Moderating Risks of CCRC Living

THE ROLE OF STATE INSURANCE DEPARTMENTS IN CONTINUING CARE RETIREMENT COMMUNITY OVERSIGHT

A White Paper inspired by an RFP from the Washington State Office of the Insurance Commissioner

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How Aging America lives

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Sponsor ActionAging.com seeks to create an Age Friendly America for today's generation of elderly, for the coming generation to follow, and for subsequent generations.

No one should be diminished in their self-determination merely because they are visibly older or because they have taken up residence in a communal setting.

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1. Introduction

In July 2010, the Federal Government Accountability Office published an inquiry titled, *"Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk."* The Senate Special Committee on Aging then held a hearing, concluding that action was needed, but that the responsibility was with the states, not with the Federal government. With that, the initiative ended. Since then, the GAO inquiry sits on office shelves, gathering dust, largely unheeded.

This introduces a white paper inspired by a Request for Proposals (RFP) from the Washington State Office of the Insurance Commissioner (OIC). The RFP is responsive to the perception that CCRCs are risky. The intent of this paper is to provide perspective to the promulgators of the RFP and to other parties who may have an interest in the financial strength and contractual integrity of CCRCs.

The RFP specifically states as its purpose an inquiry into "a system of shared regulatory oversight" consistent with established practice in other states. This white paper goes beyond that narrow purpose to look at parallels between CCRC undertakings and insurance undertakings and to consider how lessons from insurance might give CCRCs a record of trust comparable to that of insurance companies.

This material is not without controversy. The challenge with the RFP approach is that most of those who might submit proposals have a financial interest in the CCRC industry that could distort the response. Moreover, the time allowed for the project and other circumstances make it problematic.

This paper addresses the topic through the eyes of a resident who is also an actuary. Thus, this material carries a consumer protective bias. While the industry has several trade associations, none of them give more than token representation to the resident perspective. Very few CCRCs give residents an ownership stake. As far as the author knows only one CCRC enterprise allows residents to be members in the nonprofit corporations which dominate the industry.

Most nonprofit provider corporations have no members, or in the case of nonprofit holding company structures, only a sole corporate member, i.e., the parent nonprofit. That leaves residents with little say and few financial or contract protections. Nonprofit CCRCs and closely-held for-profit CCRCs are self-governed by the executives and their boards. There is little accountability beyond nominal oversight by state attorneys general or by state-level secretaries of state.

The Washington State OIC RFP stated: "This project is designed to assess federal and state authorities regulating continuing care retirement communities (CCRCs) and provide a report with recommendations on creating a legal framework for shared regulatory oversight of CCRC products under Chapter 18.390 RCW, which may achieve heightened consumer protections."

The project deadlines were extremely tight. "The Contractor will complete their study and submit their final report to OIC no later than October 1, 2022. OIC will submit a report on the Contractor's assessment and recommendations to the health care committees of the legislature by December 1, 2022."

The survey of existing Federal and state "authorities" is readily available from industry trade associations and some law firms, including Hanson Bridgett, a law firm with many CCRC industry clients. The centrality of the OIC in the RFP suggests that an unstated core question is whether the Washington State OIC should assume a role in regulating CCRCs consistent with its expertise, capabilities, and resources.

This white paper probes that question among other matters. The parallels between the history of CCRCs with that of the insurance industry, particularly the life and annuity insurance sector, is compelling.

Is there a role for the OIC in regulating CCRCs? Yes. Will the legislature fund and support the OIC in assuming that role? Unknown. Can the OIC use its experience and expertise with insurance industry regulation to inform CCRC oversight? Absolutely. Do incoming residents in CCRCs understand the risks? Most do not.

The gist of this paper is to take a deep look into how regulation of CCRCs comparable to that of life, annuity, and health insurance companies could make the benefits of CCRC living more secure for residents, better suited to the residents need for the ongoing benefits of self-determination, and thus more acceptable for the public. This is consistent with the shared regulatory oversight framework toward which the State of Washington aspires.

Financial soundness means raising minimum standards to those of insurance companies, which is above and beyond the negative net asset diversion of contract cash considerations (entrance fees) which is common in today's CCRC industry. This higher standard of trust will not be easy for the industry to achieve, but it can be done, and the industry will benefit from greater popular trust.

Let's get started.

About the author: John B. "Jack" Cumming, CASP, CLU, ChFC, FSA, MAAA, believes that the senior living industry is essential to America's response to an aging population. He's convinced that the industry will thrive by better responding to the reasonable expectations of residents.

Mr. Cumming's career was in the life and health insurance industry. He is an actuary by training, while his education was as an historian. One of his insurance responsibilities was on the qualification committee for licensed salespeople of the New York Insurance Department, while another was to advise the New York Insurance Department on the rehabilitation of financially troubled life insurance companies.

Since moving to a California CCRC in 2006, he has become active in senior housing, including qualifying by examination as a Certified Aging Services Professional.

2. Origins and History

There are many parallels between the history of the insurance industry, especially life and annuity insurance, and the CCRC industry. Those parallels can inform consideration of the role that insurance departments might play in a coordinated system of shared regulatory oversight. We'll start with that history.

Historical Parallels.

Life insurance origins are often ascribed to the founding on January 11, 1759, of the "The Corporation for Relief of Poor and Distressed Widows and Children of Presbyterian Ministers" (later the "Presbyterian Ministers Fund for Life Insurance.") Its initial purpose was recently described as "… a benevolent fund to support the people spreading the message of God."

Homes for the Aged, as the IRS likes to call CCRCs had a similar faith-based origin in 1823, 64 years later. The founders of Philadelphia's Indigent Widows' and Single Women's Society wrote that "through the indulgence of Divine Providence" they "preserved many who once lived respectfully from becoming residents of the Alms House."

Life insurance as a business began to be a consumer-oriented force later in the middle of the 19th century. More than a century later, the CCRC industry's success in having the IRS issue Revenue Ruling 72-124, resulted in what we know as today's "market-based" CCRC.

Although the life insurance industry found its growth through the mutual form of organization, in which policyholders were the ultimate governing force, the IRS authorization allowed the CCRC industry to grow through nonprofit organizations in which state attorney's general are the somewhat distant ultimate governing force.

Historical Reflection.

History shows that, what are now called CCRCs, began as covenantal communities with a variety of faith-based and other sponsors. From that community-fostering beginning, it has evolved

gradually and by nearly imperceptible stages into more of a business, seeking to avoid risk and liability, to grow revenues, and to expand into larger and larger enterprises.

Recently, the CCRC industry, after a long marketing study, has tried to rebrand Continuing Care Retirement Communities as Life Plan Communities (LPCs). Market research showed that words like “care” and “retirement,” as descriptive as they may be, were no longer popular with prospective residents.

There is a widespread public perception that nonprofit CCRCs are more consumer protective than are for-profit operations. The evidence, though, shows that both non-profit and for-profit operators are capable of admirable service while other operators are motivated by greed and personal aggrandizement. The public interest challenge is to encourage best practices and to discourage or eliminate those who take advantage of the gullibility often found among older people.

Covenantal vs. Contract Communities.

With their origin in affinity organizations such as churches or fraternal orders, the early CCRCs were covenantal. That is, civic-minded members came together to pursue the possibility of forming a home for safe and secure aging. Some of those were more faith based than soundly rooted in commonsense business practices.

Aging is accompanied by increasing risk of physical or mental decline, so it was a matter of course that such grassroots communities hired experts, nurses, and other specialized staff to carry out the communal mission to house the elderly. With increasing professional management, covenantal communities evolved into staff managed enterprises with contracts of adhesion to limit risk to the enterprise and to contain resident dissatisfaction when, and as, it arose. The rationale was that contracts made clear from the outset what the members of the community could expect.

Thus it was, with time, that commonality of purpose between residents and those who managed the community diverged into managers – who worked for the evolving business organizations –

and residents – who increasingly were viewed as customers acceding to the business's practices as the condition for their residency.

It is that divergence that has led to the existing tension between the expectations of residents and the business interests of those who house them.

This white paper seeks to find a way back toward that shared vision of healthy aging with purpose and meaning in a safe and secure home. That home may be a collective home, or it can be an individual home, or it can be a dispersed community configured to make aging safe and fulfilling.

3. The Expertise of Insurance Departments

This section addresses the special, applicable expertise that insurance departments have that other departments of state government generally lack. We should quickly add that mere expertise is not sufficient. Agencies of government, like the OIC, need statutory authority and budgeted resources to fulfill their potential even as it is assigned to them as a mission.

Special Expertise of Insurance Departments.

Many states already assign primary regulatory responsibility for CCRCs to the states' insurance department, though other states place regulation within departments of social services, departments of aging, departments of public health, or combinations of departments, reflecting the life affirming business commitments of the CCRC model of aging citizens.

The ideal would coordinate the expertise that each department should be expected to have within its functional structure to ensure a sensible, uniform regulatory structure for CCRCs. There are specific capabilities, however, for which insurance departments are uniquely suited.

> Contracts: Insurance Departments generally have expertise in reviewing insurance company policy forms, which are contracts of adhesion not unlike the lifetime contracts of adhesion commonly offered by CCRCs.
>
> Insurance policy forms must be approved before use in most states, though many states rely on the state of domicile of the insurer to take the primary lead in reviewing contracts and suggesting changes. Most such contract requirements, including standard policy provisions and required phrasing, are intended to protect consumers from overreaching corporate interests.
>
> The intensity of insurance contract scrutiny has varied over time. Click here for an in-depth article discussing the review of insurance contracts. Thus, contract review capability is an expertise that insurance departments can bring to CCRC oversight if the

legislature gives the departments statutory authority comparable to that given them for their insurance oversight function.

Finances: Ensuring that insurance companies have sufficient capital to accept the risks that they market to the public is one of the primary tasks for insurance departments. To carry out these responsibilities many insurance departments employ actuaries and financial examiners or have access to such competencies.

The insurance department's authority and abilities include uniform statutory accounting standards and forms (aka "blanks") expertise as a reliable guide to require corrective action for enterprises that are drifting into financial difficulty; and qualified staff, or other resources, to take control in receivership of enterprises that the Insurance Commissioner deems that the policyholders and creditors will be best served by intervention. Click here for information about that process.

CCRC residents now have no such protection. The result may be that the regulators are helpless to intervene effectively as the magnitude of the insolvency continues to deepen. That was the case years ago with Pacific Homes and recently with Air Force Village West, both situated in California.

Guaranty Law: Policyholders of insurance companies are sheltered from having to bear as general creditors most of the effects of financial mismanagement and failure. This is accomplished through Guaranty Corporations in every state including the Washington Life & Disability Insurance Guaranty Association, which was created by the Washington legislature in 1971. These laws provide the industry incentive and means to advise the insurance department on early intervention to minimize losses when an insurer shows signs of deteriorating financial condition or unsound practices.

