Cite as Det. No. 01-014, 23 WTD 103 (2004)

BEFORE THE APPEALS DIVISION
DEPARTMENT OF REVENUE
STATE OF WASHINGTON

In the Matter of the Petition	)	D E T E R M I N A T I O N
For Correction of Assessment of	)	
	)	No. 01-014
. . .	)	
	)	Registration No. . . .
	)	Docket No. . . .
	)	FY . . . /Audit No. . . .
	)	

[1] RULE 111: B&O TAX – EXCLUSION – EMERGENCY ROOM PHYSICIAN FEES. Even though An ER physician organization's contract with a hospital contained an "agency" billing clause, Rule 111 exclusion will not be allowed when the contract, construed as a whole, also indicates that the organization was accountable to, and performing duties for and on behalf of, the hospital and the patients and their payments belonged to the hospital; the hospital, and not the patients alone, were responsible for the organization's payment.

[2] RCW 82.04.4297: B&O TAX – DEDUCTION - MEDICARE/MEDICAID COINSURANCE AND DEDUCTIBLES. Amounts received as coinsurance and deductibles directly from a hospital's patients are not deductible under RCW 82.04.4297 because they are not amounts received "from the United States or any instrumentality thereof or from the state of Washington or any municipal corporation or political subdivision thereof."

[3] RCW 82.04.4297: B&O TAX – DEDUCTION – CHAMPUS REVENUES. CHAMPUS revenues are "amounts received under an employee health benefit plan" and are, thus, ineligible for the RCW 82.04.4297 deduction.

[4] RULE 168(3)(a); RCW 82.04.260(12): B&O TAX – PUBLIC AND NONPROFIT HOSPITAL CLASSIFICATION – "SERVICES TO PATIENTS" -- INTEREST ON PATIENT ACCOUNTS. Because it was the legislature's intent to extend tax treatment under this classification to services rendered by nonprofit hospitals to its inpatients, i.e., "services to patients," interest charges are not taxable under this rate because it is not a hospitalization service.

Headnotes are provided as a convenience for the reader and are not in any way a part of the decision or in any way to be used in construing or interpreting this Determination.

NATURE OF ACTION:

Petition of a nonprofit hospital concerning the taxability of emergency room physician fees, Medicare and Medicaid coinsurance and deductibles, CHAMPUS revenues, kidney dialysis revenues, and interest on unpaid patient accounts.[1]

FACTS:

Bauer, A.L.J. – -- Taxpayer's business records were reviewed by the Audit Division (Audit) of the Department of Revenue (Department) for the period July 1, 1993 through December 31, 1993. As a result, the above-referenced assessment was issued on December 17, 1997 in the total amount of $ . . . which amount included interest accrued through that date.

Taxpayer, a nonprofit hospital, disagrees with the assessment and has timely appealed. Taxpayer has submitted two written petitions on its behalf dated January 22, 1988 and March 9, 1999. Taxpayer agreed no hearing was necessary.

TAXPAYER'S EXCEPTIONS:

1. Revenue Reconciliation. In its first petition, Taxpayer objected to Audit's listing in Schedule II of a total amount due for the "Test Period – June through December 1993," and the source as "Taxpayer WP & Trial Balance." Taxpayer complained that it had been unable to determine how Audit arrived at that total for the last six months of 1993, and argued that it is inappropriate to present a total amount for the last six months without showing the detail used to arrive at that amount. Taxpayer further argued that it was equally inappropriate to merely reconcile the gross amount without verifying the amounts involved in arriving at the net taxable amount. According to Taxpayer, if the amount causing the difference to be understated was a government source, no additional tax would be due in any event. Taxpayer stated that it needed to review the balances for patient service revenue to determine if Audit's numbers were correct. Taxpayer noted that it did not believe the net amount upon which the tax[2] was paid included an adjustment for bad debts expense.[3] In its supplementary petition, Taxpayer further complained that "ER Physician Revenue" (argued alternatively to be totally exempt) was included not only in Schedule II, but also in Schedule III, subjecting Taxpayer to double taxation for the same revenues.

2. Emergency Room (ER) Physician Fees.[4] Taxpayer objects to the assessment of business and occupation (B&O) tax on amounts Taxpayer billed on behalf of its emergency room physicians.

[1] Identifying details regarding the taxpayer and the assessment have been redacted pursuant to RCW 82.32.410.
[2] $ . . . .
[3] $ . . . .
[4] Schedule III. The amount of tax in question is $ . . . .

According to Taxpayer, its contract with [Physicians' Organization] clearly established the nature of its relationship as one of agent and principal as to the collection of fees by Taxpayer for [Physicians' Organization]. Taxpayer particularly quotes Section 3, Paragraph a,[5] and Section 3, paragraph f,[6] of the contract, as amended in 1994,[7] as supportive of its argument. Taxpayer argues that the physicians of [Physicians' Organization] were not guaranteed a fixed amount for the services they rendered to patients. Taxpayer further complains that Audit ignored the findings in Det. No. 88-208, 5 WTD 403 (1988), which Taxpayer states not only mirrors the facts in this case, but upon which it relied in not including the amount earned by [Physicians' Organization] in its taxable base. According to Taxpayer, it separately stated the physicians' "professional component" on the detail hospital bill, and billed the third party carriers on different billing forms in order to make actual collection. Only a patient without insurance of some sort would pay from the detail hospital bill. Taxpayer believes the assessment is in error, and the tax should be vacated. Finally, Taxpayer contends that it did pay B&O tax on the portion of the ER billings that it retained for services rendered.

