**Exhibit 7.20.4-9 (09-01-2006)**
**Health Care Providers Reference Guide**

**Hospitals, Clinics and Similar Health Care Providers Reference Guide Sheet**

**INSTRUCTIONS –** This guide sheet is designed to assist in the processing of health care provider IRC 501(c)(3) exemption applications. Generally, a "Yes" response indicates a favorable factor, whereas, a "No" response indicates a potential concern. "Does Not Apply" means that the question is not applicable. See the accompanying Hospitals, Clinics and Similar Health Care Providers Reference Guide, which is keyed to the numbered items, for assistance in completing this guide sheet.

| | Yes | No | Does Not Apply |
|---|---|---|---|
| 1. If the health care provider is a hospital, does it have a community board of directors? | | | |
| a. If the health care provider does not have a community board and is part of a multi-entity health care system, are there any other IRC 501(c)(3) entities in the system with a community board that has structural control over the health care provider? | | | |
| 2. If the health care provider is a hospital, does it maintain an open medical staff whereby medical staff privileges are available to all qualified physicians in the area consistent with the size and nature of its facilities? | | | |
| 3. If the health care provider is a hospital, does it maintain a full-time emergency room? | | | |
| a. Is the emergency room open to all persons regardless of their ability to pay? | | | |
| b. Does the hospital have arrangements with police, fire and ambulance services to deliver patients to its emergency room? | | | |
| 4. Does the health care provider accept persons covered under Medicare or Medicaid? | | | |
| a. If the health care provider has not obtained a Medicaid contract, has it pursued good faith negotiations to obtain a Medicaid contract? | | | |
| b. If the health care provider doesn't accept Medicare, contact EO Technical. | | | |
| 5. Does the health care provider have a charity care policy and is it communicated to the public? | | | |
| a. Was a copy of the charity care policy submitted with the application? | | | |
| b. Does the charity care policy provide for free or reduced rate medical care consistent with the patient's financial resources? | | | |
| 6. Does the health care provider conduct a formal program of medical training, medical research, or community educational programs? | | | |
| 7. Does the health care provider have a conflict of interest policy covering its directors, principal officers, highly paid employees, and members of committees with board delegated authority that is similar to the policy recommended by the Service? | | | |
| 8. Does the health care provider lease office space to physicians with whom it has a financial relationship? | | | |
| a. Was a copy of the lease submitted? | | | |
| b. Has the health care provider explained how it established a lease at fair market value? | | | |

**Exhibit 7.20.4-9 (Cont. 1) (09-01-2006)**
**Health Care Providers Reference Guide**

| | Yes | No | Does Not Apply |
|---|---|---|---|
| 9. Does the health care provider lease any equipment, assets, or office space from physicians or other individuals, corporations or partnerships (aside from structurally controlled organizations) with an on-going financial relationship with the provider? | | | |
| a. Was a copy of the lease submitted? | | | |
| b. Has the health care provider explained how it established a lease at fair market value? | | | |
| 10. Has the health care provider purchased medical practices, ambulatory surgery centers, or other business assets from physicians or other persons (1) who have substantial influence over the health care provider; (2) who are employed by the health care provider; or (3) who contract back with the health care provider to operate the business? | | | |
| a. Was a copy of the asset purchase agreement (purchase and sale contract) submitted? | | | |
| b. Is there an appraisal supporting the purchase price? | | | |
| c. Does the appraisal utilize the cost, market and/or income methods or some combination thereof to arrive at fair market value? | | | |
| d. Does the asset purchase agreement include any retained rights by the seller to (1) affect future affiliations with others; (2) to determine if additional physicians can be hired; or (3) to repurchase the assets within a certain time period (other than a right of first refusal)? | | | |
| 11. Does the health care provider offer recruitment incentives to physicians? | | | |
| a. Are recruitment incentives consistent with Rev. Rul. 97-21, 1997-1 C.B. 121? | | | |
| 12. Has the health care provider explained the amounts and bases by which it compensates its officers, highly compensated employees, and physicians? | | | |
| a. Were representative employment contracts submitted? | | | |
| b. Are compensation arrangements approved by an independent board of directors or compensation committee subject to a conflict of interest policy? | | | |
| c. If a physician's compensation is based on revenues, is there an incentive for providing charity care and/or meeting quality-of-care or patient satisfaction benchmarks? | | | |
| d. If a physician's compensation is based on revenues, is there a cap on total compensation based on reasonable compensation for physicians in similar specialties in similar geographic locales? | | | |
| e. If a physician's compensation is based on revenues, are the revenues limited to the work product of the physician and/or nurse practitioner(s) under the direct supervision of the physician? | | | |
| 13. Does the health care provider employ a for-profit medical group to serve its patients? | | | |
| a. Was the professional services agreement or employment contract submitted with the application? | | | |
| b. Is total compensation reasonable based on the factors in Q12? | | | |
| 14. Does the health care provider participate in a joint venture, partnership or limited liability company (LLC) arrangement with a for-profit entity? | | | |
| a. Were copies of all such agreement(s) provided? | | | |