CCRC residents have no such protection, and as alluded to above, the results can be devastating for those who entrusted entrance fees and more to a CCRC enterprise. In most cases, the residents are considered fortunate if they are able to continue living in the afflicted CCRC, though there is no guarantee that even that can be possible.

Interstate Cooperation. Insurance regulation would never have become as effective as it is if it weren't for the National Association of Insurance Commissioners (NAIC). The NAIC is an alliance organization among the states. The insurance commissioners are the members. This cooperative alliance began in 1871 with the development of uniform accounting and financial reporting. That avoided the conflicts of interest inherent with private audit firms.

That beginning evolved into an apolitical organization to provide insurance departments with the expertise that they need to carry out their mission deliberatively and in the public interest. The NAIC pools resources to provide insurance regulators with access to expertise, model laws, regulations, and practices. These are developed by staff with input from all stakeholders at recurring NAIC meetings, which occur generally three times a year. For instance, the NAIC will meet in Seattle from August 13th to 17th, 2023.

The originating purpose of the NAIC was to make insurance trustworthy and to ensure that deferred promises could be kept. Objective government accounting and examination ensured that insurance companies would steward funds so that promises made would be promises kept.

More than 100 years later, that originating purpose was strengthened with the development by the NAIC of The Life And Health Insurance Guaranty Association Model Act and the formation of The National Organization of Life and Health Insurance Guaranty Associations (NOLHGA). Insurance policyholders can now rely on insurance company commitments.

CCRC residents lack such assurance. There is no such national regulatory organization for CCRCs, though they could become part of the NAIC structure if the insurance commissioner members agreed to do so. Instead, the industry trade associations claim to speak to the regulatory needs though they include only providers and with at least one such trade association narrowly limited to only tax exempt providers. CCRC residents have had no practical voice.

These are the resources and expertise that can bring the same level of consumer trust to CCRCs as that which has long enabled insurance to thrive. When someone pays a premium to an insurance company, they have reasonable assurance that valid claims will be paid when the time comes. CCRC residents deserve the same assurance.

To enable insurance departments to do what they do so well, ranging from assuring principled accounting curated by government authorities to fair contracts and to guaranties that even rare defaults will be avoided, statutes and budgeted resources are needed. The resources can be funded, as they are for insurance, by levies specific to the industry that benefits from sound regulation. In a later section, we will consider statutory alternatives.

4. Principles and Fundamentals

In the opening sections of this paper, we've detailed a brief history of comprehensive, age-specific housing for older Americans. After its earliest beginnings, the industry evolved into a business from a grassroots covenantal start, often among church members, to ensure security in old age. As a business, the care and housing model became a centrally directed enterprise with professional executives, trained staff, and residents as three essential elements.

There are many parallels between the history of life and annuity insurance and that of CCRCs. State insurance departments have many skills and resources that might apply to CCRCs as they now apply to life and annuity insurers. In this section we consider whether there are principles that should apply to CCRCs much as our nation's Declaration of Independence (and the Preamble to the Constitution) declared principles for the new American nation.

Principles.

Great undertakings begin with high minded principles. Those undertakings, as they evolve into industries, then either put in place mechanisms, including regulation, to maintain those principles, or the visionary beginning may be superseded by a new, less salutary vision.

Thus it was that the life insurance corporate failures of the 1870s, and the excesses of some large insurers, led to the Armstrong Investigation of 1906 and over time to the well-regulated industry that life insurance is today. CCRCs are now at that crossroads either to restore and maintain high-minded principles or to devolve into something else.

Specifics.

We consider these principles to be self-evident concepts of fairness in a justly regulated society.

1. Any continuing care community should be fully licensed and qualified to provide the continuing care that it appears to offer.

2. The financial and physical security of the residents, as the weaker, and trusting, parties, is essential.

3. Encouraging sound growth of the CCRC industry to help older people to continue to contribute to society and to lead purposeful lives is a positive public benefit.

4. Those enterprises that can afford to pay their fair share of taxes should do so.

5. Contracts should be crafted to ensure a reasonable meeting of the minds without unfairly disadvantaging adhering residents.

6. Enterprises that prove themselves trustworthy should be more lightly overseen and scrutinized as long as they maintain that status.

7. The trust nature of continuing care contracts, and the declining capacities of the residents during residency, should obligate those who provide services to put the interests of customers before what they may believe their own corporate or individual interests to be.

There might be more but these seven are a good start.

Covenants, Compacts, Contracts, and CC&Rs.

There are many concepts for how people affiliate with each other. At one extreme are voluntary covenants, like the Mayflower Compact or the U. S. Constitution, by which people affiliate as equals for their shared common good. At the other extreme are contracts of adhesion by which a powerful party offers goods or services to others with the more powerful party's preferences a precondition to the offer.

With adhesion contracts, the accepting party is at a disadvantage and has no opportunity to revise the contract to reflect implied promises that may have led to the acceptance. For practical reasons, i.e., mass solicitation and distribution, insurance policies are contracts of adhesion. For less pressing practical reasons, and with greater consequences for the accepting parties, CCRC Residential Agreements are also contracts of adhesion.

Few residents read the contract, much less understand all its implications, since they can't change it even if they do read it and grasp its nuances. They accept in good faith that the offering party will deal fairly with them, and most organizations believe that they do. That belief extends even to good intentions when new written contracts are introduced with providers often acting as though all residents had similar contracts and overlooking differences between contract editions or marketing promises that may have been made to induce contract acceptance.

A common perception, among non-legal administrators and residents alike, is that the whole operates as a mutual covenantal undertaking with the administrators setting the rules, and changing them from time to time, to meet corporate objectives and to accord with management's perceptions of the needs of the community as a whole.

The problem is that a governance structure, in which one set of interests – those of management – take precedence in law or in fact over those of other stakeholders, is not at all a community of mutuality. It's no more than a business. In that, it is less communal than the other forms of organizational documents cited in the title, namely, covenants, compacts, and homeowner association CC&Rs. It's just a one sided contract to protect the interests of the power party with other stakeholders dependent on the good will of that power party.

The Residents' Plight.

As an example, residents who are retrospectively critical of their own decision to take up residence in a CCRC, are often reluctant to share their concerns for fear it may adversely affect occupancy resulting in elevation of their own fees. They fear that diminished occupancy will result in higher fees as enterprise costs will need to be spread over a smaller base of residents. Thus, residents tend to avoid sullying the reputations even of the least savory of CCRCs.

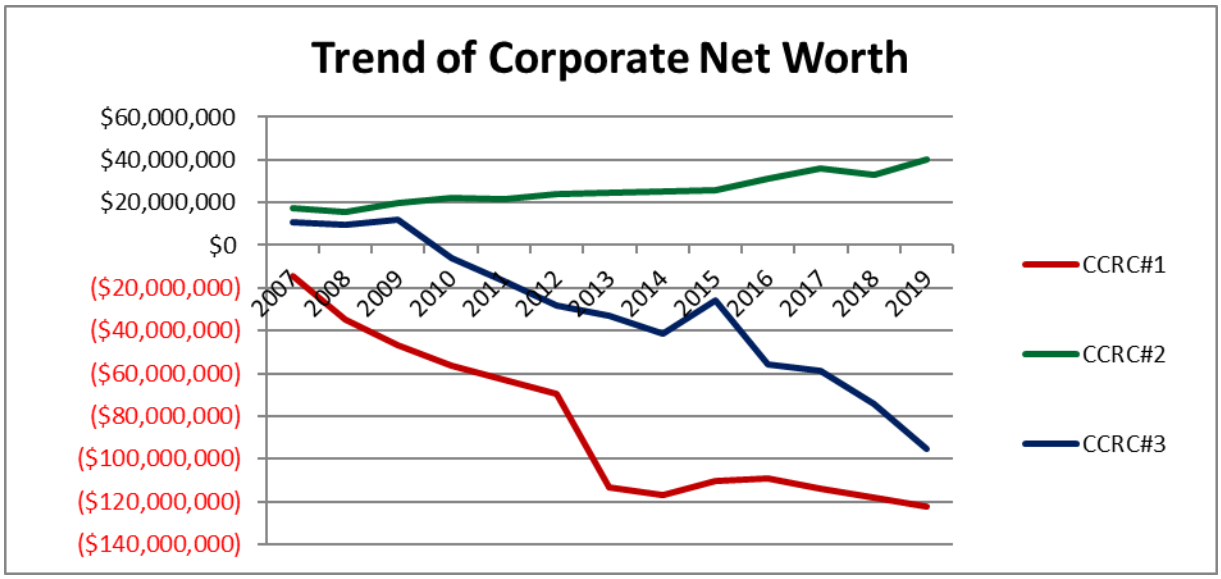
That outlook reveals a common resident anticipation that the enterprise will operate cooperatively. It's common for residents to overlook that there may be other interests – often corporate interests – seeking enrichment beyond the fair cost of providing the promised services. Residents may also fear that utterance that displeases those in power may result in

retaliation in the form of expulsion or in the withholding of needed services or delays in the provision of services.

Thus, the industry has moved from a covenantal model toward a contractual model in which a naïve buyer has little recourse if the buyer makes a bad deal in accepting the proffered contract. In the next section we'll delve into what those contracts – contracts of unalterable adhesion – have become.

How Are Residents Impacted by Today's CCRC Business Model?

The power imbalance between providers and residents has resulted in financial results that are often contrary to the residents' best interests. For instance, here is the trend of GAAP net worth for three downtown Seattle CCRCs. The source is the latest IRS Form 990s for each enterprise.



Intriguingly, CCRC#2 with its positive results is also considered to be the most inclusive of residents in its governance and decision-making practices. This is a disturbing financial picture and one that should concern officials who are responsible for the public welfare and for openness in contracting.

5. One-sided Adhesion Contracts

Heretofore, in this multi-part paper, we've laid the foundation for how insurance departments might fit within a smooth, positive, continuous framework for shared regulatory oversight of CCRCs. In this part, we delve into the nature of the contracts that have emerged in the course of business for CCRC residents.

Fair Contract Approvals.

Many insurance departments have competent capabilities to review insurance policy forms and to act so that consumers are not disadvantaged. They are guided by fair contract laws, regulations, guidelines, and practices in enforcing standards to ensure that an inexpert public is not unfairly disadvantaged.

While some states now require that CCRC contracts be filed with the authorities, there are no general standards to ensure consumer fairness. Also, there is no standardization. Consumers have no guidance as to what they might expect when they move into a CCRC.

Moreover, unlike the situation with CCRCs, the sales people who market insurance contracts must be licensed. Generally, insurance agent licensure requires instruction in the fair presentation of information. Insurance Departments have the expertise to bring similar standards of fairness (and safeguards for trusting consumers) to CCRC contracts as they now do for insurance policy forms.

