Toward a Workable Definition of REIT Healthcare Facility

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Since 2008 a real estate investment trust that owns a healthcare facility has been able to lease the property to a taxable REIT subsidiary (TRS), but the TRS may not manage or operate the healthcare facility. A TRS may operate and manage traditional rental housing that a REIT leases directly to tenant-residents. The IRS has struggled to draw a workable line between healthcare facilities and traditional rental housing, and one particular type of senior housing — pure independent living facilities — is at the center of the confusion and within a "zone of uncertainty." The IRS has issued a private letter ruling concluding that an independent living facility is not a healthcare facility, and thus a TRS may manage or operate that type of facility because it is a form of traditional rental housing.

We will show, however, that an independent living facility is in fact a healthcare facility under applicable provisions of the code. Accordingly, contrary to the IRS's view, it should be possible for independent living facilities to be leased by a REIT to a TRS and then operated and managed by an independent manager, not the TRS itself, to best comply with the applicable REIT provisions of the code. But even the brightest of lines can be fuzzy on closer inspection, and the authors conclude that it would be best for Congress or the IRS to adopt a policy whereby pure independent living facilities may, at the taxpayer's election, be treated either as a healthcare facility or as traditional rental housing. This proposal would in effect put independent living facilities within a zone of certainty.

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I. Overview of Healthcare REIT Legislation

After some restrictions on real estate investment trust qualification were liberalized in 1976,[1] healthcare REITs emerged during the REIT expansion that followed. The first initial public offering (IPO) of a healthcare REIT occurred in 1978, followed closely

[1]REIT qualification and taxation are governed by sections 856 through 860.

by a second in 1980, but no additional IPOs of healthcare REITs took place until 1985.[2] During the latter half of the 1980s, the two pioneering public healthcare REITs were joined by eight more, as the structure became popular with real estate investors.[3] Another nine healthcare REITs held IPOs between 1990 and 1999, firmly establishing the structure within the REIT community.[4]

At their advent, healthcare REITs could not operate or manage their facilities themselves.[5] Instead, they were generally required to lease the healthcare properties to third parties, typically the operators that provided services to patients and residents.[6] That division of responsibility had the theoretical advantage that the third-party operators could focus exclusively on their core healthcare services business, while the healthcare REITs could focus on the management of their real estate.[7]

A. Healthcare Crisis and REIT Foreclosures

Amid the expansion of healthcare REITs, the entire healthcare industry tumbled into a crisis in the late 1990s. The immediate cause of the crisis was Congress's decision to change the method of Medicare healthcare reimbursements, implemented by the Balanced Budget Act of 1997 (BBA).[8] Before the BBA, Medicare generally paid skilled nursing facilities (SNFs) on a facility-based cost-plus basis, under which the facilities were paid an amount for treating Medicare patients that covered their ''reasonable costs'' related to those patients plus a return on their investment.[9] SNFs were able to unbundle their costs for specific services, such as therapies and laboratories.[10]

In the 1990s the Health Care Financing Administration, the agency responsible for administering Medicare, concluded that Medicare's facility-based cost-plus payments to SNFs led to waste and inefficiencies in the healthcare system.[11] As a result, the BBA replaced it with an adjusted per diem, referred to as a ''prospective payment,'' that covered all services provided to patients in SNFs.[12] The transition was to take place over a four-year period, with a blended rate for the interim period for purposes of cushioning the change, transitioning more each year toward pure prospective payments.[13] However, a direct result of the BBA was that by early 2000, four national healthcare service providers — Sun Healthcare, Vencor, Mariner Post-Acute Network, and Integrated Health Services — had filed for bankruptcy.[14] Two more, Genesis and Centennial, followed shortly thereafter, along with some regional integrated operators.[15]

Although healthcare REITs were not directly affected by the changes to Medicare, their primary tenants, the third-party operators, were deeply affected. If an office REIT's tenant stops paying rent or goes bankrupt, the REIT typically evicts the nonpaying tenant and attempts to lease the vacated office space to a new tenant. However, many healthcare REIT facilities, including SNFs and assisted

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[2]James C. Brau and David B. Heywood, ''IPO and SEO Waves in Health Care Real Estate Investment Trusts,'' 35 *J. Health Care Fin*. 70, 73 (2008).

[3]*Id.*

[4]*Id*. In time, the iconoclasts become the icons. The National Association of Real Estate Investment Trusts (NAREIT) once published both an index that included all equity REITs and a separate index that included all equity REITs except healthcare REITs. In June 1996 there were seven healthcare REITs out of the 171 equity REITs included in the equity REIT index, with a combined 7.5 percent of the total capitalization of all equity REITs. As investors and other market participants became increasingly comfortable with healthcare REITs, the need diminished for a separate index that excluded healthcare REITs, and in 2000 NAREIT finally discontinued the separate index. ''FTSE NAREIT U.S. Real Estate Index Series Consultation 2010,'' REIT.com, at 5 (Aug. 2010), *available at* http://www.reit.com/Portals/0/PDF/2010-FTSE-NAREIT-Consultation.pdf.

[5]Section 856(c)(2)-(3), (d), and (l)(3)(A). In limited circumstances, a REIT could directly operate a healthcare facility as foreclosure property or have an independent contractor operate it. Section 856(c)(2)-(3), (d), and (e).

[6]Piet M.A. Eichholtz et al., ''Who Should Own Senior Housing?'' 13 *J. Real Est. Portfolio Mgmt*. 205, 206 (2007). *But see infra* Part I.B for a 2008 change to that rule.

[7]*Id*.

[8]Maryam Ghazi and Thomas E. Lumsden, ''The Health Care Industry: An Analysis of the Post-Acute Care Sector,'' *J. Corp. Renewal* 12 (Oct. 1, 2000).

[9]*Id*.

[10]*Id*.

[11]*Id*.

[12]*Id*.

[13]*Id*. The BBA transition established fiscal 1995 as the base year for SNFs. In fiscal 1996 SNFs received payments that were 25 percent prospective payment and 75 percent facility-specific. In fiscal 1997 SNFs received payments that were 50 percent prospective payment and 50 percent facility-specific. In fiscal 1998 SNFs received payments that were 75 percent prospective payment and 25 percent facility-specific. In fiscal 1999 and thereafter, SNFs received payments that were 100 percent prospective payment. *See id.* at 16; Scott C. Jolley, ''Revising Your PPS Base Year Costs,'' *Nursing Homes* (Apr. 1999).

[14]Ghazi and Lumsden, *supra* note 8, at 12, 16.

[15]''Nursing Facilities,'' *Health Care Indus. Mkt. Update* (May 20, 2003), at 20-21. In 2000 the Office of Inspector General (OIG) in the Department of Health and Human Services (HHS) claimed credit for the BBA change: ''The OIG's documentation of excessive payments led to recent statutory changes in the way and/or the amount Medicare reimburses . . . skilled nursing facilities.'' HHS, OIG ''Semiannual Report: Oct. 1, 1999 - Mar. 31, 2000'' (2000). Congress may indeed have believed that the BBA's change in payment method would serve to prevent wasteful payments in the future without affecting facilities that were billing correctly. However, the number of operator bankruptcies that immediately followed the change raised questions about the underlying rationale for the change or, at a minimum, the wisdom of implementing the change so abruptly, creating an environment in which immediate relief was required.

living facilities, were leased to third-party operators licensed by state authorities to operate those facilities, and it was not always easy or possible under applicable licensing rules for the REIT to substitute lessee-operators without permission from state authorities.[16] As a result, many healthcare REITs were placed in the untenable position of leasing facilities to nonpaying tenant-operators.[17] Further, healthcare REITs may have had no practical substitute if a financially distressed tenant decided to vacate the facility at the end of its lease term.[18]

Congress ultimately took notice of the dire straits that the BBA imposed on the healthcare industry, and in response it passed several measures in an effort to remediate the crisis. In October 1999 Congress passed a BBA relief measure, the Balanced Budget Refinement Act of 1999, to restore billions of cut Medicare payments, which relieved some of the pressure on operators that were not already bankrupted before that time.[19] In 2000 Congress further adjusted the payment rates under the Benefits Improvement and Protection Act.[20]

In addition to refining the Medicare payment mechanisms to avoid bankrupting healthcare operators, Congress in 1999 passed a relief measure directed toward healthcare REITs — that is, special foreclosure property provisions for healthcare properties. Section 856(e)(6), added by section 551(a) of the Ticket to Work and Work Incentives Improvement Act of 1999 (the 1999 act),[21] provides a special rule allowing a qualified healthcare property to be treated as foreclosure property for purposes of applying the REIT gross income tests in section 856(c)(2) and (c)(3) in the event of a simple termination or expiration of a lease (as opposed to a termination by default or imminence of default).[22] That change relieved the pressure on a healthcare REIT to immediately re-lease its vacated facility in order to meet the REIT gross income tests, in that income from foreclosure property (although generally taxable at the REIT level) counts as good REIT income for purposes of both REIT gross income tests.[23]

In that foreclosure property context, section 856(e)(6)(D)(i) defined the term ''qualified health care property'' to mean any real property, and any personal property incident to that real property, which is a healthcare facility or is necessary or incidental to the use of a healthcare facility. Section 856(e)(6)(D)(ii) then defined the term ''health care facility'' as follows:

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[16]*See, e.g.*, the fiscal 1998 Form 10-K from the former REIT Eldertrust:

> In the event the leases expire and are not renewed, we will have to find a new ''unrelated'' lessee to lease and operate the properties in order to continue to qualify as a REIT. In the event of a default on either a lease of, or a mortgage secured by, an assisted or independent living facility or skilled nursing facility, to maintain our REIT qualification, we would have to engage a new healthcare provider, which could not include Genesis or its subsidiaries or Senior Life Choice, another existing tenant, to operate the facility after we take possession of the facility. This requirement could deter us from exercising our remedies in the event of a default even though such exercise otherwise would be in our best interests. Although we would be permitted to operate the facility for 90 days after taking possession of the facility pursuant to applicable U.S. Treasury regulations without jeopardizing our REIT status, *the fact that the facility licenses are held by lessees or borrowers may preclude us from doing so under applicable healthcare regulatory requirements*. [Emphasis added.]

Eldertrust, ''Annual Report (Form 10-K)'' (Mar. 31, 1999), at 46.

[17]For example, healthcare REIT Nationwide Health Properties Inc. stated in a 2004 article that as many as 40 percent of its holdings were operated by bankrupt tenants during the period from 1998 to 2001, driving its net income from $62 million in 1998 down to a low of $29 million in 2002. Vita Reed, ''Nationwide Health Sees Payoff From Medicare Gains,'' *Orange Co. Bus. J.* (Nov. 1, 2004).

[18]*See supra* text accompanying note 16. Even when state licensing permission was achievable in a timely fashion (or not required in the first place), there may simply not have been enough potential substitutes to whom the vacated facility could be leased. *See infra* note 22.

[19]HHS, OIG, ''Trends in the Assignment of Resource Utilization Groups by Skilled Nursing Facilities,'' OEI-02-01-00280, at 3 (2001).

[20]*Id.* at 3-4.