3. Medicare and Medicaid Coinsurance and Deductibles.[8] Taxpayer objects to the assessment of B&O tax on that portion of Medicare and Medicaid Revenue that the federal government requires participants in those programs to pay. Neither Taxpayer nor patients have control over the amount of the charges that the hospital may bill or the amount to be paid directly by the government, or that the government requires to be remitted in satisfaction of the coinsurance and deductibles it establishes. Taxpayer believes that all amounts recorded as Medicare or Medicaid revenue are received through the same plan, and that ultimately it is the government, through its mandatory setting of reimbursement regulations, that is the payer in fact. In its supplementary petition dated March 9, 1999, Taxpayer further disagrees with the amounts in this category set forth by Audit as taxable, disagreeing with the methodology used in computing the ratio of coinsurance and deductibles to total Medicare and Medicaid gross revenues.

4. CHAMPUS.[9] Taxpayer objects to the assessment of B&O tax on the revenue Taxpayer received from the federal government through CHAMPUS, a federal program for dependents of active military and retired military. Taxpayer argues the program does not cover active military personnel, and does not meet the test of being an employee benefit program as described in RCW 82.04.430 because uniformed service personnel are not employees and because retired members and active duty dependents do not receive the same health coverage as do military personnel themselves.

[5] "[Physicians' Organization] and its Physicians hereby appoint [Taxpayer] as their agent for the limited purpose of acting as billing and collecting agent for the professional physician charges made by Physicians pursuant to this Agreement. [Physicians' Organization] shall provide [Taxpayer] with an agreement signed by each of its Physicians authorizing and assigning collection of such charges to [Taxpayer]."

[6] "Notwithstanding anything hereinabove or hereinafter stated or implied to the contrary, it is the expressed intent of the parties that all of [Physicians' Organization]'s and Physicians' professional fees generated at [Taxpayer's hospital] pursuant to this Agreement shall be the sole and exclusive property of [Physicians' Organization] and its Physicians, and the above-described billing and collection procedure for professional charges by [Taxpayer] is merely for the convenience of the parties in collecting the same and paying for costs of collection."

[7] Earlier versions in effect during the audit period were not made available.

[8] Schedule IV. The amount of tax in question is $ . . . .

[9] Schedule V. The amount of tax in question is $ . . . .

Taxpayer instead argues that CHAMPUS revenue is a proper deduction from the measure of B&O tax for health or social welfare organizations, and supports this position with a copy of a letter from a third party attorney.

5. Tax Levy Receipts.[10] Taxpayer had understood that these amounts were to have been deleted because they represented amounts received from taxes collected either by the hospital district or another taxing authority in the area and transferred to the hospital.

6. Interest on Patient Accounts.[11] Taxpayer objects to the assessment of B&O tax under the service and other activities classification on the interest charged on patient accounts receivable. Taxpayer contends that, in the instance of the hospital industry, this is not appropriate after the enactment of RCW 82.04.260(12).[12] Unlike in most industries, Taxpayer stresses that most of this revenue is never collected. When it is finally written off as a bad debt, there is no distinction made between the patient charges and the interest. Therefore, the interest that was accrued with little likelihood of being collected is written off as anticipated, but the interest income account is not reduced. Non-profit hospitals, according to Taxpayer, often do not even charge interest on past due accounts. The terms for repayment of amounts owed are much more generous than would be found in most industries. Credit is often extended to give the patient a sense of being able to contribute to the care received. Thus, Taxpayer believes the very nature of its being, and the way it handles patient credit, justifies this activity as different than the usual or average business that actually expects to make money on the extension of credit.

7. Kidney Dialysis revenue. Taxpayer argues that the assessment of kidney dialysis income in Schedule II, collected from inpatients and outpatients, was in error because such income is exempt under RCW 82.04.4289.

ISSUES:

1. Whether Audit's listing of a total amount due for the "Test Period – June through December 1993," in Schedule 2, using the source as "Taxpayer WP & Trial Balance," is accurate.

2. Whether B&O tax was properly due on amounts Taxpayer billed on behalf of its emergency room physicians, or whether Taxpayer was merely collecting these fees on behalf of the emergency room physicians as agent, and whether these revenues have been duplicated in Schedules II and III.

3. Whether revenues that Medicare and Medicaid require participants in those programs to pay as coinsurance and deductibles should be deductible under RCW 82.04.4297, and whether the auditor's methodology in arriving at these amounts was correct.

4. Whether CHAMPUS[13] revenues are properly subject to B&O tax.

[10] Schedule VI. The amount of tax in question is $ . . . .
[11] Schedule VII. The amount of tax in question is $ . . . .
[12] Originally RCW 82.04.260(15).
[13] Civilian Health and Medical Program for the Uniformed Services.

5. Whether tax levy receipts should have been deleted from the assessment, as Taxpayer understood Audit intended, because they represented amounts received from taxes collected either by the hospital district or another taxing authority in the area and transferred to the hospital.