Realities Common in Today's CCRC Contracts.

To examine how the existing undisciplined CCRC contracting structure might be rethought to better reflect reasonable consumer expectations, I'll use as a contract model, the "Model Residence & Services Agreement" offered for sale by the American Senior Housing Association. Since there are no regulatory standards for CCRC contracts, as there are for life and health insurance contracts, this "Model" is as close to a standard as we can come. Click here for a discussion of how insurance policy form regulation has evolved.

Here are some noteworthy provisions in the CCRC "Model Contract" that would likely be prohibited in life and health insurance adhesion contracts.

Unilateral amendment by provider: "You [resident] agree to be bound by all the policies, rules, and regulations of the Community, as they now exist or as they later may be amended. You hereby acknowledge receipt of a copy of the current Resident Handbook of the Community, which is attached hereto as Appendix A." Needless to say, the Policies and Procedures Manual for a CCRC can be quite extensive and are seldom available to residents, nor would residents be expected to be aware of policy changes until they are impacted.

Residents' Rights Limited: "Operator will endeavor to be responsive to the suggestions raised by the Residents' Association."

Financial Subordination: "Your rights under this Agreement are and shall be subordinate to the rights of a secured lender under any mortgage, deed of trust, or other senior security interest that is placed on Operator's property, now or in the future."

Residents' Disclosure Obligation: "Throughout the term of this Agreement, you agree to give Operator, upon request, information about your financial condition including, without limitation, financial statements and tax returns."

Mandated Single Arbitrator: "Both parties give up their constitutional right to have any such dispute decided in a court of law before a jury, and instead accept the use of arbitration." This requirement favors the more sophisticated party over the less sophisticated.

Attorneys' Fees: "Generally attorneys' fee clauses are not common in this kind of agreement as they tend to favor a plaintiff suing for alleged deficiencies in the performance of services." The aim of drafting party is to favor defendants over plaintiffs, who are likely to be residents.

Vanishing Lifetime Commitment: "Operator may terminate this Agreement at any time, for good and sufficient cause, by giving you _____ (__) days' written notice, unless both parties agree to a shorter notice period. Good and sufficient cause shall include, but not be limited to, the following: …

(b) Needs Beyond Operator's Capacity. Your need for care or services that Operator is not licensed to provide or does not routinely provide;

(c) Violation of Community Rules: You or your guest's failure to abide by the rules and regulations of Operator, as contained in the Resident Handbook (Appendix A) as it now exists or may later be amended, or as otherwise communicated to you."

Legal Technicality: The "Model Contract" requires accepting residents to "warrant that all information contained in these attachments [application documents] is true and correct, and you understand that Operator has relied on this information in accepting you for residency at the Community." Since residents can't know, for instance, of wrongdoing at, say, a brokerage with the resident does business, e.g., Bernard L. Madoff Investment Securities LLC., the common regulatory practice for insurance contracts require only that adhering parties only provide information "to the best of knowledge and belief." No resident could be expected to warrant information given by a fraudster such as Mr. Madoff.

From this cursory review of a "Model" contract, it is evident that there is no equity between providers and residents in the existing contractual model of community regulation. In fact, it is a stretch to use the term "community" for what is provided, though the residents may form a community among themselves after they commit to residence. Even when residents do form such a community, it is relatively powerless compared with the overwhelming authority of the management.

6. Fair Compacts For Residents

In the previous section of this paper, we looked at a model contract that is as close as the CCRC industry comes to having a "typical" contract. It's evident that without the kind of strong oversight that insurance departments bring to policy forms reviews, the industry is free to draft contracts that benefit enterprises – for-profit or nonprofit – to the detriment of the residents they serve. The nature of the lifelong dependency on the good faith of the provider calls more for what we might call a compact of mutuality rather than a one-sided contract to benefit management and owners.

Anomalies.

Without much oversight, it's not uncommon for residents to be expelled (either counseled to leave or evicted) when they are at their most vulnerable. For instance, a CCRC may promise a home for life, but it may not be licensed for memory care. Residents who decline cognitively may then be required to leave. Imagine how bewildering that can be for those affected. Such actions by a CCRC management can seem heartless, and they are.

Still, there is no requirement that CCRCs be fully licensed to provide the lifetime residence they appear to offer. In this part, we consider what might be done. In a later section we'll discuss alternative potential legislative approaches to address distressing situations like this.

An Ethical Challenge.

As a starting point, we observe that it's intuitively obvious that CCRCs that don't offer a Type A (care inclusive) contract can have a conflict of interest when a resident who occupies a high value residential unit begins to show signs of age-related cognitive decline or even high acuity frailty. Transferring the resident out of the unit, makes it available for "resale" bringing in a large cash infusion in the form of the entrance fee.

CCRCs vary widely in what they promise and in financial practices. Few consumers shopping for the haven that CCRCs promise to provide for safe aging are aware of these variations and the material impact they can have on the cost and security of what they are undertaking.

Fair Comparisons.

Consumers could benefit from some uniform baseline, common to all CCRCs, that they could use to compare the cost/benefit tradeoffs from CCRC to another and from one market offering to another. To achieve that all CCRCs would be required to offer at least one contract option common to all.

As is true with insurance contracts that offer options, financial options of what's included and what requires an extra payment can mostly be financially equated to achieve neutrality. For instance, actuaries and other finance professionals, skilled in life contingencies and the mathematics of finance, can determine stochastic equivalencies (actuarial equivalency) among bundles and among refund options.

Contract Options.

Generally, for insurance the pricing of options is actuarial. Many CCRC leaders have been skeptical of actuarial analyses. Click here for one knowledgeable CCRC regulator's view of why that is so and, in general, why CCRC regulation is as weak as it is. Moreover, to allow CCRCs to offer financial equivalent options without practical risk requires a reinsurance market and CCRCs have not participated in reinsurance. If this lack of industry expertise were remediated, then it is possible for the industry to coalesce around a standard contract which consumers could use to make valid comparisons.

Whether this is something that the industry could accomplish through a rating system of best practices, or whether it would require legislation, is a matter of policy.

Rewarding Trust.

A sound oversight system maintains fairness between the interests of enterprises and the customers on whose patronage they depend. Sound regulatory enforcement interventions prevent practices that verge on the fraudulent, even if they don't cross statutory or legal lines, or that unjustly take advantage of customer gullibility.

Insurance Departments are versed in making these distinctions. Insurance regulators spend more time trying to save and rehabilitate faltering insurance companies than they give to the well-established, professionally managed insurers. Likewise, insurance regulators focus on those insurance enterprises that provide very little value to consumer, say, a safe drivers' accident policy with a 10% or less loss ratio, thus leaving 90+% of revenue to profit, than they do to a customer committed old line mutual insurance organization.

This regulatory discernment and distinction is more common in insurance regulation than for many other regulatory undertakings in which uniform regulatory oversight is a guiding principle. Thus, a system that gives closer scrutiny to "bad actors" than to firms of proven trust can respond to the implied aim of the Washington State regulators to find what they believe to be a "a legal framework for shared regulatory oversight of CCRC products under Chapter 18.390 RCW." Chapter 18.390 RCW is the Washington State statute now governing Continuing Care Retirement Communities.

Takeaways.

Thus the most compelling reason for the State of Washington to take the lead with its own legislature and, nationally, with the NAIC, is the need:

1. to empower consumers to be able to make wise choices;
2. to ensure that contracts are fair and mutual and not instruments of corporate aggrandizement;
3. to act so that deferred promises are properly funded and prudently reserved so that CCRCs can meet their obligations as they come due even under circumstances of enterprise discontinuance and liquidation;

4. to provide a means to ensure dependent residents that their lifetime expectations can be met without detriment even if the enterprise they trust falters and fails;

5. to ensure that consumers don't get so scrambled by contractual fine print and legalese that they encounter ouster late in life when expulsion can be deadly; and

6. to encourage CCRC enterprises to act as high-minded stewards of the best interests of the vulnerable aging residents who trust the enterprise with their care and well-being.

High-minded elements like these have made the insurance industry a trusted resource for people wanting to shield themselves from devastating contingencies. The CCRC industry similarly purports to enable trusting consumers to shield themselves from the potential devastation that can come unexpectedly with advancing age. It is wise public policy to make CCRC residence as trustworthy as is the much older insurance industry.

Wise legislation and easily understood consumer information can provide that boost to the industry. For now, consumers are often understandably skeptical though they may take those risks despite their qualms. Many consumers simply assume that the regulation is there to protect them. Consumers shouldn't have to take those risks. We need to find a way to make the CCRC industry what many imagine it to be and what it could become.

7. Fair Business Practices

In the previous sections of this paper, we looked at how contract-directed legislation, regulation, and enforcement might result in fairer contracts to balance provider interests with consumers' reasonable expectations. The sad truth, though, is that integrity cannot be legislated. Those who look for advantage can circumvent the equitable purpose of legislation by perfunctory compliance. Moreover, such lip service toward laws and regulations is not uncommon.

The Love of Money Creates Temptations.

Many older people have accumulated savings intended to secure their retirement years without having to be dependent on welfare, family, or other resources. Those savings may be in the form of pensions, tax qualified savings, home equity, or prudent investments. That creates a pool of money that can attract enterprises or schemes.

As we have seen throughout this white paper, sometimes the line between legitimate operators and profit-maximizing schemers can be blurry and difficult for even sophisticated consumers to discern. Even very well-intentioned operators can be misled by the representations of others who purport to be experts. One example is the widespread belief that it is okay to deplete the entrance fee contract consideration paid by residents allowing an enterprise to drift toward deepening insolvency. As Sir Walter Scott put it succinctly as long ago as 1808, "Oh, what a tangled web we weave, when first we practice to deceive!"

Developing and operating a CCRC calls for a high degree of personal integrity, whether it is a nonprofit funded by debt (generating large profits for the investment banking originators of the debt) or a for-profit funded by investors.

Fair Consumer Comparisons.

In the previous section we suggested standardizing around a universal contract offering, which would then give consumers a tool by which they could compare the value of alternative CCRC offerings. We suggested the full care inclusive "Type A" as best suited for that purpose.

Before 1972, when nonprofit CCRCs were still charitable in the conventional sense of depending on charitable donations, Type A ("life care") contracts were the norm. Later, narrow-minded business interests gradually replaced comprehensive contracts as executives and boards shifted risks away from corporate providers and onto unsuspecting residents, many of whom had no way of fully grasping the significance of the shift.

Standardization.

Just as MedPac has been moving Congress to specify standard plans for Medicare Supplement and similar plans sold to aging Americans, standardization can bring lucidity to the CCRC marketplace. The most generous, full care inclusive (Type A) contract is the obvious starting place for standardization. Deviations from that standard can then be offered to meet the individual needs of prospects with the requirement that the options be actuarially equivalent just as is now required for Medicare Advantage plans.

