services are the extent to which the bank provides community development services and the innovativeness and responsiveness of the community development services.

Overview of Affordable Care Act requirements for nonprofit hospitals

The Patient Protection and Affordable Care Act (ACA) added new requirements for nonprofit hospitals.¹⁷ The intent of this section is to provide non-health care professionals, specifically bankers, with a foundational understanding of the ACA and its complementarity to the CRA. Of relevance to this article, nonprofit hospitals conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. A CHNA provides comprehensive information about the community's current health status, needs, and issues, which can inform a community health improvement plan to show how and where resources should be allocated to best meet community needs.¹⁸

Conducting a CHNA

To conduct a CHNA, a nonprofit hospital must complete the following steps:¹⁹

- Define the community it serves.
- Assess the health needs of that community.
- Solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
- Create a written CHNA report that is adopted by an authorized body of the hospital facility.
- Make the CHNA report available to the public.

Community served

A nonprofit hospital may take into account all the relevant facts and circumstances in defining the community it serves. This includes:

- The geographic area served;
- Target populations served; and
- Principal functions, including a focus on a particular specialty area.

However, the institution may not define its community in a way that excludes medically underserved, low-income, or minority populations who reside in the geographic areas from which it draws its patients.²⁰ Additionally, in determining its patient populations for purposes of defining its community, a nonprofit

hospital must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the nonprofit hospital's financial assistance policy.

If a nonprofit hospital consists of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the nonprofit hospital is the aggregate of these areas or populations.

Penalties for non-compliance with these requirements include a \$50,000 excise tax and the possibility of temporary taxation of income and revocation of tax-exempt status.²¹

The evolution of community building

Hospitals have a long history of providing 'charity care' to patients. Recognition of such activities by the Internal Revenue Service (IRS) has evolved over time. The summarized descriptions that follow, including the evolution of 'community benefit,' provide useful context for new mandates under the ACA.

Tax-exempt status in exchange for charity care

Section 501(c)(3) of the Internal Revenue Code confers tax-exempt status on corporations organized and operated for charitable purposes.²² Hospitals were not originally considered tax-exempt because the promotion of health was not considered by the IRS to be a charitable purpose. This began to change in the 1950s, with the IRS requiring a hospital to demonstrate that it served patients who were either unable to pay or that care was rendered (to them) at below-cost rates.^{23, 24}

From charity care to community benefit

In 1969, the charity care requirement was replaced by a more flexible "community benefit" standard to determine if a hospital qualified for federal tax-exempt status. The new standard provided hospitals with a large degree of latitude regarding what constituted charitable activities.²⁵

Beginning in 2009, the IRS mandated the public reporting of community benefit activities, as well as the demonstration of an identified need.^{26, 27} The rationale was that by identifying prevailing community issues, dominant health concerns, and addressing health care equity and access, nonprofit hospitals can create targeted programs to satisfy community benefit obligations while reducing cost and improving outcomes.²⁸ Programs or activities that are designed to address a demonstrated community need targeted to low-income, minority, or underserved populations will satisfy the IRS criteria for community benefit.²⁹ Nonprofit hospitals must not only quantify the cost of such services, but also the impact on population health.³⁰

From community benefit to community building

Community building includes activities that nonprofit hospitals engage in to protect or improve the overall health or safety of a community, some of which may also meet the definition of community benefit.³¹ To illustrate this distinction, community benefit is intended to improve the health of individuals and populations; activities associated with community *building* strengthen the community's ability to support the health and welfare of its residents. Community building activities focus on the social determinants of health such as the quality of schools, affordability and stability of housing, access to good jobs with fair pay, and the safety of neighborhoods³²—upstream factors that impact health outcomes.³³ Through community building activities, nonprofit hospitals can target the root causes of poor population health.³⁴

Examples where banks received CRA credit for promoting health services activities

A review of CRA public evaluations revealed an array of ‘health services activities.’³⁵ These examples include banks of various asset sizes and markets. What follows are excerpts from individual bank CRA public evaluations that briefly describe the CRA-

qualifying activity (a loan, an investment, a service, or a combination thereof, etc.). As shown, activities vary widely from providing home buyer seminars in conjunction with a local health care provider to granting a loan for the purchase of nursing facilities. Clicking on the bank’s name will link to its CRA public evaluation, where the actual examples cited in the table can be found. This list is not meant to be exhaustive, but merely to highlight a diversity of situations where banks have received CRA credit in their communities for health-related activities.

