

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

Notice 2013-30, page 1099.

This notice provides a 3-month extension of time to file and pay tax under sections 6081 and 6161 of the Code for those individuals affected by the Boston Marathon explosions.

Notice 2013-31, page 1099.

This notice provides adjustments to the limitation on housing expenses for purposes of section 911 of the Code for specific locations for 2013. These adjustments are made on the basis of geographic differences in housing costs relative to housing costs in the United States. Notices 2006-87, 2007-25, 2007-77, 2008-107, 2010-27, 2011-8, and 2012-19 superseded.

Rev. Proc. 2013-25, page 1110.

This revenue procedure provides the 2014 inflation adjusted amounts for Health Savings Accounts (HSAs) under section 223 of the Code.

EXEMPT ORGANIZATIONS

REG-106499-12, page 1111.

These proposed regulations provide guidance to charitable hospital organizations on the community health needs assessment requirements, and related excise tax and reporting obligations, enacted as part of the Patient Protection and Affordable Care Act of 2010. These proposed regulations also clarify the consequences for failing to meet these and other requirements for charitable hospital organizations. Notice 2011-52 is obsolete after October 5, 2013.

Announcement 2013-31, page 1135.

The IRS has revoked its determination that 21st Century Animal Resource & Education Services of Dolan Springs, AZ, Books for People of Yuma, AZ, California Nairobi International Childrens Organization of Fresno, CA, Cape Verdean Club of Falmouth Inc. of Teaticket, MA, Congressional District Programs, Inc. of Falls Church, VA, Dr. R.C. Samanta Roy Institute of Science and Technology, Inc. of Green Bay, WI, Eko Club, Inc. of Houston, TX, Everything Must Change, Inc. of Philadelphia, PA, Excalibur Foundation of Sparks, NV, Functional Social Solutions, Inc. of Long Beach, CA, Gateway Educational Services of Honolulu, HI, Good Housing, Inc. of Merrick, NY, Holland Peck Charitable Foundation of Carefree, AZ, Kona University, Inc. of Honolulu, HI, Lakeland-Winter Haven Kennel Club, Inc. of Lakeland, FL, Life Changes Ministries International Inc. of Fort Mill, SC, Marley Fund of Greenville, NC, and Needham Community Theatre, Inc. of Needham, MA, qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Code.

ADMINISTRATIVE

Announcement 2013-30, page 1134.

This announcement provides that for payments due in 2013, a 2012-2013 fiscal year partnership should pay withholding tax under section 1446 on effectively connected taxable income allocable to foreign individual partners at the rates in effect in 2012.

Finding Lists begin on page ii.



The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and en-

force the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered,

and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part III. Administrative, Procedural, and Miscellaneous

Filing and Payment Extension for Those Affected by the Boston Marathon Explosions

Notice 2013-30

This notice provides a 3-month extension of time to file and pay tax under sections 6081 and 6161 of the Code (Code) for those individuals affected by the Boston Marathon explosions.

BACKGROUND

Generally, the Code requires individuals to file their individual income tax returns and pay tax on or before April 15th (or the next succeeding day that is not a Saturday, Sunday, or legal holiday). Secs. 6072(a), 6151(a) and 7503. Section 6651 of the Code imposes an addition to tax when a taxpayer does not file a return or pay the tax shown on the return by the extended due date for filing a return or payment of tax.

Section 6081(a) of the Code authorizes the Secretary to grant an extension of time to file any return. Such extension may not exceed 6 months. Section 6161(a) of the Code authorizes the Secretary to extend the time to pay tax. Such extension generally may not exceed 6 months. Interest, however, will apply on any amounts paid after the date that the tax was due without regard to the extension. Sec. 6601(b).

On April 15, 2013, two explosive devices were detonated in Boston, Massachusetts near the finish line of the Boston Marathon (the Boston Marathon explosions). The resulting explosions injured hundreds of individuals, some fatally, who were participating in, or watching, the Boston Marathon or who were in the general vicinity of the race's finish line. Several streets and offices in the Boston area remained closed after the explosions for law enforcement to investigate the explosions and pursue suspects, disrupting business activity in the area and potentially the ability of some taxpayers and return preparers to access their files.

RELIEF FOR THOSE AFFECTED BY THE BOSTON MARATHON EXPLOSIONS

The Internal Revenue Service (Service) is granting an extension of time to file 2012 tax returns and pay any tax due on those returns until July 15, 2013, to those affected by the Boston Marathon explosions. The Service will not impose an addition to tax for late filing or payment on these individuals provided they file their tax returns and pay any tax due by July 15, 2013, regardless of whether the individual requested an extension of time to file on or before April 15, 2013. By law, however, interest will apply to any payments made after the April due date for payment.

This relief applies to all individuals who live in Suffolk County, Massachusetts, including the city of Boston, victims of the explosions, their families, first responders, others impacted by the tragedy who live outside of Suffolk County, and taxpayers whose tax return preparers were adversely affected. The Service will automatically provide this relief to any individual living in Suffolk County. Eligible taxpayers living outside Suffolk County can claim this relief by calling 1-866-562-5227 starting Tuesday, April 23, and identifying themselves to the Service before filing a return or making a payment. Eligible taxpayers who receive notices requesting the payment of additions to tax for late filing or payment from the Service can call this number to have these additions to tax abated. Taxpayers affected by the events surrounding the Boston Marathon explosion with a filing or payment requirement other than an individual income tax requirement (Form 1040 series requirement) from April 15, 2013 to April 19, 2013, inclusive, also may receive relief. These taxpayers should call 1-866-562-5227 if they receive a notice requesting the payment of additions to tax for late filing or payment to have these additions abated.

Individual taxpayers eligible for this relief who need more time to file their returns may receive an additional extension of time to file their returns to October 15, 2013, by filing Form 4868, *Application for Automatic Extension of Time to File U.S. Individual Income Tax Return*, by July 15, 2013. This additional extension of time to

file will not further extend the time for payment of tax. Forms, instructions, and other tax assistance are available on IRS.gov. The IRS toll-free number for general tax questions is 1-800-829-1040.

CONTACT INFORMATION

The principal author of this notice is Mary E. Keys of the Office of Associate Chief Counsel (Procedure & Administration). For further information regarding this notice, contact Ms. Keys at (202) 622-4570 (not a toll-free call).

Determination of Housing Cost Amount Eligible for Exclusion or Deduction for 2013

Notice 2013-31

SECTION 1. PURPOSE

This notice provides adjustments to the limitation on housing expenses for purposes of section 911 of the Internal Revenue Code (Code) for specific locations for 2013. These adjustments are made on the basis of geographic differences in housing costs relative to housing costs in the United States.

SECTION 2. BACKGROUND

Section 911(a) of the Code allows a qualified individual to elect to exclude from gross income the foreign earned income and housing cost amount of such individual. Section 911(c)(1) defines the term "housing cost amount" as an amount equal to the excess of (A) the housing expenses of an individual for the taxable year to the extent such expenses do not exceed the amount determined under section 911(c)(2), over (B) 16 percent of the exclusion amount (computed on a daily basis) in effect under section 911(b)(2)(D) for the calendar year in which such taxable year begins (\$267.40 per day for 2013, or \$97,600 for the full year), multiplied by the number of days of that taxable year within the applicable period described in section 911(d)(1). The applicable period is the period during which the individual meets the tax home requirement of section

911(d)(1) and either the bona fide residence requirement of section 911(d)(1)(A) or the physical presence requirement of section 911(d)(1)(B). Assuming that the entire taxable year of a qualified individual is within the applicable period, the section 911(c)(1)(B) amount for 2013 is \$15,616 ($\$97,600 \times .16$).

Section 911(c)(2)(A) of the Code limits the housing expenses taken into account in section 911(c)(1)(A) to an amount equal to (i) 30 percent (adjusted as may be provided under the Secretary's authority under section 911(c)(2)(B)) of the amount (computed on a daily basis) in effect under section 911(b)(2)(D) for the calendar year in which the taxable year of the individual begins, multiplied by (ii) the number of days of that taxable year within the

applicable period described in section 911(d)(1). Thus, under this general limitation, a qualified individual whose entire taxable year is within the applicable period is limited to maximum housing expenses of \$29,280 ($\$97,600 \times .30$) in 2013.

Section 911(c)(2)(B) of the Code authorizes the Secretary to issue regulations or other guidance to adjust the percentage under section 911(c)(2)(A)(i) based on geographic differences in housing costs relative to housing costs in the United States. Pursuant to this authority, the Internal Revenue Service (IRS) and the Treasury Department published Notice 2006-87, 2006-2 C.B. 766, and Notice 2007-25, 2007-1 C.B. 760, for 2006; Notice 2007-77, 2007-2 C.B. 735, for 2007; Notice 2008-107, 2008-2 C.B. 1266, for

2008 and 2009; Notice 2010-27, 2010-15 I.R.B. 531, for 2009 and 2010; Notice 2011-8, 2011-8 I.R.B. 503, for 2010 and 2011; and Notice 2012-19, 2012-10 I.R.B. 440, for 2012 and 2013 to provide adjustments to the limitation on housing expenses for qualified individuals incurring housing expenses in countries with high housing costs relative to housing costs in the United States.

SECTION 3. TABLE OF ADJUSTED LIMITATIONS FOR 2013

The following table provides adjusted limitations on housing expenses (in lieu of the otherwise applicable limitation of \$29,280) for 2013.

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Angola	Luanda	230.14	84,000
Argentina	Buenos Aires	154.79	56,500
Australia	Adelaide	96.44	35,200
Australia	Brisbane	95.34	34,800
Australia	Canberra	83.84	30,600
Australia	Darwin, Northern Country	83.84	30,600
Australia	Gold Coast	95.34	34,800
Australia	Melbourne	122.19	44,600
Australia	Oakey	95.34	34,800
Australia	Perth	130.68	47,700
Australia	Sydney	89.81	32,782
Australia	Toowoomba	95.34	34,800
Austria	Vienna	96.99	35,400
Bahamas, The	Grand Bahama Island	84.66	30,900
Bahamas, The	Nassau	136.16	49,700
Bahrain	Bahrain	120.55	44,000
Barbados	Barbados	103.29	37,700
Belgium	Antwerp	96.16	35,100
Belgium	Brussels	128.77	47,000
Belgium	Gosselies	115.34	42,100
Belgium	Hoogbuul	96.16	35,100
Belgium	Mons	115.34	42,100
Belgium	SHAPE/Chievres	115.34	42,100
Bermuda	Bermuda	246.58	90,000

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Bosnia-Herzegovina	Sarajevo	82.19	30,000
Brazil	Brasilia	126.03	46,000
Brazil	Rio de Janeiro	96.16	35,100
Brazil	Sao Paulo	155.07	56,600
Canada	Calgary	129.86	47,400
Canada	Dartmouth	107.95	39,400
Canada	Edmonton	103.29	37,700
Canada	Halifax	107.95	39,400
Canada	London, Ontario	88.22	32,200
Canada	Montreal	166.03	60,600
Canada	Ottawa	148.49	54,200
Canada	Quebec	126.03	46,000
Canada	Toronto	153.97	56,200
Canada	Vancouver	136.71	49,900
Canada	Victoria	97.53	35,600
Canada	Winnipeg	93.15	34,000
Cayman Islands	Grand Cayman	131.51	48,000
Chile	Santiago	153.70	56,100
China	Beijing	195.07	71,200
China	Hong Kong	313.15	114,300
China	Shanghai	156.17	57,001
Colombia	Bogota	160.82	58,700
Colombia	All cities other than Bogota	135.34	49,400
Costa Rica	San Jose	87.67	32,000
Denmark	Copenhagen	119.74	43,704
Dominican Republic	Santo Domingo	124.66	45,500
Ecuador	Guayaquil	84.38	30,800
Ecuador	Quito	89.32	32,600
Estonia	Tallinn	127.67	46,600
France	Garches	226.03	82,500
France	Le Havre	91.23	33,300
France	Lyon	127.12	46,400
France	Marseille	121.92	44,500
France	Montpellier	102.47	37,400
France	Paris	226.03	82,500
France	Sevres	226.03	82,500
France	Suresnes	226.03	82,500
France	Versailles	226.03	82,500

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Germany	Babenhhausen	110.96	40,500
Germany	Bad Aibling	94.52	34,500
Germany	Bad Nauheim	88.77	32,400
Germany	Baumholder	107.40	39,200
Germany	Berlin	135.34	49,400
Germany	Birkenfeld	107.40	39,200
Germany	Boeblingen	134.52	49,100
Germany	Bonn	115.07	42,000
Germany	Butzbach	86.58	31,600
Germany	Cologne	153.97	56,200
Germany	Darmstadt	110.96	40,500
Germany	Frankfurt am Main	115.62	42,200
Germany	Friedberg	88.77	32,400
Germany	Garmisch-Partenkirchen	102.47	37,400
Germany	Gelnhausen	139.73	51,000
Germany	Germersheim	83.84	30,600
Germany	Giebelstadt	95.89	35,000
Germany	Giessen	98.63	36,000
Germany	Grafenwoehr	110.41	40,300
Germany	Hanau	139.73	51,000
Germany	Hannover	82.74	30,200
Germany	Heidelberg	103.56	37,800
Germany	Idar-Oberstein	107.40	39,200
Germany	Ingolstadt	156.16	57,000
Germany	Kaiserslautern, Landkreis	133.70	48,800
Germany	Kitzingen	95.89	35,000
Germany	Leimen	103.56	37,800
Germany	Ludwigsburg	134.52	49,100
Germany	Mainz	149.86	54,700
Germany	Mannheim	103.56	37,800
Germany	Munich	156.16	57,000
Germany	Nellingen	134.52	49,100
Germany	Neubruecke	107.40	39,200
Germany	Ober Ramstadt	110.96	40,500
Germany	Oberammergau	102.47	37,400
Germany	Pirmasens	133.70	48,800
Germany	Rheinau	103.56	37,800
Germany	Schwetzingen	103.56	37,800

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Germany	Seckenheim	103.56	37,800
Germany	Sembach	133.70	48,800
Germany	Stuttgart	134.52	49,100
Germany	Vilseck	110.41	40,300
Germany	Wahn	115.07	42,000
Germany	Wertheim	95.89	35,000
Germany	Wiesbaden	149.86	54,700
Germany	Wuerzburg	95.89	35,000
Germany	Zweibruecken	133.70	48,800
Germany	All cities other than Augsburg, Babenhausen, Bad Aibling, Bad Kreuznach, Bad Nauheim, Baumholder, Berchtesgaden, Berlin, Birkenfeld, Boeblingen, Bonn, Bremen, Bremerhaven, Butzbach, Cologne, Darmstadt, Delmenhorst, Duesseldorf, Erlangen, Flensburg, Frankfurt am Main, Friedberg, Fuerth, Garlstedt, Garmisch-Partenkirchen, Geilenkirchen, Gelnhausen, Germersheim, Giebelstadt, Giessen, Grafenwoehr, Grefrath, Greven, Gruenstadt, Hamburg, Hanau, Handorf, Hannover, Heidelberg, Heilbronn, Herongen, Idar-Oberstein, Ingolstadt, Kaiserslautern, Landkreis, Kalkar, Karlsruhe, Kerpen, Kitzingen, Koblenz, Leimen, Leipzig, Ludwigsburg, Mainz, Mannheim, Mayen, Moenchen-Gladbach, Muenster, Munich, Nellingen, Neubruecke, Noervenich, Nuernberg, Ober Ramstadt, Oberamergau, Osterholz-Scharmbeck, Pirmasens, Rheinau, Rheinberg, Schwabach, Schwetzingen, Seckenheim, Sembach, Stuttgart, Twisteden, Vilseck, Wahn, Wertheim, Wiesbaden, Worms, Wuerzburg, Zirndorf and Zweibruecken	108.77	39,700
Ghana	Accra	98.63	36,000
Greece	Argyroupolis	86.30	31,500
Greece	Athens	110.68	40,400
Greece	Elefsis	110.68	40,400
Greece	Ellinikon	110.68	40,400
Greece	Mt. Hortiatis	86.30	31,500
Greece	Mt. Parnis	110.68	40,400
Greece	Mt. Pateras	110.68	40,400
Greece	Nea Makri	110.68	40,400
Greece	Perivolaki	86.30	31,500
Greece	Piraeus	110.68	40,400