**Exhibit 7.20.4-9 (Cont. 2) (09-01-2006)**
**Health Care Providers Reference Guide**

| | Yes | No | Does Not Apply |
|---|---|---|---|
| b. Did the health care provider receive ownership interest in the joint venture, partnership or LLC proportionate to its contribution? | | | |
| c. Are all returns of capital and distributions of earnings made to the members proportional to their ownership interests? | | | |
| d. Is a majority of the governing board chosen by the tax-exempt health care provider? | | | |
| e. Does a majority of the governing body approve major decisions that include: the annual capital and operating budgets; distribution of earnings; selection of key executives; acquisition or disposition of health care facilities; contracts in excess of a specific dollar amount threshold; changes to the types of services offered by the hospital; and renewal or termination of any management agreements? | | | |
| f. Do the governing documents require it to operate all of its health care entities (including any health care entities contributed by the for-profit) in a manner furthering charitable purposes? | | | |
| g. Do the governing documents explicitly provide directors have a duty to operate in a manner furthering charitable purposes and this may override their duty to operate for the financial benefit of the for-profit members? | | | |
| h. Are the governing documents legal, binding and enforceable under applicable state law? | | | |
| i. Are any management contracts for a definite term of years and terminable for cause? Were copies of management contracts provided? | | | |
| j. Has the Applicant provided information to establish that the terms, fees and conditions of any management agreements are reasonable and comparable to management contracts of other organizations providing similar services at similarly situated health care entities? | | | |
| k. Have you determined that no officers, directors, or other employees of the health care provider who were involved in the decision-making or the negotiations involving the formation of the joint venture, partnership, or LLC, were promised employment or any other inducements by the for-profit and any of its related entities, or the joint venture, partnership or the LLC itself? | | | |
| l. Have you determined that none of the individuals referenced in k, above, has any interest, directly or indirectly, in the for-profit or any of its related entities? | | | |
| 15. Is the health care provider a professional corporation organized under a corporate practice of medicine state law? If Yes, send the application to EO Technical. | | | |
| 16. Is the health care provider an HMO? If Yes, send application to EO Technical. | | | |
| 17. Is the health care provider a faculty group practice? If Yes, send application to EO Technical. | | | |
| 18. If the organization is a fire, rescue, or emergency service provider, does it offer comparable services to the entire community? | | | |
| 19. Does the hospital or clinic qualify as a hospital described in IRC 509(a)(1) and 170(b)(1)(A)(iii)? | | | |
| 20. Is the health care provider a drug treatment center, a community mental health center or skilled nursing facility? | | | |

**Exhibit 7.20.4-9 (Cont. 3) (09-01-2006)**
**Health Care Providers Reference Guide**

**Hospitals, Clinics and Similar Health Care Providers Reference Guide**

The community benefit standard is addressed separately in Questions 1 through 6.

The community benefit standard is the test used for determining if a health care provider is operated to promote health in a way that accomplishes a charitable purpose. The community benefit standard was enunciated in Revenue Ruling 69-545, 1969-2 C.B. 117, and court cases that apply Rev. Rul. 69-545.

Rev. Rul. 69-545 defined the community benefit standard in the context of a hospital. The Service and the courts have applied this standard to hospital and non-hospital health care providers. See IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188 (10th Cir. 2003); Sound Health Association v. Commissioner, 71 T.C. 158 (1978); and Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993).