Bank and CRA public disclosure	Health services activity
1st State Bank Saginaw, Michigan	The bank began steps to improve performance including hiring a new lender to focus on LMI borrower relationships and working with a local healthcare company to offer new home buyer seminars to low-income borrowers.
Bank of Springfield Springfield, Illinois	The bank originated a \$1 million operating line of credit to a not-for-profit agency that operates food pantries, provides crisis assistance, and operates a health clinic for the needy. This loan assists in providing community services to LMI individuals in the assessment area.
Busey Bank Champaign, Illinois	Busey purchased two loans totaling \$7,500,000 that were for the purchase of six skilled nursing facilities in central and northern Illinois. Three of the skilled nursing facilities are located within the bank’s Peoria assessment area; however, the other three are located outside of the bank’s assessment area, but within the state of Illinois. More than 50 percent of the revenues at each facility are derived from Medicaid payments. Thus, these facilities provide important medical and health-related services to a high percentage of LMI individuals from within the state of Illinois.
MainSource Bank Greensburg, Indiana	A loan of approximately \$1,119,000 financed a building that provides mental health services and childcare for LMI persons.
Prairie State Bank and Trust Springfield, Illinois	In 2013, a loan for \$1.3 million, and in 2014, a loan for \$2.0 million were originated to help develop a community of affordable housing for seniors. The seniors are able to purchase accessible modular homes at below the average and median sale price for homes in the area and are provided easy access to certain health and recreational activities as well.
The PrivateBank and Trust Company Chicago, Illinois	<p>A majority of the bank’s community development loans (all of the community services loans) support organizations that provide skilled nursing facilities where a majority of the patients receive Medicaid. The loans assist the organization in funding its operations, bridging the lag-time between payments of receivables, and providing health services to primarily LMI individuals.</p> <p>Seventy-two loans totaling \$361 million were used to support organizations that provide community services targeted to LMI individuals. In most cases, these are renewals of lines of credit to skilled nursing facilities where a majority of the patients receive Medicaid. The loans assist the organization in funding its operations, bridging the lag-time when Medicaid payments are received, and providing health services to primarily LMI individuals.</p> <p>A \$45 million loan used to support an organization that provides skilled nursing facilities where a majority of the patients receive Medicaid. The loans assist the organization in funding its operations, bridging the lag-time between providing health services and when Medicaid payments are received.</p>
Republic Bank & Trust Louisville, Kentucky	<p>Republic Bank & Trust assisted in economic development by funding renovations to a community hospital in a moderate-income census tract, which created employment opportunities for local residents.</p> <p>In 2014, the bank fulfilled a community need by providing a \$40 million line of credit to the University Health Center (UHC). UHC is a licensed health maintenance organization that administers a pre-paid health care program for the benefit of Medicaid enrollees in Kentucky’s Region 3, which includes Jefferson County and the surrounding 15 counties.</p>
Traditional Bank, Inc. Mount Sterling, Kentucky	In 2016, Traditional Bank made three loans totaling \$1.7 million to build a new health facility within a distressed middle-income census tract. The health facility will help stabilize this area and offer health services to LMI individuals.
Waukesha State Bank Waukesha, Wisconsin	Twenty-nine employees served on either the board or a committee of a local nonprofit agency that assists the LMI population of the assessment area with community services, health care, education, and training. These nonprofit organizations include but are not limited to free and reduced-cost health clinics, food pantries, and other immediate needs organizations, and organizations that specialize in particular issues faced by the immigrant population.

