(REPRINTED FROM THE JOURNAL OF TAXATION, JAN. 2007, AT PAGE 50.)

Maximizing Medical Deductions for Residents of Retirement Communities

By Vorris J. Blankenship

The combination of aging baby boomers and medical advances means that more and more people are living longer and are likely to require some form of care, often in a facility that has different levels of care depending on need. Ensuring a tax-advantaged structure for such living arrangements requires planning and a careful examination of the contracts and costs involved.

A taxpayer generally may deduct a portion of the fees paid for residence in a continuing care retirement community (CCRC). A taxpayer generally acquires residence in a CCRC by agreeing to pay certain fees to the CCRC. The fees may consist of either or both (1) an immediate lump-sum payment or (2) monthly payments during the period of residence. [1] Payment of the fees generally entitles the retiree to certain lifetime medical and long-term care services, in addition to residence in the CCRC.

There are many different types of CCRCs, providing various degrees of long-term care for retirees. In fact, a typical CCRC may provide several different types of units or facilities, each of which provides a different level of medical or long-term care. For example, most CCRCs offer independent living units (ILUs), consisting of apartments or similar housing made available generally to retirees who do not have serious medical impairments that would prevent them from caring for themselves. Not surprisingly, annual fees paid for an ILU generally will be higher than the rents paid for an ordinary but comparable house or apartment (unless the latter also includes medical services). Nevertheless, as much as 30% or more of the ILU fees may be potentially deductible as medical expenses (even if the health of the ILU resident is excellent). [2]

In addition, a CCRC may operate an assisted living facility, a skilled nursing facility, or an Alzheimer's and dementia facility. As would be expected, a skilled nursing facility (SNF) is a facility providing accommodations for retirees who are in need of full-time skilled nursing care. An assisted living facility (ALF) normally provides apartments and long-term care for retirees who need assistance with the normal activities of daily living but who do not need full-time skilled nursing care. An Alzheimer's and dementia facility (ADF) generally provides accommodations and supervision for retirees who suffer from mental impairments so severe that it is unsafe to leave them alone.

The deductibility of long-term care expenses will be examined first, since those expenses also enter into the subsequent discussion of the deductibility of fees paid to CCRCs. References in this article to "the taxpayer" are references to the person entitled to take a medical deduction and not necessarily to the recipient of the related medical services. That is, in addition to his or her own medical expenses, a taxpayer generally may deduct medical expenses the taxpayer pays for his or her spouse or dependent. [3]

The tax law does subject aggregate medical expenses, including the medical expense portion of CCRC fees, to limitations based on AGI. [4] Thus, general tax planning techniques applicable to aggregate medical deductions (e.g., planning the timing of income and expenses) also may reduce the taxes of CCRC residents.

QUALIFIED LONG-TERM CARE SERVICES

A taxpayer may deduct as medical expenses the unreimbursed cost of certain long-term care services ("qualified long-term care services"), subject to the usual overall limitations on medical expense deductions. [5] In addition to most of the more familiar types of medical expenses, qualified long-term care services include "maintenance or personal care services" prescribed by a physician, registered nurse, or licensed social worker for a "chronically ill individual." [6]

Maintenance and personal care services consist largely of (1) assistance with the "activities of daily living" for the physically disabled and (2) supervision of the mentally impaired. [7] Activities of daily living include eating, toileting, transferring, bathing, dressing, and continence. [8]

A chronically ill individual is an individual certified within the preceding 12-month period (by a physician, registered nurse, or licensed social worker) as suffering from certain mental and physical impairments. [9] The licensed professional must certify that the individual's health and safety are at risk due to his or her mental impairment (e.g., due to dementia, etc.). Alternatively, the professional may certify that the individual has been unable to perform two of the activities of daily living for at least 90 days, or suffers a comparable level of disability. [10]

Workers who provide qualified long-term care services generally need not be licensed medical professionals. [11] Nevertheless, a taxpayer may not deduct the cost of services provided to a chronically ill individual by the individual's spouse or relative unless the spouse or relative is licensed to provide the service (for example, is a registered nurse). [12] For this purpose, "relative" includes a child (or the child's spouse), a grandchild, a brother (or brother-in-law), a sister (or sister-in-law), and a nephew or niece. [13]