[21]H.R. Rep. No. 106-478 (1999), at 92-93. Per section 500 of the 1999 act, Title V of the 1999 act may be cited as the Tax Relief Extension Act of 1999.

[22]Congress was apparently motivated by the belief that the scarcity of qualified operators would block healthcare REITs from pursuing foreclosure or locating new tenants. That viewpoint may be seen in an April 28, 1999, press release by William M. Thomas, the original cosponsor of the Real Estate Investment Trust Modernization Act of 1999 (which was not enacted into law, but which contained an identical provision regarding foreclosure property for healthcare REITs as the 1999 act), that contains an unofficial technical explanation of the bill. Under section 201 (which became section 551 of the 1999 act), the technical explanation states that the provision enables healthcare REITs ''to deal with the unique problem that is inherent in a Medicare-eligible health care facility'' because ''there are a limited number of alternative Medicare-eligible service providers'' when a lease expires or when a service provider defaults on a lease. *See Doc 1999-15876*, *1999 TNT 83-34*. Although operator lessees for congregate care facilities and assisted living facilities did not have to be ''Medicare-eligible service providers,'' the reality of the healthcare marketplace was that most operator-lessees at the time were.

[23]H.R. Rep. No. 106-478, at 179. In other words, under this special provision for healthcare property, actual foreclosure (or imminence of actual foreclosure) was not required; a REIT was able to treat healthcare property as foreclosure property even when the lease term for the property merely ended. *See* sections 856(c)(2)(F), (c)(3)(F), and (e) and 857(b)(4).

> **Health care facility.** For purposes of clause (i), the term ''health care facility'' means a hospital, nursing facility, assisted living facility, congregate care facility, qualified continuing care facility (as defined in section 7872(g)(4)), or other licensed facility which extends medical or nursing or ancillary services to patients and which, immediately before the termination, expiration, default, or breach of the lease of or mortgage secured by such facility, was operated by a provider of such services which was eligible for participation in the medicare program under title XVIII of the Social Security Act with respect to such facility.

After all the legislative relief packages had taken effect, the 1990s healthcare crisis finally subsided.[24] Because of the turmoil caused by the crisis, there was some discussion in the financial press that healthcare REITs might decline and possibly even disappear, the view being that healthcare tenant-operators would not want to pay high lease rates (possibly including annual escalators) while losing the possibility of appreciation in the real estate that they had formerly owned.[25] However, that ultimately proved to be a misguided concern: Healthcare REITs not only survived but have been thriving and making annual new investments in the billions of dollars.[26] Today, healthcare REITs commonly invest in healthcare-related properties such as senior housing facilities, hospitals, medical office buildings, rehabilitation facilities, and life science facilities.[27]

The 1999 act also made several other important changes to REIT law that were not specific to healthcare REITs. Among other provisions, the 1999 act added section 856(l), which created a new type of wholly owned or partially owned REIT subsidiary called a ''taxable REIT subsidiary'' (TRS), generally effective for tax years beginning after 2000.[28] Among other roles for that new form of taxpaying subsidiary, a TRS could provide service-oriented amenities to a REIT's tenants, such as maid or meal services to tenants of an apartment REIT, without tainting the REIT's receipt of rental income from its tenants.[29] The only direct statutory restrictions on the activities of a TRS were contained in section 856(l)(3), which excluded from TRS qualification a very limited list of corporate activities. Significantly for healthcare REITs, ''any corporation which directly or indirectly operates or manages'' a healthcare facility cannot be a TRS.[30] Section 856(l)(4)(B) then defined healthcare facility by reference to the healthcare foreclosure provision, section 856(e)(6)(D)(ii).

B. RIDEA's Impact on Healthcare REITs

In 2008 the Housing and Economic Recovery Act of 2008 (RIDEA)[31] made important changes to the

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[24]*See* ''Health Care REITs: Ready to Fund the Rebound?'' *SeniorCare Investor* (Oct. 2003), at 1. At the end of 1999, there were 12 public healthcare REITs. Their financial results show the end of the crisis:

> Since the end of 1999, six health care REITs have provided positive returns (including dividends) to shareholders in every year, with most producing double-digit returns. In two years, 2001 and 2003 through the third quarter, all 12 REITs produced double-digit returns. In 2001, nine of the 12 had total returns in excess of 50 percent each.

Id. That return to profitability, however, was linked to a significant increase in overall healthcare spending. The amount of U.S. healthcare spending as a percentage of GDP remained relatively constant between 13.7 and 13.8 percent from 1993 to 2000, perhaps in part because of reform measures. It then jumped dramatically to 14.5 percent in 2001 and stood at 17.6 percent of GDP in 2009. *See* Centers for Medicare and Medicaid Services, ''Table 1 — National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Select Calendar Years 1960-2009'' (Jan. 2010).

[25]''Health Care REIT Market Has Best Showing Since 2003,'' *SeniorCare Investor* (Jan. 2007), at 1.

[26]Zeeshan Siddique, ''Health Care REITs Are Prepared to Catapult,'' *The Motley Fool* (Mar. 8, 2011).

[27]Brau and Heywood, *supra* note 2, at 73.

[28]H.R. Rep. No. 106-478, at 177-178. Both the subsidiary and the REIT had to elect jointly TRS status before the subsidiary could become a TRS. *Id.* at 177. Before the 1999 act, REITs sometimes employed third-party subsidiaries or preferred stock subsidiaries — entities in which the REIT owned much of the value but little of the vote — for purposes comparable to some of the roles that TRSs play today, and the IRS approved those structures in various private letter rulings. *See*, *e.g.*, LTR 9440026, LTR 9340056, and LTR 8825112. As part of the 1999 legislative change, the asset testing rules for REITs were revised to ban ownership of more than 10 percent of the securities of a corporation by value as well as vote, other than, in general, a TRS or a section 856(i) qualified REIT subsidiary (which is treated as a disregarded entity); that forced REITs to adopt the TRS format in place of third-party subsidiaries or preferred stock subsidiaries. Section 856(c)(4)(B)(iii)(III). *Cf.* sections 860A and 7701(i) (taxable mortgage pool rules as backstop to real estate mortgage investment conduit rules).

[29]Section 856(c)(7)(C)(i); Rev. Rul. 2002-38, 2002-2 C.B. 4, *Doc 2002-13973*, *2002 TNT 113-16*. As long as the applicable transfer pricing and thin capitalization norms were respected, neither the REIT nor the TRS would be penalized with excise taxes or other tax sanctions. *See* sections 163(j), 857; Rev. Rul. 2002-38.

[30]Section 856(l)(3)(A). *See*, *e.g.*, LTR 200813003, *Doc 2008-6838*, *2008 TNT 62-33* (TRSs leased two healthcare facilities — an assisted living/Alzheimer's care facility and an independent living/assisted living facility — and hired an eligible independent contractor as manager: The IRS stated that ''ownership of lodging or health care facilities without other activity on the part of a TRS is distinguishable from the operation or management of those facilities'' and ruled that the entities continued to qualify as TRSs under section 856(l)).

[31]Sections 3031-3071 were originally part of the proposed REIT Investment Diversification and Empowerment Act of 2007, also known as RIDEA, and those sections are still referred to as

(Footnote continued on next page.)

definition of rents from real property in section 856(d) that significantly affected how healthcare REITs could own and lease their real estate. Before RIDEA, a hospitality REIT could earn qualifying REIT rents by leasing its lodging facilities to a TRS, which would then contract with an eligible independent contractor (EIK) as defined in section 856(d)(9)(A) to operate the lodging facilities.[32] RIDEA expanded the scope of section 856(d)(8)(B) so that it applied to healthcare properties as well as lodging facilities. Accordingly, for tax years beginning on or after July 31, 2008,[33] rents from real property for REITs include rents from a qualified healthcare property (as defined in section 856(e)(6)(D)(i)) leased to a TRS if the property is operated on behalf of the TRS by an EIK.[34] Thus, healthcare REITs no longer need to lease their healthcare facilities to third-party tenant-operators; they can now lease those facilities to a captive TRS instead.

RIDEA also made conforming changes to the definitions of EIK in section 856(d)(9)(A) and of taxable REIT subsidiary in section 856(l)(3).[35] Although the official legislative history for RIDEA does not discuss the rationale underlying the expansion of the types of facilities that a REIT may lease to a TRS, including a captive TRS, the introductory statements in both the House and Senate when RIDEA was introduced do provide that background:

> These complex rules were adopted because hotel management companies did not want to assume the leasing risk inherent in lodging facilities but rather wanted to be compensated purely for operating the facilities. A similar situation has arisen with regard to health care properties such as assisted living facilities. Operators that now lease such facilities would rather have a REIT (through its TRS) assume any leasing risk and instead be hired purely to operate the facilities. Accordingly, this provision would extend the exception made in 1999 for lodging facilities to health care facilities. This change should make it easier for health care facilities to be provided to senior citizens and others in need of such services.[36]

II. RIDEA and Healthcare Facilities

Rather than provide a new definition for healthcare property, RIDEA cross-referenced to the existing definition that was added to section 856(e)(6) and (l) by the 1999 act. The following is a careful parsing of the healthcare facility definition as it applies to current healthcare REITs and TRS lease structures.

As noted above, section 856(e)(6)(D)(i) defines qualified healthcare property to mean any real property, and any personal property incident to that real property, which is a healthcare facility or is necessary or incidental to the use of a healthcare facility. Section 856(e)(6)(D)(ii) then defines healthcare facility as follows:

> **Health care facility.** For purposes of clause (i), the term ''health care facility'' means a hospital, nursing facility, assisted living facility, congregate care facility, qualified continuing care facility (as defined in section 7872(g)(4)), or other licensed facility which extends medical or nursing or ancillary services to patients and which, immediately before the termination, expiration, default, or breach of the lease of or

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RIDEA. The final legislation included all but one of the provisions from the proposed 2007 RIDEA. *See generally* NAREIT, ''RIDEA REIT Provisions Are Enacted,'' *Nat'l Policy Bulletin* (July 30, 2008).

[32]Section 856(d)(2)(B) provides that qualifying rents from real property do not include amounts received directly or indirectly from a corporation if the REIT owns 10 percent or more of the total combined voting power or 10 percent or more of the total value of the shares of the corporation. That would normally exclude rents received from a lease to a 10 percent or more owned TRS. However, section 856(d)(8)(B) provides that amounts paid to a REIT by a TRS of that REIT shall not be excluded from rents from real property by reason of section 856(d)(2)(B) if the REIT leases a qualified lodging facility (as defined in section 856(d)(9)(D)) to a TRS, and the facility or property is operated on behalf of the TRS by a person who is an EIK. *Cf.* LTR 201139005, *Doc 2011-20728*, *2011 TNT 191-19* (providing a liberal interpretation of the requirement that the TRS engage an EIK to operate the facility on behalf of the TRS).

[33]Housing and Economic Recovery Act of 2008, P.L. 110-289, section 3071(a).

[34]*Id.* at section 3061(a).

[35]*Id.* at section 3061(b)-(c).