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Greece	Tanagra	110.68	40,400
Greece	Thessaloniki	86.30	31,500
Guatemala	Guatemala City	113.70	41,500
Guyana	Georgetown	95.89	35,000
Holy See, The	Holy See, The	150.41	54,900
Hungary	Budapest	89.04	32,500
Hungary	Papá	121.92	44,500
India	Mumbai	186.08	67,920
India	New Delhi	82.88	30,252
Indonesia	Jakarta	103.50	37,776
Ireland	Dublin	130.96	47,800
Ireland	Shannon Area	103.56	37,800
Israel	Tel Aviv	139.18	50,800
Italy	Catania	88.22	32,200
Italy	Genoa	114.52	41,800
Italy	Gioia Tauro	85.48	31,200
Italy	La Spezia	110.68	40,400
Italy	Leghorn	94.25	34,400
Italy	Milan	224.93	82,100
Italy	Naples	143.01	52,200
Italy	Parma	114.25	41,700
Italy	Pisa	94.25	34,400
Italy	Pordenone-Aviano	114.25	41,700
Italy	Rome	150.41	54,900
Italy	Sigonella	88.22	32,200
Italy	Turin	112.60	41,100
Italy	Vicenza	115.34	42,100
Italy	All cities other than Avellino, Brindisi, Catania, Florence, Gaeta, Genoa, Gioia Tauro, La Spezia, Leghorn, Milan, Mount Vergine, Naples, Nettuno, Parma, Pisa, Pordenone-Aviano, Rome, Sardinia, Sigonella, Turin, Verona, and Vicenza.	92.05	33,600
Jamaica	Kingston	112.88	41,200
Japan	Akashi	107.12	39,100
Japan	Akizuki	94.25	34,400
Japan	Atsugi	139.73	51,000
Japan	Camp Zama	139.73	51,000
Japan	Chiba-Ken	150.96	55,100
Japan	Fussa	139.73	51,000

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Japan	Gifu	203.56	74,300
Japan	Gotemba	102.19	37,300
Japan	Haneda	139.73	51,000
Japan	Iwakuni	107.95	39,400
Japan	Kanagawa-Ken	139.73	51,000
Japan	Komaki	203.56	74,300
Japan	Machidi-Shi	139.73	51,000
Japan	Misawa	116.16	42,400
Japan	Nagoya	203.56	74,300
Japan	Okinawa Prefecture	188.22	68,700
Japan	Osaka-Kobe	248.39	90,664
Japan	Sagamihara	139.73	51,000
Japan	Saitama-Ken	139.73	51,000
Japan	Sasebo	115.89	42,300
Japan	Tachikawa	139.73	51,000
Japan	Tokyo	320.82	117,100
Japan	Tokyo-to	139.73	51,000
Japan	Yokohama	175.89	64,200
Japan	Yokosuka	163.01	59,500
Japan	Yokota	139.73	51,000
Kazakhstan	Almaty	131.51	48,000
Korea	Ammo Depot #9	81.10	29,600
Korea	Camp Carroll	88.77	32,400
Korea	Camp Colbern	153.42	56,000
Korea	Camp Market	153.42	56,000
Korea	Camp Mercer	153.42	56,000
Korea	Chinhae	82.19	30,000
Korea	K-16	153.42	56,000
Korea	Kimhae	83.84	30,600
Korea	Kimpo Airfield	153.42	56,000
Korea	Munsan	94.25	34,400
Korea	Osan AB	96.71	35,300
Korea	Pusan	83.84	30,600
Korea	Pyongtaek	96.16	35,100
Korea	Seoul	153.42	56,000
Korea	Suwon	153.42	56,000
Korea	Taegu	92.05	33,600
Korea	Tongduchon	87.40	31,900

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Korea	Uijongbu	90.96	33,200
Korea	Waegwan	88.77	32,400
Korea	All cities other than Ammo Depot #9, Camp Carroll, Camp Colbern, Camp Market, Camp Mercer, Changwon, Chinhae, Chunchon, K-16, Kimhae, Kimpo Airfield, Kunsun, Kwangju, Munsan, Osan AB, Pusan, Pyongtaek, Seoul, Suwon, Taegu, Tongduchon, Uijongbu, and Waegwan	88.77	32,400
Kuwait	Kuwait City	176.44	64,400
Kuwait	All cities other than Kuwait City	158.08	57,700
Luxembourg	Luxembourg	123.56	45,100
Macedonia	Skopje	96.99	35,400
Malaysia	Kuala Lumpur	126.58	46,200
Malaysia	All cities other than Kuala Lumpur	92.33	33,700
Mexico	Malta	138.36	50,500
Mexico	Mazatlan	84.93	31,000
Mexico	Merida	103.84	37,900
Mexico	Mexico City	131.23	47,900
Mexico	Monterrey	90.96	33,200
Mexico	All cities other than Ciudad Juarez, Cuernavaca, Guadalajara, Hermosillo, Matamoros, Mazatlan, Merida, Metapa, Mexico City, Monterrey, Nogales, Nuevo Laredo, Reynosa, Tapachula, Tijuana, Tuxtla Gutierrez, and Veracruz	107.95	39,400
Mozambique	Maputo	108.22	39,500
Namibia	Windhoek	87.95	32,100
Netherlands	Amsterdam	144.93	52,900
Netherlands	Aruba	98.63	36,000
Netherlands	Brunssum	106.30	38,800
Netherlands	Eygelshoven	106.30	38,800
Netherlands	Hague, The	179.45	65,500
Netherlands	Heerlen	106.30	38,800
Netherlands	Hoensbroek	106.30	38,800
Netherlands	Hulsberg	106.30	38,800
Netherlands	Kerkrade	106.30	38,800
Netherlands	Landgraaf	106.30	38,800
Netherlands	Maastricht	106.30	38,800
Netherlands	Papendrecht	108.22	39,500
Netherlands	Rotterdam	108.22	39,500
Netherlands	Schaesburg	106.30	38,800

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Netherlands	Schinnen	106.30	38,800
Netherlands	Schiphol	144.93	52,900
Netherlands	Ypenburg	179.45	65,500
Netherlands	All cities other than Amsterdam, Aruba, Brunssum, Coevorden, Eygelshoven, The Hague, Heerlen, Hoensbroek, Hulsberg, Kerkrade, Landgraaf, Maastricht, Margraten, Papendrecht, Rotterdam, Schaesburg, Schinnen, Schiphol, and Ypenburg.	108.22	39,500
Netherlands Antilles	Curacao	125.48	45,800
New Zealand	Auckland	97.81	35,700
New Zealand	Christchurch	87.95	32,100
New Zealand	Wellington	92.60	33,800
Nicaragua	Managua	87.12	31,800
Nigeria	Abuja	98.63	36,000
Norway	Oslo	147.40	53,800
Norway	Stavanger	125.21	45,700
Norway	All cities other than Oslo and Stavanger.	103.29	37,700
Panama	Panama City	97.26	35,500
Peru	Lima	107.12	39,100
Philippines	Cavite	106.85	39,000
Philippines	Manila	106.85	39,000
Poland	Poland	80.55	29,400
Portugal	Alverca	137.81	50,300
Portugal	Lisbon	137.81	50,300
Qatar	Doha	99.35	36,264
Qatar	All cities other than Doha	88.77	32,400
Russia	Moscow	295.89	108,000
Russia	Saint Petersburg	164.38	60,000
Russia	Sakhalin Island	212.33	77,500
Russia	Vladivostok	212.33	77,500
Russia	Yekaterinburg	129.86	47,400
Rwanda	Kigali	86.30	31,500
Saudi Arabia	Jeddah	84.02	30,667
Saudi Arabia	Riyadh	109.59	40,000
Singapore	Singapore	246.03	89,800
South Africa	Pretoria	107.67	39,300
Spain	Barcelona	111.23	40,600
Spain	Madrid	183.56	67,000

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
Spain	Rota	112.05	40,900
Spain	Valencia	105.48	38,500
Suriname	Paramaribo	90.41	33,000
Switzerland	Bern	193.70	70,700
Switzerland	Geneva	269.32	98,300
Switzerland	Zurich	107.45	39,219
Switzerland	All cities other than Bern, Geneva and Zurich	90.14	32,900
Taiwan	Taipei	126.54	46,188
Tanzania	Dar Es Salaam	120.55	44,000
Thailand	Bangkok	161.64	59,000
Trinidad and Tobago	Port of Spain	149.32	54,500
Turkey	Izmir-Cigli	86.58	31,600
Turkey	Yamanlar	86.58	31,600
Ukraine	Kiev	197.26	72,000
United Arab Emirates	Abu Dhabi	136.13	49,687
United Arab Emirates	Dubai	156.64	57,174
United Kingdom	Basingstoke	112.60	41,099
United Kingdom	Bath	112.33	41,000
United Kingdom	Bracknell	170.14	62,100
United Kingdom	Bristol	106.03	38,700
United Kingdom	Brookwood	120.55	44,000
United Kingdom	Cambridge	117.81	43,000
United Kingdom	Caversham	202.19	73,800
United Kingdom	Cheltenham	146.03	53,300
United Kingdom	Croughton	122.74	44,800
United Kingdom	Fairford	122.74	44,800
United Kingdom	Farnborough	149.86	54,700
United Kingdom	Felixstowe	115.62	42,200
United Kingdom	Gibraltar	122.24	44,616
United Kingdom	Harrogate	129.04	47,100
United Kingdom	High Wycombe	170.14	62,100
United Kingdom	Kemble	122.74	44,800
United Kingdom	Lakenheath	152.05	55,500
United Kingdom	Liverpool	106.30	38,800
United Kingdom	London	241.64	88,200
United Kingdom	Loudwater	173.97	63,500
United Kingdom	Menwith Hill	129.04	47,100
United Kingdom	Mildenhall	152.05	55,500

Country	Location	Limitation on Housing Expenses (daily)	Limitation on Housing Expenses (full year)
United Kingdom	Oxfordshire	119.45	43,600
United Kingdom	Plymouth	119.45	43,600
United Kingdom	Portsmouth	119.45	43,600
United Kingdom	Reading	170.14	62,100
United Kingdom	Rochester	124.66	45,500
United Kingdom	Samlesbury	120.55	44,000
United Kingdom	Southampton	121.10	44,200
United Kingdom	Surrey	132.61	48,402
United Kingdom	Waterbeach	124.11	45,300
United Kingdom	Wiltshire	113.97	41,600
United Kingdom	All cities other than Basingstoke, Bath, Belfast, Birmingham, Bracknell, Bristol, Brookwood, Brough, Cambridge, Caversham, Chelmsford, Cheltenham, Chicksands, Croughton, Dunstable, Edinburgh, Edzell, Fairford, Farnborough, Felixstowe, Ft. Halstead, Gibraltar, Glenrothes, Greenham Common, Harrogate, High Wycombe, Hythe, Kemble, Lakenheath, Liverpool, London, Loudwater, Menwith Hill, Mildenhall, Nottingham, Oxfordshire, Plymouth, Portsmouth, Reading, Rochester, Samlesbury, Southampton, Surrey, Waterbeach, Welford, West Byfleet, and Wiltshire.	120.55	44,000
Venezuela	Caracas	156.16	57,000
Vietnam	Hanoi	128.22	46,800
Vietnam	Ho Chi Minh City	115.07	42,000

SECTION 4. ELECTION TO APPLY 2013 ADJUSTED LIMITATIONS TO 2012 TAXABLE YEAR

For some locations, the limitation on housing expenses provided in section 3 of this notice may be higher than the limitation on housing expenses provided in the “Table of Adjusted Limitations for 2012” in Notice 2012–19. A qualified individual incurring housing expenses in such a location during 2012 may apply the adjusted limitation on housing expenses provided in section 3 of this notice in lieu of the amounts provided in the “Table of Adjusted Limitations for 2012” in Notice 2012–19 (and as set forth in the Instructions to Form 2555 (2012)).

The IRS and the Treasury Department anticipate that future annual notices providing adjustments to housing expense limitations will make a similar election available to qualified individuals that incur housing expenses in the immediately preceding year. For example, when adjusted housing expense limitations for 2014 are issued, it is expected that taxpayers will be permitted to apply those adjusted limitations to the 2013 taxable year.

SECTION 5. EFFECT ON OTHER DOCUMENTS

This notice supersedes Notice 2006–87, 2006–2 C.B. 766; Notice 2007–25, 2007–1 C.B. 760; Notice 2007–77; 2007–2 C.B. 735; Notice 2008–107,

2008–2 C.B. 1266; Notice 2010–27, 2010–15 I.R.B. 531; Notice 2011–8, 2011–8 I.R.B. 503; and Notice 2012–19, 2012–10 I.R.B. 440.

SECTION 6. EFFECTIVE DATE

This notice is effective for taxable years beginning on or after January 1, 2013. However, as provided in section 4, a taxpayer may elect to apply the 2013 adjusted housing limitations contained in section 3 of this notice to his or her taxable year beginning in 2012.

DRAFTING INFORMATION

The principal author of this notice is Susan E. Massey of the Office of Associate Chief Counsel (International). For further

information regarding this notice contact Ms. Massey at (202) 622-3840 (not a toll-free call).

26 CFR 601.602: Tax forms and instructions.
(Also: Part 1, §§ 1, 223.)

Rev. Proc. 2013-25

SECTION 1. PURPOSE

This revenue procedure provides the 2014 inflation adjusted amounts for Health Savings Accounts (HSAs) as determined under § 223 of the Internal Revenue Code.

SECTION 2. 2014 INFLATION ADJUSTED ITEMS

Annual contribution limitation. For calendar year 2014, the annual limitation on

deductions under § 223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is \$3,300. For calendar year 2014, the annual limitation on deductions under § 223(b)(2)(B) for an individual with family coverage under a high deductible health plan is \$6,550.

High deductible health plan. For calendar year 2014, a “high deductible health plan” is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than \$1,250 for self-only coverage or \$2,500 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed \$6,350 for self-only coverage or \$12,700 for family coverage.

SECTION 3. EFFECTIVE DATE

This revenue procedure is effective for calendar year 2014.

SECTION 4. DRAFTING INFORMATION

The principal author of this revenue procedure is Bill Ruane of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding § 223 and HSAs, contact Karen Levin at (202) 622-6080 (not a toll-free call). For further information regarding the calculation of the inflation adjustments in this revenue procedure, contact Mr. Ruane at (202) 622-4920 (not a toll-free call).

Part IV. Items of General Interest

Notice of Proposed Rulemaking

Community Health Needs Assessments for Charitable Hospitals

REG-106499-12

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations that provide guidance to charitable hospital organizations on the community health needs assessment (CHNA) requirements, and related excise tax and reporting obligations, enacted as part of the Patient Protection and Affordable Care Act of 2010. These proposed regulations also clarify the consequences for failing to meet these and other requirements for charitable hospital organizations. These regulations will affect charitable hospital organizations.

DATES: Comments and requests for a public hearing must be received by July 5, 2013.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-106499-12), room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG-106499-12), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC, or sent electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (IRS REG-106499-12).

FOR FURTHER INFORMATION CONTACT: Concerning these proposed regulations, Amy F. Giuliano or Preston J. Quesenberry at (202) 622-6070; concerning submissions of comments and requests for a public hearing, Oluwafunmilayo Taylor at (202) 622-7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review and approval under OMB control number 1545-0047, in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by June 4, 2013.

Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collection of information may be minimized, including through forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information in these proposed regulations is in §1.501(r)-3 and §1.6033-2(a)(2)(ii)(I). The collection of information flows from sections 501(r)(3) and 6033(b)(15) of the Internal Revenue Code (Code), which require a hospital organization to conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years, report on its annual information return how it is meeting the needs

identified through the CHNA, and attach to its annual information return a copy of its audited financial statements. The expected recordkeepers are hospital organizations described in sections 501(c)(3) and 501(r)(2).

The following estimates are based on information that is available to the IRS and averaged over a three-year time period, to reflect the fact that the information collection generally will be spread over the statutory three-year cycle during which a hospital organization is required to conduct a CHNA and adopt an implementation strategy. A particular hospital organization may require more or less time, depending on the circumstances.

Estimated number of recordkeepers: 3,377.

Estimated average annual burden hours per recordkeeper: 80 hours.

Estimated total annual recordkeeping burden: 270,160 hours.

The burden for the collection of information contained in the proposed amendments to §1.6033-2 will be reflected in the burden on Form 990, *Return of Organization Exempt From Income Tax*, after it is revised to require the additional information in the regulation.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

Background

The Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)) (the "Affordable Care Act"), enacted section 501(r) of the Code, which imposes additional requirements on charitable hospital organizations. Section 501(r)(1) states that a hospital organization described in section 501(r)(2) will not be treated as a tax-exempt organization described in section 501(c)(3) unless the organization meets the requirements of

section 501(r)(3) through 501(r)(6). The Affordable Care Act did not otherwise affect the substantive standards for tax exemption that charitable hospital organizations are required to meet under section 501(c)(3).

Section 501(r)(2)(A) defines a hospital organization as: (i) an organization that operates a facility required by a state to be licensed, registered, or similarly recognized as a hospital; and (ii) any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).

Section 501(r)(2)(B)(i) requires a hospital organization that operates more than one hospital facility to meet the requirements of section 501(r) separately with respect to each hospital facility. Section 501(r)(2)(B)(ii) provides that a hospital organization will not be treated as described in section 501(c)(3) with respect to any hospital facility for which the requirements of section 501(r) are not separately met.

Section 501(r)(3) requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. The CHNA must also be made widely available to the public.

Section 4959 imposes a \$50,000 excise tax on a hospital organization that fails to meet the CHNA requirements for any taxable year. A hospital organization must report the amount of any excise tax imposed on it under section 4959 on its annual information return (that is, Form 990, *Return of Organization Exempt From Income Tax*, and related schedules) pursuant to section 6033(b)(10)(D).

Section 6033(b)(15)(A) requires a hospital organization to report on its Form 990 a description of how the organization is addressing the needs identified in each CHNA and a description of any needs that are not being addressed together with the reasons why the needs are not being addressed.