A taxpayer also may not take a qualified long-term care deduction for the cost of services provided by certain related corporations or partnerships. [14] Any insurance reimbursement for the cost of such services, however, is not taxable to the taxpayer. [15]

SPECIFIED FACILITIES

Taxpayers may normally take medical expense deductions for all amounts paid for care in an SNF, ALF, or ADF—subject to the usual overall limitations on medical deductions. That is, a taxpayer may continue to deduct the usual types of medical expenses (including qualified long-term care expenses) even if the facility includes those expenses in its overall fee. [16] In addition, though, the taxpayer normally may deduct the cost of meals and lodging included in the fee. In this regard, Reg. 1.213-1(e)(1) provides that the cost of meals and lodging paid to an institution other than a hospital will be deductible as medical expenses if the following conditions are satisfied:

> (1) The institution is regularly engaged in providing medical care or services (including qualified long-term care). [17]

(2) One of the principal reasons for the individual's presence in the institution is the availability of medical care (including supervisory care for an individual who is unsafe when left alone due to severe cognitive impairment). [18]
(3) The institution furnishes meals and lodging as a necessary incident to the medical care. [19]

SNFs, ALFs, ADFs, and their residents normally will satisfy these conditions. [20] Thus, in most instances, fees paid to such a facility will constitute fully deductible payments for meals, lodging, and normal medical expenses (including qualified long-term care expenses). As with hospital bills, it would be unusual (though possible) for such fees to include other kinds of expenses that are not deductible.

INDEPENDENT LIVING UNITS

Early on, the IRS held that taxpayers generally could take medical expense deductions for portions of lump-sum fees or monthly fees paid under contract to CCRCs—even though paid by or for residents who were healthy enough to reside in ILUs. [21] The Service stated it would not treat any of the fees as premiums paid for medical insurance. [22] It also would not treat any of the fees as nondeductible prepayments of medical expenses if the fees were required under the contract and were nonrefundable, or refundable only under penalty. [23] It did not matter that the fees covered future medical services for the ILU resident, or that a particular resident might never actually require the medical services. [24]

To take the medical deduction, a taxpayer need only prove the portion of the fee paid for medical care. [25] The taxpayer (or more usually the CCRC) may determine the deductible portion of the fee using the percentage of the CCRC's total expenses that constitute medical expenses—based on the CCRC's prior experience. [26] If the CCRC does not have sufficient prior experience to develop a reliable percentage, the CCRC may use the prior experience of a comparable CCRC. [27]

Although the IRS has offered little authoritative guidance on the details of the computation of the medical expense percentage, a few old letter rulings provide some indication of the Service's thinking. These rulings hold that the medical expense portion of a CCRC's budget includes both direct medical expenses and an allocable portion of the indirect expenses of operating the CCRC. Medical expenses also include interest and depreciation allocable to the CCRC's medical facilities.

By contrast, the Service held that such expenses do not include debt service (i.e., debt principal payments) or the cost of medical services provided to individuals not resident in the CCRC. The IRS also said, without providing details, that the CCRC must "weight" the medical expense portion of the fees paid by the residents in order to neutralize differences in the amounts residents pay for their units. [28]

After issuing these letter rulings, the IRS apparently became uneasy with the broader implications of authorizing current deductions for future medical services. In 1993, it announced it would limit current deductions for future medical services to fees paid to CCRCs. [29] The Service also announced it was suspending the issuance of additional rulings on the subject—and to the best of the author's knowledge, it has not since issued any such rulings. [30]

The *Baker* Case

The Tax Court provided some additional guidance on the computation of the deductible portion of an ILU fee in *Baker,* 122 TC 143 (2004).

The taxpayers, husband and wife, were ILU residents of a CCRC. Under their contract with the CCRC, the taxpayers were required to pay a lump-sum entrance fee and monthly fees. At issue in the case was the portion of their 1997 and 1998 monthly fees they could deduct as medical expenses.