It's a Business.

IRS Revenue Ruling 72-124 grants "homes for the aged" Federal tax-exempt status regardless of profitability or charitable purpose provided they meet three "needs" of older people. These are the need for housing, the need for health care, and the need for financial security. To these IRS denominated "needs," we might add the needs for life meaning and self-determination. Revenue Ruling 72-124 allowed a change from charitable CCRC undertakings.

Before "market-priced" tax exempt CCRCs for the affluent thus emerged fifty years ago, homes for the aged were dependent on charitable outreach to secure donations to provide for the needs of the residents. From that covenantal beginning, has evolved a business in which the money interests (debt procurement, expansion, risk avoidance, rate increases) often take precedence over what's best for those who have entrusted their lives to the care of the CCRC.

Marketing.

The public perception that CCRCs may be more business-driven than concerned for the welfare and well-being for residents has created a challenge for the industry in which trust in the good

faith of CCRC operators has dwindled. The public now overwhelmingly prefers to "age in place" rather than to face the uncertain prospects of institutionalization in a CCRC. CCRC managements have responded by stepping up the intensity of sales and marketing efforts. CCRC sales people are unlicensed, unlike the case with insurance agents and brokers.

A responsive regulatory structure can go a long way toward countering this popular mistrust and toward a greater reliance on reputation to attract new residents instead of the sales emphasis that has emerged. That will require legislation and an affirmative commitment by industry leaders and trade associations to elevating the residential experience, especially concerning fair contracts, secure financial standards, enforcement, and for open, honest disclosure of the true nature of what residents should expect.

Marketing standards are an area in which insurance departments have expertise. Insurance companies are subject to "market conduct" requirements. Click here for the current state of market conduct regulation of insurance companies. CCRCs can benefit from such consumer-reassuring practices and requirements.

Financial Security.

It seems so obvious that it almost doesn't need to be said that CCRC residents, many of whom sell their homes to invest their home equity in an unregulated entrance fee, are at least as dependent on trust as are life insurance policyholders. Life insurance policyholders have at least four safeguards – statutory accounting, minimum capital requirements, periodic independent insurer financial examinations, and guaranty law protections – that CCRC residents don't have.

Moreover, most CCRC residents have a bigger financial stake in the contracts of adhesion they sign, and they are less sophisticated due to the common inroads of old age, than are most life insurance policyholders. This is without considering the policyholder safeguards in effective policy form reviews, insurance department seizure and receivership capabilities, etc. which apply to life insurance and annuities but for which there is little or no counterpart for CCRC residents.

Takeaways.

The consumer-residents in CCRCs are vulnerable to misguided unregulated business practices and, yet, they have minimal financial and contract protections. As in an unregulated world, these aging residents are dependent on the integrity and good will of those who run the enterprises to which they have entrusted their wherewithal and their lives.

Gradually, slowly, the marketplace hears stories. Those stories of ineptitude, financial failure, and resident subordination erode trust. Not only would a sound system of regulation be positive public policy, but it could also help restore public faith in a industry that has succeeded in resisting all regulation, no matter how constructive it may be.

One might have hoped that conscientious business leaders, and their trade associations, would have made CCRCs a model of resident-serving and resident-empowering practices. There are CCRCs that meet that standard. Still, there is a need for oversight to eliminate exploitative (consciously or unconsciously) managements and to restore the reputation for integrity and trust that is the watchword for the CCRC industry.

8. Learning from Insurance

.

CCRCs have not been the only commercial response to the challenges of aging. There are other offerings, including financial products offered by licensed insurers, to address these challenges. In this section, we examine what the lessons of old age insurance products tell us about the challenges of the entrance fee CCRC residential aging living and care model.

Comparisons.

Typically, CCRCs offer lifelong residence and access to levels of care ranging from "independent" living, in which people theoretically need no more than minimal care services; assisted living (usually care needed for two or more activities of daily living); memory care; high acuity assisted living (an alternative to skilled nursing suitable for some chronic conditions); and skilled nursing.

Thinking of CCRCs in insurance terms suggests that entrance fees are tantamount to single premium annuities assigned to offset future recurring (monthly) fees. The care commitments are like guaranteed insurability contracts with assurance that care needs will be accommodated when and as they arise. Type A, full care inclusive contracts, offer uncapped, unlimited long term care insurance (LTCi) to supplement the housing and other benefits included.

Most recently, advisors to the CCRC industry have developed the Continuing Care at Home (CCaH) concept. CCaH is positioned to be similar to a CCRC but without the bricks and mortar residential living component. Some CCaH contracts, though not all, are developed by CCRC operators as ancillary to their residential contracts. In essence, by facilitating the delivery of care and other age-related services to contract holders in their homes, CCaH is like a specialized LTCi contract though no CCaH offerings are now provided by licensed insurers.

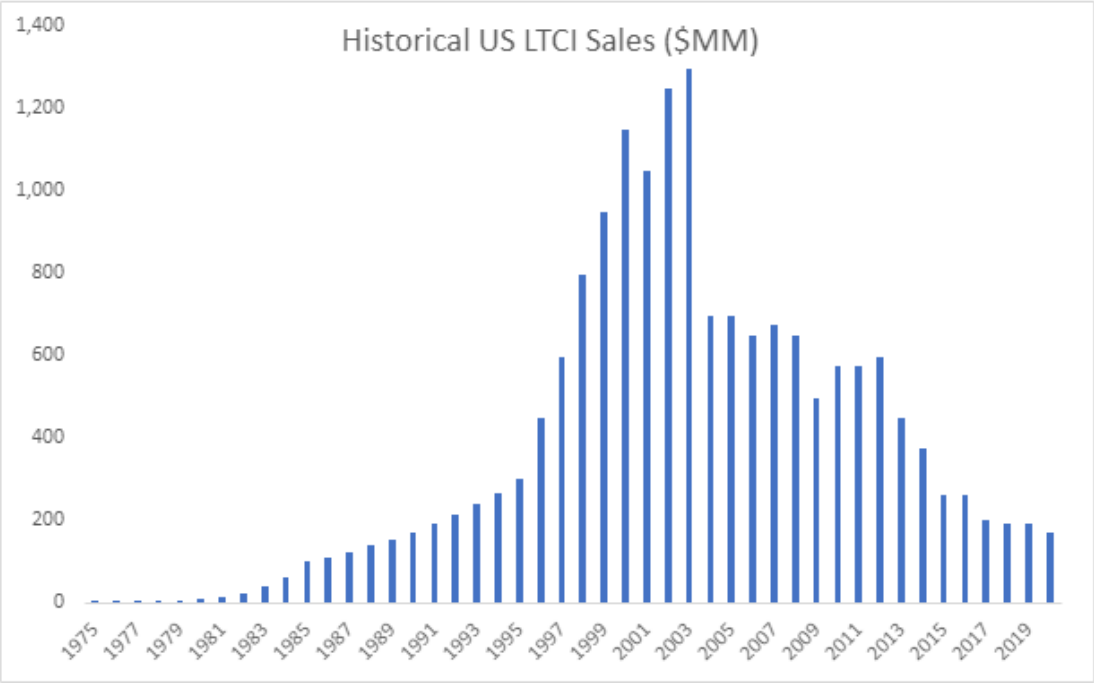
With that overview of the parallels between insurance products and CCRC-related products, we can consider what we can learn about CCRCs (and CCaHs) from the experience – regulatory and practical – with insured products, including particularly life annuities, LTCi, and health insurance for older people.

Long Term Care Insurance.

The insurance industry has offered long term care insurance (LTCi) over a period comparable to that of today's tax-exempt CCRC housing for affluent Americans as enabled by Revenue Ruling 72-124. The LTCi industry has struggled to develop products that prove financially viable. The shortfall of premiums relative to claims has required rate increases that can seem draconian.

Insurance departments with rate approval authority have struggled to balance the need for insurer financial adequacy against the natural consumer pushback against staggering rate increases (or benefit reductions). These philosophical conflicts can lead to regulatory drift, as may have been a factor in the failure of the Penn Treaty Life Insurance Company, which can end disastrously. What is a financial disaster for the policyholders of a failed insurer is a life-altering disaster for the trusting residents of a CCRC.

Not surprisingly, after a promising beginning, LTCi sales have languished more recently [Source: Milliman]. The needs that LTCi and CCRCs address continue, however. These needs will become socially more prominent in the years to come as the Baby Boomer demographic bulge moves through the stages of old age. This is a major looming national challenge.



Social Insurance.

Since 1965, the United States has evolved programs of social insurance to address the physical challenges of aging through Medicare and Medicaid. The 1935 Social Security Act earlier introduced minimal ("floor of protection") income security.

These programs have all struggled in one way or another. Social Security, for instance, relies on the assumption of perpetuity to avoid having to meet the reserving and financial standards that are required of similar private pension funds. There are persistent dire projections for the future of the Medicare and Medicaid programs which Congress seems unable to address with permanent sustainability.

That's the rub. The natural politics of a democracy work contrary to establishing sound financial structures. The result is that social insurance rests on a less rigorous financial foundation than that which is required of private enterprises like CCRCs. Social insurance also can get tangled in rigidities like the absurd Medicare requirement that those needing skilled nursing must have been "admitted" (not held for "observation") for at least three full days in a hospital first.

Even worse, to receive Medicaid long term care benefits, people with a middle-class pride in lives of self-sufficiency, have to spend themselves down into poverty to qualify for benefits. Even then, access to those benefits requires certain care-delivery settings and other constraints that inhibit imaginative innovations.

Moreover, promising programs like the Program of All-Inclusive Care for the Elderly (PACE) have been artificially curtailed by political interests. The experience with social insurance suggests that the private industry can do better if the will, wisdom, and sound regulation are there.

The one thing that social insurance can do well, is to ensure universal payments into a mandated coverage system. The Social Security Administration has developed a very efficient structure for collecting FICA "contributions," and that could make a universally mandated system work effectively without the mandate-avoidance that has been a challenge for universal coverage requirements, as say, for automobile liability insurance.

Single Premium Life Annuities.

At one time, in the mid-1800s, some insurance company managements would spend or invest the funds that were paid for insured life annuities with little regard for the commonsense obligation to have on hand funds to meet the deferred income benefit obligations. The collapse of many insurers during the late 1860s and 1870s led to the formation of the National Association of Insurance Commissioners (NAIC) and the beginnings of what has become today's insurance regulatory structures.

The consequence of early insurance abuses was the emergence of nonforfeiture laws which ensured that funds mathematically needed to meet promises to policyholders would be used to benefit those policyholders. Insurance laws require that funds earmarked for deferred benefits be reserved and prudently invested to avoid speculative activity and to ensure that contracts can be honored by the enterprises selling them. There's no reason other than special interests why CCRCs shouldn't have similar requirements. CCRCs are still operating in their "early" phase with little financial oversight.