6. Whether interest earned on unpaid patient accounts should be taxed under the public or nonprofit hospital classification of the B&O tax.

7. Whether kidney dialysis income rendered to inpatients and outpatients by Taxpayer was properly exempt under RCW 82.04.4289.

DISCUSSION:

1. Revenue Reconciliation. The "revenue reconciliation" issue raised, as described by Taxpayer, constitutes factual questions best resolved by a meeting between Audit and Taxpayer. This issue is therefore remanded to Audit for resolution.

2. Emergency Room (ER) Physician Fees. WAC 458-20-111 (Rule 111) provides an exclusion for "advances" and "reimbursements" received by a taxpayer from its customer, to be paid to another business entity on behalf of that customer, but only when the customer alone is liable for the payment of the fees or costs, and when the taxpayer making the payment on behalf of the customer has no personal liability therefor, either primarily or secondarily, other than as an agent for its customer. This "pass-through" arrangement must be in accordance with the regular and usual custom of the business entity's business or profession. The rule goes on to provide, however, that this exclusion is not permitted unless a taxpayer is procuring a service for its customer which it does not, or cannot, render. Further, it does not apply when the customer is making payment to the taxpayer for services to be rendered by the taxpayer.[14]

Det. No. 88-208, supra, cited by Taxpayer, stated:

> More important than the billing arrangement in ascertaining the tax consequences that flow from the billing arrangement is the business relationship between the taxpayer and the physician. In order for the taxpayer to be held liable for Service B&O tax on its gross billing which included the "professional component," it must be shown that the physician was either an employee or a subcontractor of the taxpayer in the rendition of the medical services to the patient.

[14] "The foregoing is limited to cases wherein the taxpayer, as an incident to the business, undertakes, on behalf of the customer, guest or client, the payment of money, either upon an obligation owing by the customer, guest or client to a third person, or in procuring a service for the customer, guest or client which the taxpayer does not or cannot render and for which no liability attaches to the taxpayer. It does not apply to cases where the customer, guest or client makes advances to the taxpayer upon services to be rendered by the taxpayer or upon goods to be purchased by the taxpayer in carrying on the business in which the taxpayer engages." Rule 111.

In Det. No 88-208, supra, it was determined that the physicians were neither employees nor subcontractors to the taxpayer/hospital, but were primary contractors, instead, to their patients. This was because each physician was free to fix his or her professional fees, the physicians assumed no duties of the hospital, there was no contractual relationship between the hospital and the patient when professional emergency services were rendered, and such services were apparently rendered in the physician's office and not in an emergency room, per se. If an emergency room patient had to be admitted to the hospital, and had no primary care physician, the on-call emergency physician would assume that role retroactively.

In this case, even without addressing the billing arrangements between the parties, we note the following facts which vary from those in Det. No. 88-208:

(1) [Physicians' Organization] was required to "assume and discharge all responsibilities consistent with all applicable [Taxpayer] policies. . .[and] bylaws, rules, and regulations,[15]

(2) [Physicians' Organization] was required to appoint a Medical Director to interact and perform, unreimbursed, administrative non-patient care duties for Taxpayer for a total of 700 hours per year,[16]

(3) [Physicians' Organization]'s physicians were required, upon request, to perform teaching, administrative, and other duties for Taxpayer,[17]

(4) [Physicians' Organization]'s physicians, upon Taxpayer's request, were required to render courtesy services (i.e., at no cost) to visitors and hospital employees injured while on Taxpayer's campus,[18]

(5) The emergency room medical records produced by [Physicians' Organization] and its physicians were considered to be Taxpayer's exclusive property and were not to be removed from Taxpayer's facilities,[19]

(6) [Physicians' Organization]'s physicians were entitled to only . . . % of their patient billings; the remainder was retained by Taxpayer, regardless of the amounts actually collected;

(7) Absent other agreements to the contrary, [Physicians' Organization] and its physicians were required to "cooperate with and participate in any and all Managed Health Care Plans and other contractual arrangements . . . through which [Taxpayer] agree[d] to provide healthcare services"[20] and finally,

(8) [Physicians' Organization] physicians were subject to a covenant not to compete, wherein they were prohibited, without the prior written consent of Taxpayer, from rendering emergency room or urgent care medical services (whether in connection with another hospital or otherwise) within a 15-mile radius of Taxpayer's campuses for a period of six months after the termination of their services in Taxpayer's emergency room.[21]

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[15] Agreement, paragraph 1.
[16] Agreement, paragraph 1f.
[17] Agreement, paragraph 1q.
[18] Agreement, paragraph 1v.
[19] Agreement, paragraph 1k.
[20] Agreement, paragraph 1n.
[21] Agreement, paragraph 10.

[1] We must conclude, from the above contract construed as a whole -- despite its "agency" billing clause -- that [Physicians' Organization] was clearly accountable to, and was performing duties for and on behalf of, Taxpayer. It is, further, clear that the patients who sought emergency room treatment -- and the remuneration which thereby resulted -- belonged to Taxpayer, and not [Physicians' Organization]. Taxpayer contracted with these physicians to actually staff its emergency room on an ongoing basis, and to provide other related services deemed necessary to Taxpayer's operation. Taxpayer, by contracting with the physicians, was merely procuring the professionals which allowed Taxpayer to render its emergency service to patients.