The CCRC in *Baker* completed construction of its facilities in phases over the 7.5-year period ended in June 1997 and thereafter provided a full complement of retirement housing and care. In addition to offering ILUs, it operated an ALF, an SNF, and an ADF. [31] If an ILU resident moved on to the higher level of care offered by the ALF, SNF, or ADF, the resident enjoyed a substantial discount off the regular nonresident fee (60% discount for the ALF and ADF and approximately 50% for the SNF). In addition, ILU residents enjoyed use of an emergency-pull-cord system that allowed the residents to summon medical assistance at any time.

How to compute the deduction. The threshold issue in *Baker* was whether the taxpayers should compute the medical expense portion of their monthly CCRC fees using (1) the percentage method (discussed above) or (2) an actuarial method newly proposed by the Service.

The IRS had retained an actuary to compute the deductible portion of the taxpayers' fees under the proposed actuarial method. In making his computation, the actuary made use of the same CCRC operating expense data developed for the percentage method. In addition, the actuary took into account (1) the time value of money (related to current payments for future medical services), (2) the taxpayers' life expectancies, and (3) the time the taxpayers might be expected to spend at each level of care (i.e., in the ALF, SNF, or ADF).

The court, however, rejected the actuarial method, for two reasons. First, the court cited the implied endorsement of the percentage method in the Service's previously discussed rulings and the Service's longstanding practice allowing use of the method. Second, the court found the percentage method much easier to use, and thus more practical, than the actuarial method.

Application of the percentage method. The court then addressed the percentage method of computation, starting with the CCRC data and computations submitted by the taxpayers. [32] Those computations involved the separate aggregations of (1) total CCRC expenses and (2) CCRC medical expenses—and, after certain adjustments, the division of medical expenses by total expenses. After making some additional adjustments of its own, the court computed the appropriate medical expense percentages for monthly fees paid in 1997 and 1998, as shown in Exhibit 1.

Exhibit 1. Computing the Medical Expense Percentage for Monthly Fees in *Baker*

	1997	1998
Total adjusted expenses		
Total expenses for entire facility	$16,069,104	$16,986,770
Amortization of debt issue cost	(98,395)	(107,134)
SNF noncontract ancillary billings	(448,462)	(378,905)
SNF noncontract patient billings	(1,207,747)	(1,301,382)
ALF noncontract patient billings	(80,156)	(104,083)
ADF noncontract patient billings	(3,640)	(110,202)
Total adjusted expenses (A)	$14,230,704	$14,985,064
Adjusted medical expenses		
SNF operating expenses	3,044,041	3,330,031
ALF and ADF operating expenses	929,275	1,780,639
SNF noncontract patient fees	(1,207,747)	(1,301,382)
ALF noncontract patient fees	(80,156)	(104,083)
ADF noncontract patient fees	(3,640)	(110,202)
Emergency pull-cord system	87,374	88,257
Food service adjustment	482,769	0
Environmental service adjustment	112,617	0
Utilities adjustment	81,146	103,641
Insurance adjustment	18,234	0
SNF noncontract ancillary billings	(448,462)	(378,905)
SNF interest expense	479,734	470,432
ALF interest expense	319,823	313,778
ADF interest expense	159,991	313,778
Adjusted medical expenses (B)	$3,974,999	$4,505,984
Medical percentage (B/A)	27.93%	30.07%

In its computations, the court generally tried to take into account all the expenses, and only the expenses, that the CCRC expected to pay from fees received from ILU residents. In addition, the court treated all the expenses of the ALF, SNF, and ADF as medical expenses presumably because (as discussed above) fees paid for services of these types of facilities are normally fully deductible as medical expenses. [33]

Total adjusted expenses. In the Tax Court's view, total adjusted expenses properly included interest and depreciation (buried above in total CCRC operating expenses), but should not include debt service (i.e., debt principal payments) or debt issue cost. In addition, the court reduced total operating expenses by the Medicare, HMO, and other billings for medical services provided to "noncontract patients"—whether the patients resided in the ALF, SNF, and ADF, or were merely receiving outpatient ancillary services. For this purpose, "noncontract patients" were those individuals receiving ALF, SNF, or ADF medical services who had not previously contracted to reside in an ILU (i.e., who were not "contractual residents").

