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TO THE  
HEALTH CARE  
INDUSTRY**  
*Coursebook*

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## **CHAPTER 9**

### **TAX EXEMPTION FOR NON-PROFIT HOSPITALS**

#### **I. Introduction**

Neither the Internal Revenue Code nor the underlying regulations explicitly provide for the exemption from federal income tax of non-profit hospitals. Nevertheless, the Service has long recognized that non-profit hospitals can qualify for exemption as organizations described in IRC 501(c)(3). This was based on the fact that hospitals were historically considered charitable institutions.

#### **A. History of Voluntary Hospitals**

The provision of health care services is in many cases a business activity. However, because it involves issues of life and death and the well-being of people, providing health care services is perceived as something more than a mere profit-making activity. “For many, it is crucial that the relationship between provider and patient be one of ‘care giving,’ for in no ‘business’ except prostitution is the pursuit of profit alone seen as so antithetical to the professional relationship clients seek [cite omitted].”<sup>1</sup>

The earliest American hospitals were established to serve as an alternative to the sick wards in almshouses for the deserving poor. The almshouse sick wards were the last refuge for the destitute and were populated by such “unworthy” poor as prostitutes and alcoholics. Medical care for those who could afford it was provided in their residences. Hospitals were established by prominent citizens, frequently at the urging of local physicians, who generally served as lay trustees overseeing the operations of the hospital. Some hospitals received a portion of their funding from governmental sources. While the majority of patients in the hospitals were unable to pay for their medical care, the early American hospitals did have some paying or part-paying patients, including some third party payer patients. In the late eighteenth century, an insurance fund

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<sup>1</sup>Marmor, Theodore, Mark Schlesinger, and Richard W. Smithey, "Nonprofit Organizations and Healthcare," The Nonprofit Sector, Yale University Press, 1987, p. 223.

to cover the costs of medical care for American sailors was established. In addition, there were a small number of people who might be stricken with illness, be able to afford medical care, but lack the domestic arrangements to receive their medical treatment in the home, such as bachelors, travelers, and merchants. Paying patients, other than sailors, generally received better treatment and more privacy than the indigent patients.

Physicians encouraged the establishment of hospitals in part because they served an educational function by providing clinical experience to doctors. The indigent patients provided the numbers and varieties of illness for those fortunate enough to be able to train in the hospitals. “The objects of charity that filled a hospital's beds could hardly refuse to cooperate in clinical teaching; it was the principal way in which they could repay society for the gratuitous care they received.”<sup>2</sup> Additionally, positions as attending physicians in the hospitals were a source of prestige to those elite few able to obtain them. Although attending physicians served without pay, those positions were highly sought after because of their value in aiding the physician to establish his private practice. As one commentator has noted, “[f]or both economic and scientific reasons, the rise of hospitals was a key precondition for the formation of a sovereign profession.”<sup>3</sup>

Over the course of the nineteenth century, the number of hospitals increased. While many were established by the predominantly white Anglo-Saxon Protestant community leaders, others were established by various religious and ethnic groups. In the latter part of the century, scientific medicine and the development of aseptic surgery began changing the nature of medical practice, particularly in hospitals. Hospitals were increasingly becoming the site of surgical activities, although surgery continued to be performed in the home well into the twentieth century. Hospitals actively sought increased numbers of private pay patients and more people with means to pay for medical care were going to hospitals rather than staying at home. The indigent were increasingly being referred to government hospitals, an outgrowth of the almshouse sick wards, for hospital treatment. By the end of the century, private patient fees were the primary source of hospital income, although they continued to seek voluntary contributions, particularly for capital projects. The relationship of the hospital to the community has been described as follows:

*Pragmatism in money-raising resulted in some new hospitals of the 1920s being county-owned, town-owned, or organized under*

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<sup>2</sup>Charles E. Rosenberg, The Care of Strangers: The Rise of America's Hospital System 190 (1987).

<sup>3</sup>Paul Starr, The Social Transformation of American Medicine, 72 (1982).

