

# Part III. Administrative, Procedural, and Miscellaneous

## Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals

### Notice 2011-52

#### SECTION 1. PURPOSE

This notice addresses the community health needs assessment (“CHNA”) requirements described in section 501(r)(3) of the Internal Revenue Code (“Code”) and related excise tax and reporting obligations, applicable to hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) of the Code. The CHNA requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which was added to the Code by section 9007(a) of the Patient Protection and Affordable Care Act (“Affordable Care Act”), Pub. L. No. 111-148, 124 Stat. 119, enacted March 23, 2010.<sup>1</sup> This notice describes specific provisions related to the CHNA requirements that the Treasury Department (“Treasury”) and the Internal Revenue Service (“IRS”) anticipate will be included in regulations to be proposed under section 501(r). This notice also invites comments from the public regarding the CHNA requirements.

Although the CHNA requirements are not effective until taxable years beginning after March 23, 2012, Treasury and the IRS are publishing this notice regarding the CHNA requirements now because they understand that some hospital organizations may choose to start the process of conducting CHNAs and developing implementation strategies in advance of the effective date. A hospital organization may rely on the anticipated regulatory provisions described in this notice with respect to 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.

#### SECTION 2. BACKGROUND

Section 9007 of the Affordable Care Act added sections 501(r) and 4959 to the Code and amended section 6033(b). These provisions are applicable to “hospital organizations” described in new section 501(r)(2). Section 501(r)(1) provides that hospital organizations described in section 501(r)(2) will not be treated as described in section 501(c)(3) unless they satisfy the requirements specified in section 501(r), including the CHNA requirements described in section 501(r)(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 (“State-licensed hospital facility”), 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).

If a hospital organization operates more than one hospital facility, section 501(r)(2)(B)(i) requires the organization to meet all of the section 501(r)(1) requirements, including the CHNA requirements, separately with respect to each hospital facility. Section 501(r)(2)(B)(ii) provides that the organization will not be treated as described in section 501(c)(3) with respect to any hospital facility for which such requirements are not separately met.

Section 501(r)(3)(A) provides that a hospital organization meets the CHNA requirements with respect to any taxable year only if the organization (i) has conducted a CHNA that meets the requirements of section 501(r)(3)(B) in such taxable year or in either of the two taxable years immediately preceding such taxable year, and (ii) has adopted an implementation strategy to meet the community health needs identified through such CHNA. Section 501(r)(3)(B) requires that a CHNA (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, and (ii) be made widely available to the public.

Although most of the requirements under section 501(r) are effective for taxable years beginning after March 23, 2010, the CHNA requirements are effective for taxable years beginning after March 23, 2012. See section 9007(f)(2) of the Affordable Care Act.

Section 501(r)(7) provides that the Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of section 501(r).

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 (*i.e.*, 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.

On May 27, 2010, the IRS released Notice 2010-39, 2010-24 I.R.B. 756, which requested comments regarding the new requirements under section 501(r), including the need, if any, for guidance regarding such requirements. In response to Notice 2010-39, the IRS received numerous comments requesting guidance on the CHNA requirements. In issuing this notice, Treasury and the IRS have considered all of the comments regarding the CHNA requirements received in response to Notice 2010-39.

#### SECTION 3. ANTICIPATED REGULATORY PROVISIONS

This section describes anticipated regulatory provisions regarding hospital organizations required to meet the CHNA requirements (section 3.01); hospital organizations with multiple hospital facilities (section 3.02); the documentation of a CHNA (section 3.03); how and when a CHNA is conducted (section 3.04); the

<sup>1</sup> A related bill, the Health Care Education Affordability Reconciliation Act of 2010 (H.R. 4872) (Reconciliation Act), was signed into law on March 30, 2010 (Pub. L. No. 111-152). The Reconciliation Act amends the Affordable Care Act and related laws.

community served by a hospital facility (section 3.05); persons representing the broad interests of the community (section 3.06); making a CHNA widely available to the public (section 3.07); implementation strategy (section 3.08); how and when an implementation strategy is adopted (section 3.09); excise taxes on failures to meet the CHNA requirements (section 3.10); reporting requirements related to CHNAs (section 3.11); and effective dates (section 3.12).