Conclusion: Implications for practice

The CRA incentivizes banks to promote community development in their defined assessment area. Using a flexible approach adapted to the size and resources of a bank, regulators look at a bank's efforts to lend, make investments, and to provide services throughout their entire community, including LMI geographies and people. Likewise, through the tax code and various other laws, nonprofit hospitals are incentivized to provide community benefits throughout their defined community. As a result of these similar mandates, banks and nonprofit hospitals often work in the same neighborhoods with the same populations. This is because the programs or services that are eligible to receive CRA credit for banks may also qualify to be reported by nonprofit hospitals for community benefit and/or community building activities.

Banks and nonprofit hospitals looking to collaborate in the same community could start by jointly reviewing the bank's most recent CRA public disclosure and the nonprofit hospital's most recent CHNA. This exercise would compare and contrast the identified needs in the community and the strategies developed to address those needs. For example, a close look at the community benefit and community building activities of a nonprofit hospital could identify areas for mutually beneficial partnerships, particularly if the bank can offer loans, investments, and/or services to further those activities. Conversely, the nonprofit hospital may discover that the bank is engaged in activities that address community health needs that surfaced during its CHNA. Intentional alignment and collaboration, including (joint) public listening sessions, can augment the impact of these activities, elevate their visibility, and contribute to their sustainability.

Other resources in the community, such as government entities, philanthropies, or other anchor institutions (e.g., community colleges), can expand the scope of the collaboration and ensure that the work is done in an inclusive manner. Such broader coalitions can bring more robust resources and data tracking, as well as increased diversity of thought, experience, and expertise. This coordinated approach provides the best opportunity to promote economic growth, address upstream social determinants of health, and provide a strong foundation for community health and economic wellbeing.

Regardless of the activity, banks and nonprofit hospitals are encouraged to engage early in the planning stages of new initiatives in order to maximize synergies and avoid duplications.

Additional resources

Since 2013, the Federal Reserve Bank of Chicago and other Reserve Banks have been engaged in issues and opportunities surrounding the social determinants of health. Below is a list of resources, originating from throughout the Federal Reserve System, that readers may find helpful to expand their knowledge in this area:

- [Motivating Collaborations: The Convergence of Public Health and Community Development](#)
- [Investing in Healthy Communities: Ideas to Action for Healthy People, Places, and Planet – A Conference Summary](#)
- [Investing in Healthy Rural Communities – Lessons Learned and Future Directions](#)
- [Healthy Communities – Milwaukee](#)
- [The Converging Visions of Public Health and Community Development](#)
- [Exploring the Correlations between Health and Community Socioeconomic Status in Chicago](#)
- [A New Tool for Measuring the Convergence of Community Development and Public Health](#)
- [Healthy Communities: The Intersection of Community Development and Health](#)
- [Investing in What Works for America's Communities](#)
- [What Counts: Harnessing Data for America's Communities](#)
- [What It's Worth: Strengthening the Financial Future of Families, Communities and the Nation](#)
- [What Matters: Investing in Results to Build Strong, Vibrant Communities](#)