*special tax districts, some voluntary not-for-profit, some owned and operated by physicians, and some proprietary corporations. Irrespective of ownership, the community hospital assumed and symbolized community allegiance; hospitals continued to attest, in the 1920s as in earlier years, to the wider values of community success. It followed that the hospital which was built by local fund drives and community contributions was viewed as a community endeavor in spirit, even if it sold all of its services to paying patients.<sup>4</sup>*

With the increase in paying patients, hospital doctors began demanding that hospitals remove the restrictions prohibiting the doctors from charging the patients for their services while in the hospital. By the early twentieth century, all hospitals were permitting their doctors to charge patients for the doctor's services while the patient was in the hospital. Additionally, the hospital's increasing dependence upon paying patients for revenue led to the opening of hospital medical staffs, since the doctors were the ones who referred the patients to the hospital.

In the early twentieth century, hospital standards were adopted on a national basis. Hospitals became the primary source of the new medical technology. With the Depression, many government hospitals began seeking private paying patients. Voluntary non-profit hospitals joined together to establish a national identity separate from government institutions and from proprietary for-profit hospitals. The voluntary hospitals sought to prevent the loss of paying patients to government hospitals and to require that care for the indigent be funded by the government, preferably without government regulation.

To encourage paying patients, a number of voluntary hospitals were active in the creation of the Blue Cross program to provide insurance for the payment of hospital bills. The success of the Blue Cross program encouraged commercial health insurance programs. By the mid-twentieth century, a substantial number of people had some form of health insurance, primarily through employers. However, significant segments of society, in particular the poor and the elderly, typically did not have health insurance. This led to the establishment of Medicare and Medicaid in 1965.

Under the Medicare and Medicaid programs, hospitals were reimbursed for care of the elderly and poor. The availability of this reimbursement was a

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<sup>4</sup>Rosemary Stevens, *In Sickness and In Wealth: American Hospitals in the Twentieth Century* 122 (1989).

major factor in the rise of for-profit hospital chains. At the same time, voluntary hospitals were responding to the changed environment by developing their own large systems of hospitals and related organizations.<sup>5</sup> Consequently, today a substantial number of hospitals, both not-for-profit and for-profit, are part of large, multiple organization systems.

**B. Service Treatment of Non-Profit Hospitals**

Similarly, the Service's treatment of non-profit hospitals has evolved over the years as the health care industry has changed. The Service originally viewed the term "charitable" in the statute in a limited sense as providing relief to the poor. Accordingly, the first published position of the Service regarding hospitals recognized hospitals as charitable organizations provided they accepted patients without regard for their ability to pay to the extent of the hospital's financial ability. Rev. Rul. 56-185, 1956-1 C.B. 202. This was also in accordance with the original mission of hospitals of providing medical care for the poor.

The Service subsequently determined that the term "charitable" in IRC 501(c)(3) should be interpreted in its generally accepted legal sense and not limited to relief of the poor. In keeping with this, and with other changes in the health care industry, the Service revised its position concerning the standards for tax exemption for hospitals. Instead of requiring a specific level of care to the poor in order to qualify for tax exemption, the Service adopted the community benefit standard for hospitals. Rev. Rul. 69-545, 1969-2 C.B. 117.

In recent years, the tax exempt status of hospitals has been a priority for the Service. Hospital audits have constituted a major portion of the Exempt Organizations Coordinated Examination Program. In addition, the Service designated tax exempt health care as part of the Industry Specialization Program in 1990. In 1992, the Service issued revised hospital audit guidelines (Manual Transmittal 7(10)69-38 (March 27, 1992)).

To qualify as an IRC 501(c)(3) organization, a hospital must be organized and operated for a charitable purpose. To meet the organizational test, the hospital's organizational document (typically Articles of Incorporation) must specify that the organization is organized for a charitable purpose, that it is not organized to engage in substantial non-exempt activities, and that its assets are irrevocably dedicated to exempt purposes upon dissolution. In addition, the

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<sup>5</sup>See Chapter 10 for a discussion of exemption issues arising from the development of not-for-profit hospital systems.

hospital's earnings must not inure to the benefit of individuals or private shareholders, it must be operated for a public purpose rather than to provide a private benefit, and it may not engage in substantial lobbying activities or in any political campaign activity. Only by meeting each of these requirements will a hospital be exempt from taxation.

## **II. Charitable Purpose**

### **A. Community Benefit Standard**

The first requirement for an organization to qualify for tax exemption as an organization described in IRC 501(c)(3) is that it must be organized and operated exclusively for a charitable purpose. The promotion of health is not specifically set forth as a charitable purpose in either the statute or the regulations.