Adjusted medical expenses. Total medical expenses, as adjusted by the court, included interest and depreciation allocated to the ALF, SNF, and ADF (buried in operating expenses in Exhibit 1). Also included were the cost of the emergency-pull-cord system for ILU residents, and certain other routine computational corrections of expense allocations

to the ALF, SNF, and ADF. Again, the court reduced medical expenses by the Medicare, HMO, and other billings for medical services provided by the ALF, SNF, and ADF to noncontract patients.

Depreciation of facilities, equipment, etc. As noted, the court treated depreciation of CCRC capital assets as a component of adjusted total expenses, and it included depreciation of the ALF, SNF, and ADF assets in adjusted medical expenses. This seems appropriate since the CCRC would have expected to recover the cost of its capital assets from fees paid by ILU residents. Note that the CCRC is in no danger of counting capital costs twice in determining an ILU resident's medical expense deductions since the Service will not allow a medical deduction for a CCRC's mere acquisition of a capital asset. [34]

Interest expense, debt service, and debt issue cost. The Tax Court treated total interest expense of the CCRC as a component of adjusted total expenses, and included interest expense allocable to the ALF, SNF, and ADF in medical expenses. This treatment seems appropriate since (1) the CCRC would have expected to recover its total cost of borrowing from the fees paid by ILU residents, and (2) borrowing allocable to the ALF, SNF, and ADF allowed the CCRC to construct and maintain facilities devoted entirely to providing medical services. [35]

On the same principle, the court should have—but did not—include the amortization of debt issue cost in total expenses and medical expenses. [36] This appears to be an oversight attributable to the small amounts involved and the failure of either litigant to raise the issue. On the other hand, the court properly excluded the amount of debt service (i.e., debt principal payments) since the CCRC necessarily used its borrowings to pay for operating expenses or capital asset acquisitions already included in the computation.

Medicare, HMO, and other billings for noncontract patients. The court reduced both total expenses and medical expenses by the Medicare, HMO, and other billings for medical services provided by the ALF, SNF, and ADF to *noncontract patients.* The court's theory was that the ILU fees did not need to cover CCRC expenses offset by other revenues. This seems appropriate. Under this theory, however, the court also should have offset expenses by the amount of Medicare, HMO, and other direct billings for medical services provided to *contractual residents* that were not services covered by regular ILU fees. The IRS so contended and the court probably would have agreed if the Service had been able to provide the needed data.

Expense allocations to medical facilities and medical operations. The court largely accepted the taxpayers' allocations of other expenses between medical and nonmedical categories, primarily because the IRS did not challenge the allocations. Specifically, the taxpayers allocated all direct expenses of the ALF, SNF, and ADF to medical expenses. They then generally used cost accounting techniques to allocate a portion of each type of general CCRC expense between medical and nonmedical facilities and operations. That is, they allocated the overhead expenses based on square footage, time studies, or other techniques, as seemed appropriate.

Use of the medical percentage to compute the medical deduction. In completing the computation of the taxpayers' deductions for the medical expense portion of monthly fees, the court was careful to "weight" the deductions to eliminate potential inequities due to differences in apartment size and numbers of occupants. First, the court computed *the average fees paid per resident* by dividing (1) the total monthly fees paid by all the ILU residents for the entire year by (2) the total number of ILU residents. Each resident then could deduct as medical expense (subject to normal overall limitations) an amount

equal to *the average fees paid per resident* multiplied by the medical services percentage for the year, as determined in Exhibit 1.

Some Problems With *Baker*

Implicit in use of the percentage method is the assumption that the percentage of medical expenses in the fees charged ILU residents is generally the same as the percentage of total CCRC expenses constituting medical expenses. This assumption is based on the expectation that fees paid by ILU residents will cover the expenses of housing and other services (including medical care) provided to them over their lifetimes. A necessary corollary is that the percentage method should take into account only those CCRC expenses covered by ILU fees, and not those expenses offset by receipts from other sources.