Prior to Rev. Rul. 69-545, tax-exempt hospitals were required by Rev. Rul. 56-185, 1956-1 C.B. 202 to admit and treat patients who were unable to pay, either without charge or at rates below cost. This requirement was referred to as the "financial ability standard" because this uncompensated care had to be provided to the extent of the hospital's financial ability.

Rev. Rul. 69-545 modified the financial ability standard by introducing additional considerations known as the community benefit standard. Although a formal policy to provide charity care is still relevant, the new standard also takes into account a number of additional factors indicating that the operation of the hospital benefits the community as a whole.

Similarly, a rehabilitation institution, outpatient clinic, community mental health center, dental clinic, drug treatment center, or community chiropractor may qualify as an exempt health care provider if it meets the community benefit standard and otherwise qualifies under IRC 501(c)(3).

As used with regard to a hospital, the "community benefit standard" in Rev. Rul. 69-545 includes the following factors:

- Does the hospital have a governing board, community board, board of trustees, or board of directors composed of prominent civic leaders rather than exclusively members who are hospital administrators, physicians, or others professionally connected to the hospital?

- Is admission to the hospital's medical staff open to all qualified physicians in the area, consistent with the size and nature of the facilities?

- Does the hospital operate a full-time emergency room open to everyone, regardless of his or her ability to pay? (However, Rev. Rul. 83-157, 1983-2 C.B. 94, in some situations, allows hospitals not to operate an emergency room.)

**Exhibit 7.20.4-9 (Cont. 4) (09-01-2006)**
**Health Care Providers Reference Guide**

- Does the hospital provide non-emergency care to everyone in the community who is able to pay either privately or through third parties, including Medicare and Medicaid?

Does the hospital serve a broad cross section of the community through research, training, education or charity care (as defined in Rev. Rul. 56-185)?

**1. Community Board**

A "community board" is one in which independent persons representative of the community comprise a majority. Practicing physicians affiliated with the hospital, officers, department heads, and other employees of the hospital are not independent due to their close and continuing connection with the hospital. They may serve on the hospital's board of trustees, but cannot comprise a majority. Other persons who may have some business dealings with the hospital are usually included in the majority. Rev. Rul. 69-545 states that control of a charitable hospital in a board of directors composed of "independent civic leaders" is a significant factor in determining community benefit.

a. In a multi-entity hospital system, a subsidiary tax-exempt organization (an applicant) that does not have a community board is considered to have a community board if it is controlled by an IRC 501(c)(3) organization whose board is comprised of a majority of voting members who are independent community members.

Control means authority over structural and financial aspects. For example, structural control may include the right to appoint, elect, or remove the directors of the applicant. Financial control may include the right to approve annual operating and capital budgets, strategic planning initiatives, and significant sales, leases, mortgages or other transfers or encumbrances of real or personal property.

**2. Open Hospital Staff/Open Hospital Staff Privileges**

A hospital's medical staff privilege refers to permission a hospital provides to physicians, who are not employees of the hospital, to practice at the hospital. A policy of having an open medical staff demonstrates that a hospital furthers the interests of the community rather than the private interests of a select group of physicians. Contrast *Situation 2* in Revenue Ruling 69-545, 1969-2 C.B. 117, where there was not an open medical staff.

Open hospital staff privileges do not mean that any or all physicians may practice there. A hospital may place limitations on its medical staff based on physicians meeting professional standards of care, education, licensure, and accreditation, and on practice and capacity limitations of the facility. The requirement for open staff privileges is not necessarily applicable to clinics, specialty hospitals, or similar health care providers.

Note: Where a hospital's medical staff is restricted solely to physicians from a particular medical practice, this would raise the question of possible private benefit that should be explored through further development.

**3. Emergency Rooms Open to All**

Usually, a hospital must have an emergency room open to all persons regardless of their ability to pay to meet the community benefit standard.

**Exhibit 7.20.4-9 (Cont. 5) (09-01-2006)**
**Health Care Providers Reference Guide**

However, an emergency room is not required if a governmental planning agency has determined it would unnecessarily duplicate an existing service or if the health care provided by the hospital is not the type of care requiring an emergency room (e.g., specialized eye care). Therefore, an emergency room is not required for a clinic or specialty hospital. See Rev. Rul. 83-157, 1983-2 C.B. 94.