[36]153 *Cong. Rec.* S10931 (2007) (introductory remarks for RIDEA by Senate Finance Committee member Orrin G. Hatch, R-Utah). *See also* 153 *Cong. Rec.* E384-E385 (extended remarks for RIDEA by Rep. Joseph Crowley, D-N.Y.):

> Congress in 1999 carved out an exception under which a REIT may establish a TRS that can lease lodging facilities from a REIT holding a controlling interest, with the payments to the REIT considered good ''rents'' under the REIT rules. Under these rules, a TRS is not allowed to operate or manage lodging or health care facilities; instead an independent contractor must do so. When this change was made in 1999, health care operators did not object to bearing the risks associated with being liable as a long-term lessee. Recently, many operators of health care assets such as assisted living facilities have indicated that they would rather be independent operators of the facilities and instead rely on a REIT to bear all real estate related financial risks. Most health care REITs now believe that the TRS restriction is interfering with their ability to manage their operations in the most efficient manner.

mortgage secured by such facility, was operated by a provider of such services which was eligible for participation in the medicare program under title XVIII of the Social Security Act with respect to such facility.

At the most basic level, when read outside the foreclosure property context and in the context of section 856(d)(8)(B), the prepositional phrase ''immediately before the termination, expiration, default, or breach of the lease of or mortgage secured by such facility'' should sensibly be read out of the definition. The IRS has interpreted the provision in exactly that fashion in several private letter rulings.[37]

Another, more complex interpretive question lies in the clause ''*which* extends medical or nursing or ancillary services to patients and *which* . . . was operated by a provider of such services which was eligible for participation in the medicare program under title XVIII of the Social Security Act with respect to such facility'' (emphasis added), referred to as the ''Medicare clause.'' From the construction of the sentence, it is initially unclear whether the Medicare clause modifies only the last type of healthcare facility in the list, ''other licensed facility,'' or whether it modifies all types of healthcare facilities in the list. After closely reviewing the provision, the clear conclusion is that Congress intended the Medicare clause to modify only ''other licensed facility'' and not the preceding items in the list. That interpretation follows from the following five considerations, each of which leads to the same conclusion.[38]

First, Medicare programs under Title XVIII of the Social Security Act do not apply to (and in 1999, when the definition of healthcare facility was first enacted into the code, did not apply to) assisted living facilities, thus rendering the inclusion of ''assisted living facilities'' a nullity if the Medicare clause is read to modify the entire list.[39] Among the types of facilities covered by Title XVIII are hospitals, skilled nursing facilities (that is, nursing homes), outpatient rehabilitation facilities, hospices, religious non-medical-care institutions, and home health services; assisted living facilities are not included.[40] One of the few universally accepted canons of statutory construction is that any interpretation of an ambiguity that renders a statutory term such as ''assisted living facility'' in section 856(e)(6)(D)(ii) as surplusage or a nullity is strongly disfavored.[41] If the Medicare clause were to apply to all the items on the list of healthcare facilities, that would produce exactly the disfavored statutory interpretation. As a result, Congress must not have intended the Medicare clause to apply to all the healthcare facilities in the list.

Second, another important canon of statutory construction is that the use of parallel language and parallel construction in modifying clauses indicates that the clauses are intended to be interpreted the same way.[42] In this case, the only proper grammatical reading of the two ''which'' subclauses in the

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[37]*See* LTR 201125013, *Doc 2011-13833*, *2011 TNT 123-26*; LTR 201104023, *Doc 2011-1942*, *2011 TNT 20-23*; LTR 201104033, *Doc 2011-1952*, *2011 TNT 20-22*; LTR 201049013, *Doc 2010-26341*, *2010 TNT 238-34*; LTR 201041034, *Doc 2010-22483*, *2010 TNT 200-36*; LTR 200813005, *Doc 2008-6840*, *2008 TNT 62-34*; LTR 200813003, *Doc 2008-6838*, *2008 TNT 62-33*.

[38]The recent Supreme Court decision in *Mayo Foundation for Medical Education and Research v. United States*, 131 S. Ct. 704 (2011), *Doc 2011-609*, *2011 TNT 8-10*, granting *Chevron* deference to administrative proclamations such as Treasury regulations, does not alter that analysis, since the first step in an administrative agency's construction of a statute is to determine ''whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter.'' *Chevron U.S.A. Inc. v. Natural Ress. Def. Council Inc.*, 467 U.S. 837, 842 (1984). As the following analysis shows, despite the initial appearance of ambiguities in the wording in this provision, the intent of Congress is nevertheless clear.

[39]''Assisted living facility'' would become a nullity because the Medicare clause would have to apply ''with respect to such facility.'' Even an operator that was generally eligible for participation in the Medicare program would not be eligible to participate in Medicare with respect to an ineligible facility.

[40]*See* Social Security Act section 1861, 42 U.S.C. section 1395x.

[41]*See*, *e.g.*, *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (refusing to adopt construction of a statute that would leave statutory term ''insignificant, if not wholly superfluous''); *Williams v. Taylor*, 529 U.S. 362, 404 (2000) (describing that rule as a ''cardinal principle of statutory construction''); *United States v. Menasche*, 348 U.S. 528, 538-539 (1955) (''It is our duty 'to give effect, if possible, to every clause and word of a statute'" (quoting *Montclair v. Ramsdell*, 107 U.S. 147, 152 (1883))); *Market Co. v. Hoffman*, 101 U.S. 112, 115 (1879) (''As early as in Bacon's Abridgment, section 2, it was said that 'a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant'"); *Blak Inv. v. Commissioner*, 133 T.C. 431 (2009), *Doc 2009-28206*, *2009 TNT 245-9*. The IRS has adopted that doctrine in its own interpretations. *See* TAM 9637008, *Doc 96-25208*, *96 TNT 181-15* (rejecting an interpretation of section 58(h) that would leave section 56(b) as ''statutory deadwood''); TAM 8940005 (rejecting an interpretation of reg. section 1.864-4(c)(2)(ii) that would make the word ''otherwise'' in reg. section 1.864-4(c)(2)(ii)(c) meaningless).

[42]*Cf. Russello v. United States*, 464 U.S. 16, 23 (1983) (holding that use of differing language in legislation should be interpreted as intending different meanings). However, this factor is not conclusive, as evidence of intent may be taken into account. *Compare* the application of this rule of statutory construction by the Third Circuit in *Swallows Holding Ltd. v. Commissioner*, 515 F.3d 162 (3d Cir. 2008), *Doc 2008-3372*, *2008 TNT 33-41*, with that of the Tax Court in *Swallows Holding Ltd. v. Commissioner*, 126 T.C. 96 (2006), *Doc 2006-1541*, *2006 TNT 18-10*. Unlike that case, however, there is no evidence here of an intent to interpret the two ''which'' subclauses differently.

Medicare clause is that both subclauses are intended to modify the same item, principally because of the ''and which'' construction used to start the second subclause and the second subclause's reference to ''such services,'' which is a reference to the services described in the first subclause. The first ''which'' subclause (''which extends medical or nursing or ancillary services to patients'') is best read as modifying only ''other licensed facility,'' in that the occupants of assisted living facilities, congregate care facilities, and qualified continuing care facilities are almost universally described as ''residents'' instead of as ''patients.''[43] Because both ''which'' subclauses in the Medicare clause should be interpreted to modify the same term or terms, the modified term should only be ''other licensed facility.''

Third, the interpretation that the Medicare clause applies only to the term ''other licensed facility'' is the interpretation favored by commentators.[44] Some commentators favor that view because only domestic facilities typically qualify for Medicare funding, while section 856(d)(8)(B)(ii) clearly contemplates qualifying healthcare facilities outside the United States.[45] If the Medicare clause applied to other items on the list such as hospitals, then a TRS could not lease, for example, a hospital located outside the United States. For that and other reasons, commentators, including tax counsel from NAREIT, believe that the Medicare clause applies only to the last term in the list.[46]

Fourth, another rule of statutory construction is *reddendo singular singulis* (by rendering each to each),[47] also known as the ''rule of the last antecedent,'' which generally holds that a ''limited or restrictive clause contained in a statute is generally construed to refer to and limit and restrict an immediately preceding clause or the last antecedent.''[48] Applying that rule in this case would have the two which subclauses in the Medicare clause only apply to the item ''other licensed facility'' and not apply to the rest of the list.[49] A corollary guide states generally that ''where there is a comma before a modifying phrase, that phrase modifies all of the items in a series and not just the immediately preceding item.''[50] Here, no comma appears before either ''which'' subclause in the Medicare clause, supporting the conclusion that the rule of the last antecedent should apply to that clause.

Finally, that interpretation is consistent with Congress's treatment of a parallel ambiguity in the definition of lodging facility in section 856(d)(9)(D)(ii). That section, when introduced in the 1999 act, the same legislation that introduced the definition of healthcare facility in section 856(e)(6)(D)(ii), read as follows:

> Lodging facility. The term ''lodging facility'' means a hotel, motel, or other establishment more than one-half of the dwelling units in which are used on a transient basis.

That original definition contained an ambiguity whether the clause beginning ''more than one-half'' modified only the final item on the list (other establishment) or the entire list, identical to the potential ambiguity in the Medicare clause. However, the lodging facility ambiguity attracted much more attention from practitioners than the Medicare clause ambiguity, which prompted Congress to make a technical correction in 2007 that added parenthetical numerals and broke out the list over

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[43] *See*, *e.g.*, section 7872(g)(4)(A)(ii) (''substantially all the *residents* of'' a qualified continuing care facility) (emphasis added).

[44] *See* Tony M. Edwards and Dara F. Bernstein, ''REITs Empowered,'' 24-11 *Tax Mgm't Real Est. J.* 7 n.37 (Nov. 5, 2008); s*ee also* Tim Hall, ''Health Care REIT Tax Issues: Qualified Health Care Property,'' Presentation at NAREIT Law, Accounting, and Finance Conference (Mar. 24, 2011).

[45] Section 856(d)(8)(B)(ii) refers to a TRS employing individuals to manage healthcare property ''located outside the United States.'' For a detailed treatment of REIT investments outside the United States, see, *e.g.*, Ameek A. Ponda, ''REITs Abroad,'' Practising Law Institute's Tax Strategies for Corporate Acquisitions, Dispositions, Spinoffs, Joint Ventures, Financings, Reorganizations, and Restructurings (2006-2008).

[46] *See supra* note 44.

[47] *Black's Law Dictionary* 1390 (2009).

[48] Norman J. Singer and J.D. Shambie Singer, *Sutherland Statutes and Statutory Construction* section 47:26 (vol. 2A 2007).