## **.01 Hospital Organizations Required to Meet the CHNA Requirements**

Section 501(r)(2)(A) defines a “hospital organization” as (i) an organization that operates a State-licensed hospital facility, 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). A number of commenters asked that the Secretary not exercise its determination authority under section 501(r)(2)(A)(ii) until there is an opportunity to comment on a proposed rule.

### *(1) Organizations with the Principal Purpose of Providing Health Care*

Treasury and the IRS have not yet exercised the authority described in section 501(r)(2)(A)(ii) to determine whether any categories of organizations have the provision of hospital care as their principal exempt function or purpose. Treasury and the IRS intend that any future guidance regarding any such categories of organizations will only apply prospectively, after an opportunity for notice and comment. Prior to the effective date of any such future guidance, only organizations operating State-licensed hospital facilities will be considered “hospital organizations” that must satisfy the CHNA requirements.

### *(2) Hospital Organizations Operating State-licensed Hospital Facilities*

Several commenters asked for confirmation that section 501(r) applies to an organization described in section 501(c)(3) that operates a State-licensed hospital facility through a disregarded entity or a joint venture treated as a partnership for federal tax purposes. A number of commenters

also asked whether section 501(r) will apply to an organization as a result of its operating a hospital facility located outside of the United States.

Section 501(r)(2)(A)(i) includes within the definition of a hospital organization any organization described in section 501(c)(3) that operates a State-licensed hospital facility. Rev. Rul. 2004–51, 2004–1 C.B. 974, 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. In addition, when an entity is disregarded as separate from its owner, its operations are treated as a branch or division of the owner. *See, e.g.,* Ann. 99–102, 1999–2 C.B. 545. Accordingly, Treasury and the IRS intend to include within the definition of a hospital organization any organization described in section 501(c)(3) that operates a State-licensed hospital facility through a disregarded entity or a joint venture, limited liability company, or other entity treated as a partnership for federal income tax purposes. Treasury and the IRS request comments regarding whether (or under what circumstances) an organization should not be considered to “operate” a State-licensed 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 income tax purposes that operates the hospital facility.

Treasury and the IRS also intend to provide that a hospital facility located outside of the United States will not be considered a State-licensed hospital facility for purposes of section 501(r)(2)(A)(i) because the term “State” includes only the 50 States and the District of Columbia and not any U.S. possession or territory or foreign country. *See* section 7701(a)(9), (10).

### *(3) Government Hospitals*

A number of commenters requested that Treasury and the IRS provide an exception from the requirements imposed by section 501(r) for certain government hospitals. For example, some commenters

suggested that the requirements of section 501(r) should not apply to a hospital the income of which is excluded from gross income under section 115 but which has nonetheless applied for and received recognition as an organization described in section 501(c)(3). Other commenters suggested that the section 501(r) requirements should not apply to any hospital that is “a governmental unit” or “an affiliate of a governmental unit” as described in Rev. Proc. 95–48, 1995–2 C.B. 418 (relieving such organizations from the annual filing requirement under section 6033).

The statutory language of section 501(r) applies to all hospital organizations that are (or seek to be) recognized as described in section 501(c)(3). Section 501(r) does not explicitly address government hospitals, nor does it include a specific exception for government hospitals. Accordingly, Treasury and the IRS intend to apply section 501(r) to every hospital organization that has been recognized (or seeks recognition) as an organization described in section 501(c)(3). However, in recognition of the unique position of government hospitals, Treasury and the IRS request comments regarding alternative methods a government hospital may use to satisfy the requirements of section 501(r)(3).

## **.02 Hospital Organizations with Multiple Hospital Facilities**

Section 501(r)(2)(B) provides that if a hospital organization operates more than one hospital facility (i) the organization shall meet the requirements of section 501(r) separately with respect to each hospital facility, and (ii) the organization shall 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. Accordingly, Treasury and the IRS intend to require a hospital organization to conduct a CHNA and adopt an implementation strategy for each hospital facility it operates. Moreover, as described further in sections 3.04 and 3.08 of this notice, although hospital organizations will be able to collaborate with other organizations when conducting CHNAs and developing implementation strategies, Treasury and the IRS intend to require a hospital organization operating multiple hospital facilities to document separately the

CHNA and the implementation strategy for each of its hospital facilities.