Key factors in determining if the emergency room is open to all regardless of ability to pay are:

a. No one is denied treatment in the emergency room based on ability to pay. (Note: Admission to the hospital may be based on ability to pay directly or through third party providers.)

b. The hospital's emergency room generally has patient transportation arrangements with police, fire, and ambulance services.

**4. Medicare or Medicaid**

Participation in Medicare (government program that pays health care for the elderly or disabled) or Medicaid (government program that pays health care for the poor) is a factor that helps establish that a health care provider meets the community benefit standard.

**5. Charity Care**

The provision of charity care is relevant in determining whether a hospital meets the community benefit standard of Rev. Rul. 69-545. Many hospitals adopt a charity care policy to help them meet the health care needs of low income and uninsured members of their communities. A charity care policy is reflected by the formal adoption of a written policy providing objective standards that are used in determining who qualifies for such care. Hospital bad debt is not considered to be charity care.

Further, because clinics and other health care providers are not required to have an emergency room, many demonstrate community benefit by implementing a charity care policy and by providing a significant amount of charity care. Treating patients covered through Medicare and Medicaid may also demonstrate community benefit.

a. Charity care policies must be available to the public.

b. A charity care policy provides that certain patients will be offered free or reduced-cost care, often using a sliding scale, based on the patient's ability to pay. Health care providers should be in a position to describe the amounts expended or anticipated to be expended on charity care.

**6. Medical Training, Research and Other Health Related Activities**

Other activities that serve the community, when combined with factors enumerated in Rev. Rul. 69-545, help to demonstrate the required benefit to the community. Medical training or research are ways that a health care provider can serve the health needs of the community. Additional activities demonstrating community benefit include free health education programs (e.g., cardiac information, pregnancy counseling), seminars (e.g., stop smoking seminars), or community health fairs (e.g., blood pressure or cholesterol testing).

**Exhibit 7.20.4-9 (Cont. 6) (09-01-2006)**
**Health Care Providers Reference Guide**

**7. Conflict of Interest Policy**

The presence and enforcement of a conflict of interest policy applicable to a health care provider's directors, trustees, principal officers, highly compensated employees, and members of committees with board-delegated powers, can help assure fulfillment of charitable purposes.

While not mandatory, adoption of a conflict of interest policy is almost universal because it represents an important opportunity for health care providers to avoid potential private benefit, inurement, and intermediate sanction violations. A sample conflict of interest policy recommended by the Service is contained in the Form 1023 Package and is also provided in Article E, *Tax-Exempt Health Care Organizations Revised Conflicts of Interest Policy,* in the CPE volume for FY 2000.

**8. Physician Office Space**

The terms of any lease must be at fair market value to prevent excessive private benefit. Rev. Ruls. 69-463, 1969-2 C.B. 131, and 69-464, 1969-2 C.B. 132, state a hospital may lease space to physicians and to medical groups at locations adjacent to the hospital campus. This is considered to further the hospital's exempt purposes by facilitating patient access to the hospital.

The lease must be at fair market value and the hospital should explain how it arrived at a commercially reasonable lease.

**9. Lease of Assets**

When an exempt health care provider leases equipment, office space or other assets from individuals and entities with whom it has an ongoing financial relationship, such as a member of its board of directors, an employee, officer, or a physician with staff privileges, the possibility that the lease is not at fair market value is greater than if the lease is at arm's-length. In these situations, it is important to review the lease and any documentation about how the lease was negotiated to ensure that it is commercially reasonable and represents fair market value.

If the dollar amounts are significant, the health care provider should obtain independent verification that the transaction is commercially reasonable and is at fair market value.

**10. Hospital Purchase of Physician Practices**

Hospitals may purchase medical practices, ambulatory surgery centers, magnetic imaging centers, and other for-profit health care operations and often employ or contract back with the selling physicians to operate these entities as wholly owned, IRC 501(c)(3) health care providers.

When the purchase involves significant amounts of money, the organization should be in a position to justify the terms of the purchase through, for example, timely valuation of the assets purchased. Such valuations help ensure the hospital has not overpaid. See Article Q, *Valuation of Medical Practices,* in the FY 1996 CPE text for a discussion of acceptable valuation methods.