[49] Use of this rule of statutory construction, which has been irregular in American law since the Supreme Court used a context rule in place of it in *Ex parte Bollman*, 8 U.S. (4 Cranch) 75 (1807), has increased since the Supreme Court both used and explained it in *Barnhart v. Thomas*, 540 U.S. 20 (2003). In that case, the Court stated that ''a limiting clause or phrase (here, the relative clause 'which exists in the national economy') should ordinarily be read as modifying only the noun or phrase that it immediately follows.'' *Id*. at 26. The Court also gave an example of the rule's application in everyday life: parents warning their teenage son, ''You will be punished if you throw a party or engage in any other activity that damages the house,'' which the Court stated ''proscribed (1) a party, and (2) any other activity that damages the house.'' The son could not avoid punishment after throwing a party ''by arguing that the house was not damaged.'' *Id*. at 27-28. Since then, the rule of the last antecedent has also been applied to code interpretation. *See Estate of Gerson v. Commissioner*, 127 T.C. 139, 172-173 (2006), *Doc 2006-21771*, *2006 TNT 206-15* (*reviewed*) (Laro, J., dissenting) (arguing that the rule of the last antecedent makes *Chevron* deference to reg. section 26.2601-1(b)(1)(i)'s interpretation of section 1433(b)(2)(A) of the Tax Reform Act of 1986 (''any generation-skipping transfer under a trust which was irrevocable on September 25, 1985'') inappropriate, because the ''which'' clause should apply only to ''trust'' and not also to ''transfer'').

[50] *Stepnowski v. Commissioner*, 456 F.3d 320, 323 (3d Cir. 2006), *Doc 2006-14169*, *2006 TNT 145-5*.

separate lines to eliminate that ambiguity.[51] Section 856(d)(9)(D)(ii) now reads:

> Lodging facility. The term ''lodging facility'' means a —
>
> (I) hotel,
>
> (II) motel, or
>
> (III) other establishment more than one-half of the dwelling units in which are used on a transient basis.[52]

Notably, that clarification related back to the effective date of the original legislation.[53] Although Congress has not yet stepped in to offer a similar clarification in the context of the Medicare clause in the healthcare facility definition, a context rule would hold that two similar ambiguities in the same code section, especially when created by the same legislation (the 1999 act), should be resolved in the same manner.[54] Thus, like its counterpart in the definition of lodging facility, the Medicare clause should be read as modifying only the last item in the list.

For the five reasons above, each item on the list of healthcare facilities in section 856(e)(6)(D)(ii) stands alone, and only ''other licensed facility'' is modified by the Medicare clause.

III. Independent Living Facilities

Once the phrases and clauses of section 856(e)(6)(D)(ii) are properly interpreted, the list of healthcare facilities therein is seemingly straightforward. A healthcare facility for purposes of that provision can be a hospital, a nursing facility (including a skilled nursing facility), an assisted living facility, a congregate care facility, or specific other facilities. It seems clear that any facility composed exclusively of a property type or multiple property types that qualify as healthcare facilities under section 856(e)(6)(D)(ii) will constitute a healthcare facility, whether it is a single-category facility or a single campus comprising units of different, qualifying facility types. For example, a facility composed exclusively of skilled nursing units and assisted living units will constitute a healthcare facility. This part focuses on the treatment of pure independent living facilities — that is, facilities composed exclusively of independent living units.[55]

A. Industry Classifications of Senior Housing

Before 2004 there was no standardized terminology for describing senior housing types. In April 2004 the ''Classifications for Seniors Housing Property Types'' (the ''Standard Classifications'') were developed by the National Investment Center for

[51] *See* Joint Committee on Taxation, ''Description of the Tax Technical Corrections Act of 2007,'' JCX-119-07 (Dec. 18, 2007), at 12, *Doc 2007-27705*, *2007 TNT 244-21* (''The provision clarifies that the transient basis language in the definition of a lodging facility applies only in determining whether an establishment other than a hotel or motel qualifies as a lodging facility''). *See also* Tax Technical Corrections Act of 2007, P.L. 110-172, section 9(b) (2007).

[52] The grammatical error (''a other establishment'') is included in the statutory language in section 856(d)(9)(D)(ii)(III).

[53] *See* Tax Technical Corrections Act of 2007, P.L. 110-172, section 9(c) (2007) (''EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the provisions of the Tax Relief Extension Act of 1999 to which they relate''). *See supra* note 21 (''Tax Relief Extension Act of 1999'' is another name for the tax title of the 1999 act).

[54] As noted previously, in some cases the courts have ignored the rules of statutory construction and looked to a context rule. Here, however, both the rules of statutory construction and the context rule lead to the same result.

[55] The IRS has ruled several times in private rulings that mixed-use facilities with an independent living section as well as a significant assisted living and/or SNF section qualify as healthcare facilities. *See* LTR 201125013, LTR 201104033, and LTR 201104023. In LTR 201104023, the IRS ruled that both a single building with a mix of independent and assisted living units and a mixed campus that contained independent living units along with a ''significant number'' of assisted living units were qualified healthcare properties. The ruling describes some of the properties as consisting ''of multiple buildings on the same campus that are operated as one facility.'' In LTR 201104033, the IRS again ruled that both single-building and campus-style senior housing properties with a mix of independent and assisted living units, in which there were a ''significant number'' of assisted living units, were qualified healthcare properties. The properties at issue in the ruling shared ''common area facilities for front desk reception, meals, social activities, and fitness activities.'' Also, the same events and activities were offered to all residents, regardless of the type of unit they occupied. The properties were operated by a management company that markets the properties as one integrated community with different service options and units available. Also, the same housekeeping, food services, administrative, and activities staff provided services for both independent and assisted living units. The nursing staff, although primarily devoted to the assisted living units, also assisted those in the independent living units with ''the medical assessment that is performed to determine whether a resident will be placed in'' assisted or independent living and in the event of an emergency. Finally, in LTR 201125013, mixed-use communities that consisted of ''a significant number of'' assisted living and Alzheimer's care units along with independent living in each of those communities were held to be qualified healthcare properties. Those three private rulings are consistent with a representation made by the taxpayer in LTR 200813003, stating that a property containing ''either or both assisted living and Alzheimer's facilities in combination with an independent living facility (where no healthcare or medically related services are provided), all in a single building or as a single continuum care center with an undivided property interest'' met the definition of a healthcare facility in section 856(e)(6)(D)(ii). *See also* James M. Lowy et al., ''Real Estate Investment Trust Corner: Mixed Use Senior Living Communities,'' 14-4 *J. Passthrough Entities* 37 (July-Aug. 2011). For the reasons discussed in Part III.B *infra*, all this is the correct answer for those types of properties, even though the analysis in all the private letter rulings presupposes that pure independent living facilities would not have qualified as healthcare facilities.

the Seniors Housing & Care Industry Inc. (NIC) and the American Senior Housing Association (ASHA) in an effort to reduce confusion and eliminate conflicting data about senior housing property types. According to the April 14, 2004, press release from NIC and ASHA, the ''standardized classifications are expected to eliminate conflicting data on construction starts, supply and demand that has been previously reported throughout the industry.''[56]

The standard terms and descriptions that NIC and ASHA agreed on for different property types are the following:

1. *Active Adult Communities*: For-sale single-family homes, townhomes, cluster homes, mobile homes and condominiums with no specialized services, restricted to adults at least 55 years of age or older. Rental housing is not included in this category. Residents generally lead an independent lifestyle; projects are not equipped to provide increased care as the individual ages. May include amenities such as clubhouse, golf course and recreational spaces. Outdoor maintenance is normally included in the monthly homeowner's association or condominium fee.

2. *Senior Apartments*: Multifamily residential rental properties restricted to adults at least 55 years of age or older. These properties do not have central kitchen facilities and generally do not provide meals to residents, but may offer community rooms, social activities, and other amenities.

3. *Independent Living Communities*: Age-restricted multifamily rental properties with central dining facilities that provide residents, as part of their monthly fee, access to meals and other services such as housekeeping, linen service, transportation, and social and recreational activities. Such properties do not provide, in a majority of the units, assistance with activities of daily living (ADLs) such as supervision of medication, bathing, dressing, toileting, etc. There are no licensed skilled nursing beds in the property.

4. *Assisted Living Residences*: State regulated rental properties that provide the same services as independent living units listed above, but also provide, in a majority of the units, supportive care from trained employees to residents who are unable to live independently and require assistance with activities of daily living (ADLs) including management of medications, bathing, dressing, toileting, ambulating and eating. These properties may have some nursing beds, but the majority of units are licensed for assisted living. Many of these properties include wings or floors dedicated to residents with Alzheimer's or other forms of dementia. A property that specializes in the care of residents with Alzheimer's or other forms of dementia that is not a licensed nursing facility should be considered an assisted living property.

5. *Nursing homes*: Licensed daily rate or rental properties that are technically referred to as skilled nursing facilities (SNF) or nursing facilities (NF) where the majority of the individuals require 24-hour nursing and/or medical care. In most cases, these properties are licensed for Medicaid and/or Medicare reimbursement. These properties may include a minority of assisted living and/or Alzheimer's/dementia units.

6. *Continuing care retirement communities (CCRCs)*: Age-restricted properties that include a combination of independent living, assisted living and skilled nursing services (or independent living and skilled nursing) available to residents all on one campus. Resident payment plans vary and include entrance fee, condo/coop and rental programs.[57]

The Standard Classifications have also been endorsed by the American Association of Homes & Services for the Aging, the American Health Care Association, the Assisted Living Federation of America, and the National Center for Assisted Living. Thus, in a major change since 2004, the above list and its accompanying descriptions are now used almost exclusively throughout the senior housing industry.[58]

B. Congregate Care Facility Definition

In determining whether pure independent living facilities should be classified as healthcare facilities, the task is to determine what Congress meant by the various terms it used in the definitions in section 856(e)(6)(D)(ii), all of which do not necessarily correspond to the Standard Classifications. In particular, the term ''congregate care facility'' has no counterpart in the Standard Classifications and is not defined anywhere in the code. Because that term is also not defined in the Investment Company

[56]NIC and ASHA press release, *available at* http://www.nic.org/press/2004/Apr%2014.pdf.

[57]NIC and ASHA, ''Classifications for Senior Housing Property Types,'' *available at* http://www.nic.org/research/Classifications.pdf (last visited Sept. 22, 2011).

[58]NIC and ASHA press release, *supra* note 56.

Act of 1940 and imported into section 856 through section 856(c)(5)(F), its meaning in ordinary or natural usage would be determinative of its meaning in section 856.[59] As explained more fully below in this part, ''congregate care facility'' had a specific and common meaning in the healthcare industry in 1999, when section 856(e)(6)(D)(ii) was added to the code: It meant what the term ''independent living facility'' (or ''independent living community'') means today.[60] As a consequence, pure independent living facilities should be treated as healthcare facilities.

The principal contrary authority to that finding is the IRS's ruling in LTR 200813005[61] that a pure independent living facility as defined in the Standard Classifications was not a healthcare facility. That conclusion implicitly indicates that the IRS determined that a pure independent living facility was separate and distinct from a congregate care facility.[62] However, the private letter ruling contains no analysis regarding the meaning of the terms used in the code to describe healthcare facilities. Instead, after noting that an independent living facility failed to meet the definition for other licensed facility because it was not licensed and would not extend medical, nursing, or ADL services to patients,[63] the IRS then analyzed an independent living facility using reg. section 1.42-11(b), which provides that a building in which continual or frequent nursing, medical, or psychiatric services are provided is not eligible for the low-income housing credit as residential real property.[64] Based on those facts, the ruling concluded that a pure independent living facility was not a healthcare facility. Had the IRS instead examined common usage at the time the statute was passed, it would have found that the terms ''congregate care facility''

[59]*See The Limited Inc. v. Commissioner*, 286 F.3d 324, 333 (6th Cir. 2002), *Doc 2002-8860*, *2002 TNT 71-10* (''When a word is not defined by statute, courts construe the undefined term in accordance with its ordinary or natural meaning.'' (citing *Fed. Deposit Ins. Corp. v. Meyer*, 510 U.S. 471, 476 (1994); *Smith v. United States*, 508 U.S. 223, 228 (1993); *United States v. Moses*, 137 F.3d 894, 899 (6th Cir. 1998))).