A number of commenters requested guidance on the potential consequences of a failure to satisfy the requirements of 501(r) separately with respect to a particular hospital facility. Treasury and the IRS intend to address the potential consequences of a failure to satisfy the CHNA requirements (or other requirements under section 501(r)) with respect to one or more hospital facilities in proposed regulations or other future guidance.

### **.03 Documentation of a CHNA**

Section 501(r)(3)(A)(i) requires a hospital organization to conduct a CHNA that meets the requirements of section 501(r)(3)(B) at least once every three taxable years.

Many commenters requested that Treasury and the IRS define a CHNA in a manner sufficiently flexible to allow hospitals to design a CHNA appropriate to their unique community and available resources. At the same time, a number of commenters asked that Treasury and the IRS provide clear guidance regarding the required contents of a CHNA. Several commenters asked the IRS to define a CHNA as a written document developed for a hospital facility that includes a description of the community served by the hospital facility; the process used to conduct the assessment, including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

Treasury and the IRS intend to require a hospital organization to document a CHNA for a hospital facility in a written report that includes the following information:

(1) A description of the community served by the hospital facility (as defined in section 3.05 of this notice) and how it was determined.

(2) A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. The report should also

describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital organization collaborates with other organizations in conducting a CHNA (as described in paragraph (2) of section 3.04 of this notice), the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist it in conducting a CHNA, the report should also disclose the identity and qualifications of such third parties.

(3) A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility (as defined in section 3.06 of this notice), including a description of when and how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organization with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge or expertise in public health (as provided in paragraph (1) of section 3.06 of this notice) by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report also must identify any individual providing input who is a "leader" or "representative" of populations described in paragraph (3) of section 3.06 of this notice by name and describe the nature of the individual's leadership or representative role.

(4) A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.

(5) A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Some commenters suggested that a CHNA include a description of the needs identified in the CHNA that the hospital intends to address, the reasons those needs were selected, and the means by which the

hospital will undertake to address the selected needs. Treasury and the IRS intend to require a hospital organization to specifically address each of the community health needs identified through a CHNA for a hospital facility in an implementation strategy, as described in section 3.08 of this notice, rather than in the written report documenting the hospital facility's CHNA.

### **.04 How and When a CHNA Is "Conducted"**

Section 501(r)(3)(A) provides that a hospital organization meets the CHNA requirements with respect to any taxable year only if it has conducted a CHNA in such taxable year or in either of the two immediately preceding taxable years. Numerous commenters requested that Treasury and the IRS provide that a CHNA may be based on information collected by a public health agency or non-profit organization. Commenters also requested that hospital organizations be permitted to conduct CHNAs together with one or more other organizations, because collaboration will allow for more cost effective and efficient identification of a community's health care needs from a more fully-informed perspective.

#### *(1) When a CHNA Is Considered Conducted*

Treasury and the IRS intend to consider a CHNA as being "conducted" in the taxable year that the written report of its findings (containing all of the information described in section 3.03 of this notice) is made widely available to the public (as defined in section 3.07 of this notice).

Treasury and the IRS request comments on what, if any, guidance is needed regarding when a hospital organization must conduct a CHNA for a new hospital facility that the hospital organization acquires or places into service after March 23, 2010.

#### *(2) How a CHNA is Conducted*

Treasury and the IRS intend to provide that a CHNA will satisfy the CHNA requirements with respect to a hospital facility only if it identifies and assesses the health needs of, and takes into account input from persons who represent the broad interests of, the community served by that

specific hospital facility (as defined in section 3.05 of this notice). Treasury and the IRS intend to allow a hospital organization to base a CHNA on information collected by other organizations, such as a public health agency or non-profit organization. Treasury and the IRS also 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 state and local agencies, such as public health departments. However, in order to ensure that the hospital organization meets the CHNA requirements separately with respect to each hospital facility and that information for each hospital facility is clearly presented and easily accessible, Treasury and the IRS intend to require a hospital organization to document the CHNA for each of its hospital facilities in separate written reports that include the information described in section 3.03 for each hospital facility.