Section 6033(b)(15)(B) requires a hospital organization to file with its Form 990 a copy of its audited financial statements (or, in the case of an organization the financial statements of which are included in consolidated financial statements with other organizations, its consolidated financial statements).

Notice 2010–39

In May 2010, the Department of the Treasury (“Treasury Department”) and the IRS issued Notice 2010–39, 2010–24 I.R.B. 756 (May 27, 2010), which solicited comments regarding the application of the additional requirements imposed by section 501(r). The Treasury Department and the IRS received approximately 125 comments in response to Notice 2010–39 and considered the comments relating to the consequences for failing a section 501(r) requirement in drafting these proposed regulations. The principal comments considered are discussed in this preamble under Explanation of Provisions.

Notice 2011–52

In July 2011, the Treasury Department and the IRS issued Notice 2011–52, 2011–30 I.R.B. 60 (July 8, 2011), which addressed the CHNA requirements of section 501(r)(3). Notice 2011–52 described provisions related to the CHNA requirements that the Treasury Department and the IRS anticipated would be included in these proposed regulations and solicited comments from the public. Specifically, Notice 2011–52 described anticipated regulatory provisions regarding the documentation of a CHNA, how and when a CHNA is conducted, the community served by a hospital facility, persons representing the broad interests of the community, making a CHNA widely available to the public, the implementation strategy, excise taxes on failures to meet the CHNA requirements, reporting requirements related to CHNAs, and the effective dates of the CHNA provisions. The Treasury Department and the IRS received more than 80 comments in response to Notice 2011–52. The principal comments considered in drafting these proposed regulations on the CHNA requirements are discussed in this preamble under Explanation of Provisions.

Notice 2011–52 provided that hospital organizations could rely on the anticipated

regulatory provisions described in the notice for any CHNA made widely available to the public, and any implementation strategy adopted, on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued. Thus, hospital organizations may continue to rely on the interim guidance described in Notice 2011–52 for any CHNA made widely available to the public, and any implementation strategy adopted, on or before October 5, 2013.

Notice of Proposed Rulemaking on Section 501(r)(4) through 501(r)(6)

On June 26, 2012, the Treasury Department and the IRS published a notice of proposed rulemaking in the **Federal Register** (REG–130266–11; 77 FR 38148) (“2012 proposed regulations”) that contains proposed regulations regarding the requirements of section 501(r)(4) (which requires hospitals to establish financial assistance and emergency medical care policies), section 501(r)(5) (which limits the amount hospitals can charge for certain care provided to individuals eligible for financial assistance), and section 501(r)(6) (which prohibits a hospital from engaging in extraordinary collection actions before making reasonable efforts to determine whether an individual is eligible for financial assistance).

The 2012 proposed regulations also provide guidance on the hospital organizations and facilities that must meet the section 501(r) requirements. In particular, the 2012 proposed regulations contain a definitions section that defines “hospital organization,” “hospital facility,” and other key terms used in the regulations. See §1.501(r)–1 of the proposed regulations. In accordance with section 501(r)(2)(A)(i), the 2012 proposed regulations define “hospital organization” as an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities, including a hospital facility operated through a disregarded entity. Also in accordance with section 501(r)(2)(A)(i), the 2012 proposed regulations define “hospital facility” as a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. In addition, the 2012 proposed regulations note that references

to a hospital facility taking certain actions are intended to include instances in which the hospital organization operating the hospital facility takes action through, or on behalf of, the hospital facility. These definitions and concepts generally apply for purposes of these proposed regulations on the CHNA requirements and the consequences for failing to meet the section 501(r) requirements, although these proposed regulations make minor amendments to the definitions of “hospital facility” and “hospital organization” contained in the 2012 proposed regulations, as discussed further in the “Explanation of Provisions” section of this preamble.

The comment period for the 2012 proposed regulations closed on September 24, 2012. The Treasury Department and the IRS have received more than 200 comments in response to the 2012 proposed regulations and are continuing to consider these comments as they work toward finalizing those proposed regulations. The Treasury Department and the IRS intend to finalize the 2012 proposed regulations in conjunction with the finalization of these proposed regulations.

Explanation of Provisions

These proposed regulations provide guidance on the CHNA requirements of section 501(r)(3), and on the related reporting obligations of section 6033. In addition, these proposed regulations provide guidance on the consequences described in sections 501(r)(1), 501(r)(2)(B), and 4959 for failing to satisfy any of the section 501(r) requirements, including the section 501(r)(4) through 501(r)(6) requirements addressed in the 2012 proposed regulations. These proposed regulations generally do not otherwise provide further guidance regarding the section 501(r)(4) through 501(r)(6) requirements. They do, however, make minor amendments to the definitions of “hospital facility” and “hospital organization” contained in the 2012 proposed regulations and also provide a new definition of “operating” a hospital facility that is applicable for purposes of all of the section 501(r) requirements.

In interpreting the CHNA requirements of section 501(r)(3), the Treasury Department and the IRS sought to preserve hospital facilities’ flexibility to determine the best way to identify and meet the particu-

lar health needs of the specific communities they serve while requiring a transparent assessment process with ample opportunity for community input.

1. Hospital Facilities and Organizations

a. Hospital organization for purposes of section 4959

Section 4959 imposes a \$50,000 excise tax on “a hospital organization to which section 501(r) applies” that fails to meet the requirements of section 501(r)(3) for any taxable year. For purposes of section 501(r), the 2012 proposed regulations define the term “hospital organization” to mean an organization “recognized (or seeking to be recognized) as described in section 501(c)(3)” that operates one or more hospital facilities. These proposed regulations clarify that the section 4959 excise tax will apply to a hospital organization that fails to meet the section 501(r)(3) requirements during a taxable year in which its section 501(c)(3) status is revoked. These proposed regulations do not otherwise change the substance of the “hospital organization” definition contained in the 2012 proposed regulations.

b. Multiple buildings under a single hospital license

The definition of “hospital facility” in the 2012 proposed regulations provides that multiple buildings operated by a hospital organization under a single state license may be considered a single hospital facility. This special rule for multiple buildings was intended to allow flexibility but has the disadvantage of making it harder for the IRS and the public to understand and to evaluate the information reported on a hospital organization’s Form 990, particularly if multiple buildings under a single state license are reported differently (as a single facility or as multiple facilities) from year to year. To increase the certainty and consistency in the designation of hospital facilities, these proposed regulations amend this definition to provide that multiple buildings operated by a hospital organization under a single state license “are” (rather than “may be”) considered a single hospital facility. The Treasury Department and the IRS request comments regarding whether (and under what circumstances) a hospital

organization should be able to treat multiple buildings under a single state license as separate hospital facilities for purposes of the CHNA and other section 501(r) requirements and, if so, how certainty and consistency in the designation of hospital facilities can be achieved.

c. Tribal hospital facilities

Several commenters recommended that these proposed regulations make clear that a hospital facility operated by an Indian tribe or tribal organization is not subject to the section 501(r) requirements, even if the hospital facility is part of an organization described in section 501(c)(3). These commenters stated that tribal hospital facilities are not typically “required by a state to be licensed, registered, or similarly recognized as a hospital,” as contemplated in section 501(r)(2)(A)(i). The Treasury Department and the IRS note that section 501(r)(2)(A)(i) refers only to a hospital facility licensed or registered by a state, not an Indian tribal government, and that section 7871 does not provide that an Indian tribal government is treated as a state for purposes of section 501(r). Accordingly, pending any future guidance regarding other categories of hospital organizations or facilities, a tribal facility that is not required by a state to be licensed, registered, or similarly recognized as a hospital is not a “hospital facility” for purposes of section 501(r), and a section 501(c)(3) organization will not be considered a “hospital organization” solely as a result of operating such a tribal facility.

d. Operating a hospital facility through a partnership

Notice 2011–52 stated the intention of the Treasury Department and the IRS to include within the definition of “hospital organization” any organization described in section 501(c)(3) that operates a hospital facility through a joint venture, limited liability company, or other entity treated as a partnership for federal tax purposes. Notice 2011–52 also requested comments regarding whether (and under what circumstances) an organization should not be considered to “operate” a hospital facility for purposes of section 501(r) as a result of its owning a small interest (other than a general partner or similar interest) in an entity

treated as a partnership for federal tax purposes that operates the hospital facility.

In response to Notice 2011-52, a few commenters recommended that a hospital organization generally should not be considered to operate a hospital facility through a partnership when it holds a minority interest in that partnership. In defining “minority interest,” commenters suggested ownership thresholds ranging from less than 50 percent to less than 20 percent. Commenters stated that a hospital organization with such a minority interest in a hospital facility joint venture would not have the necessary control over the joint venture to ensure that the hospital facility in question complied with the requirements of section 501(r).

Another commenter recommended that section 501(r) should not apply to a hospital facility operated by a partnership if the partner described in section 501(c)(3) treats the income derived from that facility as unrelated business taxable income (UBTI) that is taxed under section 511. This commenter argued that the line on the applicability of section 501(r) should be drawn based on the taxability of the hospital facility’s income rather than on the basis of a particular percentage of ownership.

Yet another commenter suggested that these proposed regulations should provide that an organization that owns a minority limited partnership interest in a partnership that operates a hospital facility should not be considered to “operate” that hospital facility for purposes of section 501(r) if the organization entered into the limited partnership agreement prior to the date section 501(r) was enacted (that is, March 23, 2010) and has a primary tax-exempt purpose other than the provision of community health care. As an example of such an organization, this commenter cited a university medical school that entered into a partnership agreement to operate a hospital facility that gives the university control over the joint venture sufficient to ensure the operation of the hospital facility furthers its exempt educational purpose, but insufficient to ensure the hospital facility is in compliance with section 501(r).

Rev. Rul. 2004-51, 2004-1 C.B. 975, provides that the activities of an entity that is treated as a partnership for federal tax purposes are treated as the activities of the tax-exempt partner for purposes of determining whether the tax-exempt partner is

operated exclusively for exempt purposes and engages in an unrelated trade or business. *See also* Rev. Rul. 98-15, 1998-1 C.B. 718. Consequently, consistent with Notice 2011-52, these proposed regulations provide that, as a general rule, a hospital organization “operates” a hospital facility if it is a partner in a joint venture, limited liability company, or other entity treated as a partnership for federal income tax purposes that operates the hospital facility.

However, in light of the comments received, these proposed regulations provide two exceptions to this general rule. First, as commenters observed, an organization without the control over the operation of a hospital facility sufficient to ensure that the hospital facility furthers an exempt purpose is unlikely to have the control sufficient to ensure compliance with section 501(r). As a general rule, if a tax-exempt partner does not have control sufficient to ensure that a trade or business activity regularly carried on by the partnership furthers (or is substantially related to) its exempt purposes, that activity will be considered an unrelated trade or business with respect to the tax-exempt partner. *See* Rev. Rul. 2004-51; Rev. Rul. 98-15. These proposed regulations provide that if a section 501(c)(3) partner of a partnership operating a hospital facility does not have control over the operation of the hospital facility sufficient to ensure that the operation of the hospital facility furthers an exempt purpose described in section 501(c)(3) and thus treats the operation of the hospital facility, including the facility’s provision of medical care, as an unrelated trade or business, the hospital organization will not be considered to “operate” the hospital facility for purposes of section 501(r).

Second, as another commenter observed, some tax-exempt organizations may have entered into partnership arrangements prior to the enactment of section 501(r) that gave them control over a partnership sufficient to ensure that the partnership furthers charitable purposes other than the provision of community health care, but not sufficient to ensure compliance with section 501(r). In response to this comment, these proposed regulations provide a grandfather rule under which a hospital organization will not be considered to “operate” a hospital

facility for purposes of section 501(r) if certain conditions are met. First, at all times since March 23, 2010, the hospital organization must have been organized and operated primarily for educational or scientific purposes and must not have engaged primarily in the operation of one or more hospital facilities. Second, pursuant to a partnership arrangement (including any side agreements) entered into before March 23, 2010, the hospital organization must not own more than 35 percent of the capital or profits interest in the partnership, not own a general partner or similar interest, and not have sufficient control over the operation of the hospital facility to ensure that the hospital facility complies with the requirements of section 501(r).

Finally, like both Notice 2011-52 and the 2012 proposed regulations, these proposed regulations make clear that a hospital organization operates a hospital facility if it operates a hospital facility through a wholly-owned entity that is disregarded as separate from the hospital organization for federal tax purposes.

e. Activities unrelated to the operation of a hospital facility

In response to Notice 2010-39, a few commenters asked whether the requirements of section 501(r) apply to those aspects of a hospital organization’s operations that do not relate to the operation of a hospital facility. Section 501(r)(2)(B) provides that the requirements of section 501(r) apply separately with respect to each of the hospital facilities a hospital organization operates. Similarly, §1.501(r)-2 of these proposed regulations (which describes consequences for failing to satisfy the requirements of section 501(r)) only applies to circumstances in which a hospital organization fails to meet one or more of the requirements of section 501(r) “separately with respect to one or more hospital facilities” it operates. Thus, the Treasury Department and the IRS intend that a hospital organization is not required to meet the requirements of section 501(r) with respect to any activities unrelated to the operation of a hospital facility. For example, if a hospital organization operates a facility that is not required to be licensed as a hospital by the state in which the facility is located, the hospital organization is not required

to meet the requirements of section 501(r) with respect to that facility.

f. Authorized body of a hospital organization or facility

For purposes of determining whether a hospital organization has established a policy required under section 501(r)(4) for a hospital facility it operates, the 2012 proposed regulations would require an authorized body to adopt the policy for the hospital facility. The 2012 proposed regulations define the term “authorized body” to include: (1) the governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization; (2) a committee of, or other party authorized by, the governing body of the hospital organization, to the extent permitted under state law; or (3) in the case of a hospital facility that has its own governing body and is recognized as an entity under state law but is a disregarded entity for federal tax purposes, the governing body of that hospital facility, or a committee of, or other party authorized by, that governing body to the extent permitted under state law.

Because the definition of an “authorized body” of a hospital facility that adopts a CHNA report or implementation strategy required under section 501(r)(3) should be the same as the definition of an “authorized body” for purposes of section 501(r)(4), the term “authorized body of a hospital facility” is defined in §1.501(r)-1 of these proposed regulations so that it may apply for purposes of both the section 501(r)(3) and the section 501(r)(4) requirements.

2. Failures to Satisfy the Requirements of Section 501(r)

a. Minor and inadvertent omissions and errors

Numerous commenters to Notice 2010-39 requested guidance on the consequences of failing to meet one or more of the requirements of section 501(r). In addition, commenters have noted that the guidance released so far on section 501(r) (in Notice 2011-52 and the 2012 proposed regulations) has proposed multiple specific requirements, and that hospitals, as large complex institutions, may experience minor and inadvertent compliance

failures notwithstanding their good faith efforts to comply with the requirements. Commenters representing hospitals expressed the view that a failure to meet a section 501(r) requirement should only result in adverse consequences for a hospital organization if the failure is a substantial one. The Treasury Department and the IRS received similar informal comments from patient advocates. Commenters also recommended that no adverse consequences should result from a hospital organization’s failure if the organization corrects the failure, with many of these commenters specifically suggesting that such corrections be required to be made “by the end of the fiscal year being reported.”

The Treasury Department and the IRS recognize that minor and inadvertent errors may occur even in circumstances in which a hospital facility has practices and procedures in place that are reasonably designed to facilitate overall compliance with section 501(r) and has implemented safeguards reasonably calculated to prevent errors. Therefore, these proposed regulations provide that a hospital facility’s omission of required information from a policy or report described in §1.501(r)-3 or §1.501(r)-4, or error with respect to the implementation or operational requirements described in §1.501(r)-3 through §1.501(r)-6, will not be considered a failure to meet a requirement of section 501(r) if the omission or error was minor, inadvertent, and due to reasonable cause, and the hospital facility corrects such omission or error as promptly after discovery as is reasonable given the nature of the omission or error.

b. Excusing certain failures if a hospital facility corrects and makes disclosure

With respect to omissions or errors that rise above the level of minor and inadvertent, the Treasury Department and the IRS recognize that a hospital facility’s prompt discovery and correction of such omissions or errors is in the best interests of patients and that requiring hospital facilities to report such omissions or errors and disclose how such omissions or errors were corrected (for example, on the Form 990) would achieve transparency, which is an important objective of section 501(r). Increased transparency, in turn, will permit

organizations concerned with community health needs to use this information to promote adoption of practices and procedures that advance the goals of the section 501(r) requirements and encourage promulgation of best practices. To provide an incentive for hospital facilities to take steps not only to avoid errors but to correct and provide disclosure when they occur, the Treasury Department and the IRS will issue a revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin which will provide that a hospital facility’s failure to meet one or more of the requirements described in §1.501(r)-3 through §1.501(r)-6 that is neither willful nor egregious will be excused if the hospital facility corrects and provides disclosure in accordance with the rules set forth in the guidance. The Treasury Department and the IRS anticipate that this guidance will provide that correction and disclosure should be reasonable and appropriate for the failure at issue.