Thus, the following necessary elements of Rule 111 were not met: First, the patients alone were not liable for the emergency room physicians' fees – Taxpayer, by its contract, was liable for a certain percentage of patient billings, whether or not these billings were actually collected. Second, Taxpayer's contract made it clear that patients coming to the emergency room for treatment were Taxpayer's patients, and were thus being supplied emergency treatment by Taxpayer through its subcontractors. In so doing, Taxpayer was not "procuring a service for the customer . . . which the taxpayer does not or cannot render and for which no liability attaches to the taxpayer." See Rule 111. Taxpayer was, thus, not eligible for the Rule 111 exclusion.

This issue is, however, remanded to Audit to address Taxpayer's concern that some of these revenues might have been included in both Schedules II and III.

3. Medicare and Medicaid Coinsurance and Deductibles. Revenues received from Medicare and Medicaid are deductible under RCW 82.04.4297, which provides:

> In computing tax there may be deducted from the measure of tax amounts received from the United States or any instrumentality thereof or from the state of Washington or any municipal corporation or political subdivision thereof as compensation for, or to support, health or social welfare services rendered by a health or social welfare organization or by a municipal corporation or political subdivision, except deductions are not allowed under this section for amounts that are received under an employee benefit plan.

[2] (Emphasis added.) To be deductible, it is clear that amounts must be received from "the United States or any instrumentality thereof or from the state of Washington or any municipal corporation or political subdivision thereof" and not from individual recipients of the services provided. Co-payments and deductibles due from Taxpayer's patients themselves are not included in the statutory deduction, and the fact that providers may have no control over the amount of billings, or the percentage of these billings to be due from individual patients, does not alter the plain language of RCW 82.04.4297. Tax statutes conferring credits, refunds, or deductions are construed narrowly. Lacey Nursing Center v. Department of Rev., 128 Wn.2d 40, 905 P.2d 338 (1995). Taxpayer's petition as to this issue is therefore denied. However, the issue is remanded to Audit to address Taxpayer's concern that the methodology used to ascertain the portion of Medicare and Medicaid revenues which were coinsurance or deductibles was incorrect.

[3] 4. CHAMPUS Revenues. As to the deductibility of CHAMPUS revenues, RCW 82.04.4297 provides an exemption from B&O tax for:

> . . . amounts received from the United States or any instrumentality thereof from the state of Washington or any municipal corporation or political subdivision thereof as compensation for, or to support, health or social welfare services rendered by a health or social welfare organization or by a municipal corporation or political subdivision, except deductions are not allowed under this section for amounts received under an employee benefit plan.

(Emphasis added.)

For Taxpayer to deduct CHAMPUS revenues under RCW 82.04.4297, therefore:

(1) Payment must be received from the United States,
(2) The compensation must be for "health or social welfare services," and
(3) Taxpayer must be a "health or social welfare organization."
(4) Payment must not be for amounts received under an "employee benefit plan."

Because the first three elements were not discussed in either the audit report or Taxpayer's petition, we will assume, without a finding, for the limited purpose of resolving this administrative appeal, that the first three elements were satisfied. Therefore, the issue before us is whether payments by CHAMPUS were received under an "employee benefit plan."

Taxpayer has always treated CHAMPUS revenue as deductible under RCW 82.04.4297. Taxpayer disagrees with Audit's description of CHAMPUS as "one of the United States government health insurance plans for employees and dependents." Taxpayer instead argues that CHAMPUS does not cover active military personnel, but is a program solely for dependents of the military. Thus, Taxpayer argues, there must be employees before there can be "an employee benefit plan," and "soldiers are not employees." Taxpayer has presented, in support of its argument, a letter from a third party attorney (the letter), which states:

> This definition [of "employee benefit plan in RCW 82.04.293] establishes four major types of arrangements which constitute employee benefit plans, namely: ERISA covered plans; arrangements which enjoy special federal tax treatment; similar plans maintained by state or local governments; and self-insured benefits mandated by federal, state or local law.

The letter further argues that the definition in RCW 82.04.293 is the "common understanding" of "employee benefit plan," and goes on to explain "our view" of the "common meaning" of that term. In particular, the letter states:

> We believe[22] that employee benefit plans are characterized by the following:

[22] We note that no authority is given for these beliefs.

> 1. Benefits under employee benefit plans are not mandated by law.
> 2. The level of benefits is determined by the employer or by agreement between the employer and the employee(s).
> 3. Benefit levels are often subject to unilateral change by the employer.
> 4. Benefits arise out of, and in the context of, the employer-employee(s).
> 5. Benefits are often regulated by ERISA.
>
> CHAMPUS is very different form an employee benefit plan. The following is a partial list of these differences:
>
> 1. Coverage under CHAMPUS is "not a mere act of grace . . . [it is] a full-fledged matter of right." Barnett v. Weinberger, 818 F.2d 953, 957 (D.C. Cir. 1987).
> 2. CHAMPUS coverage satisfies a "statutory entitlement to medical care."
> 3. CHAMPUS is not covered by ERISA (See, McGee v. Funderburg, 17 F.3d 1122, 1125 (8th Cir. 1994)).
> 4. Benefits arise not out of the employment contract, but as "an earned entitlement in gratitude for services [by members of the armed forces] to their country and as a means of making more attractive service in the armed forces of the United States." Id. at 1125.
> 5. Benefits levels are statutorily determined.
>
> We believe that CHAMPUS is not an employee benefit plan. In our view, it is a government entitlement program. . . .