Treasury and the IRS request comments regarding whether, and under what circumstances, documenting CHNAs for multiple hospital facilities together in one written report might improve the quality of the CHNAs, while still ensuring that information for each hospital facility is clearly presented and easily accessible.

#### **.05 Community Served by a Hospital Facility**

Numerous commenters recommended that any definition of the “community served by the hospital facility” give hospitals the flexibility to define the scope of a CHNA so that it focuses on the communities actually served by hospital facilities, whether those communities are defined by geographic area or target populations (*e.g.*, women or children). On the other hand, some commenters recommended defining the community served by a hospital facility as a specific geographic area. For example, one commenter recommended defining the community served by a hospital facility as a geographic area, identified by the zip codes of discharged patients, from which at least 75 percent of the hospital’s patients reside.

For purposes of section 501(r)(3), Treasury and the IRS intend to provide that a hospital organization may take into account all of the relevant facts and circum-

stances in defining the community a hospital facility serves. Generally, Treasury and the IRS expect that a hospital facility’s community will be defined by geographic location (*e.g.*, a particular city, county, or metropolitan region). However, in some cases, the definition of a hospital facility’s community may also take into account target populations served (*e.g.*, children, women, or the aged) and/or the hospital facility’s principal functions (*e.g.*, focus on a particular specialty area or targeted disease). Notwithstanding the foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.

Treasury and the IRS request comments regarding the relative merits of different geographically-based definitions of community. Treasury and the IRS specifically request comments regarding whether future regulations should define the geographic community of a hospital facility as the Metropolitan Statistical Area (MSA) or Micropolitan Statistical Area (μSA) in which the facility is located or, if the hospital facility is a rural facility not located in a MSA or μSA, as the county in which the facility is located.

#### **.06 Persons Representing the Broad Interests of the Community**

Section 501(r)(3)(B)(i) states that a 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. A number of commenters asked that a hospital be given discretion to determine the type of input and expertise that it needs in conducting a CHNA. Other commenters asked that Treasury and the IRS provide guidance on the qualifications necessary for a person to be considered as having special knowledge of or expertise in public health. In addition, numerous commenters requested that CHNAs should, at a minimum, be required to take into account input from state and/or local public health agencies or departments. A few

commenters also recommended that hospital facilities be required to consult with representatives of underserved or disadvantaged communities.

In order to meet the requirement to take into account input from persons who represent the broad interests of the community served by a hospital facility, Treasury and the IRS intend to provide that a CHNA must, at a minimum, take into account input from—

(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.

Treasury and the IRS expect that certain persons may fall into more than one of the categories listed above in paragraphs (1) through (3). For example, taking into account input from certain government officials with special knowledge of or expertise in public health may allow a hospital organization to satisfy the requirements described in both paragraphs (1) and (2). Treasury and the IRS request comments regarding what specific qualifications (whether in terms of degrees, positions, experience, or affiliations) should be necessary for an individual or organization to be considered as having special knowledge of or expertise in public health.

In addition to persons described above in paragraphs (1), (2), and (3), a hospital organization or facility may also consult with and seek input from other persons located in and/or serving the hospital facility’s community. For example, a hospital organization or facility may consult or seek input from healthcare consumer advocates; nonprofit organizations; academic experts; local government officials; community-based organizations, including organizations focused on one or more health issues; health care providers, including community health centers and other providers focusing on medically underserved populations, low-income persons, minority groups, or those with chronic disease needs; private businesses;

and health insurance and managed care organizations.

#### **.07 Making a CHNA Widely Available to the Public**

Section 501(r)(3)(B)(ii) provides that a CHNA must be made widely available to the public. Many commenters suggested patterning the rules for making the CHNA widely available to the public after the rules for making Forms 990 “widely available” under Treas. Reg. § 301.6104(d)–2(b).

In defining widely available to the public for purposes of section 501(r)(3)(B)(ii), Treasury and the IRS intend to adopt rules similar to those set forth in Treas. Reg. § 301.6104(d)–2(b). Thus, a hospital organization will be considered to have made a hospital facility’s CHNA widely available to the public by posting the written report of the CHNA findings on the hospital facility’s website or, if the hospital facility does not have its own website separate from the hospital organization that operates it, on the hospital organization’s website. Alternatively, the written report may be posted on a website established and maintained by another entity as long as either —

(1) the hospital organization or facility’s website provides a link to the website on which the report is posted, along with clear instructions for accessing the report on that website; or

(2) if neither the hospital organization nor the hospital facility has a website, the hospital organization or facility provides any individual requesting a copy of the written report with the direct website address, or url, where the document can be accessed.