For purposes of this provision, willful is to be interpreted consistent with the meaning of that term in the context of civil penalties, which would include a failure due to gross negligence, reckless disregard, or willful neglect. Furthermore, correction and disclosure will not create a presumption that the failure was neither willful nor egregious.

The Treasury Department and the IRS intend to issue the guidance regarding correction and disclosure in proposed form in order to provide an opportunity to comment on the procedures described therein.

c. Facts and circumstances considered in determining whether to revoke section 501(c)(3) status

Section 501(r)(1) provides that a hospital organization will not be treated as described in section 501(c)(3) unless it meets the requirements of section 501(r). These proposed regulations interpret this language as giving the IRS the authority to revoke a hospital organization’s section 501(c)(3) status if the organization fails to meet one or more requirements of section 501(r). However, the Treasury Department and the IRS agree with commenters that the IRS should consider the relative size, scope, nature, and significance of any failures to meet the section 501(r) requirements, as well as the reasons

for such failures and whether the same type of failures have previously occurred, when determining whether revocation of section 501(c)(3) status is warranted. In addition, the Treasury Department and the IRS consider it desirable that these proposed regulations provide incentives for a hospital facility to establish and routinely follow practices and procedures reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements and identify any problems that arise and the reasons for their occurrence. Hospital facilities should also have incentives to correct any section 501(r) failures as promptly after discovery as is reasonable given the nature of the failure and implement safeguards reasonably calculated to prevent similar failures from occurring in the future. Accordingly, these proposed regulations provide that the IRS will consider all of these facts and circumstances in determining whether to continue to recognize the section 501(c)(3) status of a hospital organization that fails to meet one or more requirements of section 501(r). In general, the Treasury Department and the IRS expect that application of these facts and circumstances will ordinarily result in revocation of the section 501(c)(3) status of a hospital organization if the organization's failures to meet the requirements of section 501(r) are willful or egregious.

d. Taxation of noncompliant hospital facilities

A number of commenters recommended that if a hospital organization fails to meet a section 501(r) requirement with respect to a particular hospital facility it operates, only that hospital facility should be treated as not described in section 501(c)(3), and the facility's failure should not negate the tax exemption of the hospital organization as a whole. A few commenters recommended that if a hospital organization ceases to qualify as an organization described in section 501(c)(3) with respect to a particular hospital facility but continues to qualify as an organization described in section 501(c)(3) overall, then any net income derived from the disqualified facility should be subject to the unrelated business income tax under section 511.

Section 501(r)(2)(B)(ii) provides that a hospital organization operating more than one hospital facility shall not be treated as described in section 501(c)(3) with respect to any such hospital facility for which the requirements of section 501(r)(1) are not separately met (a "noncompliant hospital facility"). Status under section 501(c)(3) is determined at the organizational level, and treating an organization as not described in section 501(c)(3) "with respect to" a particular hospital facility it operates (or a particular branch, division, or activity of the organization) has no generally recognized meaning under the provisions of the Code governing tax-exempt organizations. Notwithstanding this fact, the language in section 501(r)(2)(B)(ii) suggests that a particular noncompliant hospital facility operated by a hospital organization with more than one facility may be treated as not described in section 501(c)(3) without affecting the section 501(c)(3) status of the hospital organization. A noncompliant hospital facility that is treated as not described in section 501(c)(3), but that is owned and operated by a hospital organization that continues to be described in section 501(c)(3), cannot be described in another subsection of 501(c) (such as section 501(c)(4)), since the plain language of section 501(c) makes clear that only organizations (not facilities, branches, divisions, or other components of organizations) can be described in any one subsection of 501(c). Thus, these proposed regulations interpret section 501(r)(2)(B)(ii) to mean that a hospital organization that is not treated as described in section 501(c)(3) "with respect to" a particular noncompliant hospital facility ceases to be exempt from taxation under section 501(a) with respect to that facility, even while the hospital organization as a whole (with respect to its other hospital facilities and activities) continues to be otherwise exempt from taxation under section 501(a) because it is described in section 501(c)(3).

Accordingly, these proposed regulations provide that if a hospital organization operating more than one hospital facility fails to meet one or more of the requirements of section 501(r) separately with respect to a hospital facility during a taxable year but continues to be recognized as described in section 501(c)(3), the income derived from the noncompliant hospital facility during that taxable year will be

subject to tax computed as provided in section 11 (or as provided in section 1(e) if the hospital organization is a trust described in section 511(b)(2)). To maintain consistency with the treatment of organizations operating a single hospital facility, this tax will apply only if the hospital organization would not continue to be described in section 501(c)(3) based on the facts and circumstances described in section 2.c of this preamble if the noncompliant hospital facility were the only hospital facility that the organization operated. This tax would not apply in the event of minor and inadvertent omissions or errors described in section 2.a of this preamble or of failures that are excused in accordance with the guidance described in section 2.b of this preamble.

In applying the tax, the income derived from a noncompliant hospital facility during a taxable year will be the gross income derived from that hospital facility during the taxable year, less the deductions allowed by chapter 1 of the Code that are directly connected to the operation of that hospital facility during the taxable year. These proposed regulations provide that this computation will exclude any gross income and deductions already taken into account in computing any UBTI described in section 512 derived from the facility during the taxable year.

To be directly connected with the operation of a noncompliant hospital facility, these proposed regulations provide that an item of deduction must have proximate and primary relationship to the operation of the hospital facility. Expenses, depreciation, and similar items attributable solely to the operation of a hospital facility are proximately and primarily related to such operation, and therefore qualify for deduction to the extent that they meet the requirements of section 162, section 167, or other relevant provisions of the Code. These proposed regulations further provide that where expenses, depreciation, and similar items are attributable to more than one hospital facility operated by the hospital organization (and/or to activities of the hospital organization unrelated to the operation of hospital facilities), such items shall be allocated between the hospital facilities (and/or other activities) on a reasonable basis.

In addition, these proposed regulations provide the gross income and allowed

deductions of a noncompliant hospital facility may not be aggregated with the gross income and allowed deductions of the hospital organization's other noncompliant hospital facilities or its unrelated trade or business activities described in section 513. Thus, a hospital organization operating more than one noncompliant hospital facility that is subject to the facility-level tax must compute each facility's taxable income separately and may not use net operating losses from one noncompliant hospital facility to offset taxable income derived from another noncompliant hospital facility. Similarly, a hospital organization may not use net operating losses from a noncompliant hospital facility to offset any UBTI derived from the organization's unrelated trade or business activities.

A number of commenters expressed concern that interest on bonds issued as qualified 501(c)(3) bonds to finance a hospital facility will become taxable if the facility fails one or more requirements of section 501(r). These proposed regulations make clear that if a hospital organization operating a noncompliant hospital facility continues to be recognized as described in section 501(c)(3) and otherwise exempt from tax under section 501(a), the fact that a facility-level tax is imposed as a result of the facility's failure to comply with section 501(r) will not itself cause the interest on such bonds to be taxable.

Finally, these proposed regulations make clear that the facility-level tax described in this section 2.d of the preamble will be reported on the Form 990-T.

3. Community Health Needs Assessments

Consistent with section 501(r)(3)(A), these proposed regulations provide that a hospital organization meets the requirements of section 501(r)(3) in any taxable year with respect to a hospital facility it operates only if the hospital facility has conducted a CHNA in such taxable year or in either of the two immediately preceding taxable years and an authorized body of the hospital facility has adopted an implementation strategy to meet the community health needs identified through the CHNA by the end of the taxable year in which the hospital facility conducts the CHNA. In general, these proposed regulations are consistent with the anticipated rules de-

scribed in Notice 2011-52, with certain modifications intended to be responsive to the more than 80 comments received on Notice 2011-52.

a. Conducting a community health needs assessment

In conducting a CHNA, these proposed regulations provide that a hospital facility must define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must, consistent with section 501(r)(3)(B)(i), take into account input from persons who represent the broad interests of its community, including those with special knowledge of or expertise in public health. The hospital facility must also document the CHNA in a written report ("CHNA report") that is adopted for the hospital facility by an authorized body of the hospital facility. Finally, consistent with section 501(r)(3)(B)(ii), the hospital facility must make the CHNA report widely available to the public. These proposed regulations provide that a CHNA is considered "conducted" on the date the hospital facility has completed all of these steps. Because a hospital facility must make a CHNA report widely available to the public continuously for a number of years (as discussed in section 3.a.vi of this preamble), these proposed regulations clarify that a hospital facility is considered to have completed the step of making the CHNA report widely available to the public on the date it first makes the CHNA report widely available to the public.

i. Community Served by the Hospital Facility

Notice 2011-52 stated the intention of the Treasury Department and the IRS to allow a hospital facility to take into account all of the relevant facts and circumstances in defining the community it serves. Notice 2011-52 noted that, generally, the Treasury Department and the IRS would expect a hospital facility's community to be defined geographically but that, in some cases, the definition might also take into account target populations served or specialized functions. Notwithstanding this generally flexible approach to defining community, Notice 2011-52 stated that a community could not be defined in a manner that circumvented the

requirement to assess the health needs of the hospital facility's community by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs. Finally, Notice 2011-52 requested comments on the relative merits of different geographically-based definitions of community and, more specifically, on whether future guidance should define the geographic community of a hospital facility as the Metropolitan Statistical Area (MSA) or Micropolitan Statistical Area (μ SA) in which the facility is located or, if the hospital facility is a rural facility not located in a MSA or μ SA, as the county in which the facility is located.

Many commenters supported the facts-and-circumstances approach to defining a hospital facility's community outlined in Notice 2011-52 and recommended against a definition based on specified geographic boundaries. These commenters noted that each hospital facility is in the best position to determine its community and that requiring the community to be defined as a specific geographic area may not be appropriate or correspond to the actual populations served, especially in the case of specialized and regional hospitals. These commenters also recommended against defining the community served by a hospital facility as the MSA, μ SA, or county in which the facility is located, noting that such areas or politically-defined jurisdictions are often unrelated to hospital service areas.

Other commenters recommended a geographic definition of community, but requested one that would be flexible in the method of definition (for example, not restricted to specific political jurisdictions). A few commenters went further and stated that the geographic definition of community should include the political jurisdiction in which the hospital facility is located or where the hospital facility is an essential provider. These commenters recommended against definitions of community based on the demographics or residence of the hospital facility's specific patient populations, noting that a hospital facility's current patient population does not necessarily reflect the broader community.

Consistent with Notice 2011-52, these proposed regulations provide a hospital facility with the flexibility to take into account all of the relevant facts and cir-

cumstances in defining the community it serves, including the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). These proposed regulations also clarify that a hospital facility may define its community to include populations in addition to its patient populations and geographic areas outside of those in which its patient populations reside. For example, a hospital facility collaborating with other hospital facilities in its MSA in conducting a CHNA may define its community as the entire MSA in which all of the collaborating hospital facilities are located, even if the hospital facility itself only generally serves and draws its patients from a portion of that MSA.

While desiring to give a hospital facility the flexibility it needs to define its community served in a manner appropriate to its specific facts and circumstances, the Treasury Department and the IRS continue to share the interest expressed by some commenters in ensuring that hospital facilities assess and address the needs of medically underserved, low-income, and minority populations in the areas they serve. Thus, similar to the restriction included in Notice 2011–52, these proposed regulations provide that a hospital facility may not define its community in a way that excludes medically underserved, low-income, or minority populations who are part of its patient populations, live in geographic areas in which its patient populations reside (unless they are not part of the hospital facility’s target populations or affected by its principal functions), or otherwise should be included based on the method used by the hospital facility to define its community. These proposed regulations clarify that medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers. (For reasons discussed in section 3.a.iii.B of this preamble, these proposed regulations do not list those with chronic disease needs as a separate category of persons that must not be excluded.) Finally, if a hospital facility

uses a method of defining its community that takes into account patient populations, these proposed regulations require the hospital facility to treat as patients all individuals who receive care from the hospital facility, without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for financial assistance.

ii. Assessing Community Health Needs

These proposed regulations provide that in order to “assess” the health needs of the community it serves, a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs. For these purposes, health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). Requisites for the improvement or maintenance of health status in a community may include improving access to care by removing financial and other barriers to care, such as a lack of information regarding sources of insurance designed to benefit vulnerable populations.

Notice 2011–52 stated the intention of the Treasury Department and the IRS to require a hospital facility to prioritize all of the community health needs identified through the CHNA. A few commenters suggested that only the most significant of the likely extensive list of community health needs identified through a CHNA should have to be prioritized. These proposed regulations respond to this comment by clarifying that a CHNA need only identify significant health needs and need only prioritize, and otherwise assess, those significant health needs identified. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves.

A few commenters asked for additional guidance regarding how a CHNA should prioritize community health needs. These proposed regulations do not require a hospital facility to use any particular

methods or criteria in prioritizing health needs. They do, however, list as possible examples of prioritization criteria the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; and/or the importance the community places on addressing the need. This list of possible prioritization criteria is not intended to be exhaustive, and a hospital facility may use any criteria it deems appropriate.

iii. Persons Representing the Broad Interests of the Community

In assessing the health needs of the community it serves, these proposed regulations require a hospital facility to (consistent with section 501(r)(3)(B)(i)) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. Specifically, these proposed regulations require a hospital facility to take into account input from, at a minimum: (1) at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community; (2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and (3) written comments received on the hospital facility’s most recently conducted CHNA and most recently adopted implementation strategy.

Notice 2011–52 stated that the Treasury Department and the IRS intended to require a CHNA to take into account input from, at a minimum: (1) persons with special knowledge of or expertise in public health; (2) federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and (3) leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

A. Governmental public health departments

With respect to the requirement described in Notice 2011–52 to take into account input from federal, tribal, regional, state, or local health or other departments, many commenters urged that a hospital facility should be able to choose the level and type of governmental public health department from which it seeks input, noting that not every local jurisdiction has a local public health department. On the other hand, a number of public health organizations suggested that these proposed regulations should require a hospital facility to consult with the state public health department in the state where the hospital facility is licensed and/or the local public health department in the local jurisdiction where the hospital facility is located. These organizations noted that such departments can play a critically important role in coordinating CHNA efforts and provide expertise in CHNA planning and execution, access to existing health data, and knowledge of local conditions, needs, and resources.

These proposed regulations preserve the flexibility in Notice 2011–52 of allowing a hospital facility to choose the jurisdictional level of government (for example, state, local, tribal, or regional) that it feels is most appropriate for its CHNA. These proposed regulations do not require a hospital facility to seek input from a local public health department, in particular, in recognition of some commenters' observation that not all jurisdictions will have local public health departments available to participate in the CHNA process. However, in recognition of the planning and subject-matter expertise that public health departments can offer to the CHNA process, a hospital facility is required to seek input from a public health department (or equivalent department or agency) in particular, rather than any governmental departments with current data or other information relevant to the health needs of the community (as described in Notice 2011–52). Such input could include input from the state public health official or any local public health official.

In addition, given commenters' emphasis on the importance of input from public health departments at the state or local level, these proposed regulations require a

hospital facility to seek input from a public health department at a state or local, not a federal, level. Because a governmental public health department presumably has special knowledge of or expertise in public health, requiring input from a public health department eliminates the need for a separate requirement to consult with a person with special knowledge of or expertise in public health (as provided in Notice 2011–52).

B. Medically underserved, low-income, and minority populations

Commenters generally supported the purpose behind the requirement to take into account input from medically underserved, low-income, and minority populations in the community but asked for clarification on who may be considered “leaders” or “representatives” of such populations. One commenter noted that the term “chronic disease needs” is broad and could potentially require a hospital facility to seek input from a large number of individuals in order to address every chronic disease in its community.

These proposed regulations maintain the requirement to take into account input from medically underserved, low-income, and minority populations in the community served by the hospital facility but respond to comments by clarifying and simplifying the approach taken in Notice 2011–52. To address the numerous comments expressing confusion over the terms “leaders” and “representatives” of such populations, these proposed regulations clarify that a hospital facility may seek input either directly from members of medically underserved, low-income, and minority populations in the community (for example, in the form of meetings, focus groups, surveys, or interviews) or from individuals or organizations serving or representing the interests of those populations. To address the concern with requiring input related to every chronic disease in a community, these proposed regulations do not refer to chronic disease needs in particular but rather define “medically underserved populations” in a manner that focuses on disparities in coverage, access, and other barriers to care for persons with health needs that may include, but are not limited to, chronic diseases.

C. Written comments

A few commenters recommended an input requirement not contained in Notice 2011–52: a requirement that a hospital facility take into account public input and comments on a draft version of its CHNA report before the report is finalized. These commenters noted the importance of a public comment process for ensuring that the CHNA accurately reflects the community's views and priorities and adequately analyzes available data.