CCRC entrance fees are no different from single premium life annuities. Residents are required to pay a large upfront payment in return for which the "annuity" benefits are used to offset future recurring fees that would otherwise be required. It's the same as an annuity with an assignment of the periodic payments to the CCRC to offset future fees.

Despite this obvious equality with single premium annuities, entrance fees are not similarly regulated. It's not uncommon for entrance fees to be used as equity investment proceeds to protect debt providers from loss. Nonprofit CCRC debt has a senior claim over residents in CCRCs.

Entrance fees, or the debt secured by them, may also be used speculatively to fund expansion projects or, as in one case, to fund a speculative adult living community in Mexico. That investment proved a total loss and had to be written off. There are no standards for prudent investment of CCRC capital funds, including entrance fees.

There's no reason why entrance fees shouldn't be regulated as what they are, single premium life annuities, sold and backed by unlicensed insurance entities, i.e., CCRCs.

Continuing Care at Home.

The newest foray into the provision of unregulated insurance products offered by unlicensed insurance entities is that of Continuing Care at Home (CCaH) products. CCaH policies (contracts) offer care benefits without the cost dampening offsets from the residential component of CCRCs. CCaH is, therefore, identical to LTCi, but the continuing care industry has argued that it ought not to be subject to insurance regulation.

CCaH can be price competitive because it doesn't have to meet the minimum capital and pricing disciplines to which regulated licensed insurers are subject. So far, CCaH has had minimal market acceptance, and there are very few enrollees. Still, it has the potential to develop rapidly if it were spurred by the kind of marketing effort that the insurance industry brought to LTCi. Given the history of the LTCi industry, it's likely that CCaH will be subject to escalating rates as the enrollees age.

CCaH programs should be treated the same as other unlicensed insurers are treated today. Given the history of LTCi, insurance departments should be scrutinizing CCaH insurance with eye to preventing a replay of what has proven to be a troubling LTCi history.

Conclusion.

There are many lessons to be gleaned from the insurance parallels to CCRC contracting and financing. It's evident that CCRCs should be brought up to the same level of credibility as that of the insurance industry. Insurance departments, if authorized by appropriate legislation, are the state agencies best equipped to provide that regulatory leadership. CCRC residents have so much at stake that it is a compelling public interest priority to give them the same safeguards that insurance policyholders already have.

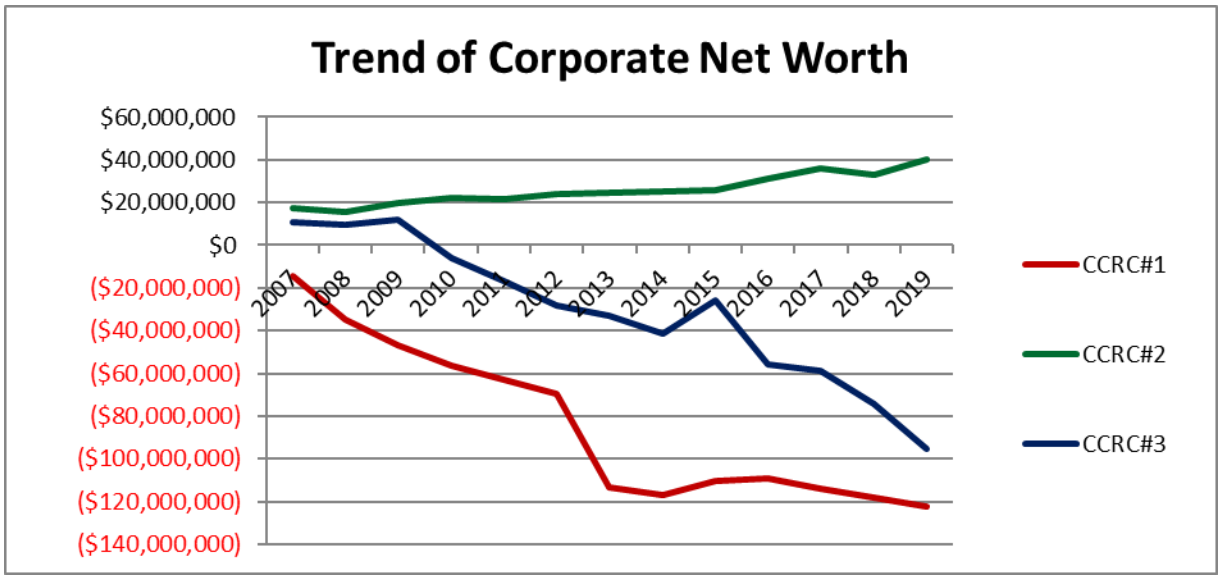
9. Legislative Alternatives

In the previous sections of this white paper, we have made the case that there is a need for legislation, and commensurate funding, to enable insurance departments, with their expertise in financial and contract matters, to foster a sound continuing care industry for an aging population. It's also evident that this oversight has been so long delayed, that practices have evolved that leave a vulnerable residential population at risk. There is a public interest in addressing that reality.

Pragmatics.

We start with some ideas for legislative alternatives that might get CCRC reform underway. For the industry to achieve the reputation for trustworthiness that it will need to thrive, it will need to establish and enforce standards for fair contracts and financial soundness.

Meeting standards like those for insurance will be a tall order for some enterprises while others are already on a sound footing. For those enterprises that do not now have strong balance sheets, a period of rehabilitation will be needed under stringent insurance department oversight. To set the stage for the challenge, we repeat here the trend of GAAP net worth for three downtown Seattle CCRCs.



Digging out of an impairment of $100 Million or more can be daunting both for Chief Financial Officers and for regulators.

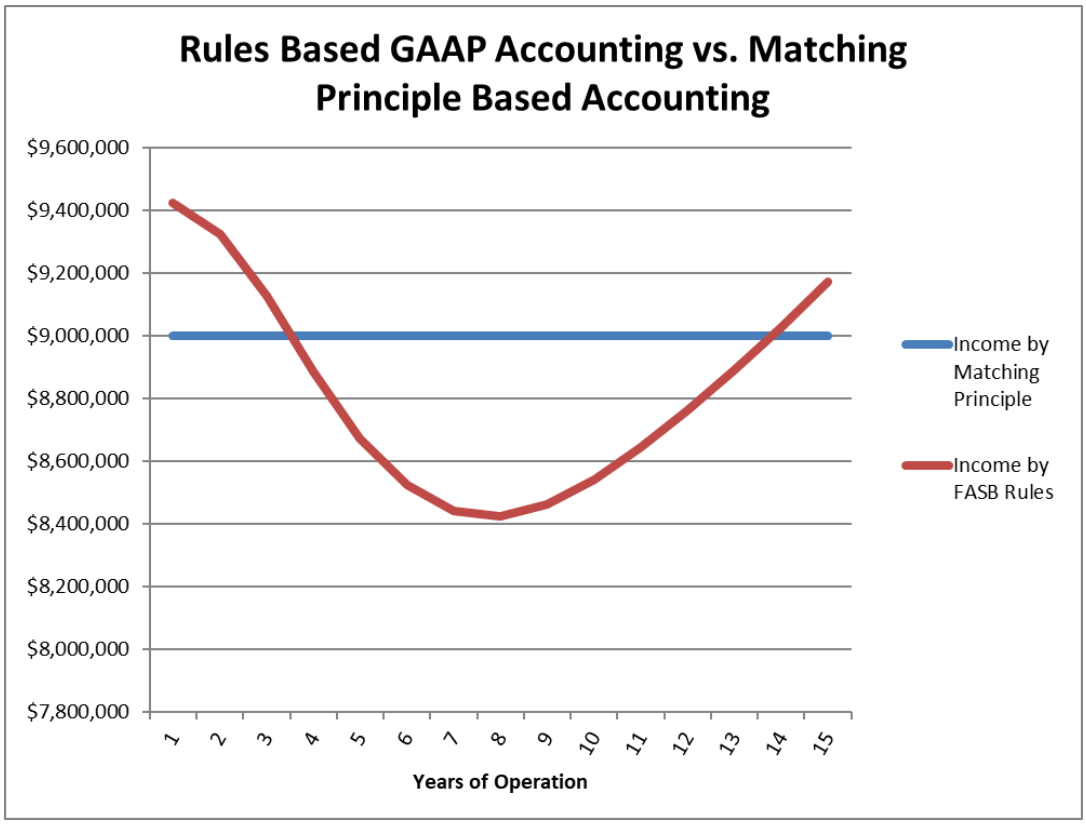
Accountancy.

Economic interests beyond adherence to the general welfare have begun to take hold as accountancy has moved from a principled approach for the fair presentation of finances to a quasi-legislative “codification” approach, prey to the manipulation of the drafting, enacting, and interpreting process that dog legislatures, e.g., self-interested lobbying pressures in lieu of deliberation. This phenomenon is particularly evident in GAAP CCRC accounting.

The challenges arise from GAAP’s focus on the use of life expectancies as a tool to achieve matching of revenue recognition with fulfillment of performance obligations instead of adopting matching codifications that are consistent with the GAAP treatment of annuity contracts, i.e., taking into account both mortality and interest, as well as other contingencies such as that of requiring long term care if relevant. The accounting rules, for instance, ignore the reasonable expectation of residents investing in entrance fees that they will receive some investment return for their sizable investment.

The accounting methodology was derived in the 1990s from work with mathematician David L. Hewitt, who advised the Kendal Corporation on financial matters. The accountants, though, imperfectly understood Mr. Hewitt’s work, so they relied solely on life expectancies rather than considering interest and other contingencies. They also provided little guidance to matching the assumed mortality underlying the expectancies with the selection criteria for CCRCs’ admissions. The result is to front end apparent CCRC earnings, leading to subsequent shortfalls with equilibrium reached sometime after 15 or more years of operation.

That is illustrated in the following normalized graph of GAAP vs. principled accounting. To simplify the analysis, the math here assumes a model CCRC comprised of all women age 85 at entry who are then replaced by new 85 year old women as earlier entrants pass away. The takeaway is that today’s GAAP can mislead executives into making decisions that are adverse to the reasoned management of the CCRC.



For the mathematical details of this graphic demonstration click here.

For instance, the appearance of favorable early results may lead to lower rate increases than what a true financial analysis would call for. Then as the accounting results reverse, rate increases may exceed what is needed. That affects the financial stability of the CCRC. The accounting for "contingent refund" contracts is even more misleading as will be explained subsequently.

Given the lack of audit independence and the questionable AICPA "guidance" interpretations, it would be wise to bring CCRCs into the statutory accounting framework, at least to the same extent as are, say, charitable gift annuities in those states that regulate them. California is a good example of effective charitable gift annuity regulation. An entrance fee as contract consideration is tantamount to a single premium life annuity. Click here for an overview of state variations in the oversight of charitable gift annuities and also here.