Although the *Baker* court largely adhered to these principles, there were some exceptions. As noted above, the taxpayers should have reduced total expenses and medical expenses by the Medicare, HMO, and other direct billings for medical services provided to ILU residents that were not services covered by regular ILU fees. In fairness, it appears likely the court would have required that adjustment if the Service had provided the needed data.

Discount available on transfer. A more glaring omission was the failure of the *Baker* court to take into account properly the 50% to 60% discount provided to ILU residents who moved on to the higher level of care offered by the ALF, SNF, or ADF. In a somewhat similar case, *Estate of Smith,* 79 TC 313 (1982), *acq.,* ILU residents of a CCRC were entitled to a limited number of free days of care in an affiliated SNF. The court in *Smith* allowed a medical deduction for a portion of the entrance fee paid by an ILU resident that was attributable to possible use of the free SNF days. Nevertheless, the court did not allow a medical deduction for possible future use of the SNF that the resident would be required to pay for at normal undiscounted rates.

Thus, *Smith* established that the cost of SNF care should factor into the deductible portion of an ILU resident's fees only to the extent of the fee reduction the ILU resident might receive for future SNF care. This was consistent with the principle that the percentage method used by the *Baker* court should take into account only those CCRC expenses covered by ILU fees—and thus not ALF, SNF, or ADF expenses covered by additional fees required after transfer to those facilities.

To illustrate, assume that an ILU resident in facts similar to *Baker* would not be entitled to any discount on transfer to the ALF, SNF, or ADF (i.e., that the contractual resident had to pay the same ALF, SNF, and ADF fees as a noncontract patient). The ILU fees then would cover none of the future cost of residence in those facilities and the expenses of those facilities should be irrelevant in determining the deductible portion of ILU fees. Now assume that an ILU resident in the *Baker* situation was entitled to a 100% discount on transfer to the ALF, SNF, or ADF (i.e., that the ILU resident was entitled to free care in the facility). The ILU fees then would cover all of the future cost of residence in those facilities and all the expenses of those facilities would be relevant in determining the deductible portion of ILU fees.

It is apparent the IRS and the *Baker* court treated the ALF, SNF, and ADF as if the discount afforded ILU residents was 100%, rather than the 50% to 60% discount actually provided. That is, the court computed the deductible portions of ILU fees as if they covered the entire future cost of care in the ALF, SNF, or ADF, rather than the 50% to 60% actually covered. Thus, ILU residents transferring to the ALF, SNF, or ADF might

obtain, in effect, a double deduction on subsequent payment of the reduced facility fees (since a taxpayer may normally deduct the entire amount of such fees). [37]

Although it is not entirely clear how the court should have accounted for the 50% to 60% discount, at least two potential methods come to mind. The court could have included in the medical percentage computation only the 50% to 60% of the ALF, SNF, and ADF expenses effectively covered by ILU fees. Alternatively, the court could have offset ALF, SNF, and ADF expenses by the actual reduced amounts former ILU residents were currently paying for care in those facilities (consistent with the treatment of noncontract patient fees).

Use of multiple-year experience of a comparable CCRC. In Rev. Rul. 76-481, 1976-2 CB 82, the IRS allowed residents of a CCRC that had been in existence for only a short period to compute the deductible portion of their fees using the "long-term financial information" [38] of a comparable CCRC. Thus, taxpayers were able to use the more realistic data generated by a more mature CCRC. In addition, the use of data covering multiple years of operation smoothed out year-to-year distortions and was more consistent with the fact that a CCRC generally renders medical services long after the residents have paid for the services.

The taxpayers or the Service in *Baker* might have similarly advocated use of the multiple-year experience of a comparable CCRC. The CCRC in *Baker* was relatively new during the 1997 and 1998 tax years at issue. The CCRC had completed construction of its facilities and had begun operating them in phases over the 7.5-year period ended in June 1997. The first phase, completed in December 1989, included some ILUs, a portion of the ALF, and the SNF. The second phase, completed in October 1993, included additional ILUs. The final phase, completed in June 1997, included expansion of the ALF and construction of the ADF.