These proposed regulations do not adopt the specific recommendations to require hospital facilities to make a draft copy of a CHNA report available for public comment due to the complexity of the additional timeframes and procedures such a process would require. However, the Treasury Department and the IRS recognize the value of providing a mechanism for public feedback on CHNA reports and their related implementation strategies. Therefore, these proposed regulations respond to these comments by requiring a hospital facility to consider written comments received from the public on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy. (As discussed in section 4 of this preamble, the public will be able to review a hospital facility's most recently adopted implementation strategy because it will either be attached to the Form 990 of the hospital organization that operates it or made widely available on a Web site.) Because a new CHNA must be conducted and an implementation strategy adopted at least once every three years, this requirement establishes the same sort of continual feedback on CHNA reports suggested by commenters, albeit over a longer period of time. It is anticipated that this opportunity for feedback on CHNA reports and implementation strategies will result in a meaningful exchange over time and that the longer timeframe will give the public sufficient time to provide comments and hospital facilities sufficient time to consider the public's comments and take the comments into account when conducting their next CHNA. In addition, as discussed in section 3.a.vi of this preamble, to help facilitate the option of posting a draft CHNA report for public review and comment, these proposed regulations provide that the posting of draft

CHNA reports will not trigger the start of a hospital facility's next three-year CHNA cycle.

D. Input on financial and other barriers and from other sources

In addition, some commenters recommended that a hospital facility should be required to integrate evaluations of financial assistance policies and procedures and the need for uncompensated care into its CHNA. The Treasury Department and the IRS recognize that the need to improve access to care by removing financial barriers can be among the significant health needs assessed in a CHNA. Accordingly, these proposed regulations provide that input from persons representing the broad interests of the community includes, but is not limited to, input on any financial and other barriers to access to care in the community.

Finally, similar to Notice 2011-52, these proposed regulations provide that a hospital facility may take into account input from a broad range of persons located in or serving its community who may have special knowledge of or expertise in public health, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives. As discussed in section 3.a.vi of this preamble, one way for a hospital facility to take into account input from such a broad range of persons is to pursue the option of posting on its Web site a draft CHNA report for public review and comment. The Treasury Department and the IRS believe a CHNA with broad input from the community can increase the likelihood of well-targeted initiatives that address the needs of communities and improve the health of residents.

iv. Documentation of a CHNA

Similar to the documentation rule described in Notice 2011-52, these proposed regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes: (1)

a definition of the community served by the hospital facility and a description of how the community was determined; (2) a description of the process and methods used to conduct the CHNA; (3) a description of how the hospital facility took into account input from persons who represent the broad interests of the community it serves; (4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing such significant health needs; and (5) a description of potential measures and resources identified through the CHNA to address the significant health needs.

Like Notice 2011-52, the proposed regulations provide more detail about two of these required elements of the CHNA report: the description of the process and methods used to conduct the CHNA and the description of how the hospital facility took into account input from persons who represent the broad interests of the community. However, in response to comments about the need for greater flexibility, these proposed regulations provide that a hospital facility's CHNA report "will be considered to" describe each of these elements if it contains certain information instead of prescribing a single method of meeting the requirement.

A. Description of process and methods

These proposed regulations provide that a hospital facility's CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report: (1) describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and (2) identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA.

B. Description of community input

In describing how the hospital facility took into account input from persons who represent the broad interests of the community it serves, Notice 2011-52 stated that a hospital facility would have to describe when and how the organization

consulted with such persons. A number of commenters sought clarification that a general summary of "when and how" would be sufficient. Specifically, some of these commenters noted that a detailed account of each instance of feedback could be quite burdensome and may create the impression that less formal interactions with community members are insufficient or unworthy of consideration or hinder the free flow of information.

In response to these comments, these proposed regulations clarify that the CHNA report may summarize, in general terms, how and over what time period input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what dates) and need not provide a detailed description of each instance of feedback. These proposed regulations also clarify that the CHNA report may contain a general summary of the input received. Thus, for example, a hospital facility may describe a series of town hall meetings by noting that four meetings were held over a three-month period and generally summarizing the input received, without necessarily having to provide the specific dates of each meeting, a list of attendees, or minutes of the discussion.

Notice 2011-52 stated that a hospital facility taking into account input from an organization would be required to identify in the CHNA report not only the organization but also the name and title of at least one individual in the organization with whom the hospital facility consulted. Commenters, however, were generally opposed to inclusion in the publicly available CHNA report of the names and roles of private individuals who gave input into the CHNA process, noting that the information may not add much value to the overall CHNA but could raise privacy concerns and deter individuals from providing input. In response to these comments, these proposed regulations do not specifically require the CHNA report to contain the names or titles of any individuals contacted within an organization. In addition, the proposed regulations specify that a CHNA report does not need to name or otherwise individually identify any individuals participating in community forums, focus groups, survey samples, or similar groups.

However, the Treasury Department and the IRS continue to believe that a CHNA report should identify the organizations that provided input into the CHNA and summarize the nature and extent of that input. In addition, a CHNA report should describe the medically underserved, low-income, or minority populations being represented by the organizations or individuals providing input. Accordingly, these proposed regulations provide that a hospital facility's CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report: (1) summarizes, in general terms, the input provided and how and over what time period such input was provided; (2) provides the names of organizations providing input and summarizes the nature and extent of the organization's input; and (3) describes the medically underserved, low-income, or minority populations being represented by organizations or individuals providing input.

The Treasury Department and the IRS request comments regarding whether these proposed rules provide for sufficient disclosure regarding the community input into a CHNA report, or whether the CHNA report should be required to provide any other information regarding input provided, in order to ensure transparency in the CHNA process.

C. Description of prioritization of the community's health needs and of potential measures and identified resources to address such needs

With respect to the requirement in Notice 2011-52 to describe the existing health care facilities and other resources within the community available to meet the health needs identified through the CHNA, many commenters asked that the description of these resources be limited to known or available facilities and resources. These commenters argued that a community-wide inventory of health care resources is not the responsibility of any one hospital facility, but rather a task more appropriate to public health departments. Accordingly, these proposed regulations limit the description of resources available to address health needs to those known or identified in the course of conducting the CHNA.

Additional commenters remarked that both the prioritization of health needs and a description of resources available to meet the health needs identified through the CHNA are more appropriate in an implementation strategy than in a CHNA report. On the other hand, other commenters noted the importance of community input in the overall CHNA process and sought an opportunity to provide input on potential interventions and programs that may be included in a hospital facility's implementation strategy. In fact, such commenters asked that the implementation strategy, in addition to the CHNA, be subject to public input and made widely available to the public.

The Treasury Department and the IRS recognize that conducting a CHNA and developing an implementation strategy are part of one fluid process, with no definite point at which the CHNA ends and the implementation strategy begins. Prioritizing health needs and identifying potential measures and resources to address health needs, for example, could reasonably be interpreted as part of "assessing" those health needs or, alternatively, as the first step in devising a strategy to meet those needs. Accordingly, these proposed regulations respond to commenters' requests for enhanced transparency and an opportunity for community input by requiring items that could reasonably be included as part of either the CHNA or the implementation strategy to be described in the CHNA report. Thus, these proposed regulations require the CHNA report to include a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in prioritizing these health needs. These proposed regulations also require the CHNA report to include a description of the potential measures and resources identified through the CHNA to address the significant health needs.

v. Collaboration on CHNA Reports

Notice 2011-52 stated that the Treasury Department and the IRS intend to allow a hospital organization to conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and public health

and other departments of state and local governments. However, even in cases where collaboration between hospitals occurs, Notice 2011-52 stated that the Treasury Department and the IRS intended to require each hospital facility to document its CHNA in a separate written report. Many commenters recommended that when several hospital facilities within the same defined community work collaboratively on a CHNA, they should be able to issue a joint CHNA report or separate CHNA reports that are substantively identical. These commenters argued that joint reporting would encourage collaboration, reduce redundancy and expense, and provide a more coherent picture of the community's health needs. Some of these commenters suggested that the joint CHNA report could be required to contain different sections for each particular hospital facility. On the other hand, other commenters recommended retaining the requirement for separate CHNA reports, noting that facility-level reporting ensures that information for each hospital facility is clearly presented and easily accessible.

In balancing these concerns, these proposed regulations provide, generally, that every hospital facility must document its CHNA in a separate CHNA report. However, these proposed regulations provide that if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or is basing its CHNA, in part, on a CHNA for all or part of its community conducted by another organization, portions of the hospital facility's CHNA report may be substantively identical to the CHNA report of a collaborating hospital facility or the other organization conducting a CHNA, if appropriate under the facts and circumstances. For example, if a hospital facility conducts a survey of the health needs of residents of homeless shelters located in the community in collaboration with other hospital facilities, the description of that survey in the hospital facility's CHNA report may be identical to the description contained in the CHNA reports for the other collaborating hospital facilities. Similarly, if the state or local public health department with jurisdiction over the community served by the hospital facility conducts an inventory of community health improvement resources available in that community, the hospital

facility may include that inventory in its CHNA report.

These proposed regulations also provide an exception to the general requirement of separate CHNA reports: namely, if a hospital facility collaborates with other hospital facilities in conducting its CHNA, all of the collaborating hospital facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process. In addition, the joint CHNA report must clearly identify each hospital facility to which it applies and an authorized body of each collaborating hospital facility must adopt the joint CHNA report as its own.

Thus, for example, if a hospital facility collaborates with nine other hospital facilities that are all located in and serving a particular MSA, all ten hospital facilities define their community as constituting the entire MSA, and all ten hospital facilities conduct a joint CHNA process, the ten hospital facilities may prepare a joint CHNA report that identifies all of the collaborating hospital facilities by name. Under these proposed regulations, such a joint CHNA report would satisfy the requirement to document the CHNA in a written CHNA report for any one of the collaborating hospital facilities as long as the joint CHNA report is adopted by an authorized body of the hospital facility.

vi. Making the CHNA Report Widely Available to the Public

Consistent with Notice 2011–52, these proposed regulations provide that in order to make its CHNA report widely available to the public, a hospital facility must post the CHNA report on the hospital facility’s Web site or, if the hospital facility does not have its own Web site separate from the hospital organization that operates it, on the hospital organization’s Web site. Alternatively, the hospital facility may post the CHNA report on a Web site established and maintained by another entity as long as either the hospital facility or hospital organization’s Web site (if the facility or organization has a Web site) provides a link to the web page on which the CHNA report is posted, along with clear instructions for accessing the report on that Web site. In addition, the hospital facility must ensure that individuals with access to the Inter-

net can access, download, view, and print a hard copy of the CHNA report without requiring special computer hardware or software (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital facility, hospital organization, or other entity maintaining the Web site. Finally, the hospital facility must provide individuals who ask how to access a copy of the CHNA report online with the direct Web site address, or URL, of the web page on which the document is posted.

Commenters generally supported the requirement outlined in Notice 2011–52 to make the CHNA report widely available on a Web site. Many of these commenters believed that this Web posting requirement alone was sufficient to make the CHNA report widely available to the public. Others, however, urged the Treasury Department and the IRS to expand the requirements for making a CHNA widely available to the public to require the hospital facility to provide paper copies of the CHNA report for free to any individual requesting it. Some commenters requested a requirement that the hospital facility identify strategies to inform various sectors of the community that the CHNA report is widely available on a Web site.

A few commenters also recommended expanding the requirements associated with making CHNA reports widely available on a Web site. Some commenters recommended requiring that the CHNA reports be conspicuously posted on the applicable Web site, for example by requiring a highly visible link on the Web site’s homepage. Another commenter recommended requiring past, as well as current, CHNA reports to be posted, to demonstrate improvement of health care objectives over the long term. Yet another commenter recommended requiring that individuals do not need to provide personally identifiable information or create an account to access the CHNA report.

Because of the focus on increased transparency of hospital facilities in section 501(r), the Treasury Department and the IRS have adopted most of the comments seeking to enhance transparency of a hospital facility’s CHNA by expanding the requirements to make the CHNA report widely available to the public. Specifically, these proposed regulations make

four changes to the interim rule described in Notice 2011–52 for making the CHNA report widely available to the public. First, these proposed regulations require a complete version of the CHNA report to be “conspicuously” posted on a Web site, to ensure that the CHNA report can be easily located on the Web site. Second, instead of requiring the CHNA report to be posted on the Web site until the next CHNA report is posted, these proposed regulations require the CHNA report to remain on the Web site until two subsequent CHNA reports have been posted, so information on trends will be available to the public. Third, these proposed regulations add that an individual must not be required to create an account or otherwise be required to provide personally identifiable information in order to access the CHNA report on a Web site. Fourth, these proposed regulations add a requirement that a hospital facility must make a paper copy of its CHNA report available for public inspection without charge at the hospital facility at least until the date the hospital facility has made available for public inspection, without charge, a paper copy of its two subsequent CHNAs.

Because the requirement to make a document “widely available on a Web site” applies not only to a hospital facility’s CHNA reports but also, under the 2012 proposed regulations, to its financial assistance policy and related documents, the term “widely available on a Web site” is defined in the definitions section of these proposed regulations and will apply to both rules.

Finally, to facilitate the sharing of draft versions of the CHNA report for comment as requested by some commenters, these proposed regulations provide that a hospital facility will not be considered to have made the CHNA report widely available to the public for purposes of determining the date on which the hospital facility has conducted the CHNA if it makes widely available on a Web site (and/or for public inspection) a version of the CHNA report that is expressly marked as a draft on which the public may comment. Thus, a hospital facility may post a draft CHNA report for public review and comment without starting its next three-year CHNA cycle.

b. *Implementation strategies*

Notice 2011–52 noted the intention of the Treasury Department and the IRS to define an “implementation strategy” for a hospital facility as a written plan that addresses each of the health needs identified through a CHNA for the facility. Notice 2011–52 further provided that an implementation strategy would “address” a health need identified through a CHNA if the written plan either: (1) describes how the hospital facility plans to meet the health need, or (2) identifies the health need as one the hospital facility does not intend to meet and explains why the hospital facility does not intend to meet the health need.

A number of commenters asked that the implementation strategy be required to address only significant or priority health needs identified through the CHNA. Other commenters asked if the implementation strategy could address health needs identified from a source other than the hospital facility’s CHNA.

As indicated in section 3.a.ii of this preamble, these proposed regulations limit the health needs that a hospital facility must identify through its CHNA to significant health needs and the health needs covered in the implementation strategy are limited to those significant health needs identified through the CHNA. In addition, these proposed regulations do not require a hospital facility to develop a strategy or plan to address each identified significant health need. Rather, consistent with section 6033(b)(15)(A) of the Code, these proposed regulations follow the approach set forth in Notice 2011–52 and clarify that a hospital facility’s implementation strategy must, with respect to each significant health need identified through the CHNA, either: (1) describe how the hospital facility plans to address the health need; or (2) identify the health need as one the hospital facility does not intend to address and explain why the hospital facility does not intend to address the health need. Accordingly, an implementation strategy may describe how the hospital facility plans to address only a few of the significant health needs identified through a CHNA, as long as it explains why it does not intend to address the other identified significant health needs for which no plan is provided.

Although an implementation strategy must address the significant health needs identified through a hospital facility’s CHNA, these proposed regulations do not limit an implementation strategy to addressing only those health needs, and it may describe activities to address health needs that the hospital facility identifies in other ways.

i. Describing How a Hospital Facility Plans to Address a Significant Health Need

Commenters recommended that the implementation strategy be required to describe its intended impact on health outcomes. Some of these commenters recommended that the descriptions of intended impacts include short- and long-term measurable goals and objectives, as well as methods to evaluate the plan’s effectiveness. One commenter stated that an implementation strategy should assign an economic value to each strategy or activity, and an aggregate total benefit. Others recommended requiring the implementation strategy to include a mechanism to receive ongoing community feedback.

In describing how a hospital facility plans to address a significant health need identified through the CHNA, these proposed regulations adopt some of the commenters’ recommendations by requiring the implementation strategy to describe, in addition to the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions and the plan to evaluate such impact. For example, a hospital facility’s CHNA may identify as significant health needs financial or other barriers to care in the community, such as high rates of financial need or large numbers of uninsured individuals and families. Its implementation strategy could describe a program to decrease the impact of these barriers, such as by expanding its financial assistance program or helping uninsured individuals and families learn about and enroll in sources of insurance such as Medicare, Medicaid, Children’s Health Insurance Program (CHIP), and the new Health Insurance Marketplaces (also known as the Exchanges); state how it anticipates its program will reduce these barriers to care; and identify the data sources it will use to track the program’s impact on the barriers.

These proposed regulations also require the implementation strategy to identify the programs and resources the hospital facility plans to commit to address the health need. Finally, the implementation strategy must describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

While these proposed regulations do not require the implementation strategy itself to include any particular mechanism for community input, they do provide that a hospital facility must establish an ongoing feedback mechanism by requiring a hospital facility, in conducting a CHNA, to take into account written comments received on its most recently adopted implementation strategy, as described in section 3.a.iii.C of this preamble.

ii. Describing Why a Hospital Facility Is Not Addressing a Significant Health Need

Several commenters sought clarification regarding the level of detail required in the implementation strategy’s explanation of why the hospital facility does not intend to address a significant health need. Some of these commenters stated that an explanation of the prioritization strategy together with comments noting that another facility or organization is addressing the health need should be sufficient.