A review of the underlying documents is necessary to determine if there is retained authority over the use of the assets by the seller. For example, the right to direct future affiliations with other medical practices, the right to hire additional physicians, or the right to repurchase a medical practice (other than a right of first refusal) may effectively limit the ability of a hospital

to utilize its assets to further exclusively charitable purposes and also reduces the value of the assets. Retained rights can usually be found in the asset purchase agreement, but they can also be in a professional service agreement or employment contract.

**11. Recruitment Incentives**

Recruitment incentives are used by a hospital to recruit physicians to its staff or its community. Where the hospital or community is experiencing a shortage of physicians, incentives such as bonuses, housing or moving allowances, guaranteed income allowances, or below market rental of office space can be used to further the hospital's exempt purposes. See Rev. Rul. 97-21, 1997-1 C.B. 121.

Incentives should be provided at arm's-length, be consistent with written policies, should not result in excessive compensation paid to employees or unreasonable payments (including unreasonable income guarantees) paid to non-employees, and should be legal.

**12. Reasonable Compensation**

In determining whether compensation is excessive, total compensation must be determined first. Compensation includes not only salary, but also any fringe benefits and pension plans or other deferred compensation provided. The exempt organization should provide assurance that the total compensation package provided to a physician (base salary, bonuses, and benefits) is reasonable for the physician's specialty and area.

Generally, compensation is more likely to be reasonable if it is established at arm's-length by an independent board of directors or committee subject to a conflict of interest policy and is based on current compensation studies of similarly situated employees in similar geographic locales.

If compensation is based on revenues, the potential for unreasonable compensation warrants a close review of the compensation arrangement.

A fixed salary with a bonus based on a percentage of a physician's gross or net collections or billings is revenue-based. Employment contracts should be examined to determine if the amounts paid are excessive, and to ensure that the exempt organization is not using the revenue-based compensation as a vehicle for distributing the organization's profits. It may be appropriate to accept employment contracts with names and other identifying information redacted when the health care provider is concerned with confidentiality.

The compensation plan, first and foremost, must be a legitimate vehicle to compensate physicians fairly. If the health care provider cannot explain how it determines compensation is reasonable, then it needs to develop a process to ensure that its significant employment contracts will result in the payment of reasonable compensation. A process that undertakes to review compensations studies of similarly situated employees would provide an appropriate process.

**13. Compensation for a For-Profit Medical Group**

A health care provider may contract with a for-profit medical group to provide professional health care services. This is not an exempt organization issue as long as the total payment by the exempt organization is reasonable in relation to the total services it receives.

**14. Joint Ventures, Partnerships, Limited Liability Agreements**

**Exhibit 7.20.4-9 (Cont. 8) (09-01-2006)**
**Health Care Providers Reference Guide**

A joint venture between an exempt organization and a for-profit entity can take the form of a partnership or a limited liability company (LLC).

EO Technical will handle all applications for exemption submitted by health care providers that will engage in whole hospital joint ventures with for-profit entities or in joint ventures with for-profit entities when the joint venture is the applicant organization's primary activity.

Rev. Rul. 98-15, 1998-1 C.B. 718, provides two examples demonstrating when a whole hospital joint venture with a for-profit entity will or will not adversely affect exemption. In Situation 1, which does not jeopardize exemption, the organization and operation of the joint venture allows the exempt health care provider to continue to further a charitable purpose and to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners. This is the case because, among other requirements, the governing documents of the joint venture provide for the exempt organization to appoint 3 of the 5 directors and require that the joint venture operate any hospital it owns in a manner that furthers charitable purposes by promoting health for a broad cross section of the community.

In contrast, Situation 2 involves a joint venture in which the partners each name 3 members to the six-member board. A majority of the board members must approve certain major decisions regarding operation of the joint venture. The governing documents provide that the joint venture operate the health care facilities it owns and engage in other health care-related activities. However, there is no binding obligation for the joint venture to serve charitable purposes or otherwise provide its services to the community as a whole. For this and other reasons the tax-exempt partner can no longer establish that it is neither organized nor operated for the benefit of private interests nor is the benefit to the for-profit partner incidental to the furtherance of an exempt purpose. Thus, the tax-exempt partner will fail the operational test when it enters into the joint venture, adversely affecting exemption.