[60]Sometimes terminology and branding change over time, for reasons ranging from marketing to social acceptance. Consider, for example, the progression of terms to describe individuals with physical disabilities. The term ''crippled'' was replaced in common usage by the term ''handicapped,'' which was then replaced by the term ''disabled,'' which has itself been replaced by terms such as ''physically challenged'' and ''differentially abled.'' *See*, *e.g.*, Charles J. Fox and Hugh T. Miller, ''Postmodern Public Administration: A Short Treatise on Self-Referential Epiphenomena,'' 15 *Admin. Theory & Praxis* 1, 9 (1993). This process creates ''an increasing gap between names and the objects or experiences to which they were once more immediately connected.'' *Id*. at 6. In a more recent healthcare example, Alzheimer's care facilities are increasingly being referred to as ''memory care centers.'' In the case of independent living, the change in terminology has been so successful and so complete that the original meaning of congregate care was apparently lost to many.

[61]*Doc 2008-6840*, *2008 TNT 62-34*.

[62]In addition to LTR 200813005, so far the only private ruling that addresses a pure independent living facility, the logic and holdings of LTR 201104023, LTR 201104033, and LTR 201125013, suggest that a pure independent living facility is not a healthcare facility. *See supra* note 55. *See also* LTR 200813003 (taxpayer represents that ''mixed facilities'' are healthcare facilities).

[63]Although the argument was not considered in this ruling, some facilities defined as independent living for purposes of the Standard Classifications actually may be defined as assisted living under some state statutes. For example, Fla. Stat. section 429.02(5) defines assisted living facility to mean ''any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.'' Fla. Stat. section 429.02(16) defines personal services to mean ''direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar services which the department may define by rule'' but not ''medical, nursing, dental, or mental health services.'' Thus, providing direct physical assistance to one person with an activity of daily living for more than one day, when combined with normal independent living services, is sufficient to have an independent living facility classified as an assisted living facility under Florida law. However, under Fla. Stat. section 429.04(2)(g), those independent living facilities generally should not have to be licensed as assisted living facilities, although they may require other licensing.

[64]Rev. Rul. 98-47, 1998-2 C.B. 399, *Doc 98-27991*, *98 TNT 178-6*, concludes that Building X (an independent living facility) and Building Y (an assisted living facility) are both eligible for the low-income housing credit as residential real property under section 42, but Building Z (a SNF) is not. Because an assisted living facility (such as Building Y) is specifically included as a healthcare facility in section 856(e)(6)(D)(ii), that type of facility will thus qualify both as residential real property under section 42 and as a healthcare facility under section 856. Therefore, the implication in LTR 200813005 that a facility classified as residential real property under section 42 could not be a healthcare facility under section 856 is clearly untrue. *Cf.* CCA 201147025, *Doc 2011-24763*, *2011 TNT 229-20* (mixed use facilities are residential real property for section 168 purposes). In fact, the classification of a healthcare facility in section 42 correlates with the Medicare eligibility of the facility, but not with the facility's classification as a healthcare facility under section 856. The overlap in classifications is consistent with the purposes of section 42, which is to ''promote housing for low income individuals'' by providing tax credits for businesses that provide such housing. Rev. Rul. 95-49, 1995-2 C.B. 7, *95 TNT 138-7*. *See also Hous. Pioneers Inc. v. Commissioner*, T.C. Memo. 1993-120, *Doc 93-3894*, *93 TNT 71-15* (''The very purpose of section 42 . . . is to provide tax incentives to business entities. . . . To be sure, petitioner assures us that the partnerships intend to apply the property tax savings to further the low income housing purpose, but since the property is owned by the for-profit partnerships, it is the property owners who are ultimately benefited.'').

in 1999 and ''independent living facility'' today had the same meaning. In light of that omission, the accuracy of the IRS's analysis in LTR 200813005 is strongly suspect.

Before the existence of the Standard Classifications, the term ''congregate care facility'' was the most common term used to describe an age-restricted rental property where access to meals, housekeeping, and activities was provided. For example, the newsletter *Apartment Resources* from March 1988 states:

> Most congregate care developments have certain basic aspects in common: in return for a service fee, which may be financed in several ways, they provide housing and services for older adults. The services usually provided include meals, housekeeping and/or linen service, and organized activities. Although the type of services offered can vary greatly, depending on the development, one finds some combination of these basic services at most congregate care facilities.[65]

A review of Form 10-K filings with the SEC by healthcare corporations and healthcare REITs in 1999 also establishes the terminology that was in use in 1999. Most of the Forms 10-K reviewed used some form of the term ''congregate care'' to describe units that today would be called independent living, although the term ''independent living'' was also used to describe those units.[66] In time, ''congregate care'' declined in use and

[65]''The Five Pitfalls of Congregate-Care Development,'' *Apartment Resources* (Mar. 1988), at 4.

[66]For example, Senior Housing Properties Trust (SNH) referred to ''four types of senior housing accommodations'' — senior apartments, congregate communities, assisted living properties, and nursing homes — and offered these two descriptions of ''congregate communities'' and their regulatory environment in its fiscal 1999 Form 10-K:

> Congregate Communities. Congregate communities also provide a high level of privacy to residents and require residents to be capable of relatively high degrees of independence. Unlike a senior apartment property, a congregate community usually bundles several services as part of a regular monthly charge — for example, one or two meals per day in a central dining room, weekly maid service or a social director. Additional services are generally available from staff employees on a fee-for-service charge basis. In some congregate communities, separate parts of the property are dedicated to assisted living or nursing services. . . .
>
> Congregate Communities. We understand that generally government benefits are not available to congregate communities and the resident charges in these properties are paid from private resources. However, a number of Federal Supplemental Security Income program benefits pay housing costs for elderly or disabled residents to live in these types of residential facilities. The Social Security Act requires states to certify that they will establish and enforce standards for any category of group living arrangement in which a significant number of supplemental security income residents reside or are likely to reside. Categories of living arrangements which may be subject to these state standards include congregate facilities and assisted living properties. Because congregate communities usually offer common dining facilities, in many locations they are required to obtain licenses applicable to food service establishments in addition to complying with land use and life safety requirements. In many states, congregate communities are licensed by state health departments, social service agencies, or offices on aging with jurisdiction over group residential facilities for seniors. To the extent that congregate communities maintain units in which assisted living or nursing services are provided, these units are subject to applicable state regulations. In some states, insurance or consumer protection agencies regulate congregate communities in which residents pay entrance fees or prepay other costs.

Senior Hous. Prop. Trust, ''Annual Report (Form 10-K)'' (Mar. 30, 2000) at 2, 10.

CNL Health Care Properties Inc. (which became CNL Retirement Properties Inc. later in 2000), referred to independent living facilities as congregate living facilities in its fiscal 1999 Form 10-K:

> Congregate Living Facilities. Congregate living facilities are primarily apartment buildings which contain a significant amount of common space to accommodate dining, recreation, activities and other support services for senior citizens. These properties range in size from 100 to 500 units with an average size of approximately 225 units. Units include studios and one and two bedrooms ranging in size from 450 square feet to over 1,500 square feet.

CNL Health Care Prop. Inc., ''Annual Report (Form 10-K)'' (Feb. 18, 2000), at 11.

Health Care Property Investors Inc. (which became HCP Inc. in 2007) described independent living facilities as congregate care centers in its fiscal 1999 Form 10-K:

> Congregate Care and Assisted Living Centers. We have investments in 93 congregate care and assisted living centers. Congregate care centers typically offer studio, one bedroom and two bedroom apartments on a month-to-month basis primarily to individuals who are over 75 years of age. Residents, who must be ambulatory, are provided meals and eat in a central dining area; they may also be assisted with some daily living activities. These centers offer programs and services that allow residents certain conveniences and make it possible for them to live independently; staff is also available when residents need assistance and for group activities.
>
> Assisted living centers serve elderly persons who require more assistance with daily living activities than congregate care residents, but who do not require the constant supervision nursing homes provide. Services include personal supervision and assistance with eating, bathing, grooming and administering medication. Assisted living centers typically contain larger common areas for dining, group activities and relaxation to encourage social interaction. Residents typically rent studio and one and two bedroom units on a month-to-month basis.

Health Care Prop. Investors Inc., ''Annual Report (Form 10-K)'' (Mar. 30, 2000), at 5-6. Anecdotally, Health Care Property Investors Inc. is believed to be among the principal proponents of the 1999 legislation that introduced the definition of healthcare facility in the foreclosure property context. It would thus make sense that the definition in the legislation was intended to

(Footnote continued in next column.)

(Footnote continued on next page.)

"independent living" commensurately increased in use, perhaps anticipating and then reflecting the preferred nomenclature of the Standard Classifications.[67] The terminology used within the REIT industry around 1999 was also consistent with the nomenclature in the Form 10-K filings. For example, in early 2001 NAREIT published an article in its newsletter about the types of senior housing in which healthcare REITs invested. The article referred to the subject property type as "congregate seniors housing or independent living."[68]

LTR 200813005 includes the following list of services that were performed at the independent living facility at issue in that private ruling: "the preparation and serving of meals at central dining facilities, periodic housekeeping, laundry and linen services, monthly parking, valet and public parking, local transportation (to shopping, physicians' offices, hospitals and churches), social and recreational activities, and the maintenance of residents' rooms and common areas." Other than the valet parking, those are the same services listed in the 1988 definition of a congregate care facility in the *Apartment Resources* newsletter, the same services described in several 1999 Forms 10-K as being provided at a congregate care facility, the same services listed in the 2001 NAREIT newsletter as performed in congregate seniors housing or independent living, and the same services included today in the Standard Classifications for an independent living facility.[69] Therefore, those examples show that a congregate care facility in 1999 was defined to mean exactly the same thing that an independent living community is defined to mean under the Standard Classifications today, which the IRS overlooked in its ruling. But why would different terms be used in 1999 and in 2008 for the same type of facility? The answer can be found in the adoption of the Standard Classifications. The 2004 press release from NIC and ASHA states the following:

> Among the most significant changes in specialized terms is *the renaming of the property type "congregate care" to "independent living."* According to the new classification, independent living is now defined as "age-restricted multifamily rental properties with central dining facilities that provide residents, as part of their monthly fee, access to meals and other services

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cover its own congregate care facilities, which would today be referred to as independent living facilities.

