

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 for 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.

(e) *Instances in which a hospital organization is not required to meet section 501(r).* A hospital organization is not required to meet the requirements of section 501(r) (and, therefore, is not subject to any consequence described in this section for failing to meet the requirements of section 501(r)) with respect to—

(1) Any hospital facility it is not “operating” within the meaning of § 1.501(r)-1(b)(22);

(2) The operation of a facility that is not required by a state to be licensed, registered, or similarly recognized as a hospital; or

(3) Any activities that constitute an unrelated trade or business described in section 513 with respect to the hospital organization.

[T.D. 9708, 79 FR 78998, Dec. 31, 2014; 80 FR 12762, Mar. 11, 2015]

§ 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 taxable year or in either of the two taxable years immediately preceding such taxable year (except as provided in paragraph (d) of this section); and

(2) An authorized body of the hospital facility (as defined in § 1.501(r)-1(b)(4)) has adopted an implementation strat-

egy to meet the community health needs identified through the CHNA, as described in paragraph (c) of this section, on or before the 15th day of the fifth month after the end of such taxable year.

(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, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.

(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.

(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 taxable year in which a CHNA has been conducted under this paragraph (b)(2), a hospital facility will be considered to have completed the step of making a 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)(7)(i) of this section.

(3) *Community served by a 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 population(s) served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). However, a hospital facility may not define its community to exclude medically underserved, low-income, or minority populations who live in the

geographic areas from which the hospital facility draws its patients (unless such populations are not part of the hospital facility's target patient population(s) 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, in determining its patient populations for purposes of defining its community, a hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. In the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.

(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 resources (such as organizations, facilities, and programs in the community, including those of the hospital facility) potentially available to address those health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. 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—(i) In general.* For purposes of paragraph (b)(1)(iii) of this section, a hospital facility must solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

(A) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in section 338J of the Public Health Service Act (42 U.S.C. 254r), with knowledge, information, or expertise relevant to the health needs of that community.

(B) 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. 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.

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

(ii) *Additional sources of input.* In addition to the sources described in paragraph (b)(5)(i) of this section, a hospital facility may solicit and take into account input received 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.

(6) *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 solicited and took into account input received 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 those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

(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)(6)(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. In the case of data obtained from external source material, the CHNA report may cite the source material rather than describe the method of collecting the data.

(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 consid-

ered to describe how the hospital facility took into account input received from persons who represent the broad interests of the community it serves for purposes of paragraph (b)(6)(i)(C) of this section if the CHNA report summarizes, in general terms, any 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 approximate dates); provides the names of any 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 identify any specific individual providing input on the CHNA. In the event a hospital facility solicits, but cannot obtain, input from a source described in paragraph (b)(5)(i) of this section, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.

(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)(6) in a separate CHNA report to satisfy paragraph (b)(1)(iv) of this section unless it adopts a joint CHNA report as described in paragraph (b)(6)(v) of this section. However, if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or if another organization (such as a state or local public health department) 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 other organization conducting a CHNA,

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if appropriate under the facts and circumstances. For example, if two hospital facilities with overlapping, but not identical, communities are collaborating in conducting a CHNA, the portions of each hospital facility's CHNA report relevant to the shared areas of their communities might be identical. Similarly, if the state or local public health department with jurisdiction over the community served by a hospital facility conducts a CHNA for an area that includes the hospital facility's community, the hospital facility's CHNA report might include portions of the state or local public health department's CHNA report that are relevant to its community.

(v) *Joint CHNA reports*—(A) *In general.* A hospital facility that collaborates with other hospital facilities or other organizations (such as state or local public health departments) 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 the hospital facility and one or more of the collaborating facilities and organizations, provided that the following conditions are met:

(1) The joint CHNA report meets the requirements of paragraph (b)(6)(i) of this section.

(2) The joint CHNA report is clearly identified as applying to the hospital facility.

(3) All of the collaborating hospital facilities and organizations included in the joint CHNA report define their community to be the same.

(B) *Example.* The following example illustrates this paragraph (b)(6)(v):

Example. P is one of 10 hospital facilities located in and serving the populations of a particular Metropolitan Statistical Area (MSA). P and seven other 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 eight 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 solicit and receive input from the MSA's residents, including its medically underserved, low-income, and minority populations. The hospital facilities also consider

the written comments received on their most recently conducted CHNAs and most recently adopted implementation strategies. 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)(6)(i) of this section. The joint CHNA report identifies all of the collaborating hospital facilities included in the report, 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)(6)(v) and, accordingly, has satisfied paragraph (b)(1)(iv) of this section.