Other joint ventures where the hospital is the controlling partner and has an operational role generally do not raise exemption issues if participation in the partnership is necessary for the hospital's exempt purpose and the benefit to the for-profit partners is not excessive. However, the details of the partnership arrangement need to be carefully developed to ensure the joint venture falls within the confines of Situation 1 of Rev. Rul. 98-15.

A certificate of need may help to establish that an activity is necessary to accomplish exempt purposes. Return of capital (initial investment) is generally beyond the scope of an exempt partner's obligation to the for-profit partners and indicates the for-profit partners' investment is not at risk.

Some factors to consider in developing a joint venture case are whether:

- The exempt organization has an operational role
- The investment is limited to the specific amount invested
- The partners receive distributions consistent with their economic interests
- Ownership interests are proportionate to the partners' investment

**Exhibit 7.20.4-9 (Cont. 9) (09-01-2006)**
**Health Care Providers Reference Guide**

- The exempt organization obtains access to capital or expertise that is not otherwise available

When a healthcare provider that engages in other charitable activities also participates in a joint venture with for-profit entities where this activity does not further its charitable purposes, the tax-exempt entity may be subject to unrelated business income taxation under IRC 512(c). Rev. Rul. 2004-51, 2004-1 C.B. 194.

**15. Corporate Practice of Medicine**

Some states prohibit non-profit corporations from employing physicians to provide outpatient medical services. These states require physicians to incorporate under the state's for-profit professional corporation laws. This is commonly known as the corporate practice of medicine doctrine.

These laws require a physician licensed in the state to hold all the stock in the corporation providing medical services and all board members are required to be physicians licensed by the state. Generally, one physician holds all the stock.

For-profit medical practices in states that adhere to the corporate practice of medicine doctrine may qualify for exemption, but only if the health care provider implements a considerable number of safeguards to ensure charitable organization and operation. Although Article F, *Corporate Practice of Medicine,* in the FY 2000 CPE Text at page 55 provides a discussion, this type of case is currently handled by EO Technical.

**16. Health Maintenance Organizations**

Where the health care provider is a health maintenance organization (HMO), the case is currently handled by EO Technical. An HMO is generally an organization that arranges for its members or subscribers to obtain medical care by contracting with health care providers.

**17. Faculty Group Practices**

A faculty group practice is a health care provider established to employ physicians who are faculty members of a medical school. The group practice offers faculty physicians an opportunity to sharpen their skill by providing medical treatment of patients. It may be organized under corporate practice of medicine state laws. Generally, the courts have determined that faculty group practices qualify under IRC 501(c)(3). See University of Maryland Physicians, P.A. v. Commissioner, 41 T.C.M. 732 (1981); University of Massachusetts Medical School Group Practice v. Commissioner, 74 T.C. 1299 (1980); and B. H. W. Anesthesia Foundation v. Commissioner, 72 T.C. 681 (1979).

Currently, these types of cases are handled by EO Technical.

**18. Fire, Rescue, and Emergency Services**

Providing fire, rescue, or emergency services for the general community may accomplish charitable purposes under IRC 501(c)(3) because such services provide relief to the poor and distressed, or lessen the burdens of government.

**Exhibit 7.20.4-9 (Cont. 10) (09-01-2006)**
**Health Care Providers Reference Guide**

- Rescue service --- A nonprofit organization that conducts emergency rescue services for stranded, injured or lost persons provides relief of distressed persons and is exempt as an organization described in IRC 501(c)(3). See Rev. Rul. 69-174, 1969-1 C.B. 149.

Volunteer fire company --- A nonprofit organization that provides fire protection and ambulance and rescue services to a community qualifies for exemption as a charitable organization under IRC 501(c)(3). See Rev. Rul. 74-361, 1974-2 C.B. 159.

However, when a nonprofit organization operating fire, rescue, or emergency services is a membership organization, it must clearly demonstrate that it benefits the community as a whole in addition to its members.

Where an organization, otherwise qualified for exemption under IRC 501(c)(3), provides emergency, fire, rescue, and ambulance services for its members on a fee basis, the following types of factors should be considered to ensure that it does not operate for the private benefit of its members:

2. Does the organization operate on a policy of furnishing services to all individuals in need regardless of membership or the ability to pay?