Associated Estates Realty Corp., an apartment REIT, described independent living facilities as congregate care facilities in its fiscal 1999 Form 10-K and defined the term in an attached glossary:

> "*Congregate Care Facility*" means a residential apartment community for elderly persons that provides services to its residents which may include prepared meals, housekeeping and laundry service and a variety of recreational and educational activities.

Associated Estates Realty Corp., "Annual Report (Form 10-K)" (Mar. 15, 2000), at 39.

Other contemporaneous SEC filings by public companies are consistent with the above. However, some companies used the term "independent living" in their fiscal 1999 Form 10-K filings to mean the same type of facilities. For example, Eldertrust called those facilities "independent living facilities" (Eldertrust, "Annual Report (Form 10-K)," *supra* note 16), and Barcelo Crestline, a non-REIT that acquired facilities from Marriott Senior Housing, referred to them as "independent living units."

[67]For example, the Senior Housing Property Trust Form 10-K for fiscal 2001 added the term "independent living properties" to the description of congregate communities:

> Independent Living Properties. Independent living properties, or congregate communities, also provide high levels of privacy to residents and require residents to be capable of relatively high degrees of independence.

Senior Hous. Prop. Trust, "Annual Report (Form 10-K405)" (Mar. 28, 2002), at 2.

In contrast, some other REITs eliminated the term "congregate care" from their SEC filings after the standard industry terminology settled on independent living. For example, CNL Health Care Properties Inc. noted the changing terminology when it changed the wording in its 2002 Form 10-K to read:

> Congregate Living Facilities. Congregate living facilities, or commonly referred to as independent living facilities, are primarily apartment buildings which contain a significant amount of common space to accommodate dining, recreation, activities and other support services for senior citizens.

CNL Health Care Prop. Inc., "Annual Report (Form 10-K)" (Feb. 25, 2003), at 7.

The next year, the reference read:

> Congregate Living Facilities. Congregate living facilities, that are more commonly referred to as independent living facilities, are primarily apartment buildings . . .

CNL Health Care Prop. Inc., "Annual Report (Form 10-K)" (Mar. 2, 2004), at 7.

The next year, the discussion only mentioned "independent living facilities." CNL Health Care Prop. Inc., "Annual Report (Form 10-K)" (Mar. 10, 2005), at 7. Similarly, Health Care Property Investors Inc.'s Form 10-K for fiscal 2003 switched terms from "Congregate Care and Assisted Living Centers" to "Assisted and Retirement Living Facilities." Health Care Prop. Investors Inc., "Annual Report (Form 10-K)" (Mar. 15, 2004), at 5.

A few REITs never switched terms at all because of their peripheral contact with the healthcare industry. *See, e.g., infra* note 93.

[68]Deidre Darsa, "Catch the Edge," *Real Estate Portfolio* (Jan.-Feb. 2001). The definition used in the article stated:

> Congregate Seniors Housing or Independent Living: These multifamily facilities are created for less active seniors who pay for some services such as housekeeping, transportation, and meals as part of a monthly fee or rental rate. These seniors typically require little assistance in daily living and they may or may not receive some home health care services provided by in-house staff or an outside agency.

[69]In fact, LTR 200813005 references the Standard Classifications to define an independent living community and to show that this list of activities is typical.

such as housekeeping, linen service, transportation, and social and recreational activities.''[70]

However, the IRS was apparently unaware of that 2004 change in industry terminology from ''congregate care facility'' to ''independent living community'' when it issued LTR 200813005 and concluded that an independent living facility was not a section 856(e)(6)(D)(ii) healthcare facility. Yet the IRS did not need to refer to that industry press release to determine what a congregate care facility was and what services it provided. Two of its own private letter rulings issued before 1999 described the term ''congregate care facility'' in the same manner discussed above. LTR 9512014[71] (a ruling on passive investment income under section 1362) states: ''Properties consist of office buildings, apartments, shopping centers, mini-storage areas, and a congregate care facility. . . . For the congregate care facility, Corporation provides food service, housekeeping, transportation, cable TV, and free utility hookups; maintains a library; and coordinates social activities.'' Somewhat more detailed was a REIT ruling, LTR 9428033,[72] which states:

> Two apartment complexes are ''congregate care facilities'' at which an independent contractor will provide the tenants with the following services: one meal daily in a common dining room, house cleaning and laundry services, and recreational, educational, and social services. New and existing tenants sign a lease with Company for rent and a separate agreement with the independent contractor for the services it provides.[73]

Those descriptions of a congregate care facility by the IRS are entirely consistent with the descriptions used by the industry in 1999 and in the 2004 NIC and ASHA press release. The descriptions also equate to the current definition of independent living community in the Standard Classifications. Accordingly, the conclusion in LTR 200813005 appears poorly rooted.

Finally, the identification of congregate care with independent living is also supported by the legislative purpose of the 1999 statutory definition, which was to ensure ''continuous provision of health care services where the facilities are acquired by the REIT upon termination of a lease (as upon foreclosure) where there may not be enough time to obtain a new independent provider of such health care services.''[74] Many healthcare REITs leased their entire stock of congregate care facilities to third-party operators in the 1990s, generally the same operators to whom they leased their assisted living facilities and their nursing home facilities. As discussed in Part I.A, the cutback in Medicare and Medicaid payments in the BBA caused significant financial distress for nursing home operators and for assisted living facility operators.[75] Because most of those third-party operators also leased and operated congregate care facilities, foreclosure proceedings were as likely for congregate care landlords as for landlords of healthcare facilities receiving Medicare and Medicaid. As noted in some SEC filings from the time, some states also mandated licensing for congregate care facilities,[76] and so a foreclosure on a licensed congregate care center would have been no less problematic for the REIT property owner than a foreclosure on a licensed assisted living center or licensed nursing home.[77] That commercial and regulatory context explains why Congress chose to include congregate care facilities in

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[70]NIC and ASHA press release, *supra* note 56 (emphasis added).

[71]*95 TNT 59-30*.

[72]*94 TNT 138-54*.

[73]Note that this structure is an example of paradigm two, discussed in Part IV below: The healthcare REIT rents units directly to tenant-residents and then requires them to enter into a separate arrangement with an independent contractor to receive services.

[74]S. Rep. No. 106-201 (1999), at 58.

[75]As stated in the text accompanying note 39, Medicare programs under Title XVIII of the Social Security Act do not apply to assisted living facilities. However, as of 1999, more than three-quarters of states had received waivers to use Medicaid funds (as opposed to Medicare funds) to pay for residents in some assisted living facilities. *See, e.g.*, this contemporaneous discussion in SNH's fiscal 1999 annual report:

> 39 states provide Medicaid payments for residents in some assisted living properties under waivers granted by the Health Care Finance Administration of the U.S. Department of Health and Human Services or under Medicaid state plans and three other states are planning to do so. Because rates paid to assisted living property operators are lower than rates paid to nursing home operators some states use this waiver program as a means of lowering the cost of services for residents who may not need the higher intensity of medical care provided in nursing homes.

Senior Hous. Prop. Trust, ''Annual Report (Form 10-K),'' *supra* note 66, at 10-11.

[76]*Id.* (illustrating many of the ways that congregate care facilities could be regulated).

[77]Eldertrust had an extensive discussion of the foreclosure problem for healthcare REITs in its 1998 Form 10-K, which was presented only in part earlier. Eldertrust, ''Annual Report (Form 10-K),'' *supra* note 16, at 45-46. Here is Eldertrust's full discussion of the issue:

> The manner in which we derive income from the assisted and independent living facilities and skilled nursing facilities we own is governed by special considerations in satisfying the requirements for REIT qualification. *Because we would not qualify as a REIT if we directly operated an assisted or independent living facility, or a skilled nursing facility, we lease such facilities to a healthcare provider, such as subsidiaries of Genesis, that operate the facilities*. It is essential

(Footnote continued on next page.)

the definition of healthcare facilities for the section 856(e) foreclosure property rules.[78]

One remaining counterargument against that preferred interpretation is that even if the term ''congregate care facility'' was more widely used in 1999, the term ''independent living facility'' was also in use then, and Congress chose to include only the term ''congregate care'' in section 856(e)(6)(D)(ii) while apparently excluding the term ''independent living.'' For example, section 856(e)(6)(D)(ii) cross-references to section 7872(g)(4), and section 7872(g)(3)(B)(i)(I), which was added to the code in 1985, uses the term ''independent living unit'' regarding a qualified continuing care facility to mean approximately the same thing that the term means today, with meals and other personal care provided outside the unit.[79] That Congress did not use the term ''independent living'' in section 856(e)(6)(D)(ii) may indicate Congress's intent to exclude those units. However, this counterargument proves little, since the terms ''independent living'' and ''congregate care'' were, as demonstrated previously, seen as synonymous in 1999, not only within the senior housing industry but also by the IRS.[80] If Congress intended a distinction between congregate care and independent living, it did not define that distinction, which would represent a major drafting oversight given the then congruent meanings of the terms.[81]

Another possible reason for Congress's use of the term ''congregate care'' instead of ''independent living'' is that the latter is a marketing term — almost a vanity term — but perhaps not an actual description of the lifestyle in an independent living community. The natural and ordinary meaning of the term ''independent living'' implies something different than the meaning in the Standard Classifications, with its high level of meal preparation, housekeeping, and other services. In ordinary use, what are referred to as senior apartments in the Standard Classifications would be defined as independent living. Given that the technical term has a meaning inconsistent with its ordinary use and that the senior housing industry had another term (''congregate care'') that then referred to the exact same class of properties, Congress's decision to reference only congregate care in the statute may have been intended to eliminate any possible argument that properties like senior apartments, which are just regular rental apartments that are age-restricted, might be considered to be healthcare facilities under the ordinary or natural meaning rule of construction.[82]

In light of the overwhelming evidence that ''independent living'' and ''congregate care'' were interchangeable terms when the legislation in question was passed, and the strong policy arguments for including those facilities in the definition of foreclosure property, there are powerful arguments that

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to our qualification as a REIT that these arrangements be respected as leases for federal income tax purposes and that the lessees, including the subsidiaries of Genesis that lease properties from us, not be regarded as ''related parties'' of us or our operating partnership, as determined under the applicable provisions of the Internal Revenue Code. In the event the leases expire and are not renewed, we will have to find a new ''unrelated'' lessee to lease and operate the properties in order to continue to qualify as a REIT. *In the event of a default on either a lease of, or a mortgage secured by, an assisted or independent living facility or skilled nursing facility, to maintain our REIT qualification, we would have to engage a new healthcare provider, which could not include Genesis or its subsidiaries or Senior Life Choice, another existing tenant, to operate the facility after we take possession of the facility. This requirement could deter us from exercising our remedies in the event of a default even though such exercise otherwise would be in our best interests***.** Although we would be permitted to operate the facility for 90 days after taking possession of the facility pursuant to applicable U.S. Treasury regulations without jeopardizing our REIT status, *the fact that the facility licenses are held by lessees or borrowers may preclude us from doing so under applicable healthcare regulatory requirements*. [Emphasis added.]

[78]*See supra* note 22 for Congress's concerns and reaction. Those issues continue into the current senior housing healthcare environment, especially in the context of deal structuring. *See infra* Part V.