Rather, it has been recognized as a charitable purpose based on common law. The community benefit standard is the test currently used by the Service for determining whether a hospital is organized and operated for the charitable purpose of promoting health. Prior to the issuance of Rev. Rul. 69-545, a hospital had to provide charity care to the extent of its financial ability (i.e., meet the “financial ability” standard) as prescribed by Rev. Rul. 56-185, in order to qualify as an organization described in IRC 501(c)(3). There was some difficulty in administering this standard because of its subjectivity. During Congressional hearings, the ruling was criticized because of its imprecise standards concerning the extent to which a hospital must accept patients who are unable to pay in order to retain its exempt status. H.R. Rep. No. 413, 91st Cong., 1st Sess. pt. I, at 43 (1969). Partially due to this and partially in recognition of the establishment of government programs such as Medicare and Medicaid, with the belief that such programs would obviate the need for indigent care, the Internal Revenue Service issued Rev. Rul. 69-545 adopting the community benefit standard.

In that ruling, the Service recognized that the promotion of health is considered to be a charitable purpose under the general law of charity. Promotion of health is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit to the community. Therefore, in order to qualify as an organization described in IRC 501(c)(3), a hospital must demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community and it must show that it is operated to serve a public rather than a private interest.

The ruling was challenged by a group of private citizens who argued that the Service should continue to require hospitals to provide free care to those unable to pay in order to qualify for tax exemption under IRC 501(c)(3). While the district court agreed with the plaintiffs' assertion that the ruling was an improper reversal of long-standing policy, the District of Columbia Circuit Court reversed that decision. It held that the definition of charity was not limited to the relief of poverty and the Service was authorized to modify the requirements for tax exemption for non-profit hospitals. The Supreme Court subsequently vacated the Circuit Court's decision on jurisdictional grounds. Eastern Kentucky Welfare Rights Organization v. Simon, 370 F. Supp. 325 (D.D.C. 1973), rev'd, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976).

While the Supreme Court's decision effectively precluded litigation seeking a return to the financial ability standard as the sole method by which a non-profit hospital may qualify as a tax exempt organization, it has not meant that the financial ability standard has no relevance. It was not repealed when the community benefit standard was adopted. The financial ability standard was set forth in Rev. Rul. 56-185 as one of the requirements for recognition of exemption of a hospital as an organization described in IRC 501(c)(3). It required a hospital to be operated to the extent of its financial ability for those not able to pay in order to qualify as an organization described in IRC 501(c)(3). Rev. Rul. 69-545, which adopted the community benefit standard, did not revoke Rev. Rul. 56-185; it merely modified it. While a hospital is no longer required to operate to the extent of its financial ability for those not able to pay, doing so is a major factor indicating that the hospital is operated for the benefit of the community.

The community benefit standard was developed in the context of recognition of exemption as organizations described in IRC 501(c)(3) for hospitals. However, the principles of the community benefit standard are applicable in the case of any health care provider.<sup>6</sup>

The factors to be considered in determining whether a hospital meets the community benefit standard include the following:

- (1) Whether the governing body of the hospital is composed of members of the community (as opposed to financially interested individuals);

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<sup>6</sup>See discussions regarding the application of the community benefit standard to other health care providers in Chapters 11, 12 and 13.

- (2) Whether medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of the facilities;
- (3) Whether the hospital operates a full-time emergency room open to all regardless of ability to pay; and
- (4) Whether the hospital admits as patients those able to pay for care, either themselves or through third-party payers such as private health insurance or government programs such as Medicare and Medicaid.

Other factors that demonstrate that the hospital is operating for the benefit of the community may also be considered. Some factors that may be considered are whether the hospital conducts medical training or research activities, engages in activities to educate the public regarding health care matters, or provides types of health care services not otherwise available to the community.

## **B. Community Board**

Members of the hospital medical staff or administrative staff or their representatives may serve on a governing body of the hospital composed of members of the community. However, they should not control the governing body. Control of the governing body by the members of the hospital medical staff or administrative staff or their representatives indicates that the hospital may be serving private interests rather than public interests and thus not providing a community benefit.