If more rigorous accounting for entrance fees is required, as is the case with the California requirements for charitable annuities, then CCRCs will no longer be able to rely on questionable practices such as characterizing as "refunds" payments that are contingent on a speculative perpetual succession of unknown, uncommitted, future residents.

Actuarial Standard of Practice #3.

Some actuaries believe that achieving "actuarial balance" in accordance with ASOP #3 is a sufficient standard for CCRC financial soundness. Frankly, I disagree. This requires some background.

The accountants are not the only ones moving from principle toward codification and compliance. Not long after the creation of the American Academy of Actuaries, the actuaries emulated in part the "codification" structure of the accountants, though with a softer mandate.

Before the Academy and before ASOPs, actuaries were held individually to high standards of ethical practice guided by the principled generalities of the Code of Professional Conduct of that era and the guidance of the curriculum that actuaries had to master.

Cultural Shift. The shift toward rules-based codifications reflects a change not very long ago in American concepts of integrity. Our culture moved largely from a personal professional honor standard to codified standards for practice and ethics (citation). Before the Academy, the Society of Actuaries was the premier professional organization for actuaries. For disciplined, reasoned discourse on thorny actuarial questions, e.g., social insurance funding, etc., the Society of Actuaries published a distinguished journal called the Transactions.

The Transactions were widely respected among policy makers, academics, and others who sought to rise above the interplay of special interests and everyday politics. A paper titled, "Regulatory Monitoring of Individual Health Insurance Policy Experience" is a good example of how the honor system worked. A paper like this was thoughtfully discussed and the discussion of pros and cons, mandates and alternatives, was then preserved to guide actuaries in their practice. For instance, the author of this paper chaired an industry committee, while William F.

Bluhm, a peer reviewer and discussant, was then an actuary with the New York State Insurance Department.

Culture Shift Effects. With the shift to codifications and compliance and away from personal judgmental professional responsibility, ASOPs emerged, substituting quasi-legislative directives for personal professional responsibility. These codifications have now mounted to form a considerable body of overlapping directives. Mastery of that body of directives is daunting. At the same time actuarial practice has become more specialized.

Thus, just as accounting has become more compliant and less rooted in professional judgment, actuaries, too, have trended in the same direction. Practitioners become more technicians and less professionals. Although ASOPs are exposed for comments, the decision whether to ignore or incorporate comments in the final codification is left to the committee rather than to the professional integrity and judgment of a practitioner addressing a specific situation.

Thus, while a compliance culture can look to something like "ASOP #3 balance" as a standard, it does not, in my view, rise to the higher standard of a principled practice. Specifically, it is more focused on enterprise continuance than on the best interests of the residents. Public officials, though, are called to support and uphold the Federal and state constitutions, which require them to look beyond special interests to the general welfare, i.e., what's in the best interest of the jurisdiction they serve.

That is a higher standard. The standard for public service is principled. Public servants are called to promote the general welfare. That goes well beyond a mere compliance standard. Professionals, too, are expected to lift principle above merely following directions, compliance, as technicians do.

One Statute That Can Make a Difference.

In our discussion in earlier sections of the parallels between insurance and CCRCs, we've noted the public protection provided by the guaranty associations which operate in all 50 states, the District of Columbia, and the territories. Unlike Federal guaranty programs like banking's Federal

Deposit Insurance Corporation or the Pension Benefit Guaranty Corporation, insurance guaranty associations at the state level do not require anticipatory advance assessments.

With the insurance guaranty corporations, aside from the nominal costs of running the corporation, assessments only occur if there is a shortfall due to a bankruptcy. This means that the industry can avoid assessments by intervening early to minimize financial losses. It also avoids the political temptation for legislators to dip into accumulated advance assessments for other socially desirable purposes.

Enacting guaranty legislation comparable to that for insurance companies, or even adding a CCRC "account" to the existing insurance guaranty legislation, can incentivize the industry itself to adopt more financially beneficial business practices and can give the industry the mechanism for it to cooperate in rehabilitating itself.

Thus, if only a single law were to be enacted to enable insurance departments to improve the finances and stewardship of CCRCs for their residents, it would be to bring CCRCs into a guaranty system like that now existing for insurance companies. Such a law could go most of the way toward reassuring residents that they can trust the financial integrity of CCRCs.

Adapting Insurance Company Precedents.

In 2013, the National Continuing Care Residents Association (NaCCRA), exposed for comment by the industry a set of proposed model laws patterned after insurance model laws, developed by the National Association of Insurance Commissioner (NAIC) and generally adopted by all states, district, and territories of the United States. Additional model laws unique to CCRCs and beyond the insurance precedents were also included.

Instead of engaging with residents to develop trustworthy oversight concepts, the industry chose to ignore that initiative and to oppose all attempts to regulate finances and contracts. That industry position persists to this day and is followed by all three national senior living trade associations and virtually all of their state affiliates, though there are a few states which have sounder regulation than others.

With time, the leadership of NaCCRA shifted, as often occurs with volunteer led consumer organizations, but the model laws, and resident discussion of the model laws, can still be found at https://actionaging.com/ModelLaws.html or in the Appendix to this paper. Thus, one approach would be for the Washington State legislature to adopt a resolution directing the Insurance Commissioner to ask the NAIC to vet, revise, and develop a comparable set of model laws for subsequent consideration and adoption by the state, district, and territorial legislatures.

The Simplest Choice.

Most of the financial challenges for entrance fee nonprofit CCRC enterprises arise from the diversion of entrance fees from contract fulfillment toward equity shielding for debt providers. Thus, the simplest legislation would simply be to prohibit new entrance fee contracts for CCRC enterprises with assets less than, say, 110% of liabilities, provided "liabilities" include an actuarial liability reserve for the residual life annuity value of existing entrance fees.

This requires some elaboration. Prohibiting undercapitalized CCRC enterprises from charging entrance fees will not rehabilitate the CCRC. That is the responsibility of the management. All it will do is to protect the residents from investing large sums (often the proceeds from selling the family home) into an enterprise that is already failing. Such an investment into a failing business will only prolong the time till the inevitable at the expense of the gullible new resident.

Takeaways.

Thus, there are numerous legislative alternatives, some shorter term, some longer term, that the Washington State OIC might consider putting before the legislature. The most compelling takeaway, though, is that the OIC (Washington State's insurance department) has an essential role in restoring financial and contract integrity to the CCRC industry, and that the OIC will need statutory authority and resources to be able to achieve that pressing necessity.

In the next several sections, we'll consider how the OIC might undertake the rehabilitation of those CCRC enterprises that are now inadequately capitalized. It will take imagination and

resources to bring these enterprise up to standards comparable to those which insurance companies are required to meet.

The toleration by the authorities over many years of these financial shortfalls have left impacted Washington State CCRC residents (like those in other less forward-thinking states) at risk of losing any benefit from all, part, or most of their entrance fee investments. This is a public policy shortcoming that calls for rectification.

First, we'll discuss the scope of the rehabilitation challenge. Then we'll begin to consider alternative approaches, recognizing that turning a failing operation around can follow many paths. Finally, we'll look at three past failures to gain an understanding of how the process works in practice.

10. The Challenge of Undercapitalized CCRCs

Many CCRCs, especially those that are nonprofit, are operating with "negative net asset" balance sheets, which for most enterprises is considered impairment and, possibly, bankruptcy. We don't use the word "insolvency" here because some practitioners think of insolvency narrowly as a lack of cash to pay current bills. Since CCRCs have the cash from the resident entrance fees, they can draw down against those resident-provided funds to meet management- and enterprise-serving obligations.

Of course, that is not what residents expect their entrance fees to fund, especially since the entrance fees are consideration for a contract that promises the quid pro quo of benefits for that name contract holder. Thus, the more conventional standard of balance sheet strength, e.g., a minimum standard, say, that assets be greater than 110% of liabilities, leaving a ten percent cushion for adversity. The number of CCRCs that fall short of anything close to a capitalization standard like that suggests that much of the industry is not now on a sound financial footing.

In this section, we consider the public interest challenge of restoring soundness and credibility to an industry dependent on public trust. Of all departments of state government, insurance departments are best suited by expertise and resources to handle challenges of financial rehabilitation. This section is largely reflective while subsequent sections will look more at specifics of what might be and what has been done in representative past instances of financial failure.

The Challenge.

Rehabilitating a faltering industry to bring all enterprises up to minimally sound standards is a daunting undertaking. In some cases, the challenge is underpricing. In others, the challenge is redundant staff and weak cost management. In many cases, there has been a tendency to overestimate market potential by consultant advisers who stand to profit from expansion. Dwindling occupancy is a common marker for a failing CCRC.

Every case of an “impaired” CCRC is unique and requires tailored intervention to determine whether it can be salvaged or if it is best to liquidate the existing operation. Liquidation is particularly difficult when, as in the case of CCRCs, it involves people’s welfare, residence, and livelihood. This is especially true given the vulnerable, frail, and often cognitively deficient population that CCRCs house.

Pragmatics.

Given the large number of CCRC enterprises that are impaired even on a GAAP basis, meaning that their liabilities (enterprise commitments) are greater than their assets (enterprise resources), it will take time to make balance sheet strength a standard. Thus, providers domiciled in a state should be given, say, five years of supervised grace to come into compliance with any new statutes that are implemented.

Providers, which make considerable progress, but which can’t get the job done in the five-year stay, could apply for an extension if warranted. Otherwise, the enterprise should be seized and placed in receivership under the guardianship of the state.

As is common with failing insurance companies, the insurance department, then, representing the state, or acting at the request of the state attorney general, can bring in expertise to manage the property through rehabilitation or liquidation, including if necessary the sensitive and compassionate relocation of the residents.

Given appropriate statutory authority, the insurance department of the state of domicile can designate by regulation the oversight process that the insurance department will exercise to ensure that CCRCs make steady progress over the years of hiatus toward bringing the CCRC into compliance with the regulations.

That process can begin by giving those providers which don’t meet minimum capital requirements (as those might be developed by the NAIC or by individual insurance departments), say, 90 days to submit a plan of rehabilitation or to be taken into receivership. Progress with the

rehabilitation plan would then determine subsequent insurance department interventions and actions.

New Thinking.

That will require new thinking. The industry fear is that meeting such standards will make CCRCs less attractive for prospects, putting a chill on the continuing care model for supporting those who are aging through life's closing years. Responding to that challenge is the responsibility of business, not of the regulators. Legislators and regulators put in place minimum standards for financial soundness, and it's up to the creative capacity of business executives and their advisors to respond accordingly.