These proposed regulations clarify that a brief explanation of why a hospital facility does not intend to address the significant health need is sufficient. Some possible examples of reasons a hospital facility might offer for not addressing a health need, include, but are not limited to, resource constraints, relative lack of expertise or competency to effectively address the need, a relatively low priority assigned to the need, a lack of identified effective interventions to address the need, and/or the fact that the need is being addressed by other facilities or organizations in the community. This list of possible reasons is not intended to be exhaustive, and a hospital facility may provide whatever reasons reflect its particular facts and circumstances.

iii. Joint Implementation Strategies

Notice 2011–52 noted that the Treasury Department and the IRS intended to allow hospital facilities to collaborate with other facilities and organizations in

developing an implementation strategy but to still require each hospital facility to separately document its implementation strategy. Some commenters requested that hospital facilities conducting a joint CHNA should be permitted to adopt a joint implementation strategy while other commenters recommended retaining the requirement for separate implementation strategies, with each side advancing arguments similar to those advanced for and against joint CHNA reports.

In balancing these concerns, these proposed regulations state that a hospital facility may develop an implementation strategy in collaboration with other facilities and organizations. In addition, these proposed regulations provide that a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy generally must document its implementation strategy in a separate written plan that is tailored to the hospital facility and takes into account its specific programs and resources.

However, these proposed regulations also provide an exception to the general requirement of separate implementation strategies: namely, a hospital facility collaborating with other hospital facilities may adopt a joint implementation strategy as long as it documents its CHNA in a joint CHNA report (as described in section 3.a.v of this preamble) and the joint implementation strategy meets three requirements. First, the joint implementation strategy must be clearly identified as applying to the hospital facility. Second, the joint implementation strategy must clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the programs and resources the hospital facility plans to commit in taking those actions. Third, the joint implementation strategy must include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

iv. When the Implementation Strategy Must Be Adopted

In order to satisfy the CHNA requirements with respect to any taxable year, section 501(r)(3)(A)(ii) requires a hospital facility to adopt an implementation strategy to meet the health needs identified

through the CHNA described in section 501(r)(3)(A)(i). Consistent with this statutory language, Notice 2011-52 stated the intention of the Treasury Department and the IRS to require a hospital facility to adopt an implementation strategy to meet the health needs identified through a CHNA by the end of the same taxable year in which it conducts that CHNA. A number of commenters sought additional time to complete the implementation strategy, in part to accommodate collaborating hospital facilities with different taxable years. Most of these commenters recommended that the implementation strategy should be adopted within 12 months after completion of the CHNA or by the end of the next taxable year, rather than by the end of the same taxable year in which the CHNA is completed.

Because a hospital facility only has to conduct a CHNA once every three years and may begin the CHNA process at any time during the three-year period, a hospital facility should have ample time to complete the CHNA earlier in the third taxable year and adopt an implementation strategy by the end of that same taxable year. The flexibility afforded by a three-year cycle should also allow hospital facilities with different tax years sufficient time to collaborate. Thus, consistent with Notice 2011-52, these proposed regulations provide that an authorized body of the hospital facility must adopt the implementation strategy by the end of the same taxable year in which the hospital facility finishes conducting the CHNA (typically, by making the CHNA report widely available to the public). These proposed regulations also clarify that if a hospital facility begins working on a CHNA in one taxable year but completes the final required step for the CHNA (and hence is considered to have conducted it) in the subsequent taxable year, it is not required to adopt the implementation strategy until the taxable year in which the CHNA process is considered conducted, not the year it began. The Treasury Department and the IRS seek comments on whether this rule will materially inhibit the ability of hospital facilities with different taxable years to collaborate with each other or otherwise burden hospital facilities unnecessarily.

Notwithstanding the general rule that the implementation strategy must be adopted in the same taxable year the

CHNA is considered conducted, these proposed regulations provide transition relief for the adoption of a hospital facility's implementation strategy for its first CHNA conducted after the effective date of section 501(r)(3), in recognition of the fact that certain hospital facilities may not have a full three years in which to conduct their first CHNA. This transition relief is described in section 3.d of this preamble.

c. *New hospital facilities*

Notice 2011-52 requested comments regarding when a hospital facility that is newly acquired or placed into service must conduct a CHNA. Comments received on this issue ranged from requiring such a hospital facility to conduct a CHNA within the first taxable year of acquisition or licensing to allowing the facility three taxable years following the date of acquisition or licensing. In addition, at least two commenters asked for clarification on when a for-profit hospital that converts to section 501(c)(3) status must conduct a CHNA. Additional commenters asked if a short taxable year resulting from, for example, a change in ownership, is considered a "taxable year" for purposes of the three-year CHNA cycle.

These proposed regulations provide that a hospital facility that is newly acquired or placed into service by a hospital organization, or that becomes newly subject to section 501(r) because the hospital organization that operates it is newly recognized as described in section 501(c)(3), must conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through that CHNA by the last day of the second taxable year beginning after the date, respectively, the hospital facility is acquired or placed into service, or newly subject to section 501(r).

A short taxable year of less than twelve months is considered a taxable year for purposes of section 501(r). Thus, the taxable year in which a hospital facility is acquired or placed into service, or becomes subject to section 501(r), is a taxable year for purposes of the CHNA requirements, regardless of whether that taxable year is less than twelve months. As a result, a deadline of the last day of the second taxable year beginning after the date of acquisition, licensure, or section 501(c)(3) recognition provides these new hospital fa-

ilities with three taxable years (even if less than three full calendar years) to meet the section 501(r)(3) requirements.

d. *Transition rules*

A number of commenters requested various forms of transition relief, noting the complexity of the new CHNA requirements. In particular, a few commenters asked if a CHNA conducted before the effective date of the CHNA requirements could satisfy the CHNA requirements for a taxable year beginning after the effective date (that is, for a taxable year beginning after March 23, 2012). In addition, several commenters specifically requested transition relief with respect to the first implementation strategy adopted after the effective date of the CHNA requirements. The suggestions for transition relief for the adoption of the first implementation strategy ranged from 30 to 60 days after the end of the taxable year in which the CHNA was conducted to the end of the taxable year following the taxable year in which the CHNA was conducted. In response to these comments, these proposed regulations provide transition relief that is tailored to the taxable year after March 23, 2010, in which a hospital facility conducts its first CHNA.

i. CHNA Conducted in Taxable Year Beginning Before March 23, 2012

These proposed regulations provide that a hospital facility that conducted a CHNA described in section 501(r)(3) in either of its first two taxable years beginning after March 23, 2010, does not need to meet the requirements of section 501(r)(3) again until the third taxable year following the taxable year in which the hospital facility conducted the CHNA. To qualify for this transition relief, the hospital facility must adopt an implementation strategy to meet the community health needs identified through the CHNA conducted in its first taxable year beginning after March 23, 2010 or 2011 on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012. Thus, for example, if a hospital facility reporting on a calendar-year basis conducts a CHNA in 2012 and adopts an implementation strategy for that CHNA on or before May 15,

2014, it does not need to meet the section 501(r)(3) requirements again until 2015.

ii. CHNA Conducted in First Taxable Year Beginning after March 23, 2012

If a hospital facility conducts a CHNA described in section 501(r)(3) in its first taxable year beginning after March 23, 2012, these proposed regulations provide that the hospital facility will be deemed to satisfy the requirement to adopt an implementation strategy in the same taxable year the CHNA is conducted if an authorized body of the hospital facility adopts an implementation strategy to meet the community health needs identified through that CHNA on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012.

4. *Reporting Requirements Related to CHNAs*

Notice 2011–52 stated the intention of the Treasury Department and the IRS to require a hospital organization to attach to its annual information return (Form 990) the most recently adopted implementation strategy for each of the hospital facilities it operates. A few commenters stated that, rather than require the entire implementation strategy to be attached to the Form 990, the Treasury Department and the IRS should permit a narrative summary description of the contents of its implementation strategy to be provided on the Form 990. One of these commenters noted that the implementation strategy is only required to be updated every three years, so in many instances a narrative may provide more relevant and timely information. A number of other commenters recommended requiring the implementation strategy to be made widely available to the public, rather than merely attached to the Form 990, in order to encourage greater transparency and provide an opportunity for public input and comment.

These proposed regulations allow a hospital organization either to attach to its Form 990 a copy of the most recently adopted implementation strategy for each hospital facility it operates or to provide on the Form 990 the URL(s) of the web page(s) on which it has made each implementation strategy widely available on a Web site. An implementation strategy

must describe, with respect to each significant health need identified through the CHNA, how the hospital facility plans to address the health need or why the hospital facility does not intend to address the health need. Similarly, section 6033(b)(15)(A) requires a hospital organization to furnish annually information setting forth a “description of how the organization is addressing the needs identified in each” CHNA and “a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.” Thus, the requirement in these proposed regulations to attach the implementation strategy to the Form 990, or provide on the Form 990 the URL where the implementation strategy is made widely available on a Web site, partially implements section 6033(b)(15)(A).

However, the requirement in section 6033(b)(15)(A) also encompasses an annual, up-to-date description of the actions actually taken by a hospital facility during the taxable year to address the significant health needs identified through the most recently conducted CHNA (which, presumably, will typically be steps taken during a taxable year to execute the hospital facility’s most recently adopted implementation strategy). Accordingly, these proposed regulations require a hospital organization to provide annually on the Form 990 a description of the actions taken during the taxable year to address the significant health needs identified through its most recent CHNA for each hospital facility it operates or, if no actions were taken with respect to one or more of these health needs, the reason or reasons why no actions were taken.

These proposed regulations also reiterate the requirement of section 6033(b)(15)(B) that a hospital organization attach to its Form 990 a copy of its audited financial statements for the taxable year — or in the case of an organization the financial statements of which are included in consolidated financial statements with other organizations, such consolidated financial statements. The Treasury Department and the IRS request comments regarding whether hospital organizations whose financial statements are included in consolidated financial statements should be able to redact financial information

about any taxable organizations that are members of the consolidated group.

Finally, consistent with section 6033(b)(10), these proposed regulations require a hospital organization to disclose the amount of the excise tax imposed on the organization under section 4959 during the taxable year for failures to meet the requirements of section 501(r)(3).

A few commenters requested clarification regarding whether government hospitals will continue to be excepted from these and other Form 990 reporting requirements under Rev. Proc. 95-48, 1995-2 C.B. 418. In Rev. Proc. 95-48, the IRS exercised its discretionary authority under section 6033(a)(3)(B) to relieve certain governmental units and affiliates of governmental units from the requirement to file a Form 990. The Affordable Care Act did not change the requirements regarding which organizations are required to file a Form 990. Accordingly, a government hospital (other than one that is described in section 509(a)(3)) that has been excused from filing a Form 990 under Rev. Proc. 95-48 or a successor revenue procedure is not required to file a Form 990. Because government hospitals described in Rev. Proc. 95-48 (other than those described in section 509(a)(3)) are relieved from the annual filing requirements under section 6033, they are also relieved from any new reporting requirements imposed on hospital organizations by these proposed regulations under section 6033, including under sections 6033(b)(10)(D) and (b)(15) and the proposed requirement to attach one or more implementation strategies to a Form 990.

5. Excise Tax on Failure to Meet CHNA Requirements

Section 4959 imposes a \$50,000 excise tax on a hospital organization that fails to meet the CHNA requirements of section 501(r)(3) with respect to any taxable year.

Notice 2011-52 indicated the intent of the Treasury Department and the IRS to impose the \$50,000 tax with respect to a failure by a hospital facility to satisfy section 501(r)(3) in any three-year period, making it possible for the excise tax to apply in sequential years. Notice 2011-52 provided an example of a hospital organization that reports on a calendar-year basis and operates only one hospital facility,

which is subject to the \$50,000 excise tax in 2013 because the hospital facility failed to conduct a CHNA in 2011, 2012, and 2013. If the hospital facility again fails to conduct a CHNA by the last day of 2014, Notice 2011-52 noted the hospital organization will again be subject to the \$50,000 excise tax in 2014 for the hospital facility's failure to conduct a CHNA in 2012, 2013, and 2014. These proposed regulations include this example of the application of the section 4959 excise tax and confirm that the excise tax may be imposed for each taxable year that a hospital facility fails to meet the section 501(r)(3) requirements. These proposed regulations also make clear that the excise tax may be imposed in addition to any tax imposed on a noncompliant hospital facility as described in section 2.d of this preamble or that results from revocation of a hospital organization's section 501(c)(3) status.

In addition, Notice 2011-52 stated the intention of the Treasury Department and the IRS to apply the section 4959 excise tax separately with respect to each hospital facility's failure to meet the CHNA requirements. Thus, if a hospital organization that operates two hospital facilities fails to meet the requirements of section 501(r)(3) with respect to both facilities in any taxable year, the hospital organization will be subject to a total excise tax of \$100,000 (\$50,000 for each hospital facility) for that taxable year.

At least one commenter argued that applying the \$50,000 excise tax on a facility-by-facility basis is inconsistent with the statutory language in section 4959 that "there is imposed on the organization a tax equal to \$50,000." On the other hand, two commenters explicitly supported applying the section 4959 excise tax at the hospital facility level. One of these commenters expressed concern that if the \$50,000 excise tax were imposed on a hospital organization without regard to the number of hospital facilities it operates that have failed the section 501(r)(3) requirements, a hospital organization operating multiple facilities may choose to pay the tax rather than conduct a CHNA and adopt an implementation strategy for every facility it operates.

The Treasury Department and the IRS note that section 501(r)(2)(B)(i) requires a hospital organization operating more than one hospital facility to meet the

CHNA requirements "separately with respect to each such facility" and section 501(r)(2)(B)(ii) suggests that one hospital organization can fail to meet the CHNA requirements separately with respect to each hospital facility. Thus, a hospital organization with multiple hospital facilities can "fail[] to meet the requirements of section 501(r)(3)" within the meaning of section 4959 separately with respect to each hospital facility. Accordingly, these proposed regulations adopt the approach in Notice 2011-52 of applying the excise tax on a facility-by-facility basis.

One commenter requested clarification that the excise tax will be imposed on any hospital organization that fails to satisfy any requirement under section 501(r)(3), including the requirement to adopt an implementation strategy, and is not limited to a failure related to conducting the CHNA. These proposed regulations, in adopting the approach taken in Notice 2011-52, clarify that the excise tax is imposed on a failure to meet any of the requirements under section 501(r)(3), including the requirement to adopt an implementation strategy described in section 501(r)(3)(A)(ii).

Effective/Applicability Dates

The 2012 proposed regulations under section 501(r)(4) through (r)(6) were proposed to apply for taxable years beginning on or after the date those rules are published in the **Federal Register** as final or temporary regulations. By contrast, these proposed regulations provide that both these proposed regulations and the 2012 proposed regulations will generally be effective on the date these rules are published in the **Federal Register** as final or temporary regulations. Providing for an immediate effective date gives immediate effect to the transition relief described in §1.501(r)-3(e) and will also allow the Treasury Department and the IRS to consider transition relief for the requirements under §1.501(r)-4 through §1.501(r)-6 of the 2012 proposed regulations based on the estimated amount of time to come into compliance with those rules rather than a particular hospital organization's taxable year. The proposed regulations under sections 6033(b)(10) and (b)(15)(A) are proposed to be effective for returns filed on or after the date these rules are published in

the **Federal Register** as final or temporary regulations.

A hospital facility may rely on §1.501(r)-3 of these proposed regulations for any CHNA conducted or implementation strategy adopted on or before the date that is six months after the date these proposed regulations are published as final or temporary regulations in the **Federal Register**. As provided in Notice 2011-52, hospital organizations may continue to rely on the interim rules described in Notice 2011-52 for any CHNA conducted or implementation strategy adopted on or before October 5, 2013, which is the date that is six months after these proposed regulations are published. After October 5, 2013, Notice 2011-52 is obsolete. The Treasury Department and the IRS invite comments on whether, and what type of, additional transitional relief may be necessary.

Hospital organizations should note that the statutory effective date of section 501(r)(3) is a hospital organization's first taxable year beginning after March 23, 2012. The effective date for the other requirements under section 501(r) is a hospital organization's first taxable year beginning after March 23, 2010.

Availability of IRS Documents

IRS notices, revenue rulings, and revenue procedures cited in this preamble are made available by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. The collection of information is in §1.501(r)-3 and §1.6033-2(a)(2)(ii)(I) of

the regulations. This certification is based on the following:

Consistent with the requirements imposed by statute, §1.501(r)-3 of the regulations requires hospital facilities to conduct a CHNA and adopt an implementation strategy. However, these requirements need only be satisfied once over a period of three taxable years. Moreover, some hospital facilities already conduct similar community needs assessments under state law, and the Treasury Department and the IRS expect that these facilities will be able to draw upon pre-existing processes and resources to some extent.

Consistent with the requirements imposed by statute, §1.6033-2(a)(2)(ii)(I) of the regulations requires affected organizations to report annually on a Form 990 actions taken during the year to address community health needs and to attach audited financial statements to the Form 990. To assist the IRS and the public, the regulations also require affected organizations to attach to the Form 990 a copy of the most recently adopted implementation strategy or provide the URL of a web page where it is available to the public. For affected organizations, the burden of providing either a copy of the implementation strategy or the address of a Web site where it can be found will be minimal. Consequently, the regulations do not add to the impact on small entities imposed by the statutory scheme.

For these reasons, the collection of information in this regulation that is subject to the Regulatory Flexibility Act will not impose a significant economic burden upon the affected organizations. Accordingly, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small entities.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in this preamble under "Addresses." The

Treasury Department and the IRS request comments on all aspects of the proposed rules. All comments will be available at www.regulations.gov or upon request.