In recent rulings involving integrated delivery systems, the Service has recognized the exemption of health care organizations where no more than 20% of the members of the governing body will be members of the hospital medical staff or administrative staff. In the absence of other factors indicating control by the members of the medical staff and administrative staff, they were presumed not to be in control of the health care organization due to the 20% limit.<sup>7</sup> However,

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<sup>7</sup>See determination letters issued to Friendly Hills Healthcare Network (January 29, 1993), reprinted in Exempt Organizations Tax Review, March 1993, vol. 7, no. 3, p. 490; Facey Medical Foundation (March 3, 1993), reprinted in Exempt Organizations Tax Review, May 1993, vol. 7, no. 5, p. 828; Billings Clinic (December 21, 1993); and Harriman Jones Medical Foundation (February 3, 1994), reprinted in Exempt Organizations Tax Review, March 1994, vol. 9, no. 3, p. 719. These rulings were released to the public pursuant to the procedures announced in Notice 92-28, 1992-1 C.B. 515. For a discussion of the 20% safe harbor for integrated delivery systems, see "Integrated Delivery Systems," Exempt Organizations Continuing Professional Education Technical Instruction Program for Fiscal Year 1994.



the mere fact that an existing health care organization has a governing body on which more than 20% of the members are members of the hospital medical staff or administrative staff, or their representatives, would not automatically mean that the organization does not have a community board.

Members of the governing body who are also members or representatives of the medical staff or administrative staff should not participate in the decision making process where questions of inurement or private benefit to members of the medical staff or administrative staff might arise, such as compensation. However, other areas that are within the particular expertise of the members of the medical staff, such as appropriate medical treatment and medical research or education, may be subject to their unrestricted control.

### **C. Open Medical Staff**

The requirement of an open medical staff was originally intended to take care of the problem of doctor-owned hospitals seeking exemption while limiting admissions to their own patients. Today, this is less likely to be a problem since hospitals want as many physicians as possible associated with them in order to increase paying admissions. However, it remains a requirement because of the unique relationship that physicians have with hospitals. A hospital that restricts its medical staff privileges to a limited group of physicians (i.e., operates with a closed staff policy) is likely to be operating for the private benefit of the staff physicians rather than for the public interest. However, to be operating for the benefit of the community, the hospital does not need to grant medical staff privileges to every physician that requests them. A hospital may impose reasonable qualification requirements on the physicians it permits to have medical staff privileges under an open staff policy. It may also restrict the number of physicians admitted to its medical staff due to the size and nature of its facilities.

The qualification requirements must not be unduly restrictive. In addition, the qualification requirements must not be used as a way to keep a closed staff. Similarly, restrictions on staff privileges due to the size and nature of the facilities may not be used to create a closed staff. Valid restrictions on admission to the medical staff may include denying admission because there are already sufficient doctors serving that specialty on the staff or because the hospital does not require doctors of a particular specialty. On the other hand, denying a physician admission to the medical staff due to an expectation that the physician will not refer enough private pay patients to the hospital is not a valid restriction on admission. In some instances, a hospital will contract exclusively with a particular physician group to run a particular department (such as the emergency room) in order to guarantee physician coverage of the department 24 hours a day,

seven days a week. These arrangements will generally not result in the hospital having a closed medical staff, unless there are other factors that show these arrangements are being entered into to restrict the medical staff.

The hospital audit guidelines (IRM 7(10)69 § 333.1(2)) provide that an examining agent should do the following to determine if the hospital, in fact, operates with an open staff policy:

- (1) Identify qualification requirements for admission to staff by referring to the medical staff bylaws;
- (2) Review application procedures and methods of staff selection;
- (3) Review minutes of medical staff meetings;
- (4) Determine whether staff admission fees are charged on a preferential basis;
- (5) Ascertain if new doctors in the geographic area are admitted to the staff (absence of new members could indicate a closed staff);
- (6) Consider the number of doctors in each membership category (i.e., active, associate, courtesy);
- (7) Interview knowledgeable officials to determine if doctors have been denied admission to the staff for other than reasonable cause;
- (8) Review the minutes of the credentials committee; and
- (9) Review the hospital's Daily Census Report to determine the percentage of use of hospital facilities by various doctors.