Accountancy. Critical to any plan to require financial soundness is credible, independent accounting which is cognizant of all stakeholders in an enterprise. Hence, there is a need to bring CCRC accountancy within the scope of statutory accounting. Moreover, most CCRC contracts are analogous to "guaranteed renewable" healthcare contracts and are not month-to-month as the AICPA (American Institute of Certified Public Accountants) guidance has asserted.

Assessment Spiral. We have already seen the challenges to achieve financial viability with long term care insurance, LTCi, in which overoptimistic initial pricing led to setbacks and repricing. The result was an assessment spiral in which adverse selection increased rates beyond what the market can tolerate.

For those who don't know, an assessment spiral results when those who are in good health decline to accept new pricing and let their policies (contracts) lapse. Those who anticipate early claims continue, escalating claims, and further accelerating the untenable spiral.

Changing Risk Dynamic. Moreover, the nature of LTCi, like disability insurance, is that the presence of the insurance increases the probability of claims. Insured people are more likely to choose cash-costly care options, while those without insurance rely more on family or welfare for their care. That is a second form of selection that many of the early LTCi pricing actuaries, accustomed to less subjective life insurance pricing, overlooked.

CCRC Parallels.

In looking at CCRCs, we can learn from the LTCi experience. CCRCs have the advantage of having management onsite, and in addition to their community-wide responsibilities, qualified managers can act as case managers to interact directly with those who may need assistance. That allows providers to manage the risks and costs in a way that is impossible for a predominantly cash and claims business like LTCi.

Moreover, the presence of the bricks and mortar operations and the everyday living amenities (meals and more), can serve to temper the volatility that can impact a cash-based financial product like pure LTCi. As with LTCi, health screening and risk classification matter for CCRCs, though it has often been ignored.

At one time, most CCRCs included rudimentary screen protocols. For instance, prospective residents for independent living might be required to be able to walk unaided up a flight of stairs and to pass a simple cognition test like the Montreal Cognitive Assessment (MoCA). Perhaps fear of vacancies, or perhaps an interpretation of the fair housing law, has largely eliminated many of these earlier simple screens.

That this ignoring of a material screening process has proven manageable to date may be attributable to that dampening of financial exposure by the financial stability of the bricks and mortar operations. It may also reflect the circumstance that, although many entrants require more care, some CCRCs charge for that care and profit from it. For others, the shorter life expectancies of frailer residents can accelerate the receipt of entrance fees from replacement entrants.

Insurance departments have experience working with financially troubled LTCi insurers to try to find balanced strategies to minimize the losses from failing blocks of business. That takes both good judgment and a willingness to act. The failed Penny Treaty Life Insurance Company provides us with meaningful experience from which we can learn in trying to rehabilitate CCRCs with impaired balance sheets.

With Penn Treaty, the Pennsylvania insurance commissioner was dilatory in delaying state intervention until the losses mounted to levels that made liquidation inevitable. By the time, legal wrangling gave way to concrete action, industry experts estimated that the company had "long-term claims liabilities approaching $4 billion, but only about $700 million in assets." Unlike CCRC residents, though, the Penn Treaty policyholders were shielded from harm by the guaranty laws.

As the CCRC industry expands, and if CCaH (Continuing Care at Home) programs gain market share, these financial challenges are likely to become increasingly prevalent. Offsetting that future exposure, though, is the possibility that CCRCs may dwindle in importance as other, more trustworthy concepts for dealing with advanced old age and end of life continue to emerge.

11. Rehabilitating Undercapitalized CCRCs

In this section, we consider specifics of what might be done to restore soundness to an industry dependent on public trust. Of all departments of state government, insurance departments are best suited by expertise and resources to handle challenges of financial rehabilitation.

Possible Rehabilitative Steps.

Any effort to save a failing enterprise has to start with an understanding of why the failure occurred. For enterprises like LTCi and CCRCs this is the work of actuaries, or investment bankers with comparable analytical capabilities. Time, too, is of the essence since the effects of delay merely allow the deficiency to grow, compound, and ultimately, as with Penn Treaty, to become insurmountable. As noted in the previous section, credible accounting is essential to any consideration of a rehabilitation plan.

The most vulnerable class in an adverse CCRC financial situation are the residents. Moreover, residents are not investors, though providers may treat entrance fees as though they were at-risk speculative investment proceeds from sophisticated investors. That is a false and misleading premise. Hence, the first regulatory priority should be to minimize the disruption and loss to the residents. At a minimum, residents should be ably represented by independent counsel.

The second regulatory priority is to consider whether the existing management can be trusted to manage the rehabilitation process or if a qualified receiver needs to be brought in to manage the CCRC estate. That decision requires considerable judgement, and it is wise to bring in knowledgeable advisors to assist.

Third, there needs to be a reliable, credible analysis to determine whether the enterprise can be salvaged. This is where it is useful for the regulators to be able to turn to industry experts to take advantage of their knowledge of what is workable and what is not.

If the challenge is financial, a financial advisor like a top-grade management consulting firm or the consulting arm of an investment banking firm can be invaluable. With a guaranty association

in place, local industry resources are incentivized to help minimize the losses and the damage to the residents. They, too, can be valued advisors to regulators as can the advisors retained by residents to represent their stake in the proceedings.

Residents in Possession.

There are also some rehabilitation possibilities that can be more equitable toward residents than those which are now commonly implemented. First is an idea that some for-profit operators (namely, Era Living in Seattle and Continuing Life LLC in California) have adopted. These family owned and operated CCRCs give the residents a first deed of trust against the property in the event of financial collapse. That means that the residents are then debtors-in-possession rather than giving that power position to bank or similar entities with a purely financial interest.

A similar result can be achieved for nonprofit CCRCs if residents are organized as the sole members in a resident corporation (say, an incorporated version of the resident association). If the resident membership corporation is organized as a 501(c)(3) in compliance with Revenue Ruling 72-124 and comparable federal and state requirements, then a judge might order that the assets of the financially troubled CCRC be transferred (donated) tax-free to the resident corporation, giving the residents full control of the outcome. The residents can then negotiate with the debt providers the terms by which the resident corporation assumes the failed provider's debt.

Municipal Ownership.

Another approach which is common in some other countries would be for municipalities to assume ownership of troubled or failing CCRCs. Both Canada and the United Kingdom have traditions of municipal engagement to help seniors find the housing they need. While this is not now common in the U.S., it might be a popular approach to elevating the financial security of older people.

Many cities in the U. S. already have senior centers. Adding housing and care options can be a logical next step to enhance the lives of older Americans. Assuming responsibility for faltering private, tax-exempt projects could provide entry into meeting this need.

In many municipalities, IRS tax-exempt private CCRCs pay no property taxes. In those municipalities, the local government already has an investment through foregone taxes in these enterprises. This can be comparable to the residents' often unwitting equity investment made by the diversion of resident entrance fees toward meeting debt service requirements. Both residents and municipalities deserve consideration for those risky investments.

Outside Financing.

With the consent of the state attorney general, the failing nonprofit enterprise can be converted to for-profit, allowing it to seek capital in the equity markets or to sell itself to a white knight suitor. While a nonprofit could also act as a "white knight" to invest in the failing business, that is more difficult to achieve.

An investment banking firm is essential to pursuing this option. The regulator establishes that protecting the residents is the highest priority. Given that task mission, reputable investment banking firms can develop a variety of options and the pros and cons of each. The investment banking firm can then advise and assist in implementing the option chosen.

Mutual insurance companies have been allowed to use surplus note investments to achieve solvency. Reinsurance undertakings can also help insurance companies to manage their capital requirements. Neither of these tools is now used for CCRCs, but they could be. Such a possibility, too, is something that a competent actuarial or investment banking firm should be able to advise on.

The Use and Abuse of Bankruptcy Protection.

Because of Article I, Section 10, Clause 1 of the U. S. Constitution, only the Federal government can amend contracts that have proven to be financially unworkable. That clause reads, "No State shall … pass any … Law impairing the Obligation of Contracts." That means that Federal

bankruptcy courts can revise or negate contracts, and they frequently do. State courts and legislatures cannot “impair” contracts.

It's not uncommon for residents to have no legal representation in the adjudication of a financially deficient community, so the board working with the debt providers are left unrestrained to develop a “prepackaged bankruptcy” to benefit their interests, and then to argue in the bankruptcy court that this is best for all stakeholders.

Bankruptcy judges often approve with little questioning such resident deprivation. Others will give residents standing on the general creditors committee, but since the creditors collectively select the committee counsel, it’s generally unlikely that the resident voice will be well represented even in that case.

Bankruptcy judges do have the authority to consider more creative and imaginative programs to shield residents, but as a general matter, residents are the most at risk in a bankruptcy. Also, as a generalization, most bankruptcy courts, lacking the needed expertise, consider it a satisfactory outcome if residents are allowed to stay as tenants in the homes they funded with their entrance fees.

In a later section, we will consider concrete cases. Guaranty laws, like those applicable to insurance companies, could shelter residents by creating a guaranty corporation that protects residents and then takes their position in the bankruptcy reorganization.

12. Review of Past Rehabilitations

The need to rehabilitate a failed CCRC is not new. In practice, CCRCs fail frequently though the failure does not always lead to the bankruptcy courts. It's not uncommon for those new to CCRC finances to ask for statistics about the rate of such failure. The problem is that failure is not a stochastic occurrence. Financial failure is most often attributed to inept business leadership rather than to the randomly occurring events that underlie useful statistics.

In this section, we will look at three "bankruptcy" reorganizations to gain insight into the individual character of CCRC failures and the differing approaches to trying to reset them. Perhaps surprisingly, two of these emblematic CCRC collapses occurred in California. It may be that California is more political than deliberative in its oversight practices. Politically, it may be more subject to private interests than other states.

After all, most state constitutions are principled statements of the compact that unites the people in the body politic, while in California populist propositions have the effect of amending the state constitution. The result is that California's constitution is a good-sized book in sharp contrast to the U. S. Constitution, which is no more than a pamphlet, even after well over 200 years of amendments.

A Personal Story.

One cause of some bankruptcies is self-serving executive squandering of corporate assets. Early in my career I worked as an actuary for an actuarial firm that had been acquired by Coopers & Lybrand, a large accounting firm. I was in my late twenties and lived in New York City's Manhattan. I was the firm's only actuary with a listed home phone in the Manhattan phone book.

So it was that on a quiet Sunday afternoon, I got a call from an accounting partner in Philadelphia, asking me to come immediately to Philadelphia to help them with the close out statement of a bankrupt life insurer, the American Penn Life Insurance Company. It turned out that the accountants had no experience with statutory accounting, the required completion of a

regulatory Annual Statement, or with actuarial reserves. They were desperate. The year was 1963 or 1964.

As you can imagine, that stay of about a week in Philadelphia was a steep learning curve. After my arrival, they seated me in the CEOs office since with the insurance department's seizure of the company, the officers were all gone. I worked primarily with a diligent employee who handled the punched card machinery and who was retained on staff for the wind up.