As Taxpayer has correctly noted, RCW 82.04.293 (which relates to B&O taxes applied to international investment management services) defines an "employee benefit plan" as including:

> . . . any plan, trust, commingled employee benefit trust, or custodial arrangement that is subject to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. Sec. 1010 et seq., or that is described in sections 125, 401, 403, 408, 457 and 501(c)(9) and (17) through (23) of the internal revenue code of 1986, as amended, or a similar plan maintained by a state or local government, or a plan, trust, or custodial arrangement established to self-insure benefits required by federal, state, or local law.

(Emphasis added.)

Taxpayer has further admitted that:

> CHAMPUS is a program of medical benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services.

(32 CFR 199.1(d), emphasis added.) The history and intent of CHAMPUS has been more fully described in Barnett v. Weinberger, 818 F.2 953 (1987):

Traditionally, dependents of members of the Armed Forces have been provided health care in military facilities whenever the space and staff essential thereto could be utilized without jeopardizing medical service to personnel on active duty. The dependent-care practices long pursued in military circles, however, left much to be desired. Positive statutory authority to accommodate dependent medical service was fragmentary; this bred disparities in the types of care afforded and the categories of dependents able to seek them. Moreover, an estimated 40 percent of dependents could not obtain medical care in military facilities, primarily because of overcrowding, physician shortages, or residence outside the areas served by those facilities. Inadequacies of these sorts in the dependent medical care system in vogue generated what ultimately came to be recognized as "one of the most serious morale problems facing our Armed Forces.

In 1956, Congress passed the Dependent's Medical Care Act [codified as 10 U.S.C. § 1071, et seq.] as the means of rectifying these shortcomings. The broad purpose of the Act was "to create and maintain high morale throughout the uniformed services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents." Uniformity was attained by explication of the types of medical care that can and cannot be provided and precise definition of the categories of dependents eligible for them. The principal improvement was authority to contract for provision of medical care by civilian hospitals and physicians to dependents of active-duty military personnel, thus increasing the availability of medical services beyond the capacity of military hospitals and staffs. Ten years later, by the Military Medical Benefits Amendments of 1966, medical care available to dependents of active-duty personnel was expanded even further, and still other changes have been wrought by subsequent legislation.

This legislation also enlarged the class of beneficiaries by establishing inpatient and outpatient programs in civilian facilities for retired military personnel, their spouses and children, and spouses and children of deceased active-duty and retired personnel,. . . and by inaugurating a new program of financial assistance for mentally retarded or physically handicapped dependents of active-duty personnel. . . .

The truly outstanding feature of the Dependents' Medical Care Act, however, is that it converted the provision of military-dependent medical care from a mere act of grace to a full-fledged matter of right. The Act specifies, in the respects pertinent to this case, that "[a] dependent of a member of a uniformed service who is on active duty for a period of more than 30 days . . . is entitled, upon request, to the medical and dental care proscribed by [the Act] in facilities of the uniformed services, subject to the availability of space and facilities and the capabilities of the medical and dental staff." And, "to assure that medical care is available for spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days," the Act commands the Secretary of Defense, "after consulting with the other administering Secretaries, [to] contract . . . for medical care for those persons under such insurance, medical service, or health plans as he considers appropriate." With but a single exception, an eligible dependent may elect to receive authorized medical care either in a military facility or a facility provided under a plan

> contracted for. As the House Report declared, "for the first time in the history of the uniformed services, dependents will be provided with a statutory entitlement to medical care on a uniform basis throughout all the uniformed services."

(Emphasis added; citations and footnotes omitted.) It is clear that CHAMPUS is "a plan . . . established to self-insure benefits required by federal . . . law" as described in the RCW 82.04.293 definition of "employee benefit plan."

We further find no support for Taxpayer's "beliefs" that, because a plan is a statutorily determined matter of right, because it is a governmental plan not regulated by ERISA, and because it is described as "an earned entitlement" for dependents "in gratitude" for the services of those in the military, that it is not an "employee benefit plan." Indeed, even though ERISA does not regulate "governmental plans" such as CHAMPUS,[23] ERISA's definition of "employee benefit plan" in 29 USC § 1002(1) (1998) is all-inclusive:

> The term "employee welfare benefit plan" and "welfare plan" means any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise.

[Emphasis added.] Neither is Taxpayer's contention that military personnel are not "employees" well-taken. Such a conclusion would come as a surprise to many agencies and courts. See, for example: In re Kraft, 119 Wn.2d 438; 832 P.2d 871 (1992);[24] Kirtley ex rel. Kirtley v. Washington, 49 Wn.App. 894, 748 P.2d 1128 (1988);[25] In re Parks, 48 Wn.App. 166, 737 P.2d 1316 (1987);[26] Baker v. Baker, 91 Wn.2d 482, 588 P.2d 1164 (1979);[27] Wilder v. Wilder, 85 Wn.2d 364, 534 P.2d 1355 (1975);[28] Payne v. Payne, 82 Wn.2d 573, 512 P.2d 736 (1973);[29] O'Connell v. United States,

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[23] (b) The provisions of this title shall not apply to any employee benefit plan if--
(1) Such a plan is a governmental plan (as defined in section 3(32) [29 USCS § 1002(32)]). 29 USC 1003(b)(1).
29 USC § 1002(32), in turn, provides: "The term 'governmental plan' means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669).