It is likely that the CCRC's medical expenses attributable to ILU residents for these early years of operation were not representative of normal long-term operations. That is, the number of ILU residents transferred to the SNF, ALF, and ADF normally would be small in the initial years of operation and likely would increase as the residents aged and needed higher levels of care. Consequently, medical expenses of the CCRC during its early years of operation might be considerably less than in subsequent, more normal, years of operation.

Some Problems with the Percentage Method

Although there is probably no ideal way to compute the deductible portion of ILU fees, the percentage method does have its share of inherent deficiencies. For example, each ILU resident receives the same deduction under the percentage method even though:

> (1) The CCRC is likely to need a smaller portion of an ILU fee for the future medical care of a relatively young ILU resident than for an older ILU resident. [39]
> (2) The likelihood of ultimately needing care in an ALF, SNF, or ADF changes with the age of the ILU resident.
> (3) The length of time an ILU resident is likely to spend in an ALF, SNF, or ADF changes with the age of the ILU resident.

In addition, the percentage method otherwise overstates the aggregate medical deductions taken by ILU residents as a whole. Because of the time value of money, the residents should be (and almost certainly are) paying less currently for future medical care than they would have had to pay for that care in the future. The current cost is less

because the CCRC may apply, to the future cost of residents' medical care, both the medical expense portion of current fees and the income (actual or hypothetical) from the CCRC's interim use or investment of that portion of the fees. Thus, the percentage method overstates aggregate medical deductions by allowing residents to deduct the full dollar amount of expected future medical expenses rather than the discounted present value of those expenses.

Of course, the actuarial method rejected by the Tax Court in *Baker* could mitigate or eliminate many of these problems by taking into account the time value of money, the residents' life expectancies, and the estimated length of time each resident will spend at each level of care. Nevertheless, in light of *Baker* and the long line of IRS rulings supporting the percentage method, it seems unlikely the Service would now try to mandate use of the actuarial method—short of congressional legislation.

TAX PLANNING FOR CCRCs AND RESIDENTS

In light of the *Baker* case, CCRCs and their tax advisors should carefully review computations of the medical expense portions of ILU fees under the percentage method. They should consider whether to (1) use data from a larger block of years better representing the financial experience of the CCRC, (2) eliminate unrepresentative years, or (3) use financial data from a comparable CCRC. They should also:

1. Review the reasonableness of the methods used to allocate expenses between medical expenses and non-medical expenses.

2. Review the treatment of capital costs, depreciation, interest, debt service, and debt issue costs.

3. Look for medical expense allocations that they may have previously overlooked, for example, an emergency-pull-cord system.

4. Ascertain whether they have properly offset total expenses and medical expenses by the amount of revenues from services not covered by ILU fees.

5. Confirm that the "weighting" of the allocation of medical expenses among ILU residents neutralizes differences between unit sizes and numbers of occupants.

Many taxpayers seeking residence in a CCRC will be comparing attributes of the available CCRCs. One significant factor for comparison is the amount of the medical deduction available. A prospective resident of a CCRC may very well ask whether the CCRC is overstating its medical percentage—thus inviting a future challenge by the Service. Or the prospective resident may wonder whether the CCRC is understating the percentage and, if so, whether the CCRC can correct it. In either event, review of the CCRC's computations by the tax advisor of the prospective resident may be beneficial.

CONCLUSION

A taxpayer generally may deduct the cost of qualified long-term care services whether or not the service providers are medical professionals, and whether they provide their services in the recipient's home, a CCRC, or elsewhere. If, however, an SNF, ALF, or ADF provides the qualified long-term care services, a taxpayer generally may deduct the entire amount paid to the facility, including the cost of meals and lodging,

It also is clear that an ILU resident of a CCRC may deduct a portion of his or her ILU fees as medical expenses. The difficulty is in determining the amount of the deduction. Although the IRS long has implied that a taxpayer may compute the deduction under the percentage method, the Service has provided little authoritative guidance on the rationale for the method or the details of the computation.