Notes

1. The Community Reinvestment Act (CRA), enacted by Congress in 1977 (12 U.S.C. 2901) and implemented by Regulations 12 CFR parts 25, 228, 345, and 195 is intended to encourage depository institutions to help meet the credit needs of the communities in which they operate, available at <https://www.ffiec.gov/cra/>.
2. Stackhouse, J., 2018, "The Community Reinvestment Act's History and Future," *On the Economy*, Federal Reserve Bank of St. Louis, blog, January 25, available at <https://www.stlouisfed.org/on-the-economy/2018/january/community-reinvestment-act-history-future>.
3. The "Interagency Questions and Answers Regarding Community Reinvestment" (Questions and Answers) were released by the staffs of the Board of Governors of the Federal Reserve System, Federal Deposit Insurance Corporation, and Office of the Comptroller of the Currency on July 15, 2016, to provide guidance to financial institutions and the public. Available at <https://www.ffiec.gov/cra/qnadoc.htm>.
4. *Id.* at XI-12.2
5. Benton, K., and D. Harris, 2014, "Understanding the Community Reinvestment Act's Assessment Area Requirements," *Consumer Compliance Outlook*, Federal Reserve Bank of Philadelphia, First Quarter, available at <https://consumercomplianceoutlook.org/2014/first-quarter/understanding-cras-assessment-area-requirements>.
6. *Ibid.*
7. 12 CFR § 225.84 – What are the consequences of failing to maintain a satisfactory or better rating under the Community Reinvestment Act at all insured depository institution subsidiaries? Available at <https://www.law.cornell.edu/cfr/text/12/225.84>.
8. Board of Governors of the Federal Reserve System, 2018, "Agencies release annual CRA asset-size threshold adjustments for small and intermediate small institutions," joint press release, December 20, available at <https://www.federalreserve.gov/newsevents/pressreleases/bcreg20181220a.htm>. Note that there are also wholesale and limited-purpose institutions, which are assessed solely on their community development activities; however, delving into these types of specialized institutions is beyond the scope of this article.
9. Given the bank's size and financial condition; credit needs of the assessment area; other lending-related activities; considering seasonal variations. For further reference, see "A Banker's Quick Reference Guide to CRA," Federal Reserve Bank of Dallas (as amended effective September 1, 2005), available at <https://www.dallasfed.org/-/media/documents/cd/pubs/quickref.pdf>.
10. Percentage of loans and other lending-related activities in the assessment area. For further reference, see "A Banker's Quick Reference Guide to CRA," Federal Reserve Bank of Dallas (as amended effective September 1, 2005), available at <https://www.dallasfed.org/-/media/documents/cd/pubs/quickref.pdf>.
11. Use data about borrower income (individuals) or revenues (businesses) to determine the distribution of loans by borrower income and by business revenues. Further, examiners will identify categories of borrowers by income or business revenues that have little or no loan penetration. For further reference, see "A Banker's Quick Reference Guide to CRA," Federal Reserve Bank of Dallas (as amended effective September 1, 2005), available at <https://www.dallasfed.org/-/media/documents/cd/pubs/quickref.pdf>.
12. Determine distribution of loans among low-, moderate-, middle-, and upper-income geographies. Identify group of geographies, by income categories, where there is little or no loan penetration. For further reference, see "A Banker's Quick Reference Guide to CRA," Federal Reserve Bank of Dallas (as amended effective September 1, 2005), available at <https://www.dallasfed.org/-/media/documents/cd/pubs/quickref.pdf>.
13. Community development activities promote economic development by financing businesses or farms that have gross annual revenues of \$1 million or less, or that meet the size eligibility requirements of the Small Business Administration's (SBA) Small Business Development Center (SBDC), or Small Business Investment Company (SBIC) programs. Office of the Comptroller of the Currency, 2019, "CRA: Community Development Loans, Investments, and Services," *Community Developments Fact Sheet*, January, available at <https://www.occ.gov/topics/community-affairs/publications/fact-sheets/pub-fact-sheet-cra-loans-investments.pdf>.
14. *Id.* at 1.
15. 12 CFR Part 228 – Community Reinvestment (Regulation BB), available at <https://www.fdic.gov/regulations/laws/rules/2000-6500.html>. Office of the Comptroller of the Currency (January 2019), Community Developments Fact Sheet. "CRA: Community Development Loans, Investments, and Services," available at <https://www.occ.gov/topics/community-affairs/publications/fact-sheets/pub-fact-sheet-cra-loans-investments.pdf>. Note that the activities listed are not exhaustive and were selected merely to highlight possible areas of mutual interest where banks and nonprofit hospitals could work together in collaborate efforts.
16. Zirkle White, R., 2014, "Transitioning from an Intermediate Small Bank to a Large Bank Under the Community Reinvestment Act," *Consumer Compliance Outlook*, Federal Reserve Bank of Philadelphia, Fourth Quarter, available at <https://consumercomplianceoutlook.org/2014/fourth-quarter/transitioning-from-intermediate-small-bank-to-large-bank-under-cra>.
17. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), available at <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>.
18. Community Health Assessments & Health Improvement Plans, Centers for Disease Control and Prevention, U.S. Department of Health & Human Services, November 9, 2015, available at <https://www.cdc.gov/stitpublichealth/cha/plan.html>.
19. Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)(3), IRS, available at <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>.
20. Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a nonprofit hospital's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.
21. Consequence of Non-compliance with Section 501(r), IRS, available at <https://www.irs.gov/charities-non-profits/consequence-of-non-compliance-with-section-501r>.
22. 26 CFR 1.501(c)(3)-1 – Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.
23. IRS Rev. Rul. 56-185, 1956-1 C.B. 202, available at <https://www.irs.gov/pub/irs-tege/rr56-185.pdf>.
24. *Id.* at 2.
25. Rosenbaum, S., 2016, "Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement," *Economic Studies at Brookings*, No. 5, pp. 1-9, March, available at <https://www.brookings.edu/wp-content/uploads/2016/07/Rosenbaum-PDF-Layout-FINAL.pdf>.
26. Chen, A., 2016, "The Provision of Charity Care by Nonprofit Hospitals," *Scholarly Commons – Joseph Wharton Scholars*, available at http://repository.upenn.edu/joseph_wharton_scholars/22.