[24] Concerning inequity in divorce decrees because of "the payment of disability benefits to the military employee . . . ."

[25] Concerning the question of whether civilian technicians were state or federal employees. The Court held that civilian as well as military employees of the National Guard are to be treated as state employees for purposes of the Federal Tort Claims Act.

[26] ". . . military pension is deferred employee compensation . . . ."

[27] "For purposes of property dissolution, this court has characterized military retirement pay as a form of employee compensation."

[28] Contingent military pensions are to be considered deferred compensation for purposes of the disposition of property in a dissolution, even though "an element of uncertainty may exist as to whether a particular employee will receive the benefits."

110 F. Supp. 612, U.S. District Court for the Eastern District of Washington, Southern Division (1953).[30]

Lastly, Taxpayer has argued that an employee benefit plan does not normally grant dependents different benefits than those provided to the employees themselves. No authority is cited for this proposition.

Active duty members of the military are provided medical and dental care "in any facility of any uniformed service."[31] We take administrative notice, however, that the health and dental care requirements of active duty military personnel often differ significantly from those of their civilian dependents. The health and dental records of active duty personnel are official military files which impact on members' duty assignments, training, promotions, and retention. Input into these files is standardized under military regulations and, normally, only military health and dental authorities are authorized to provide input into and maintain such files. Active members of the uniformed services are deployable into combat zones, aboard ships, and to remote locations where civilian health care is unavailable or unsuitable. Civilian dependents located in the continental United States, on the other hand, normally have access to adequate civilian care. The law recognizes and accommodates these differences.

For the reasons articulated above, we conclude that CHAMPUS is clearly an employee health benefit plan ineligible for the RCW 82.04.4297 deduction.[32] Taxpayer's petition as to this issue is therefore denied.

5. Tax Levy Receipts. This is a factual issue best addressed by Audit, and is therefore remanded to that Division for resolution.

6. Interest on Patient Accounts. Taxpayer has contended that interest on its patient accounts should be taxed under the RCW 82.04.260(12)[33] Public and Nonprofit Hospital classification of the B&O tax. Taxpayer argues that, in the hospital industry, it is especially inappropriate to tax interest received on accounts receivable under the service and other activities classification of the B&O tax. Taxpayer suggests that, since the RCW 82.04.260(12) Public and Nonprofit Hospital rate was enacted,[34] this classification should be used instead. In support of this argument, Taxpayer points out that non-profit hospitals often do not even charge interest on past due accounts. The terms for repayment of amounts owed are much more generous than would be found in most industries. Credit is often extended to give patients a sense of being able to contribute to their own care. Thus, Taxpayer believes the very nature of its being a nonprofit entity, and its generous method of

[29] "A military pension is a mode of employee compensation . . . ."
[30] Concerning measures of liability of the United States for the actions "of military employees" versus those of "civilian employees."
[31] 10 USC 1074(a).
[32] We note that the Thurston County Superior Court reached a similar conclusion in Empire Health Services v. Department of Rev., No. 99-2-00312-5 (Superior Ct., December 17, 1999).
[33] Originally enacted in 1994 as RCW 82.04.260(15).
[34] Formerly RCW 82.04.260(15). This provision, since renumbered but otherwise unchanged, will be referred to throughout this determination as RCW 82.04.260(12).

handling patient credit, make this activity different than the extension of credit by the usual or average seller, who actually expects to realize interest income on its extension of payment terms.

Whether or not interest is taxed under the Public and Nonprofit Hospital rate requires a determination of what activities are covered under this rate.

Effective July 1, 1993, the legislature removed the nonprofit hospital deduction contained in RCW 82.04.4289[35] and replaced it with the "Public or Nonprofit Hospital" rate under RCW 82.04.260(12):

> (12) Upon every person engaging within this state in business as a hospital, as defined in chapter 70.41 RCW, that is operated as a nonprofit corporation or by the state or any of its political subdivisions, as to such persons, the amount of tax with respect to such activities shall be equal to the gross income of the business multiplied by the rate of 0.75 percent through June 30, 1995, and 1.5 percent thereafter. The moneys collected under this subsection shall be deposited in the health services account created under RCW 43.72.900.

Taxpayer argues that Washington hospitals agreed to support the July 1, 1993 change in the law, whereby they became subject to the B&O tax under RCW 82.04.260(12), only because the taxes were to be deposited in the health services account. Taxpayer argues the wording of RCW 82.04.260 would have exactly reflected the language of the prior nonprofit hospital exemption if the legislature intended to merely tax in-patient service revenue. Instead, according to Taxpayer, the language adopted was very broad and was intended to extend the special Public and Nonprofit Hospital rate to all business activities conducted by hospitals, and not just services to their inpatients.