In addition, Treasury and the IRS intend to provide that a CHNA will be considered widely available to the public by reason of posting on a website only if—

(1) The website through which the written report is available clearly informs readers that the document is available and provides instructions for downloading it;

(2) The document is posted in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;

(3) Any individual with access to the Internet can access, download, view, and print the document without special com-

puter hardware or software required for that format (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 organization or facility or to another entity maintaining the website; and

(4) The hospital organization or facility provides any individual requesting a copy of the written report with the direct website address, or url, where the document can be accessed.

Finally, Treasury and the IRS intend to require a hospital organization to make a CHNA for a hospital facility widely available to the public until the date on which it makes a subsequent CHNA for that hospital facility widely available to the public.

Treasury and the IRS request comments regarding whether future guidance should provide additional methods that a hospital organization could or must use to make a CHNA widely available to the public.

#### **.08 Implementation Strategy**

Section 501(r)(3)(A)(ii) provides that a hospital organization meets the CHNA requirements with respect to any taxable year only if it has adopted an “implementation strategy” to meet the community health needs identified through the CHNA. Some commenters suggested that a hospital organization be allowed to coordinate with other organizations in developing an implementation strategy. A number of commenters also suggested that at least a summary of the implementation strategy should be included in the written report of the CHNA’s findings. Several commenters requested that Treasury and the IRS not require the implementation strategy to set forth a specific plan to meet all of the health needs identified through a CHNA. One commenter recommended that the implementation strategy be a document that is available for IRS review.

As with any other requirement under section 501(r), a hospital organization must meet the requirement to adopt an implementation strategy separately with respect to each hospital facility it operates. Treasury and the IRS intend to define an “implementation strategy” for a hospital facility as a written plan that addresses each of the community health needs identified through a CHNA for such facility. For these purposes, Treasury and the IRS

intend to provide that an implementation strategy will address a health need identified through a CHNA for a particular hospital facility 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.

In describing how a hospital facility plans to meet a health need identified through a CHNA for purposes of paragraph (1), the implementation strategy must tailor the description to the particular hospital facility, taking into account its specific programs, resources, and priorities. For example, an implementation strategy could describe a hospital facility’s plans to meet a health need by identifying the programs and resources that the hospital facility plans to commit to meeting the health need and the anticipated impact of those programs and resources on the health need. The implementation strategy could also describe any planned collaboration with governmental, non-profit, or other health care organizations, including related organizations, in meeting the health need.

As discussed in section 3.11 of this notice, Treasury and the IRS intend to require a hospital organization to attach to its annual Form 990 the most recently adopted implementation strategy for each of its hospital facilities.

Treasury and the IRS intend to allow hospital organizations to develop implementation strategies for their hospital facilities in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and State and local agencies, such as public health departments. If a hospital organization collaborates with other organizations in developing an implementation strategy, the implementation strategy should identify all of the organizations with which the hospital organization collaborated. In addition, to ensure that the hospital organization meets the CHNA requirements separately with respect to each hospital facility and that the implementation strategy for each hospital facility is clearly presented and easily accessible, Treasury and the IRS intend to require a hospital organization to document

separately the implementation strategy for each of its hospital facilities.

Treasury and the IRS request comments regarding whether, and under what circumstances, documenting implementation strategies for multiple hospital facilities together in one written document might improve the quality of the implementation strategies while still ensuring that information for each hospital facility is clearly presented and easily accessible.

### **.09 How and When an Implementation Strategy is Adopted**

One commenter asked for clarification regarding when the implementation strategy must be adopted and recommended that a hospital organization be allowed to adopt an implementation strategy by the end of the taxable year following the year in which CHNA was conducted.

Treasury and the IRS intend to consider an implementation strategy as being adopted on the date the implementation strategy is approved by an authorized governing body of the hospital organization.