3. Is membership available to everyone in the community at nominal cost so that nearly all segments of the interested public could obtain services at the preferential member rate?

4. Are charges to non-members reasonably related to the cost of services rendered and not of a punitive nature?

By meeting the above factors, the organization can demonstrate that it is not impermissibly serving its members' private interests.

Volunteer Firefighters' Relief Organizations

Typical volunteer firefighters' relief organizations are created to provide ancillary benefits such as disability and accident insurance, life insurance, and pensions to unpaid, volunteer firefighters. Using a "lessening the burdens of government" rationale, some of these organizations may qualify for exemption under IRC 501(c)(3). Other volunteer firefighters' relief organizations may qualify under IRC 501(c)(4) using a "community benefit" rationale. For more information relating to the treatment of this type of organization, see Article N, *Volunteer Firefighters' Relief Organizations,* in the FY 1996 CPE Text at page 349 and Article G, *Volunteer Firefighters' Relief Organizations,* in the FY 2000 CPE Text at page 105.

**19. Hospital Foundation Status**

Applications may be submitted by organizations where it is difficult to determine if they are a hospital under IRC 509(a)(1) and 170(b)(1)(A)(iii), or a publicly supported organization under IRC 509(a)(1) and 170(b)(1)(A)(vi) or IRC 509(a)(2). They may ask for one particular foundation classification, when they may be better described under another foundation status.

This commonly occurs with small clinics, generally in rural or inner city settings. They are organized to treat patients suffering from a wide range of maladies, or suffering from a particular condition. Such an organization may not have the need for operating an emergency room, or for a wide variety of staff practicing different specialties. Examples could include, but are not

limited to, a rural medical clinic serving the poor, or a women's health clinic serving those in need of maternity care.

On occasion an applicant receiving exemption under one foundation classification, but not the requested classification, has challenged the Service's determination despite being found not to be a private foundation. In Friends of the Society of Servants of God v. Commissioner, 75 T.C. 209 (1980), petitioner had requested a definitive ruling that it was not a private foundation under IRC 509(a)(1) on the basis that it was a church described in IRC 170(b)(1)(A)(i). The Service granted an advance ruling as a public charity under IRC 509(a)(1) and 170(b)(1)(A)(vi). Under the advance ruling, the applicant would need to meet the public support requirements during the advance period or be reclassified as a private foundation. The tax court agreed that the advance ruling on petitioner's status as a private foundation under IRC 509(a) was adverse in many important respects and that the court had jurisdiction under IRC 7428(a) to review the advance ruling.

Note also that classification of foundation status under IRC 509(a)(1) and 170(b)(1)(A)(vi) or IRC 509(a)(2) does not allow health care providers to avoid the community benefit test.

**20. Drug and Mental Health Centers and Skilled Nursing Homes Foundation Status**

An organization whose principal purpose is the provision of medical or hospital care will qualify as a hospital under IRC 509(a)(1) and 170(b)(1)(A)(iii). The term hospital includes a federal, state, county or municipal hospital; a rehabilitation institution; an outpatient clinic; a community mental health center; or a drug treatment center. A health care provider whose accommodations qualify as being part of a skilled nursing facility within the meaning of 42 U.S.C. 1395x(j) may qualify as a hospital.

Medical care means the treatment of any physical or mental disability or condition, whether on an inpatient or outpatient basis, provided the cost of such treatment is deductible under IRC 213 by the person being treated. See Treas. Reg. 1.170A-9(c)(1).

An outpatient clinic includes a medical center equipped to provide health care services to persons in the community through a staff of health specialists who provide medical care to persons in the community even though it does not have facilities to maintain patients overnight or provide any non-ambulatory care. See Rev. Rul. 73-313, 1973-2 C.B. 174.

However, an organization that primarily provides health care services to patients in their own homes under the direction of their private physicians and only incidentally provides patient treatment at the organization's offices is not described in IRC 170(b)(1)(A)(iii). See Rev. Rul. 76-452, 1976-2 C.B. 60.

Hospitals do not include convalescent homes or homes for children or the aged, nor do they include institutions whose principal purpose is to train handicapped individuals to pursue a vocation.