WAC 458-20-168 (Rule 168),[36] however, implements RCW 82.04.260(12) as follows:

> (3). . .There are two B&O tax classifications which can apply to persons providing medical services through the operation of a hospital, with the tax classification dependent on the organizational structure of the hospital. The B&O tax classifications are:
>
> (a) Public or nonprofit hospitals. This B&O tax classification applies to gross income derived from personal and professional services to patients by hospitals that are operated as nonprofit corporations, operated by political subdivisions of the state, or operated but not owned by the state. These hospitals became taxable for hospital services under this B&O tax classification on July 1, 1993. These hospitals were required to report under the service B&O tax classification prior to July 1, 1993, but were entitled to a deduction for services rendered to patients.
>
> (b) Service. The gross income derived from personal and professional services of hospitals (other than hospitals operated as nonprofit corporations or by political subdivisions of the state), nursing homes, convalescent homes, clinics, rest homes, health resorts, and similar health care institutions is subject to business and occupation tax under the service and other activities classification. This classification also applies to nonprofit hospitals for

[35] Before that, the deduction was contained in RCW 82.04.430(9).
[36] Filed May 17, 1994 and effective 31 days later.

> personal or professional services which are performed for persons other than patients and not otherwise tax classified.

(Emphasis added.) As demonstrated by the phrase "services to patients" in Rule 168(3)(a), the Department has determined that the legislative intent of RCW 82.04.260(12), as discussed below, was to extend the special rate only to services rendered by nonprofit hospitals to its inpatients.

The Supreme Court's 1967 decision in Group Health Cooperative v. Washington State Tax Commission, 72 Wn.2d 422, 433 P.2d 201 (1967) (Group Health) concerned that entity's entitlement to a B&O tax deduction under RCW 82.04.430(9)[37] for the revenue from Group Health's "central clinic." RCW 82.04.430(9) at that time provided as follows:

> In computing tax there may be deducted from the measure of tax the following items:
>
> . . .
>
> (9) Amounts derived as compensation for services rendered to patients by a hospital, as defined in chapter 70.41 RCW, which is operated as a nonprofit corporation
> . . . .

RCW 70.41.020(3) provided, as it does today, the following definition of "hospital":

> "Hospital" means any institution, place building, or agency which provides accommodations, facilities and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care, of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis. "Hospital" as used in this chapter does not include . . . clinics, or physician's offices where patients are not regularly kept as bed patients for twenty-four hours or more.

The Supreme Court in Group Health, combining the pertinent portions of both these statutes, concluded that the legislature basically had in mind that the deduction applied to amounts received for services furnished to patients by a hospital, as such facilities and services are ordinarily comprehended." Group Health first reasoned that the RCW 82.04.430(9) deduction did not contemplate ordinary medical consultation and treatment, such as one seeks and obtains in a doctor's office or clinic.[38] The Court then went on to conclude that, even though Group Health was organizationally integrated and its various activities interrelated, that its "services to patients" could still be broken down into two different categories:

> ***medical*** consultation, diagnosis, treatment, and care by way of home or office calls,
>
> and
>
> ***hospitalization*** together with the usual services accompanying such a confinement.

[37] This deduction was later re-codified as RCW 82.04.4289.
[38] Group Health, 72 Wn.2d at 431.

(Group Health, 72 Wn.2d at 432, italicized emphasis in original text.) The Court noted that the bulk of the first type of service -- "medical" -- was essentially furnished and performed in respondent's outlying clinics. The second type of service -- "hospitalization" -- was supplied through respondent's central or hospital facility, including in some measure, at least, "the central clinic which served the central complex on a basis akin to the ordinary intake or emergency room in the average hospital":

> [T]he line of demarcation between the character of the services supplied by respondent is reasonably discernible. Likewise, the division between the facilities which afford the respective services is, with the exception of the central clinic, fairly observable. . . .[T]he outlying clinics are staffed, equipped, administered, and provide that type of medical service to the members which one would expect to find and receive in the average private physician's office or clinic. They are open only during regular business hours, provide no domiciliary care or overnight facilities, and are physically separate and apart from the central or hospital complex. And, as with the ordinary doctor's office, when the patient's needs exceed the resources at hand referral to specialists or to the hospital, as the case may be, is recommended and becomes available. . . .
>
> On the other hand, the central facility, including the central clinic, furnishes modern as well as all of the traditional hospital services, i.e., bed wards, surgery rooms, laboratories, X-ray equipment, pharmaceutical supplies, specialized professional staff, nursing staff, catering services, and 24 hour intake and emergency facilities. These services differ in no substantial way, except in their over-all organizational scheme, from the ordinary hospital. Within the framework of this aspect of respondent's service, the central clinic truly forms an integral, interrelated and essential part of the central facility, for, although it undertakes to provide some out-patient services akin to the outlying clinical service, it nevertheless provides the round-the-clock intake and emergency services which form a constituent part of the normal hospital operation. In this sense, then, the central clinic is no more separable from the central or hospital facility than the surgery rooms, the bed wards, the laboratory or the other components of the hospital activity, all of which might incidentally perform some out-patient service.

(Group Health, 72. Wn.2d at 432, 433, emphasis added.) The Group Health decision, for these reasons, found Group Health's "central clinic" to be, functionally, an integral part of the "hospital" portion of Group Health's activities because it provided the hospital's intake and emergency function.[39] The Court therefore determined that the clinic was rendering a deductible "hospitalization" service, as opposed to a nondeductible "medical" service." In arriving at its conclusion that the "central clinic" was part of Group Health's "hospital," the Supreme Court considered both (1) the clinic's location in the central facility and, (2) its "round-the-clock intake and emergency services" function for patients who needed immediate hospitalization as in-patients.[40]

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[39] As opposed to the outlying clinics. Group Health, 72 Wn.2d at 430.