(7) *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(b)(29), 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 upon request and without charge at the hospital facility at least until the date the hospital facility has made available for public inspection a paper copy of its two subsequent CHNA reports.

(ii) *Making draft CHNA reports widely available.* Notwithstanding paragraph (b)(7)(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 (b)(2) 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.* A hospital facility's implementation strategy will have described a plan to address a significant health need identified through a CHNA for purposes of paragraph (c)(1)(i) of this section if the implementation strategy—

(i) Describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;

(ii) Identifies the resources the hospital facility plans to commit to address the health need; and

(iii) Describes 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 brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, 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 hospital facilities or other 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 or 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 resources. However, a hospital facility

that adopts a joint CHNA report described in paragraph (b)(6)(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 one or more of the collaborating facilities or organizations plan to address the health need or identifies the health need as one the collaborating facilities or organizations do not intend to address and explains why they do not intend to address the health need. For a collaborating hospital facility to meet the requirements of paragraph (a)(2) of this section, such a joint implementation strategy adopted for the hospital facility must—

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

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

(iii) 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.

(5) *When the implementation strategy must be adopted—*(1) *In general.* For purposes of paragraph (a)(2) of this section, an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of 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 significant health needs of that community, and solicits and takes into account input received 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 of the CHNA report available for public inspection. To meet the requirements of paragraph (a)(2)

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of this section, an authorized body of M must adopt an implementation strategy to meet the health needs identified through the CHNA completed in Year 4 by the 15th day of the fifth month of Year 5.

(d) *Exception for acquired, new, and terminated hospital facilities*—(1) *Acquired hospital facilities*. A hospital organization that acquires a hospital facility (whether through merger or acquisition) must meet the requirements of section 501(r)(3) with respect to the acquired hospital facility by the last day of the organization's second taxable year beginning after the date on which the hospital facility was acquired. In the case of a merger between two organizations that results in the liquidation of one organization and the survival of the other organization, the hospital facility or facilities formerly operated by the liquidated organization will be considered "acquired" for purposes of this paragraph (d)(1).

(2) *New hospital organizations*. An organization that becomes newly subject to the requirements of section 501(r) because it is recognized as described in section 501(c)(3) and is operating a hospital facility must meet the requirements of section 501(r)(3) with respect to any hospital facility by the last day of the second taxable year beginning after the later of the effective date of the determination letter or ruling recognizing the organization as described in section 501(c)(3) or the first date that a facility operated by the organization was licensed, registered, or similarly recognized by a state as a hospital.

(3) *New hospital facilities*. A hospital organization must meet the requirements of section 501(r)(3) with respect to a new hospital facility it operates by the last day of the second taxable year beginning after the date the facility was licensed, registered, or similarly recognized by its state as a hospital.

(4) *Transferred or terminated hospital facilities*. A hospital organization is not required to meet the requirements of section 501(r)(3) with respect to a hospital facility in a taxable year if, before the end of that taxable year, the hospital organization transfers all ownership of the hospital facility to another organization or otherwise ceases its operation of the hospital facility or

the facility ceases to be licensed, registered, or similarly recognized as a hospital by a state.

(e) *Transition rule for CHNAs conducted in taxable years 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 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.

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§ 1.501(r)-4 Financial assistance policy and emergency medical care policy.

(a) *In general*. A hospital organization meets the requirements of section 501(r)(4) with respect to a hospital facility it operates only if the hospital organization establishes for that hospital facility—

(1) A written financial assistance policy (FAP) that meets the requirements of paragraph (b) of this section; and

(2) A written emergency medical care policy that meets the requirements of paragraph (c) of this section.

(b) *Financial assistance policy*—(1) *In general*. To satisfy paragraph (a)(1) of this section, a hospital facility's FAP must—

(i) Apply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity (as defined in § 1.501(r)-1(b)(28));

(ii) Be widely publicized as described in paragraph (b)(5) of this section; and

(iii) Include—

(A) The eligibility criteria for financial assistance and whether such assistance includes free or discounted care;

(B) The basis for calculating amounts charged to patients;