**D. Emergency Room**

**1. General Rule**

Generally, an acute care general hospital must operate a full-time emergency room open to everyone, regardless of ability to pay, in order to qualify as an IRC 501(c)(3) organization. The most crucial aspect of promoting health is the provision of emergency health care to anyone in need. A hospital that does not operate a full-time emergency room is not fulfilling this need and thus may not be operating for the benefit of the community. Operation of an emergency room that is not open to everyone, regardless of ability to pay, also indicates that the hospital is not operating for the benefit of the community, since a significant segment of the community is not being served. The hospital audit guidelines (IRM 7(10)69 § 333.1(3)) provide that an examining agent should do the following to determine if the hospital, in fact, operates a full-time emergency room open to everyone:

- (1) Review manual of operations, brochures, posted signs, etc.;
- (2) Interview ambulance drivers to determine whether they are instructed to take indigent patients to another hospital;
- (3) Interview emergency room staff to determine admission procedures;
- (4) Interview social workers in the community familiar with delivery of emergency health care services to determine whether such services are known to be available at the hospital; and
- (5) Ascertain when and how determinations of financial responsibility are made and whether a deposit is required of any patient before care is rendered.

In addition, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), hospitals participating in Medicare that operate emergency rooms are required to treat any patient in an emergency condition, regardless of ability to pay. This requirement applies to all patients, not just those covered by Medicare or Medicaid. A violation of these “anti-dumping” provisions could indicate that the hospital is not operating for the benefit of the community.<sup>8</sup>

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<sup>8</sup>Although the Service is not the agency that should be making a determination regarding whether the anti-dumping provisions have been violated and may not disclose information obtained during an

COBRA also requires hospitals to retain their patient transfer records for a period of five years. Thus, the examining agent may wish to review the patient transfer records to determine if the emergency room is open to all regardless of ability to pay.

## **2. Limited Exception**

However, there are certain limited exceptions to the requirement that a hospital operate a full-time emergency room. Rev. Rul. 83-157, 1983-2 C.B. 94, holds that a hospital that otherwise met the requirements of Rev. Rul. 69-545, was not required to operate an emergency room when a state health planning agency had made a determination that additional emergency facilities would be unnecessary and duplicative. In that case, a state health planning agency had independently determined that the operation of an emergency room by the hospital would not benefit the community.

An IRC 501(c)(3) hospital may not unilaterally decide not to operate a full-time emergency room without jeopardizing its exempt status. A determination by the appropriate government authority is necessary. However, the hospital may enter into agreements with the appropriate government agency concerning the operation of the emergency room. For example, if there are sufficient emergency facilities available in the community but the community is underserved in another area, the hospital may enter into an agreement with the appropriate government authority to operate a department to provide the needed services instead of operating the emergency room. Because the appropriate government authority has made the determination that the community would be benefitted by the operation of the other department, the fact that the hospital does not operate a full-time emergency room will not disqualify it as an IRC 501(c)(3) organization.

Similarly, there are certain types of specialty care hospitals, such as eye hospitals and cancer institutes, that typically do not operate emergency rooms because they treat conditions unlikely to need emergency care. Rev. Rul. 83-157 holds that in those situations, operation of an emergency room is not required. To qualify as a tax exempt organization, the hospital must otherwise show that it is operated for the benefit of the community and not for private interests.

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audit to the appropriate agency, it may take into account a finding of a violation by the appropriate agency. Similarly, the same factors that are considered in determining whether the anti-dumping provisions have been violated may be considered in determining whether the hospital in fact operates a full-time emergency room open to all regardless of ability to pay.

Nevertheless, Rev. Rul. 83-157 should not be interpreted to suggest that operation of a full-time emergency room open to all regardless of ability to pay is not a requirement for exemption, but is merely illustrative of the types of activities that demonstrate community benefit. On the contrary, the Service clarified in testimony before House Select Committee on Aging that this interpretation was not a proper reading of the revenue ruling. Rather, the operation of an emergency room and participation in Medicare and Medicaid are the two most important factors demonstrating community benefit.<sup>9</sup> The Service has characterized the operation of a full-time emergency room open to all regardless of ability to pay as a virtual requirement to demonstrate community benefit.<sup>10</sup> In testimony before the House Committee on Ways and Means in July 1991, the Service reiterated that the operation of an emergency room by a typical acute care hospital is one of the two most important factors demonstrating community benefit.<sup>11</sup>

#### **E. Admitting Patients Able to Pay**

In general, a hospital is required to admit patients with the ability to pay for non-emergency services, either themselves or through health insurance, to the extent facilities are available. A hospital that restricts admissions to patients of staff members is operating for the benefit of its staff members and not for the benefit of the community as a whole. Hence, assuming available space, once a determination is made that a particular patient is covered by health insurance or a governmental program or otherwise has sufficient resources to pay for health care, the patient should be admitted to the hospital in a nondiscriminatory manner. Otherwise, the hospital is not operating for the benefit of the community.