[40] We also note the Court did not address the clinic staff's employment or training relationship to the hospital.

Further, Taxpayer has been unable to provide any legislative history or other documentation in support of its argument that the legislature intended to extend the special Public and Nonprofit Hospital rate to all business activities conducted by hospitals, and not just services to their inpatients. In fact, fiscal notes and other documents in the legislative history files[41] indicate an intent, or at least a legislative understanding, that the new special Public and Nonprofit Hospital tax rate (initially at .75%) would be imposed on only that non-profit hospital revenue which had previously been deductible,[42] i.e., revenue received from hospital services to inpatients as previously interpreted by Group Health.

The Department historically took the position that the RCW 82.04.4289 nonprofit hospital deduction applied to gross receipts by otherwise qualifying institutions when they rendered traditional hospitalization services to patients, and did not apply to income from outpatient medical clinics, even though such clinics might be owned and operated by a nonprofit hospital. Det. No. 92-192, 12 WTD 377 (1992). Departments and services available to both inpatients and outpatients -- e.g., emergency rooms, radiology services, and laboratories -- that were an "integral, interrelated and essential part" of the hospital were evaluated using the Group Health analysis. Det. No. 90-245, 10 WTD 033 (1990).

[4] As demonstrated by the phrase "services to patients" in Rule 168(3)(a), the Department has determined that the legislative intent of RCW 82.04.260(12), as discussed above, was to extend the special rate to hospitalization services previously entitled to the RCW 82.04.4289 deduction. This would include hospitalization services rendered by nonprofit hospitals to inpatients. Additionally, for departments and services available to both inpatients and outpatients -- e.g., emergency rooms, radiology services, and laboratories -- the Public and Nonprofit Hospital rate will be applicable to those that are an "integral, interrelated and essential part" of the hospital using the Group Health analysis.[43]

In the case here at issue, Taxpayer claims interest received on patient accounts receivable should be taxed under the Public and Nonprofit Hospital rate provided by RCW 82.04.260(12) instead of the Service and Other Activities rate. We disagree. The extension of credit, no matter how generous the terms might be, is not a hospitalization service. Taxpayer's petition as to this issue is denied.

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[41] Archives Division, Office of the Washington Secretary of State.

[42] Representative language is as follows: "This bill . . . removes the B&O tax exemption for nonprofit hospitals. . . . Currently, . . . noprofit hospitals do not pay B&O tax at all." See, Fiscal Note, Bill Number E2SSB 5304 as Passed by the Legislature, dated 5/4/93. We also note the Washington Supreme Court's observation in In re Sehome Park Care Center, 127 Wn.2d 774, 781, 903 P.2d 443 (1995), as follows: "Turning to the 1993 amendment to RCW 82.04.4289, we see that the legislature deleted hospitals from the statute entirely . . . . These [published bill summary] documents reveal that the thrust of the bill was to increase, rather than decrease, taxes in order to pay for health care reform."

[43] We note that Thurston County Superior Court in Empire Health Services v. Department of Rev., No. 99-2-00312-5 (Superior Ct., December 17, 1999), similarly concluded that, in order to qualify for taxation at the nonprofit hospital rate, a taxpayer must provide a service that relates to treatment in the hospital and must provide services that are unique to those provided in a hospital (Conclusion of Law No. 1, emphasis the Court's).

7. Kidney dialysis revenues. RCW 82.04.4289, until July 1 of the 1993 audit year in question, provided:

> In computing tax there may be deducted from the measure of tax amounts derived as compensation for services rendered to patients . . . by . . . a kidney dialysis facility operated as a nonprofit corporation, whether or not operated in connection with a hospital. . . In no event shall any such deduction be allowed, unless the hospital building is entitled to exemption from taxation under the property tax laws of this state.

On July 1, 1993, the last sentence requiring the "hospital building to be entitled to exemption from property tax" was eliminated.[44]

The audit report does not explain why kidney dialysis revenues for both inpatients and outpatients were included in Schedule II. Under RCW 82.04.4289, it would appear that receipts from a kidney dialysis facility operated by and located in a nonprofit hospital should have been properly deductible. This issue is remanded to Audit for clarification or adjustment, as appropriate.

DECISION AND DISPOSITION:

Taxpayer's petition for correction of assessment is denied for the issues concerning emergency room physician fees, Medicare and Medicaid coinsurance and deductibles, CHAMPUS revenues, interest on patient accounts.

The file is remanded to Audit in order to address Taxpayer's concerns regarding Schedule II's "Revenue Reconciliation" computations and its inclusion of kidney dialysis revenues, the possible duplication of emergency room physician fees in both Schedules II and III, and the inclusion of "tax levy receipts" in Schedule VI. Taxpayer has 60 days from the date of this determination, or such additional time as Audit may provide, to present additional facts relative to those issues which have been remanded. If necessary information is not forthcoming, the issues will be deemed to be denied.

Dated this 31st day of January, 2001.

[44] 1993 Washington Laws c 492 § 305.