[79]Section 7872(g) has since been superseded by section 7872(h), and the original sunset for this revision, at the end of 2010, has been repealed. *See* section 7872(g)(6), *amended by* the Tax Increase Prevention and Reconciliation Act of 2005, section 209; section 7872(h)(4) (2005), *amended by* the Tax Relief and Health Care Act of 2006, section 425. However, this revision is immaterial to the argument here, which involves a time period before the revision.

[80]*See supra* note 66; LTR 9512014; LTR 9428033.

[81]A recent rule of statutory construction holds that drafting errors cannot be presumed and are ''for Congress to correct, not the courts.'' *Indep. Ins. Agents of Am. Inc. v. Clarke*, 955 F.2d 731, 739 (D.C. Cir. 1992), *rev'd on other grounds sub nom. U.S. Nat'l Bank v. Indep. Ins. Agents of Am., Inc*., 508 U.S. 439 (1993).

[82]*See supra* text accompanying note 59.

For an example of the natural and ordinary usage of the term ''independent living,'' see the classification on the Retirement Homes website, *available at* http://www.retirementhomes.com/homes/ (last visited July 11, 2011). This site does not use the Standard Classifications. In its list of senior property types, independent living communities are defined as ''homes, condominiums and apartments where residents maintain an independent lifestyle,'' which are active adult communities and senior apartments in the Standard Classifications. *Id.* Meanwhile, a congregate care facility is defined as a facility that ''combines private living quarters with centralized dining services, shared living spaces, and access to social and recreational activities. Many congregate care facilities offer transportation services, personal care services, rehabilitative services, spiritual programs, and other support services.'' *Id.* Those are services that are typical of independent living communities in the Standard Classifications.

Congress meant to include independent living units, by any name, in the definition of healthcare facilities. Therefore, LTR 200813005 has dubious validity at best. Based on the analysis in this part, pure independent living facilities would qualify as healthcare facilities under section 856(e)(6)(D), despite the contrary conclusion in the letter ruling.

IV. The Current Situation

As current law stands, there is a zone of uncertainty around pure independent living facilities, and healthcare REITs must contend with that unfortunate state of affairs. The uncertainty stems from two root causes: (i) conflicting authority on whether pure independent living facilities are healthcare facilities; and (ii) a ''cliff effect'' between the TRS structured as tenant for healthcare facilities versus the TRS structured as amenities provider for traditional rental housing. For a REIT that owns a pure independent living facility, the following four paradigms — presented in the historic order developed under the code — illustrate those two root causes.

A. Paradigm One: Lease to Tenant-Operator

The first paradigm is to lease the entire independent living facility to a tenant-operator. This approach is safe and well established under the code, and in fact was the only approach that provided an integrated bill to the facility residents before the advent of paradigms three and four, below. However, this paradigm sacrifices the structuring advantages and attendant economic flexibility gained by healthcare REITs from the availability of later paradigms. In particular, operators in the healthcare sector may be increasingly reluctant to take on the financial risks of being a tenant and would prefer instead to be a mere service provider that earns a management fee.[83]

B. Paradigm Two: Hire Independent Contractor

The second paradigm is to lease space in and at the independent living facility directly to residents, in effect operating the independent living facility along the lines of an apartment building.[84] For this paradigm to work, the management and the amenities services to residents that the code views as above and beyond a basic rental relationship, including but not limited to housekeeping, linen, dry cleaning, meals, home health monitoring, and recreational, educational and social activities, must be provided by someone other than the REIT,[85] such as a section 856(d)(3) independent contractor (IK) from whom the REIT does not derive or receive any income. The code and applicable regulations impose requirements and arm's-length mechanisms intended to ensure that the revenues and profit margins (and not just the costs) from providing those amenities stay with the IK, rather than result in enhanced rental income to the REIT. In particular, the REIT and the IK must comply with the standards established under reg. section 1.856-4(b)(5)(i):

> To the extent that [amenity services] are rendered to the tenants of the property by the independent contractor, the cost of the services must be borne by the independent contractor, a separate charge must be made for the services, the amount of the separate charge must be received and retained by the independent contractor, and the independent contractor must be adequately compensated for the services.

There is not a well-developed body of law interpreting these requirements. Failure to observe the applicable requirements will likely result in disqualifying all the rent received by the REIT as part of the failed structure.[86] Also, there are several operational dynamics and business tensions surrounding the separate charge requirements at an independent living facility.[87]

C. Paradigm Three: Employ TRS

The third paradigm is the same as the second, except that the management and amenities services

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[83]In fact, the 2008 RIDEA legislative history expressly notes that this reluctance has become common among healthcare operators. *See supra* text accompanying note 36.

[84]*See* LTR 9428033 for an example of paradigm two in practice, in which the residents entered into a separate agreement with the independent contractor and were billed separately by it for the amenities services.

[85]Services that are considered customary to a basic rental relationship (*e.g.*, janitorial, security, or common area maintenance) may be performed by the REIT itself. *See* Rev. Rul. 2001-29, 2001-1 C.B. 1348, *Doc 2001-15748*, *2001 TNT 108-8*.

[86]Section 856(d)(7). *See*, *e.g.*, Rev. Rul. 75-52, 1975-1 C.B. 198 (the guaranteed annual percentage of net rental income that a REIT receives from a property at which the unrelated co-owner manages the property as an IK without compensation does not constitute rent from real property for the REIT, because some portion of that income may reflect foregone management fees).

[87]Principally, paradigm two may create confusion around pricing, as the independent living residents will have to be charged separately for services not customarily offered to apartment renters, such as meals and maid service, although all that can be part of the same bill as the occupancy charge. Residents should mostly care about the total, combined cost of the living unit and the amenities services when making a residency decision, but may become confused or disenchanted when viewing the unbundled components of the total value package. Also, the IK would both benefit from, and bear the entrepreneurial risk on, all amenities services (*e.g.*, changes in food prices versus fixed-price meal plans), rather than simply being compensated for its services rendered. Again, the 2008 RIDEA legislative history expressly notes that healthcare operators prefer to be compensated for services and minimize entrepreneurial risk. *See supra* text accompanying note 36.

to residents that the code views as above-and-beyond a basic rental relationship would be performed by a TRS, as discussed in LTR 200813005. When relying on a TRS structure, the REIT and the TRS must comply with the standards established under Rev. Rul. 2002-38, which speaks to a TRS providing amenities services to the REIT's tenants at an apartment complex. Basically, the TRS can manage the units and collect rent from the residents, and then turn over the residents' rents, net of amenities services fees and management fees it retains, to the REIT. Because there is no requirement to separately state amenities services charges, that is a markedly simpler set of procedures than required when using an IK. Provided that everything is priced at arm's length and the TRS is adequately compensated for its services role, the 100 percent excise taxes on impermissible transfer pricing between a REIT and its TRS ought not to apply.[88] However, adopting this approach has risk: If a pure independent living facility is found to be a healthcare facility, then, under section 856(l)(3)(A), the TRS's operations role would cause it to lose TRS status,[89] likely disqualifying all the rent received by the REIT as part of the failed structure.[90]

D. Paradigm Four: Lease to TRS

The fourth paradigm is to take the position that the independent living facility is in fact a healthcare facility, for the reasons discussed in this report, and that it thus may be leased to a TRS (including a captive TRS) in REIT-compliant fashion, provided that the TRS engages an EIK to manage the facility. This view seems to directly oppose the IRS's current definition of healthcare facility, as expressed in LTR 200813005 and as reinforced implicitly in subsequent private letter rulings regarding mixed facilities.[91] This approach thus also has risk: If a pure independent living facility is found to be other than a healthcare facility, then the section 856(d)(8)(B) exception to section 856(d)(2)(B) is inapplicable, in effect disqualifying all the rent received by the REIT from its affiliated TRS as part of the failed structure.

The above four paradigms are generally viewed as mutually exclusive, and paradigms three and four certainly are. Thus, to move beyond the older and more limited paradigms one and two, a healthcare REIT must choose whether an independent living facility is properly subsumed within the definition of healthcare facility or is instead outside it. Choosing incorrectly will likely disqualify all the REIT's rental income from the failed structure, which can in turn lead to a potential REIT qualification issue.[92]

Although paradigms two and three are structures used by apartment REITs, the market dynamic is that pure independent living facilities are owned and/or operated almost exclusively by healthcare companies such as healthcare REITs.[93] Consequently, most major healthcare portfolio acquisitions by healthcare REITs include pure independent living facilities.[94] In short, pure independent living

[88]*See* section 857(b)(7); Rev. Rul. 2002-38. Under section 857(b)(7), a 100 percent excise tax is applied to the extent that transactions among the REIT, its tenants, and its TRS are mispriced in favor of the REIT receiving more and the TRS receiving less. The penalty represented by the excise tax is severe enough to prevent most REITs from any mispricing.

[89]*See supra* text accompanying note 30. Section 856(l)(3)(A) has remained unchanged since its introduction in the 1999 act.

[90]Per section 856(d)(7)(C)(i), ''services furnished or rendered, or management or operation provided, through an independent contractor from whom the [REIT] itself does not derive or receive any income or through a taxable REIT subsidiary of such [REIT] shall not be treated as furnished, rendered, or provided by the [REIT].'' If the intended TRS lost that status, however, this exception would no longer apply, and the amenities services would be deemed to be provided by the REIT and thus produce impermissible tenant service income. *See* section 856(d)(2)(C) and (d)(7). If the services provided represent more than a de minimis amount (defined in section 856(d)(7)(B) as more than ''1 percent of all amounts received or accrued during such taxable year directly or indirectly by the [REIT] with respect to such property''), then all amounts that the REIT received or accrued from the property are disqualified from rent from real property for purposes of the REIT gross income tests in section 856(c)(2) and (3). Only if the amount of those services performed by the failed TRS is 1 percent or less can the rent (other than that attributed to the impermissible service) be salvaged under this provision. *See* Rev. Rul. 98-60, 1998-2 C.B. 751, *Doc 98-35684*, *98 TNT 235-9* (illustrating 1 percent de minimis rule related to entire rent from building, not just rent from portion where impermissible tenant services were performed).

[91]*See supra* note 55.

[92]Section 856(c)(2) requires that 95 percent of a REIT's gross income come from qualifying sources, thus leaving room for only 5 percent of gross income from failed rental arrangements. For an otherwise qualifying REIT that fails to satisfy the 95 percent gross income requirement due to reasonable cause (and not due to willful neglect), a relief provision may be available but comes at the expense of a 100 percent penalty tax on the amount by which the REIT missed the 95 percent threshold multiplied by a fraction intended to reflect the REIT's profitability. *See* sections 856(c)(6) and 857(b)(5).

[93]Apartment REITs have sometimes ventured into independent living facilities, but they have generally exited quickly. For example, Associated Estates Realty Corp. acquired two congregate care facilities in the 1990s. Associated Estates Realty Corp., ''Annual Report (Form 10-K),'' *supra* note 66, at 2. It never acquired any more, and it soon decided to exit the congregate care business, although it was not able to dispose of its last facility until February 2007. Perhaps because the company was not in the senior housing industry, it continued to use the term ''congregate care'' instead of ''independent living'' even after adoption of the Standard Classifications.