For these purposes, an authorized governing body means—

(1) The governing body (*i.e.*, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization;

(2) A committee of the governing body, which may be composed of any individuals permitted under State law to serve on such committee, to the extent the committee is permitted by State law to act on behalf of the governing body; or

(3) To the extent permitted under State law, other parties authorized by the governing body of the hospital organization to act on its behalf by following procedures specified by the governing body in approving an implementation strategy.

Pursuant to section 501(r)(3)(A)(ii), in order to satisfy the CHNA requirements with respect to any taxable year, a hospital organization must have adopted an implementation strategy to meet the health needs identified through the CHNA described in section 501(r)(3)(A)(i). Accordingly, Treasury and the IRS intend to provide that a hospital organization must adopt an implementation strategy to meet the community health needs identified in a CHNA by the end of the same taxable year in which it conducts that CHNA. Treas-

ury and the IRS request comments regarding the need, if any, for a transition rule, under which a hospital organization would be given additional time to adopt an implementation strategy for the first taxable year in which the hospital organization is subject to the CHNA requirements (*i.e.*, the first taxable year beginning after March 23, 2012).

### **.10 Excise Tax on Failures to Meet the CHNA Requirements**

Section 4959 imposes a \$50,000 excise tax on a hospital organization that fails to meet the CHNA requirements with respect to any taxable year.

Treasury and the IRS intend to impose the \$50,000 excise tax under section 4959 on any hospital organization that fails to satisfy the CHNA requirements with respect to a hospital facility in any three-year period. For example, if a hospital organization reporting on a calendar-year basis that operates only one hospital facility fails to conduct a CHNA by the last day of 2013, and also did not conduct a CHNA in 2011 or 2012, it will be subject to a \$50,000 excise tax under section 4959 for its 2013 taxable year. If it then fails to conduct a CHNA by the last day of 2014, it will again be subject to a \$50,000 excise tax under section 4959 for its 2014 taxable year (having not conducted a CHNA in 2012, 2013, or 2014).

Because section 501(r)(2)(B)(i) requires a hospital organization to meet the CHNA requirements “separately with respect to each [hospital] facility,” Treasury and the IRS intend 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 operates two hospital facilities and fails to meet the requirements of section 501(r)(3) for both of them for any taxable year, that hospital organization will be subject to a total excise tax of \$100,000 (\$50,000 for each hospital facility) in that taxable year.

### **.11 Reporting Requirements Related to CHNAs**

Section 6033(a)(1) requires every organization exempt from taxation under section 501(a) and not excepted under section 6033(a)(3) to file an annual return stating such information for the purpose

of carrying out the internal revenue laws as the Secretary may by forms or regulations prescribe. Section 6033(a)(3)(B) provides that the Secretary may relieve any organization (other than a supporting organization described in section 509(a)(3)) from this requirement to file an annual return when the Secretary determines that filing is not necessary to the efficient administration of the internal revenue laws. Section 6033(b) lists the information that organizations described in section 501(c)(3) must furnish on their annual information returns, including any “information for purposes of carrying out the internal revenue laws as the Secretary may require.” See section 6033(b)(16).

As described above, the Affordable Care Act added two specific reporting requirements for hospital organizations to section 6033(b). Section 6033(b)(10)(D) requires a hospital organization to report on its annual information return (Form 990) the amount of the excise tax imposed on the organization under section 4959. Section 6033(b)(15)(A) requires a hospital organization to report on its annual Form 990 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.

The IRS has added new questions to Schedule H, *Hospitals*, of the Form 990 to reflect the new reporting requirements for hospital organizations under section 6033(b)(15)(A). The IRS also plans to add questions reflecting the new reporting requirements under section 6033(b)(10)(D) to the Form 990 in the future. As discussed in section 3.12 of this notice, responses to these questions are optional on Forms 990 for taxable years beginning on or before March 23, 2012.

As discussed above, section 501(r)(3)(A)(ii) requires a hospital organization to adopt an implementation strategy for each of its hospital facilities. Treasury and the IRS intend to require a hospital organization to attach to its annual Form 990 its most recently adopted implementation strategy for each of its hospital facilities. (See section 3.09 of this notice for when an implementation strategy must be adopted.) If a hospital organization only conducts one CHNA and adopts one implementation strategy

for a hospital facility in a given three-year period, Treasury and the IRS intend to allow it to attach the same implementation strategy for that hospital facility to the Form 990 for each of those three years.