The Tax Court in *Baker* has done somewhat better. It articulated the rationale for use of the percentage method and provided a detailed computation. First, the court found it reasonable to expect that the aggregate fees paid by ILU residents will cover the expenses of housing and other services (including medical care) provided to them over their lifetimes. Thus, the court concluded that the percentage of medical expenses in the fees charged ILU residents generally should be the same as the percentage of total CCRC expenses constituting medical expenses.

Nevertheless, the court acknowledged that the percentage method should take into account only those CCRC expenses covered by ILU fees, and not those expenses offset by revenues from other sources. Although the court applied this principle to some extent, it nevertheless failed to offset expenses with certain revenues from contractual residents that were not ILU fees. Specifically, the court did not offset expenses with revenues received from contractual residents for outpatient medical expenses not covered by their ILU fees (primarily because the Service did not supply sufficient data). The court also did not offset expenses with revenues received from contractual residents after their transfers to the SNF, ALF, or ADF (i.e., after they ceased to occupy ILUs and pay ILU fees).

Neither party in *Baker* asked the court to consider whether use of a single year of data for a relatively new CCRC would be representative of the expected financial history of the CCRC. Nevertheless, if a CCRC is relatively new and its financial data is limited or unrepresentative, it may be able to use the long-term financial information of a comparable CCRC to compute its medical percentage. The use of financial data generated by another, more mature CCRC may produce a more realistic medical percentage. Furthermore, financial data covering multiple years of operation will tend to smooth out year-to-year distortions.

Practice Notes

Many taxpayers seeking residence in a CCRC will be comparing attributes of the available CCRCs. One significant factor for comparison is the amount of the medical deduction available. A prospective resident of a CCRC may very well ask whether the CCRC is overstating its medical percentage—thus inviting a future challenge by the Service. Or the prospective resident may wonder whether the CCRC is understating the percentage and, if so, whether the CCRC can correct it. In either event, review of the CCRC's computations by the tax advisor of the prospective resident may be beneficial.

———————————————————————————

[1] Since CCRC residents are often required to pay fees in advance, the tax law may treat the fee payments as interest-free loans that require the reporting of imputed interest income; see Sections 7872(c)(1)(E) and (F). For years after 2005, however, a resident (or spouse) who is age 62 or older before the end of the tax year need not report imputed interest income on fees the resident pays to a "qualified continuing care facility" under a "continuing care contract." Fortunately, the tax law defines these terms expansively enough that most residents of CCRCs will not be required to report imputed interest income on their fee payments. See Section 7872(h), added by the Tax Increase

Prevention and Reconciliation Act of 2005, P.L. 109-222, 5/17/06, section 209. Prior to 2006, it was somewhat more difficult to qualify for the imputed interest exemption; see Section 7872(g).

[2] For example, the Tax Court allowed a taxpayer to deduct 27.93% and 30.07% of annual ILU fees paid for 1997 and 1998, respectively, in Baker, 122 TC 143 (2004) (appendix to the opinion).

[3] Section 213(a).

[4] A taxpayer may deduct aggregate medical expenses for regular tax purposes only to the extent they exceed 7.5% of AGI. Section 213(a). For alternative minimum tax purposes, the deduction is limited to the excess over 10% of AGI. Section 56(b)(1)(B).

[5] Section 213(d)(1)(C).

[6] Sections 7702B(c)(1) and (4).

[7] Section 7702B(c)(3).

[8] Section 7702B(c)(2)(B).

[9] Certification is a precondition for qualification as a chronically ill individual. A certified individual will cease to qualify as chronically ill on expiration of the 12-month period following the most recent certification—until certified again. See Section 7702B(c)(2)(A), flush language.

[10] Section 7702B(c)(2)(A).

[11] Section 7702B(c)(3).

[12] Section 213(d)(11)(A).

[13] Sections 152(d)(2)(A) through (G).

[14] Section 213(d)(11)(B).

[15] Section 213(d)(11).

[16] Section 213(d).

[17] This Regulation was last amended in 1979, well before the 1996 enactment of a medical deduction for qualified long-term care services. Thus, the Regulation does not include qualified long-term care services in its definition of medical care. Nevertheless, the subsequent amendment of the Code clearly provides that "[t]he term 'medical care' means amounts paid ... for qualified long-term care services." Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 8/21/96, section 322(a) (adding Section 213(d)(1)(C)).