27. 2018 Instructions for Schedule H (Form 990), IRS, available at <https://www.irs.gov/pub/irs-pdf/f990sh.pdf>.
28. Missouri Hospital Association, 2016, "Engaging Your Community: A Guide for Nonprofit Hospitals," available at https://web.mhanet.com/SQL/Engaging%20Your%20Community_A%20guide%20for%20nonprofit%20hospitals.pdf.
29. Id. at 4.
30. Ibid.
31. 2018 Instructions for Schedule H (Form 990) at 4.
32. Robert Wood Johnson Foundation, 2011, "How Does Where We Live, Work, Learn, and Play Affect Our Health?," *Health Policy Snapshot: Public Health and Prevention*, Issue Brief, September, available at <https://www.rwjf.org/en/library/research/2011/09/how-does-where-we-live--work--learn-and-play-affect-our-health-.html>. Also Winkleby, M.A., and C. Cubbin, 2003, "Influence of individual and neighbourhood socioeconomic status on mortality among black, Mexican-American, and white women and men in the United States," *Journal of Epidemiology & Community Health*, 57(6):444-52, June. Also Waitzman, N.J., and K. R. Smith, 1998, "Phantom of the area: Poverty-area residence and mortality in the United States," *American Journal of Public Health*, 88(6): 973-976, June.
33. Hospital Community Benefits after the ACA: <https://www.rwjf.org/en/library/research/2012/10/the-hilltop-institute-launches-hospital-community-benefit-progra/hospital-community-benefits-after-the-aca0.html>.
34. Missouri Hospital Association at 8.
35. Most of the examples cited in the table above appeared in public evaluations where the review period of the CRA examination occurred prior to the July 15, 2016, release date of the "Questions and Answers," which provided further clarification that the definition of community development can include activities that promote health. Therefore, in these instances, the provision of CRA credit relied on some factor(s) other than strictly the bank's involvement with activities that promote health. However, these examples are included to illustrate the many ways in which banks have already become involved with health services activities that benefit low- or moderate-income populations in their assessment area(s). As more CRA public evaluations become available, they will necessarily include a longer review period that follows the July 15, 2016, release date, and thus CRA credit could be provided for activities that promoted health during the post July 15, 2016, review period.

Biography

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