A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

Drafting Information

The principal authors of these proposed regulations are Preston J. Quesenberry and Amy F. Giuliano, Office of the Chief Counsel (Tax-Exempt and Government Entities). However, other personnel from the Treasury Department and the IRS participated in their development.

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Proposed Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 53 are proposed to be amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 1.501(r)-0 as proposed to be amended at 77 FR 38160 (June 26, 2012) is proposed to be further amended as follows:

1. Adding a new entry to §1.501(r)-1, paragraph (c).
2. Adding new entries to §1.501(r)-2 and §1.501(r)-3.
3. Revising the entry to §1.501(r)-7.

The revision and additions to read as follows:

§1.501(r)-0 Outline of regulations.

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§1.501(r)-1 Definitions.

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(c) Additional definitions.

- (1) Authorized body of a hospital facility.
- (2) Operating a hospital facility.
- (3) Partnership agreement.
- (4) Widely available on a Web site.

§1.501(r)-2 Failures to satisfy section 501(r).

- (a) Revocation of section 501(c)(3) status.
- (b) Minor and inadvertent omissions and errors.
- (c) Excusing certain failures if hospital facility corrects and discloses.
- (d) Taxation of noncompliant hospital facilities.
 - (1) In general.
 - (2) Noncompliant facility income.
 - (3) No aggregation.
 - (4) Interaction with other Code provisions.

§1.501(r)-3 Community health needs assessments.

- (a) In general.
- (b) Conducting a CHNA.
 - (1) In general.
 - (2) Date a CHNA is conducted.
 - (3) Community served by the hospital facility.
 - (4) Assessing community health needs.
 - (5) Persons representing the broad interests of the community.
 - (6) Medically underserved populations.
 - (7) Documentation of a CHNA.
 - (8) Making the CHNA report widely available to the public.
- (c) Implementation strategy.
 - (1) In general.
 - (2) Description of how the hospital facility plans to address a significant health need.
 - (3) Description of why a hospital facility is not addressing a significant health need.
 - (4) Joint implementation strategies.
 - (5) When the implementation strategy must be adopted.
- (d) New hospital facilities.
- (e) Transition rules.
 - (1) CHNA conducted in taxable year beginning before March 23, 2012.
 - (2) CHNA conducted in first taxable year beginning after March 23, 2012.

§1.501(r)-7 Effective/applicability dates.

- (a) Effective/applicability date.
 - (b) Reliance and transition period.
- Par. 3. Section 1.501(r)-1 as proposed to be amended at 77 FR 38160 (June 26,

2012) is proposed to be further amended by revising paragraphs (b)(15) and (b)(16) and adding new paragraph (c) to read as follows:

§1.501(r)-1 Definitions.

(b) ***

(15) *Hospital facility* means a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Multiple buildings operated under a single state license are considered to be a single hospital facility. For purposes of this paragraph (b)(15), the term “state” includes only the 50 states and the District of Columbia and not any U.S. territory or foreign country. References to a hospital facility taking actions include instances in which the hospital organization operating the hospital facility takes actions through or on behalf of the hospital facility.

(16) *Hospital organization* means an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities. If the section 501(c)(3) status of such an organization is revoked, the organization will, for purposes of section 4959, continue to be treated as a hospital organization during the taxable year in which such revocation becomes effective.

(c) *Additional definitions*—(1) *Authorized body of a hospital facility* means—

(i) The governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization that operates the hospital facility, or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body; or

(ii) If the hospital facility has its own governing body and is recognized as an entity under state law but is a disregarded entity for federal tax purposes, the governing body of that hospital facility, or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body.

(2) *Operating a hospital facility* includes operating the facility through the organization’s own employees or contracting out to another organization to operate

the facility. For example, if an organization hires a management company to operate the facility, the hiring organization is considered to operate the facility. An organization also operates a hospital facility if it is the sole member or owner of a disregarded entity that operates the hospital facility. In addition, an organization operates a hospital facility if it owns a capital or profits interest in, or is a member of, a joint venture, limited liability company, or other entity treated as a partnership for federal income tax purposes that operates the hospital facility unless either—

(i) The organization does not have control over the operation of the hospital facility sufficient to ensure that the operation of the hospital facility furthers an exempt purpose described in section 501(c)(3) and thus treats the operation of the hospital facility, including the facility’s provision of medical care, as an unrelated trade or business described in section 513(a) with respect to the hospital organization; or

(ii) At all times since March 23, 2010, the organization has been organized and operated primarily for educational or scientific purposes and has not engaged primarily in the operation of one or more hospital facilities and, pursuant to a partnership agreement entered into prior to March 23, 2010,—

(A) Does not own more than 35 percent of the capital or profits interest in the partnership (determined in accordance with section 707(b)(3));

(B) Does not own a general partner interest, managing-member interest, or similar interest in the partnership; and

(C) Does not have control over the operation of the hospital facility sufficient to ensure that the hospital facility complies with the requirements of section 501(r).

(3) *Partnership agreement*, for purposes of paragraph (c)(2)(ii) of this section, includes all written agreements among the partners, or between one or more partners and the partnership, concerning affairs of the partnership and responsibilities of the partners, whether or not embodied in a document referred to by the partners as the partnership agreement, entered into before March 23, 2010. A partnership agreement also includes any modifications to the agreement agreed to by all partners, or adopted in any other manner provided by the partnership agreement, but no such modifications adopted

on or after March 23, 2010, that affect whether or not the agreement is described in paragraph (c)(2)(ii) of this section. In addition, a partnership agreement includes provisions of federal, state, or local law, as in effect before March 23, 2010, that govern the affairs of the partnership or are considered under such law to be part of the partnership agreement.

(4) *Widely available on a Web site means—*

(i) The hospital facility conspicuously posts a complete and current version of the document on—

(A) The hospital facility's Web site;

(B) If the hospital facility does not have its own Web site separate from the hospital organization that operates it, the hospital organization's Web site; or

(C) A Web site established and maintained by another entity, but only if the Web site of the hospital facility or hospital organization (if the facility or organization has a Web site) provides a conspicuously-displayed link to the web page on which the document is posted, along with clear instructions for accessing the document on that Web site;

(ii) Individuals with access to the Internet can access, download, view, and print a hard copy of the document without requiring special computer hardware or software (other than software that is readily available to members of the public without payment of any fee); without payment of a fee to the hospital facility, hospital organization, or other entity maintaining the Web site; and without creating an account or being otherwise required to provide personally identifiable information; and

(iii) The hospital facility provides individuals who ask how to access a copy of the document online with the direct Web site address, or URL, of the web page on which the document is posted.

Par. 4. Sections 1.501(r)-2 and 1.501(r)-3 are added to read as follows:

§1.501(r)-2 Failures to satisfy section 501(r).

(a) *Revocation of section 501(c)(3) status.* Except as otherwise provided in paragraphs (b) and (c) of this section, a hospital organization failing to meet one or more of the requirements of section 501(r) separately with respect to one or more hospital facilities it operates may have its section

501(c)(3) status revoked as of the first day of the taxable year in which the failure occurs. In determining whether to continue to recognize the section 501(c)(3) status of a hospital organization that fails to meet one or more of the requirements of section 501(r) with respect to one or more hospital facilities, the Commissioner will consider all relevant facts and circumstances including, but not limited to, the following—

(1) Whether the organization has previously failed to meet the requirements of section 501(r), and, if so, whether the same type of failure previously occurred;

(2) The size, scope, nature, and significance of the organization's failure(s);

(3) In the case of an organization that operates more than one hospital facility, the number, size, and significance of the facilities that have failed to meet the section 501(r) requirements relative to those that have complied with these requirements;

(4) The reason for the failure(s);

(5) Whether the organization had, prior to the failure(s), established practices and procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements;

(6) Whether the practices and procedures had been routinely followed and the failure(s) occurred through an oversight or mistake in applying them;

(7) Whether the organization has implemented safeguards that are reasonably calculated to prevent similar failures from occurring in the future;

(8) Whether the organization corrected the failure(s) as promptly after discovery as is reasonable given the nature of the failure(s); and

(9) Whether the organization took the measures described in paragraphs (a)(7) and (a)(8) of this section before the Commissioner discovered the failure(s).

(b) *Minor and inadvertent omissions and errors.* A hospital facility's omission of required information from a policy or report described in §1.501(r)-3 or §1.501(r)-4, or error with respect to the implementation or operational requirements described in §1.501(r)-3 through §1.501(r)-6, will not be considered a failure to meet a requirement of section 501(r) if—

(1) Such omission or error was minor, inadvertent, and due to reasonable cause; and

(2) The hospital facility corrects such omission or error as promptly after discovery as is reasonable given the nature of the omission or error.

(c) *Excusing certain failures if hospital facility corrects and discloses.* Pursuant to guidance set forth by revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin, a hospital facility's failure to meet one or more of the requirements described in §1.501(r)-3 through §1.501(r)-6 that is neither willful nor egregious shall be excused for purposes of this section if the hospital facility corrects and makes disclosure in accordance with the rules set forth in the guidance. If a hospital facility's failure was willful or egregious, the failure will not be excused, even if the hospital facility corrects and makes disclosure in accordance with the guidance, and no presumption will be created by a hospital facility's correction and disclosure that the failure was neither willful nor egregious. For purposes of this paragraph (c), willful is to be interpreted consistent with the meaning of that term in the context of civil penalties, which would include a failure due to gross negligence, reckless disregard, or willful neglect. Furthermore, notwithstanding a hospital facility's compliance with such future guidance, a hospital facility may, in the discretion of the IRS, be subject to an excise tax under section 4959 for failures to meet the requirements of section 501(r)(3).

(d) *Taxation of noncompliant hospital facilities—(1) In general.* Except as otherwise provided in paragraphs (b) and (c) of this section, if a hospital organization that operates more than one hospital facility fails to meet one or more of the requirements of section 501(r) separately with respect to a hospital facility during a taxable year, the income derived from the noncompliant hospital facility ("noncompliant facility income") during that taxable year will be subject to tax computed as provided in section 11 (or as provided in section 1(e) if the hospital organization is a trust described in section 511(b)(2)), but substituting "noncompliant facility income" for "taxable income," if—

(i) The hospital organization continues to be recognized as described in section 501(c)(3) during the taxable year, but

(ii) The hospital organization would not continue to be recognized as described in section 501(c)(3) during the taxable year based on the facts and circumstances described in paragraph (a) of this section (but disregarding paragraph (a)(3)) if the noncompliant hospital facility were the only hospital facility operated by the organization.

(2) *Noncompliant facility income*—(i) *In general.* For purposes of this paragraph (d), the noncompliant facility income derived from a hospital facility during a taxable year will be the gross income derived from that hospital facility during the taxable year, less the deductions allowed by chapter 1 of the Internal Revenue Code (Code) that are directly connected to the operation of that hospital facility during the taxable year, excluding any gross income and deductions taken into account in computing any unrelated business taxable income described in section 512 that is derived from the facility during the taxable year.

(ii) *Directly connected deductions.* For purposes of this paragraph (d), to be directly connected with the operation of a hospital facility that has failed to meet the requirements of section 501(r), an item of deduction must have proximate and primary relationship to the operation of the hospital facility. Expenses, depreciation, and similar items attributable solely to the operation of a hospital facility are proximately and primarily related to such operation, and therefore qualify for deduction to the extent that they meet the requirements of section 162, section 167, or other relevant provisions of the Code. Where expenses, depreciation, and similar items are attributable to a noncompliant hospital facility and other hospital facilities operated by the hospital organization (and/or to other activities of the hospital organization unrelated to the operation of hospital facilities), such items shall be allocated between the hospital facilities (and/or other activities) on a reasonable basis. The portion of any such item so allocated to a noncompliant hospital facility is proximately and primarily related to the operation of that facility and shall be allowable as a deduction in computing the facility's noncompliant facility income in the manner and to the extent it would meet the requirements of section 162, section 167, or other relevant provisions of the Code.

(3) *No aggregation.* In computing the noncompliant facility income of a hospital facility, the gross income from (and the deductions allowed with respect to) the hospital facility may not be aggregated with the gross income from (and the deductions allowed with respect to) the hospital organization's other noncompliant hospital facilities subject to tax under this paragraph (d) or its unrelated trade or business activities described in section 513.

(4) *Interaction with other Code provisions*—(i) *Hospital organization operating a noncompliant hospital facility continues to be treated as tax-exempt.* A hospital organization operating a noncompliant hospital facility subject to tax under this paragraph (d) shall continue to be treated as an organization that is exempt from tax under section 501(a) because it is described in section 501(c)(3) for all purposes of the Code. Thus, for example, the application of this paragraph (d) shall not, by itself, affect the tax-exempt status of bonds issued to finance the noncompliant hospital facility.

(ii) *Noncompliant hospital facility operated by a tax-exempt hospital organization is subject to tax.* A noncompliant hospital facility described in paragraph (d)(1) of this section is subject to tax under this paragraph (d), notwithstanding the fact that the hospital organization operating the hospital facility is otherwise exempt from tax under section 501(a) and subject to tax under section 511(a) and that §1.11-1(a) of this chapter states such organizations are not liable to the tax imposed under section 11.

(iii) *Noncompliant hospital facility not a business entity.* A noncompliant hospital facility subject to tax under this paragraph (d) is not considered a business entity for purposes of §301.7701-2(b)(7) of this chapter.

§1.501(r)-3 Community health needs assessments.

(a) *In general.* With respect to any taxable year, a hospital organization meets the requirements of section 501(r)(3) with respect to a hospital facility it operates only if—

(1) The hospital facility has conducted a community health needs assessment (CHNA) that meets the requirements of paragraph (b) of this section in such tax-

able year or in either of the two taxable years immediately preceding such taxable year; and

(2) An authorized body of the hospital facility (as defined in §1.501(r)-1(c)(1)) has adopted an implementation strategy to meet the community health needs identified through the CHNA, as described in paragraph (c) of this section, by the end of the taxable year in which the hospital facility conducts the CHNA.

(b) *Conducting a CHNA*—(1) *In general.* To conduct a CHNA for purposes of paragraph (a) of this section, a hospital facility must complete all of the following steps—

(i) Define the community it serves;

(ii) Assess the health needs of that community;

(iii) In assessing the health needs of the community, take into account input from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health;

(iv) Document the CHNA in a written report (“CHNA report”) that is adopted for the hospital facility by an authorized body of the hospital facility; and

(v) Make the CHNA report widely available to the public.

(2) *Date a CHNA is conducted.* For purposes of this section, a hospital facility will be considered to have conducted a CHNA on the date it has completed all of the steps described in paragraph (b)(1) of this section. Solely for purposes of determining the date on which a CHNA has been conducted, a hospital facility will be considered to have made the CHNA report widely available to the public on the date it first makes the CHNA report widely available to the public as described in paragraph (b)(8)(i) of this section.

(3) *Community served by the hospital facility.* In defining the community it serves for purposes of paragraph (b)(1)(i) of this section, a hospital facility may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). A hospital facility may define its community to include populations in addition to its patient populations and geographic areas

outside of those in which its patient populations reside. However, a hospital facility may not define its community to exclude medically underserved, low-income, or minority populations who are part of its patient populations, live in geographic areas in which its patient populations reside (unless they are not part of the hospital facility's target populations or affected by its principal functions), or otherwise should be included based on the method the hospital facility uses to define its community. In addition, if a hospital facility's method of defining its community takes into account patient populations, the hospital facility must treat as patients all individuals who receive care from the hospital facility, 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 hospital facility's financial assistance policy.

(4) *Assessing community health needs.* To assess the health needs of the community it serves for purposes of paragraph (b)(1)(ii) of this section, a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. In addition, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.

(5) *Persons representing the broad interests of the community.* To take into account input from persons who represent the broad interests of the community it serves (including those with special knowledge of or expertise in public health)

for purposes of paragraph (b)(1)(iii) of this section, a hospital facility must take into account input from the sources listed in paragraphs (b)(5)(i), (b)(5)(ii), and (b)(5)(iii) of this section in assessing the health needs of its community. Input from these persons includes, but is not limited to, input on any financial and other barriers to access to care in the community. In addition, a hospital facility may take into account input from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives. A hospital facility must take into account input from the following sources in assessing the health needs of its community—

(i) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of that community;

(ii) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations; and

(iii) Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

(6) *Medically underserved populations.* For purposes of this paragraph (b), medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

(7) *Documentation of a CHNA—(i) In general.* For purposes of paragraph (b)(1)(iv) of this section, the CHNA report adopted for the hospital facility by an authorized body of the hospital facility must include—

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility took into account input from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing such significant health needs; and

(E) A description of the potential measures and resources identified through the CHNA to address the significant health needs.

(ii) *Process and methods used to conduct the CHNA.* A hospital facility's CHNA report will be considered to describe the process and methods used to conduct the CHNA for purposes of paragraph (b)(7)(i)(B) of this section if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA.