[18] See also Sections 213(d)(1)(C) and 7702B(c)(2)(A)(iii).

[19] Reg. 1.213-1(e)(1)(v)(*a*).

[20] See Counts, 42 TC 755 (1964), *acq.* (deductions allowed for medical care, meals, and lodging in a nursing home for the elderly). In fact, the Service and the courts have occasionally strained to find the regulatory requirements satisfied for care in some surprising types of "institutions." See Kelly, 27 AFTR 2d 71-912, 440 F2d 307 (CA-7, 1971) (post-operative care provided in a hotel room in lieu of a hospital); Ungar, TC Memo 1963-159, PH TCM ¶63159 (care in a medically equipped apartment for an elderly woman recuperating from a brain hemorrhage); Rev. Rul. 69-499, 1969-2 CB 39 (care of a retarded person in the home of an unrelated family).

[21] Rev. Rul. 67-185, 1967-1 CB 70; Rev. Rul. 75-302, 1975-2 CB 86; Rev. Rul. 76-481, 1976-2 CB 82.

[22] IRS said the fees were not medical insurance premiums because they were "calculated without regard to any similar contracts with other patients at the institution." Rev. Ruls. 75-302 and 76-481, both *supra* note 21. The reason given by the Service for its ruling position seems weak (and is perhaps factually incorrect); more exhaustive reasoning and citations in analogous authority, however, do appear to support the Service's position. See, e.g., Rev. Rul. 68-27, 1968-1 CB 315; GCM 39829, 8/24/90; Ltr. Rul. 200104011. In these pronouncements the IRS held that organizations using their own staff and employees to provide medical services for a fixed fee (as CCRCs generally do) are providing services and not insurance.

[23] Rev. Rul. 75-302, *supra* note 21; Rev. Rul. 75-303, 1975-2 CB 87. Compare Bassett, 26 TC 619 (1956); Rose, 52 TC 521 (1969), *aff'd* 26 AFTR 2d 70-5653, 435 F2d 149 (CA-5, 1970), *cert. den.* (denying deductions for prepayments of medical expenses *not*

required under a binding contract).

[24] See note 21, *supra.*

[25] *Id.*

[26] Rev. Rul. 75-302, *supra* note 21.

[27] Rev. Rul. 76-481, *supra* note 21.

[28] Ltr. Ruls. 8630005, 8641037, and 8651028.

[29] Rev. Rul. 93-72, 1993-2 CB 77.

[30] Rev. Proc. 93-43, 1993-2 CB 544.

[31] In its opinion, the Tax Court referred to the ADF as Special Care Units (or SCUs).

[32] The court used the data and computations submitted by the taxpayers as its starting point because it concluded the taxpayers had provided sufficient credible evidence to shift the burden of proof to the Service.

[33] See the text accompanying notes 16-20, *supra.*

[34] Rev. Rul. 68-525, 1968-2 CB 112; Rev. Rul. 76-481, *supra* note 21. But *cf.* Reg. 1.213-1(e)(1)(iii) (allowing a medical deduction for certain capital assets directly purchased by a taxpayer).

[35] Fees paid for services provided by an ALF, SNF, and ADF are normally fully deductible as medical expenses. See the text accompanying notes 16-20, *supra.*

[36] In its summary computation of the final medical percentages (found in the appendix to the opinion), the Tax Court specifically reduced "Total expenses" by "Issue cost."

[37] See the text accompanying notes 16-20, *supra.*

[38] See also Rev. Rul. 75-302, *supra* note 21 (in which IRS approved the use of the "prior experience" of the CCRC) and Ltr. Ruls. 8630005, 8641037, and 8651028 (approving use of the "financial history" of a CCRC).

[39] The younger ILU resident likely will spend more years residing in an ILU unit and thus will likely pay more aggregate ILU fees before transferring to the SNF, ALF, or ADF. In addition, more income is likely to accumulate on investment (whether actual or hypothetical) of the medical expense portion of fees paid by the younger ILU resident since the income likely will accumulate over a longer period—until needed for future medical costs.