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 Form 990. The Affordable Care Act did not change the requirements regarding what organizations are required to file Form 990. Accordingly, a government hospital (other than one that is described in section 509(a)(3)) that has been excused from filing Form 990 under Rev. Proc. 95-48 or a successor revenue procedure is not required to file 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 under section 6033, including the requirements under sections 6033(b)(10)(D) and (b)(15)(A) and the anticipated requirement to attach one or more implementation strategies to a Form 990.

## **.12 Effective Dates**

The CHNA requirements are effective for taxable years beginning after March 23, 2012. See section 9007(f)(2) of the Affordable Care Act. Accordingly, Treasury and the IRS intend to require a hospital organization to conduct a CHNA and adopt an implementation strategy for each of its hospital facilities by the last day of its first taxable year beginning after March 23, 2012.

Section 501(r)(3)(A) provides that an organization meets the CHNA requirements with respect to any taxable year only if the organization has conducted a CHNA in such taxable year or in either of the two taxable years immediately preceding such taxable year and has adopted an implementation strategy to meet the community health needs identified through the CHNA. Accordingly, a CHNA that is conducted and an implementation strategy that is adopted in either of the two taxable years immediately preceding the taxable year in which section 501(r)(3) becomes

effective may apply toward satisfaction of the CHNA requirements for the taxable year in which section 501(r)(3) becomes effective (and the succeeding taxable year, if within the three-year period beginning with the year the CHNA was conducted).

The reporting requirement described in section 6033(b)(15)(A) is effective for taxable years beginning after March 23, 2010, but because the CHNA requirements are not effective until taxable years beginning after March 23, 2012, Treasury and the IRS do not intend to require hospital organizations to report the information described in section 6033(b)(15)(A) on, or attach implementation strategies to, Forms 990 for any taxable year beginning on or before March 23, 2012.

## **SECTION 4. RELIANCE**

Treasury and the IRS expect to issue proposed regulations that will provide guidance regarding the requirements under section 501(r) in general and the CHNA requirements of section 501(r)(3) in particular. Hospital organizations may rely on the anticipated regulatory provisions described in this notice with respect to 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.

## **SECTION 5. REQUEST FOR COMMENTS**

Treasury and the IRS request comments regarding the CHNA requirements described in this notice. In addition to the comments specifically requested above, comments are also specifically requested regarding the definitions of a hospital organization, a hospital facility, a CHNA, a community served by a hospital facility, an implementation strategy, conducted (for purposes of the CHNA), and adopted (for purposes of the implementation strategy).

Comments should be submitted on or before September 23, 2011. Please include Notice 2011-52 on the cover page. Comments should be sent to the following address:

Internal Revenue Service  
CC:PA:LPD:PR (Notice 2011-52),  
Room 5203  
P.O. 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:

Internal Revenue Service  
Courier's Desk  
1111 Constitution Ave., N.W.  
Washington, DC 20224  
Attn: CC:PA:LPD:PR  
(Notice 2011-52)

Submissions may also be sent electronically to the following e-mail address:

*Notice.Comments@irs.counsel.treas.gov.*

Please include "Notice 2011-52" in the subject line.

All comments will be available for public inspection and copying.

## **SECTION 6. DRAFTING INFORMATION**

The principal author of this notice is Preston Quesenberry of the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Mr. Quesenberry at (202) 622-1124 (not a toll-free call).

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*26 CFR 1.1035-1: Certain exchange of insurance policies.  
(Also § 72.)*

## **Rev. Proc. 2011-38**

### **SECTION 1. PURPOSE**

This revenue procedure addresses the tax treatment of certain tax-free exchanges of annuity contracts under § 72 and § 1035 of the Internal Revenue Code. Rev. Proc. 2008-24, 2008-1 C.B. 684, is modified and superseded.

### **SECTION 2. BACKGROUND**

.01 Section 1035(a)(3) provides that no gain or loss shall be recognized on the exchange of an annuity contract for another