[94]Because of the sometimes-blurred transition lines between the property categories, many healthcare REIT transactions simply list a total of assisted living and independent living properties, instead of breaking down the total. Thus, when

(Footnote continued on next page.)

facilities are part of the healthcare ecosystem, not part of the traditional rental housing ecosystem. Against that backdrop, the disparate tax status given to pure independent living facilities by LTR 200813005 — that is, status as other than a healthcare facility — necessitates different tax structures when a healthcare REIT acquires an entire portfolio: Whereas the bulk of the acquired portfolio is structured under paradigm four, the pure independent living facilities are typically structured under paradigm one, two, or three, in deference to the holding of LTR 200813005.[95] As a result, the acquiring REIT cannot easily achieve pooled management arrangements or pooled financings, and it must devote extra time and expense to a second structure with a different set of operating rules, increasing both the cost and the complexity of the transaction.

In sum, healthcare REITs need a clearer definition of healthcare facility — one that is consistent with the code's legislative history and industry definitions and is synchronized with the market for independent living properties, rather than in opposition to all those factors. Even then, however, there will still be a cliff effect under the code rules applicable to healthcare REITs when a captive TRS transitions from being an acceptable amenities services provider to becoming an acceptable affiliated tenant.[96] Moving pure independent living facilities to one side of the cliff or the other does not do away with the cliff — but the recommendations in the following part will.[97]

V. The Way Forward

Current law has created a zone of uncertainty around pure independent living facilities, both because the definition of healthcare facility is unclear and because the code contains a cliff effect between the captive TRS as acceptable amenities services provider and the captive TRS as acceptable affiliated tenant. To replace the zone of uncertainty with a zone of certainty, two steps are necessary. First, the IRS should clarify, consistent with the analysis in Part III.B above, that the term healthcare facility includes pure independent living facilities. Right now, LTR 200813005 appears contrary to legislative history, industry definitions, and market dynamics, and it is time for the IRS to correct course.[98]

Second, either Congress or the IRS should remove the cliff between a captive TRS as acceptable amenities services provider and a captive TRS as an acceptable tenant and replace it with a gentle slope whereby pure independent living facilities may be owned and leased, at the REIT's option, either under paradigm three (REIT leases rooms directly to residents and uses a captive TRS to provide amenities services) or under paradigm four (REIT

Ventas Inc. announced the acquisition of Nationwide Health Properties Inc. on February 28, the transaction included almost 300 independent living and assisted living properties, and the transaction press release combined the two groups into the category ''seniors housing'' without giving specific numbers of properties in each category. Similarly, when Ventas acquired Atria Senior Living Group Inc. in May, the transaction press release merely specified that 118 senior living communities were acquired, without giving a precise breakdown among independent living, assisted living, and memory care facilities.

[95]Currently, some healthcare REITs are acquiring senior housing assets from corporations that are organized in an ''OpCo/PropCo'' structure, in which the operating subsidiaries (OpCos) manage the properties and the property-owning subsidiaries (PropCos) own the facilities. In those deals, the REITs generally acquire the PropCos, while the OpCos survive (perhaps via a pre-acquisition spinoff) and manage the facilities under paradigm four. However, under current guidance, this structure does not work for pure independent living facilities. *See, e.g.*, LTR 201125013.

[96]The transition nature of pure independent living facilities is illustrated by the continuum shown in the Standard Classifications. Seniors apartments are simply regular apartment complexes with age restrictions limiting residency to seniors, while assisted living residences provide supportive care in most of their units to individuals who require assistance with activities of daily living (such as bathing, dressing, and eating) or suffer from Alzheimer's. The range between those two classifications — which is occupied by independent living communities — is enormous, and placing a sharp cliff anywhere in that range seems more like setting a trap. The TRS limitation in section

(Footnote continued in next column.)

856(l)(3)(A) applies to operating and managing a lodging facility as well as a healthcare facility, and so it creates a similar cliff regarding lodging facilities in the area between extended-stay hotels versus short-term apartment rentals. In those cases, it is unclear whether rooms are being used on a transient basis, which is normally the litmus test for lodging facility status. However, in this area, both Congress and the IRS have actively provided guidance to property owners to avoid problems related to that cliff. *See, e.g.*, *supra* note 53; Notice 2005-89, 2005-2 C.B. 1077, *Doc 2005-23766*, *2005 TNT 225-2* (lodging facilities will not be disqualified for temporarily housing persons affected by hurricanes Katrina and Rita through February 28, 2006); Notice 2006-58, 2006-2 C.B. 59, *Doc 2006-11924*, *2006 TNT 119-6* (extension of relief under Notice 2005-89 until August 28, 2007).

[97]As lawyers and other tax professionals well understand, the brightest of lines, on closer and more detailed inspection, are hopelessly fuzzy. *Cf.* Benoit B. Mandelbrot, *The Fractal Geometry of Nature*, 1 (1983) (''Clouds are not spheres, mountains are not cones, coastlines are not circles, and bark is not smooth, nor does lightning travel in a straight line''). It is simply not smart to have a cliff effect in the REIT tax law whereby an otherwise careful taxpayer may innocently and inadvertently find itself on the wrong side of the line.

[98]As this report was going to press, LTR 201147015, *Doc 2011-24753*, *2011 TNT 229-52*, was publicly released, in which the IRS concluded that an independent living facility with a modicum of health monitoring and health services to residents would constitute a healthcare facility. While this is a step in the recommended direction, the proposals in this report are much broader, particularly regarding removing the cliff effect.

leases entire facility to a captive TRS, which engages an EIK to operate and manage it), as discussed above in Part IV.[99]

Congress can legislate that result by amending section 856(l)(3)(A) to add an exception to the existing language, which would then read as follows:

> any corporation which directly or indirectly operates or manages a lodging facility or a health care facility (*other than a congregate care* (*independent living*) *facility)*. [Emphasis added.]

By removing the threat of TRS disqualification for providing operations and management at pure independent living facilities, this proposed amendment would confirm the efficacy of paradigm three. If necessary or desirable, the proposed amendment could also include legislative history that pure independent living facilities are within the meaning of healthcare facilities for purposes of section 856(d)(8)(B), (d)(9), and (e)(6), thus confirming the efficacy of paradigm four.[100]

Until Congress acts in the manner recommended, the IRS can issue a revenue procedure or similar guidance under its authority in section 856(c)(5)(J)[101] to achieve comparable results for all practical purposes. Specifically, the IRS could provide that a REIT may own and lease pure independent living facilities, at the taxpayer's choosing, either in the manner prescribed by paradigm three or by paradigm four, and that either way the associated rental income will be treated as qualifying income for purposes of the REIT gross income tests.[102] While this report envisions the proposed IRS relief as being permanent, the guidance could also be employed temporarily as transitional guidance to assist those REITs that have adopted paradigm three in reliance on LTR 200813005 to transition to paradigm four or some other paradigm if independent living facilities have been subsumed within the definition of healthcare facilities.

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[99]This proposal permits existing healthcare REITs that have employed paradigm three in reliance on LTR 200813005 to continue to employ that paradigm if they so choose.

[100]Given the zone of uncertainty under current law, some REITs will prefer or adopt paradigm three for their independent living facilities, while other REITs will prefer or adopt paradigm four for their independent living facilities. A legislative amendment that creates space for both paradigms is thus preferable. Also, space for both paradigms confers upon REITs the ability to make safe choices when dealing with facilities at or near the new boundary lines. A REIT with a facility that is on or near the cusp of independent living facilities and traditional rental housing (*e.g.*, a senior apartment complex with a high level of service amenities) can safely choose paradigm three for that facility and know that it will work whether that particular facility is a healthcare facility or traditional rental housing. Conversely, a REIT with a facility that is on or near the cusp of independent living facilities and other healthcare facilities (*e.g.*, an independent living facility licensed to have some units operated on an assisted living basis, but not having any of those units occupied by assisted living residents) can safely choose paradigm four for that facility and know that it will work whether that particular facility is an independent living facility or is instead another form of healthcare facility (*e.g.*, a mixed-use facility). Thus, while the recommended proposal creates two new cusps in place of the one cusp under current law, it eliminates the cliff effect, whereby a taxpayer must choose between paradigms three and four for facilities at or near the one cusp, and cannot make that choice safely.

[101]Section 856(c)(5)(J) was added by RIDEA and provides that the Treasury secretary (and, by delegation under section 7701(a)(11), the IRS) has the authority to determine, solely for purposes of the REIT gross income tests under section 856(c)(2) and (c)(3), whether an item of gross income may be treated as qualifying income or may be excluded from income for purposes of the REIT gross income tests. It "does not affect the substantive characterization of an item as income for purposes of computing the REIT's taxable income." JCT, "Technical Explanation of Division C of H.R. 3221, the 'Housing Assistance Tax Act of 2008,'" JCX-63-08 (July 23, 2008), at 48 n.63, *Doc 2008-16214*, *2008 TNT 143-9*.

(Footnote continued in next column.)

[102]Section 856(c)(5)(J) provides relief only for REIT gross income test purposes and not the REIT asset tests of section 856(c)(4). *But see, e.g.*, LTR 201122016, *Doc 2011-12030*, *2011 TNT 108-23* (eminent domain claim also excluded from REIT asset tests). Therefore, any TRS relying on that type of revenue ruling or revenue procedure might not be treated as an actual TRS for REIT asset testing purposes. Instead, the purported TRSs would be treated differently depending on the level and nature of the REIT's ownership in the disqualified TRS. Under section 856(i)(2), a corporation wholly owned by a REIT that was not a TRS would become a disregarded entity under the REIT rules, resulting in a modest amount of non-qualifying assets being included directly in the REIT asset testing. Meanwhile, the equity interests of a corporation not wholly owned by a REIT that was not a TRS would be treated as securities, creating a set of potential REIT qualification issues under the "5-10-10" REIT asset test limits for securities under section 856(c)(4)(B)(iii). Finally, a purported TRS's failure to qualify — on account of operating or managing a healthcare facility — would presumably serve to similarly disqualify a second TRS that owned equity in the failed TRS, and so on up a chain of TRS ownership. *See* section 856(l)(3)(A) ("directly or indirectly" operating or managing a healthcare facility or a lodging facility is grounds for disqualification). Under that provision, an otherwise qualifying TRS that owned even a little bit of a company that operates healthcare property apparently would lose its status as a TRS. However, in LTR 201129031, *Doc 2011-16000*, *2011 TNT 142-28*, an otherwise qualifying TRS was permitted to own total securities in a healthcare facility operator (through some combination of equity investment and loans) possessing as much as 35 percent of the total voting power of the operator and having a value of as much as 35 percent of the total value of the outstanding securities of the operator without losing its own TRS status; *see also* LTR 201139005, in which a TRS was permitted to own a limited partnership interest in a lodging facility operator without being treated as operating or managing a lodging facility. The lesson here is that a REIT must best structure its ownership in a questionable TRS so that even a failure of the TRS to so qualify would not also jeopardize the qualification of the REIT or another TRS.