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<sup>9</sup>Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness: Hearing Before the House Select Committee on Aging, 101st Cong., 2d Sess. 57-72 (1990) (Statement of James J. McGovern, Assistant Chief Counsel (Employee Benefits and Exempt Organizations), Office of Chief Counsel, Internal Revenue Service).

<sup>10</sup>Remarks of James J. McGovern, Assistant Chief Counsel (Employee Benefits and Exempt Organizations), delivered on June 11, 1991, to a joint assembly of the Canadian and U.S. Health Associations, in Montreal, Canada reprinted in Exempt Organizations Tax Review, June 1991, vol. 4, no. 4, p. 446.

<sup>11</sup>Statement of John E. Burke, Assistant Commissioner (Employee Plans and Exempt Organizations), Internal Revenue Service, Before the House Committee on Ways and Means, July 10, 1991, reprinted in Exempt Organizations Tax Review, July 1991, vol. 4, no. 5, p. 586.

To determine if the hospital is admitting all patients able to pay, the hospital audit guidelines recommend that the examining agent review the hospital admission policy and the files on denied admissions to determine the reasons for denial. Furthermore, they suggest that the hospital's audited financial statements for years ending after June 30, 1990, be reviewed for a statement of the hospital's charity care policy and expenditures. IRM 7(10)69 § 333.1(6).

One of the primary reasons behind the adoption of the community benefit standard was the belief that the establishment of government programs such as Medicare and Medicaid would obviate the need for charity care for the indigent. Therefore, in June 1990 testimony before the House Select Committee on Aging, the Service clarified that an interpretation of Rev. Rul. 83-157 that operation of an emergency room and participation in Medicare and Medicaid programs were merely illustrative of the types of activities that demonstrate community benefit and not requirements of exemption was not a proper reading of the revenue ruling. Rather, operation of an emergency room and participation in Medicare and Medicaid programs are the two most important factors demonstrating community benefit for qualification as an IRC 501(c)(3) hospital.<sup>12</sup> The Service has indicated that participation in the Medicare and Medicaid programs is a virtual requirement to demonstrate community benefit.<sup>13</sup> The Service reiterated this position in July 1991 testimony before the House Committee on Ways and Means, characterizing nondiscriminatory care of Medicare and Medicaid patients as one of the two most important factors demonstrating community benefit.<sup>14</sup>

A failure by a hospital to admit and treat Medicare and Medicaid patients on a nondiscriminatory basis demonstrates that benefit is not being provided to a significant segment of the community and so the class of beneficiaries will not be sufficiently broad to benefit the community as a whole. The hospital examination guidelines suggest that the examining agent determine if the hospital admits and treats Medicare and Medicaid patients in a nondiscriminatory manner and to

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<sup>12</sup>Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness: Hearing Before the House Select Committee on Aging, 101st Cong., 2d Sess. 57-72 (1990) (Statement of James J. McGovern, Assistant Chief Counsel (Employee Benefits and Exempt Organizations), Office of Chief Counsel, Internal Revenue Service).

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compare the proportion of services provided to Medicaid patients to the proportion of Medicaid beneficiaries living in the hospital's service area. IRM 7(10)69 § 333.1(6).

Under some state Medicaid programs, such as Medi-Cal in California, states contract selectively with a limited number of hospitals to provide services to beneficiaries of the program in a defined service area. In those instances, the hospital will be considered to be participating in the program on a nondiscriminatory basis if it enters into good faith negotiations with the state to obtain an inpatient service contract.

Generally, once it has determined that a patient has sufficient resources to pay for treatment, the hospital is not concerned with the source of the payment. With traditional health insurance plans, the patients choose their own hospitals and the insurance companies either reimburse them or pay the hospitals directly for all or part of the incurred costs at the rates set by the hospitals. In those cases, the hospital should admit any patients covered by those plans, regardless of which plan they are covered under. However, under some health care plans, the insurance companies select the hospitals to be used by patients covered under the plans and contract directly with those hospitals to establish the rates to be charged. In those instances, the hospital is not required to contract with any particular health care plan that desires to negotiate with it. However, if the hospital, by refusing to participate in certain plans, does not provide services to a substantial segment of the community, it may not be providing services to a sufficiently broad class to be operating for the benefit of the community.