(iii) *Input from persons who represent the broad interests of the community served by the hospital facility.* A hospital facility's CHNA report will be considered to describe how the hospital facility took into account input from persons who represent the broad interests of the community it serves for purposes of paragraph (b)(7)(i)(C) of this section if the CHNA report summarizes, in general terms, the input provided by such persons and how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what dates); provides the names of organizations providing input and summarizes the nature and extent of the organization's input; and describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. A CHNA report does not need to name or otherwise individually identify any individuals participating in community forums, focus groups, survey samples, or similar groups.

(iv) *Separate CHNA reports.* While a hospital facility may conduct its CHNA in collaboration with other organizations and facilities (including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations), every hospital facility must document the information described in this paragraph (b)(7) in a separate CHNA report to satisfy paragraph (b)(1)(iv) of this section unless it is eligible to adopt a joint CHNA report as described in paragraph (b)(7)(v) of this section. However, if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or if another organization has conducted a CHNA for all or part of the hospital facility's community, portions of the hospital facility's CHNA report may be substantively identical to portions of a CHNA report of a collaborating hospital facility or the other organization conducting a CHNA, if appropriate under the facts and circumstances. For example, if a hospital facility conducts a survey of the health needs of residents of homeless shelters located in the community in collaboration with other hospital facilities, the description of that survey in the hospital facility's CHNA report may be identical to the description contained in the CHNA reports for the other collaborating hospital facilities. Similarly, if the state or local public health department with jurisdiction over the community served by the hospital facility conducts an inventory of community health improvement resources available in that community, the hospital facility may include that inventory in its CHNA report.

(v) *Joint CHNA reports*—(A) *In general.* A hospital facility that collaborates with other hospital facilities in conducting its CHNA will satisfy paragraph (b)(1)(iv) of this section if an authorized body of the hospital facility adopts for the hospital facility a joint CHNA report produced for all of the collaborating hospital facilities, as long as all of the collaborating hospital facilities define their community to be the same and conduct a joint CHNA process, and the joint CHNA report is clearly identified as applying to the hospital facility.

(B) *Example.* The following example illustrates this paragraph (b)(7)(v):

Example. P is one of ten hospital facilities located in and serving the populations of a particular

Metropolitan Statistical Area (MSA). P and the other nine facilities in the MSA, some of which are unrelated to P, decide to collaborate in conducting a CHNA for the MSA and to each define their community as constituting the entire MSA. The ten hospital facilities work together with the state and local health departments of jurisdictions in the MSA to assess the health needs of the MSA and collaborate in conducting surveys and holding public forums to receive input from the MSA's residents, including its medically underserved, low-income, and minority populations. The hospital facilities then work together to prepare a joint CHNA report documenting this joint CHNA process that contains all of the elements described in paragraph (b)(7)(i) of this section. The joint CHNA report identifies all of the collaborating hospital facilities, including P, by name, both within the report itself and on the cover page. The board of directors of the hospital organization operating P adopts the joint CHNA report for P. P has complied with the requirements of this paragraph (b)(7)(v) and, accordingly, has satisfied paragraph (b)(1)(iv) of this section.

(8) *Making the CHNA report widely available to the public*—(i) *In general.* For purposes of paragraph (b)(1)(v) of this section, a hospital facility's CHNA report is made widely available to the public only if the hospital facility—

(A) Makes the CHNA report widely available on a Web site, as defined in §1.501(r)-1(c)(4), at least until the date the hospital facility has made widely available on a Web site its two subsequent CHNA reports; and

(B) Makes a paper copy of the CHNA report available for public inspection without charge at the hospital facility at least until the date the hospital facility has made available for public inspection without charge a paper copy of its two subsequent CHNA reports.

(ii) *Making draft CHNA reports widely available.* Notwithstanding paragraph (b)(8)(i) of this section, if a hospital facility makes widely available on a Web site (and/or for public inspection) a version of the CHNA report that is expressly marked as a draft on which the public may comment, the hospital facility will not be considered to have made the CHNA report widely available to the public for purposes of determining the date on which the hospital facility has conducted a CHNA under paragraph (a) of this section.

(c) *Implementation strategy*—(1) *In general.* For purposes of paragraph (a)(2) of this section, a hospital facility's implementation strategy to meet the community health needs identified through the hospital facility's CHNA is a written plan that,

with respect to each significant health need identified through the CHNA, either—

(i) Describes how the hospital facility plans to address the health need; or

(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

(2) *Description of how the hospital facility plans to address a significant health need.* In describing how a hospital facility plans to address a significant health need identified through a CHNA for purposes of paragraph (c)(1)(i) of this section, the implementation strategy must describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and a plan to evaluate such impact. The implementation strategy must also identify the programs and resources the hospital facility plans to commit to address the health need. Finally, the implementation strategy must describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

(3) *Description of why a hospital facility is not addressing a significant health need.* In explaining why it does not intend to address a significant health need for purposes of paragraph (c)(1)(ii) of this section, a hospital facility may provide a brief explanation of its reason for not addressing the health need, including, but not limited to, resource constraints, other facilities or organizations in the community addressing the need, relative lack of expertise or competencies to effectively address the need, a relatively low priority assigned to the need, and/or a lack of identified effective interventions to address the need.

(4) *Joint implementation strategies.* A hospital facility may develop an implementation strategy in collaboration with other facilities and organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, a hospital facility that collaborates with other facilities and organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific programs and resources.

However, a hospital facility that adopts a joint CHNA report described in paragraph (b)(7)(v) of this section may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how the collaborating hospital facilities plan to address the health need or identifies the health need as one the hospital facilities do not intend to address and explains why the hospital facilities do not intend to address the health need, as long as the joint implementation strategy—

(i) Is clearly identified as applying to the hospital facility;

(ii) Clearly identifies the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the programs and resources the hospital facility plans to commit to such actions; and

(iii) Includes a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

(5) *When the implementation strategy must be adopted*—(i) *In general.* For purposes of paragraph (a)(2) of this section, in order to have adopted an implementation strategy to meet the health needs identified through a hospital facility's CHNA by the end of the same taxable year in which the hospital facility conducts that CHNA, an authorized body of the hospital facility must adopt the implementation strategy during the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

(ii) *Example.* The following example illustrates this paragraph (c)(5):

Example. M is a hospital facility that last conducted a CHNA and adopted an implementation strategy in Year 1. In Year 3, M defines the community it serves, assesses the health needs of that community, and takes into account input from persons who represent the broad interests of that community. In Year 4, M documents its CHNA in a CHNA report that is adopted by an authorized body of M, makes the CHNA report widely available on a Web site, and makes paper copies available for public inspection. To meet the requirements of paragraph (a)(2) of this section, an authorized body of M must adopt an implementation strategy to meet the health needs identified through that CHNA by the last day of Year 4.

(d) *New hospital facilities.* A hospital facility that is newly acquired or placed

into service, or that becomes newly subject to the requirements of section 501(r) because the hospital organization that operates it is newly recognized as described in section 501(c)(3), must meet the requirements of section 501(r)(3) by the last day of the second taxable year beginning after the date, respectively, the hospital facility is acquired; licensed, registered, or similarly recognized by its state as a hospital; or newly subject to the requirements of section 501(r) as a result of the hospital organization operating it being recognized as described in section 501(c)(3).

(e) *Transition rules*—(1) *CHNA conducted in taxable year beginning before March 23, 2012.* A hospital facility that conducted a CHNA described in section 501(r)(3) in either its first taxable year beginning after March 23, 2010, or its first taxable year beginning after March 23, 2011, does not need to meet the requirements of section 501(r)(3) again until the third taxable year following the taxable year in which the hospital facility conducted that CHNA, provided that the hospital facility has adopted an implementation strategy to meet the community health needs identified through that CHNA on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012.

(2) *CHNA conducted in first taxable year beginning after March 23, 2012.* A hospital facility that conducts a CHNA described in section 501(r)(3) in its first taxable year beginning after March 23, 2012, will be deemed to satisfy paragraph (a)(2) of this section during that taxable year if an authorized body of the hospital facility adopts an implementation strategy to meet the community health needs identified through that CHNA on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012.

Par. 5. Section 1.501(r)–7 as proposed to be amended at 77 FR 38169 (June 26, 2012) is proposed to be further amended by revising the section to read as follows:

§1.501(r)–7 Effective/applicability dates.

(a) *Effective/applicability date.* The rules of §1.501(r)–1 through §1.501(r)–6 are effective on the date of publication of

the Treasury decision adopting these rules as final or temporary regulations.

(b) *Reliance and transition period.* A hospital facility may rely on §1.501(r)–3 of the proposed regulations published in the **Federal Register** on April 5, 2013, for any CHNA conducted or implementation strategy adopted on or before the date that is six months after these regulations are published as final or temporary regulations in the **Federal Register**.

Par. 6. Section 1.6012–2 is amended by redesignating paragraphs (i) through (k) as paragraphs (j) through (l) and adding new paragraph (i) to read as follows:

§1.6012–2 Corporations required to make returns of income.

* * * * *

(i) *Hospital organizations with non-compliant hospital facilities.* Every hospital organization (as defined in §1.501(r)–1(b)(16)) that is subject to the tax imposed by §1.501(r)–2(d) shall make a return on Form 990-T. The filing of a return to pay the tax described in §1.501(r)–2(d) does not relieve the organization of the duty of filing other required returns.

* * * * *

Par. 7. Section 1.6012–3 is amended by adding new paragraph (a)(10) to read as follows:

§1.6012–3 Returns by fiduciaries.

(a) * * *

(10) *Hospital organizations organized as trusts with noncompliant hospital facilities.* Every fiduciary for a hospital organization (as defined in §1.501(r)–1(b)(16)) organized as a trust described in section 511(b)(2) that is subject to the tax imposed by §1.501(r)–2(d) shall make a return on Form 990-T. The filing of a return to pay the tax described in §1.501(r)–2(d) does not relieve the organization of the duty of filing other required returns.

* * * * *

Par. 8. Section 1.6033–2 is amended by adding paragraphs (a)(2)(ii)(l) and (k)(4) to read as follows:

§1.6033–2 Returns by exempt organizations (taxable years beginning after December 31, 1969) and returns by certain nonexempt organizations (taxable

years beginning after December 31, 1980).

- (a) * * *
- (2) * * *
- (ii) * * *

(I) In the case of a hospital organization (as defined in §1.501(r)-1(b)(16)) described in section 501(c)(3) during the taxable year—

(1) A copy of its audited financial statements for the taxable year (or, in the case of an organization the financial statements of which are included in consolidated financial statements with other organizations, such consolidated financial statements);

(2) Either a copy of the most recently adopted implementation strategy, within the meaning of §1.501(r)-3(c), for each hospital facility it operates or the URL of each web page on which it has made each such implementation strategy widely available on a Web site within the meaning of §1.501(r)-1(c)(4) along with or as part of the community health needs assessment (CHNA) to which the implementation strategy relates;

(3) For each hospital facility it operates, a description of the actions taken during the taxable year to address the significant health needs identified through its most recently conducted CHNA, within the meaning of §1.501(r)-3(b), or, if no actions were taken with respect to one or more of these health needs, the reason(s) why no actions were taken; and

(4) The amount of the excise tax imposed on the organization under section 4959 during the taxable year.

* * * * *

- (k) * * *

(4) The applicability of paragraph (a)(2)(ii)(I) of this section shall be limited to returns filed on or after the date the regulations adding (a)(2)(ii)(I) are published as final or temporary regulations in the **Federal Register**.

PART 53—FOUNDATION AND SIMILAR EXCISE TAXES

Par. 9. The authority citation for part 53 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 10. Section 53.4959-1 is added to read as follows:

§53.4959-1 Taxes on failures by hospital organizations to meet section 501(r)(3).

(a) *Excise tax for failure to meet the section 501(r)(3) requirements*—(1) *In general*. If a hospital organization (as defined in §1.501(r)-1(b)(16)) fails to meet the requirements of section 501(r)(3) separately with respect to a hospital facility it operates in any taxable year, there is imposed on the hospital organization a tax equal to \$50,000. If a hospital organization operates multiple hospital facilities and fails to meet the requirements of section 501(r)(3) with respect to more than one facility it operates, the \$50,000 tax is imposed on the hospital organization separately for each hospital facility's failure. The tax may be imposed for each taxable year that a hospital facility fails to meet the requirements of section 501(r)(3). The tax imposed by this section may be imposed in addition to any tax imposed by §1.501(r)-2(d) or as a result of revocation of a hospital organization's section 501(c)(3) status.

(2) *Examples*. The following examples illustrate this paragraph (a):

Example 1. (i) U is a hospital organization that operates only one hospital facility, V. In Year 1, V conducts a community health needs assessment (CHNA) and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, V does not conduct a CHNA. V fails to conduct a CHNA by the last day of Year 4. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 4 because V has failed to conduct a CHNA in Years 2, 3, and 4. U is subject to a tax equal to \$50,000 for Year 4.

(ii) V also fails to conduct a CHNA by the last day of Year 5. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 5 because V has failed to conduct a CHNA in Years 3, 4, and 5. U is subject to a tax equal to \$50,000 for Year 5.

Example 2. P is a hospital organization that operates only one hospital facility, Q. In Year 1, Q conducts a CHNA and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, Q does not conduct a CHNA. In Year 4, Q conducts a CHNA but does not adopt an implementation strategy to meet the health needs identified through that CHNA by the last day of Year 4. Accordingly, P has failed to meet the requirements of section 501(r)(3) with respect to Q in Year 4 because Q has failed to adopt an implementation strategy by the end of the taxable year in which Q conducted its CHNA. P is subject to a tax equal to \$50,000 for Year 4.

Example 3. R is a hospital organization that operates two hospital facilities, S and T. In Year 1, S and T each conduct a CHNA and adopt an implementation strategy to meet the health needs identified through

the CHNA. In Years 2 and 3, S and T do not conduct a CHNA. S and T each fail to conduct a CHNA by the last day of Year 4. Accordingly, R has failed to meet the requirements of section 501(r)(3) with respect to both S and T in Year 4. R is subject to a tax equal to \$100,000 (\$50,000 for S's failure plus \$50,000 for T's failure) for Year 4.

(b) *Effective/applicability dates*. These rules are effective on the date of publication of the Treasury decision adopting these rules as final or temporary regulations.

Steven T. Miller,
Deputy Commissioner for
Services and Enforcement.

(Filed by the Office of the Federal Register on April 3, 2013, 4:15 p.m., and published in the issue of the Federal Register for April 5, 2013, 78 F.R. 20523)

Section 1446 Tax for Fiscal Year Partnerships in 2013 Announcement 2013-30

Partnerships that have effectively connected taxable income (ECTI) allocable to a foreign partner must file a 2012 Form 8804, *Annual Return for Partnership Withholding Tax (Section 1446)*, for any taxable year that begins in 2012. In all such cases, the 2012 Form 8804 continues to apply the tax rates in effect in 2012 for purposes of determining the amount of section 1446 withholding tax that partnerships must pay for taxable years beginning in 2012.

Foreign partners in a fiscal year partnership with a taxable year ending in 2013 nonetheless must pay tax on their distributive share of the partnership's ECTI based on the tax rates in effect in the taxable year of their inclusion as determined under section 706(a).

This Announcement is effective for partnership taxable years beginning in 2012.

DRAFTING INFORMATION

The principal author of this announcement is Ronald M. Gootzeit of the Office of Associate Chief Counsel (International). For further information regarding this announcement contact Ronald M. Gootzeit at (202) 622-3860 (not a toll-free call).

Deletions From Cumulative List of Organizations Contributions to Which are Deductible Under Section 170 of the Code

Announcement 2013-31

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the Service will not disallow deductions for contributions made to a listed organization on or before the date of announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the Service is not precluded from disallowing a deduction for any contributions made after an organization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the

activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, contributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on May 20, 2013, and would end on the date the court first determines that the organization is not described in section 170(c)(2) as more particularly set forth in section 7428(c)(1). For individual contributors, the maximum deduction protected is \$1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in whole or in part, for the acts or omissions of the organization that were the basis for revocation.

21st Century Animal Resource & Education Services
Dolan Springs, AZ
Books For People
Yuma, AZ
California Nairobi International Childrens Organization
Fresno, CA
Cape Verdean Club of Falmouth Inc.
Teaticket, MA

Congressional District Programs, Inc.
Falls Church, VA
Dr. R.C. Samanta Roy Institute of Science and Technology, Inc.
Green Bay, WI
Eko Club, Inc.
Houston, TX
Everything Must Change, Inc.
Philadelphia, PA
Excalibur Foundation
Sparks, NV
Functional Social Solutions, Inc.
Long Beach, CA
Gateway Educational Services
Honolulu, HI
Good Housing, Inc.
Merrick, NY
Holland Peck Charitable Foundation
Carefree, AZ
Kona University, Inc.
Honolulu, HI
Lakeland-Winter Haven Kennel Club, Inc.
Lakeland, FL
Life Changes Ministries International Inc.
Fort Mill, SC
Marley Fund
Greenville, NC
Needham Community Theatre, Inc.
Needham, MA

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance

of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.

ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel’s Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.

PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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¹ A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2012–27 through 2012–52 is in Internal Revenue Bulletin 2012–52, dated December 27, 2012.

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¹ A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2012–27 through 2012–52 is in Internal Revenue Bulletin 2012–52, dated December 27, 2012.

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