The first lesson that I learned was that all the fancy trappings of a CEO's office, no matter how pretentious and opulent it may be, do not relieve the CEO of the buck-stops-here responsibility for the welfare of the stakeholders served by the business. Although I had never personally previously prepared an Annual Statement (popularly known then and now as the "blue book"), I followed the counsel from a book by a preeminent actuary, Charles Beardsley, which gave step by step guidance, starting with Exhibit 11 (who knew?).

It was with the help of that guide, and the commonsense that is the provenance of the actuarial profession at its best, I got through that week. I likely learned more in the intensity of that single week anxiously working in that lavish office than I did in all the actuarial exams I ever studied for. I also learned that even highly regulated businesses can fail; that failure is never pretty; and that those who clean up the mess made by others have a high-principled responsibility to act with integrity for the benefit of the stakeholders.

American Penn was liquidated. The policyholders were secured to the best of our ability in those days before there were guaranty laws outside of New York State. And a young actuary, me, was given early schooling that sometimes senior executives are not as motivated by what's best for the enterprise as they are by what's best for themselves.

Pacific Homes 1977.

The bankruptcy of Pacific Homes was an early example involving malfeasance of entrance fees. As the New York Times told the tale in a 1979 article. "The homes, ["Richard E. Matthews, a management consultant appointed by Judge James E. Moriarty to supervise the financial affairs

of the homes in Arizona, California and Hawaii"] said, 'promised residents permanent security, including complete medical care, if they would prepay large sums of money.' He added, 'Instead of reserving and investing these substantial cash prepayments, the funds were diverted into expansion projects and speculative investments, and used to pay current operating losses.'"

That has since become a common theme in CCRC failures, right up top with lagging occupancy, underpricing, and over-expansion. Mr. Matthews, sued the State of California alleging that the state had an obligation to ensure that adequate reserves were maintained but that, as stated in the lawsuit:

> "Beginning in 1964 and continuing until 1977, Pacific Homes failed to maintain the reserves required by section 16304, in spite of the fact its officers and directors were at all times cognizant of the shortages while nevertheless continuing to operate Pacific Homes as if it were a viable corporation and, inter alia, selling life care contracts against ever diminishing reserves and resources with which to satisfy them."

The lawsuit was dismissed on the grounds that Mr. Matthews lacked standing and that the state was not obligated in the way alleged.

The bankruptcy of Pacific Homes resulted in a class action lawsuit which is detailed in the opening chapter of Patrick Dillon and Carl Cannon's book, "Circle of Greed." The result of the lawsuit is that all CCRC contracts that I have seen explicitly deny any liability by the sponsoring organization for the financial results of the sponsored CCRC entity. The bankruptcy was devastating for the residents.

The alternative might have been that the churches and other well-intended sponsors might have taken full responsibility for the welfare of the residents. The sponsors could have come together to develop policies then for sound financial operation of these homes. They didn't. Instead, they wrote into contracts a denial of liability while allowing the use of their names to attract trusting residents.

The Pacific Homes debacle invited considerable media attention, as a result of which California made some reforms. Most of those have since been rescinded, including most recently Governor Jerry Brown's dismantling of the Continuing Care Advisory Committee, which brought resident representatives together with provider representatives and designated experts.

The Glebe 2010

Success has many authors. Failure has many excuses. In the case of the Glebe the excuses were sufficiently convincing that Virginia Baptist Homes remained in management even after bankruptcy reorganization. They subsequently changed their name to LifeSpire of Virginia.

Here are the excuses.

- "A 100-year flood caused 18 months of construction delays. Potential residents that couldn't wait moved elsewhere."
- They "were about 60 percent occupancy when [they] opened in 2005."
- The county sued to collect property taxes arguing that the senior housing business wasn't a true nonprofit.
- Not long after opening "the housing market plummeted…, preventing many potential residents from selling their homes."

In 2010, The Glebe filed for bankruptcy protection. The market value of the bonds used to finance the project promptly plummeted. Neuberger Berman swooped in to buy them up for pennies on the dollar. That allowed a financial restructuring which gave Neuberger Berman a healthy profit but set the project back on track. Because the debt was traded in the market, the bondholders took the hit.

In a unique twist, Neuberger Berman took less of a gain that it might have on its purchase of the distressed securities. The firm used its financial analysis expertise to advise the bankruptcy court on what it would take to make the resuscitated property market competitive. That restraint was

a major part of the successful emergence of The Glebe from bankruptcy. Moreover, the Virginia Supreme Court gave the operator the coveted tax exemption.

Air Force Village West 2017

Restraint like that shown by Neuberger Berman at The Glebe was not on display when the debtors intervened at Air Force Village West in Riverside County, California. The banks were determined to press their seniority advantage. After a lengthy period during which Eskaton as interim manager tried to turn things around doing business as AltaVista Village, eventually Air Force Village West was bought by Westmont Senior Living and turned into "independent living" as Westmont Village.

A quick bankruptcy court procedure was used to void the residents' continuing care contracts, and they were given a brief period to accept new rental agreements or get out. The California Department of Social Services Continuing Care Contracts Division (DSS) was more observer than intervenor.

Since the DSS didn't seem to understand the actuarial nature of in kind benefits funded by entrance fees, DSS only insisted that cash refunds be honored as part of the settlement. The residents, represented in the Resident Council and by minority membership on the Board, were discouraged from hiring legal counsel to represent them, so they had no meaningful representation in the settlement. It appears that whatever the State of California might have learned from the earlier Pacific Homes debacle was lost when it was time to protect the residents at Air Force Village West.

Analysis.

Entrance Fee Nonprofit CCRCs depend on four sources for financing: (1) resident entrance fee contract considerations; (2) debt, either concentrated from a lending institution or dispersed through bond sales to the public, sophisticated investors or otherwise; (3) retained earnings, which are not always seen by nonprofits to mean the excess of assets over liabilities; and (4)

donations, which most CCRCs channel through separate 501(c)(3) “foundations” which the parent CCRC “owner”/operator controls.

Of course, “retained earnings” as a source of finance are in practice funds derived from the payment of fees by residents plus investment earnings from the investment of those fees either in the business or in the capital markets. Past and current residents and the prospect of future residents are the sole purpose, the primary payers (with donors), and the only public purpose beneficiaries for a nonprofit CCRC enterprise.

Thus, in a failed undertaking, either the residents will be the losers or the debt providers. Since, in the absence of guaranty legislation, the residents are junior to the debt providers, they are fully at risk unless restraint, regulatory wisdom, and good conscience prevail in the rehabilitation efforts.

13. Contingent "Refunds"

One of the more recent CCRC "innovations" has been the emergence of CCRC contracts that seem to promise "all this and your money back." Joan M. Annett developed this plausible concept while working as a managing director for Cain Brothers Investment Bank. CCRC prospects were resistant to the rapid forfeiture of their entrance fee investments. The "refund" contract was the industry's response.

The innovation was to promise a partial or full "refund" contingent on the subsequent resale of the residential unit. Without the contingency, a CCRC would be expected to reserve the full amount of the refund much as a withdraw-able bank deposit is reserved. A truly refundable deposit is a customer deposit account within ordinary GAAP. It is treated as a current liability.

Troubling Reflection.

With the contingency, the argument was made that the liability for paying the refund was not the obligation of the contracting CCRC, since the refund obligation would be paid from funds anticipated to be received from an unknown future resident. Thus, the CCRC was able to make a promise for which it disclaimed responsibility.

Not only that, but many "refund" provisions also provided that the amount refunded would be reduced if the successor resident paid a lower entrance fee than the contracting resident. Imagine the case in which the CCRC decides that a successor resident need only pay a straight rental and no entrance fee. By thus changing its pricing structure, the CCRC can extinguish any liability for the promised "refund." Can that be valid and enforceable?

Because of this plausibility argument that the refund obligation was not the obligation of the CCRC promising the refund, GAAP accounting departed from the accounting for customer deposit accounts to allow CCRCs to amortize the "refund" ratably into income as earned revenue. In my judgment, this is not a principled practice even though it was incorporated into the GAAP codifications, guidelines, and interpretations.

In the minds of the "man (or woman) in the street," a "refund" is not contingent. Moreover, there is a question whether a promise that offloads the obligation of one contracting party, the provider and more powerful party to the contract, onto an unknown and unnamed speculative future resident, not a party to the contract, is a valid contract.

Ethical Problems.

As far as I can tell that deceptive contractual provision, which the accountants have largely facilitated, has never been tested in the courts. Can a contract be valid that is dependent for performance on a speculative, unknown future party who is not a party to the contract? Personally, I think that it is misleading and that it was intended *ab initio* to be misleading. It can only have substance if we deem the enterprise to be perpetual, and the assumption of perpetuity has generally been found to be contrary to acceptable practice.

Thus, I believe that such contracts are unethical. Beyond that, it's likely that such contracts are also invalid. The Securities and Exchange Commission has prohibited such contracts for publicly traded enterprises because they are tantamount to a Ponzi, albeit a relatively low key Ponzi, in which proceeds from future investors are diverted to provide returns to earlier investors.

Practicalities.

Since nonprofits and closely held corporations are not publicly traded, they have not been challenged on that aspect of the legitimacy of these contracts. A refund contract, though, ***can*** make sense if it is regarded as no more than a non-interest-bearing deposit as is true of some bank deposits.

In those cases, it is reasonable for the banking institution to take into income the earnings from the investment of the non-interest-bearing deposit as long as the bank maintains sufficient liquidity to meet withdrawals. Banks typically rely on the Federal Reserve Banks and the FDIC to back up their liquidity requirements.

Since CCRCs typically rely on refund delays instead of meeting liquidity needs as they occur, these so called "refund" contracts, as they now exist, place residents expecting "refunds" at risk.

This is even more the case given that CCRCs have neither access to the Fed liquidity window nor the backing of a guaranty structure. This raises the question whether such a misleading investment should be permitted.

14. Closing Thoughts

The CCRC financial and contract practices that we have probed in this white paper are indicative of what can occur when well-intentioned people put together a business without oversight and with little credible guidance. In their beginnings, what are today commonly known as CCRCs, then "homes for the aged," met a need, and relied on philanthropy to be able to shelter and care for older people with limited means – often church workers or war widows and orphans.

In those early days, faith and prayer were given coequal status with money and investment. Often rooted in a faith congregation, early residents joyfully paid "entrance fees," then sometimes called "founders fees," just to get the project off the ground. They were joining together in a common project to provide for their own aging in community. Other members of the congregation willingly stepped up with donations. Many early CCRCs were local charitable undertakings. That, for instance, was the case with The Lutheran Services of San Diego's CCRC, the story of which can be read by clicking here.

From Charity to Business.

That charitable concept changed when Revenue Ruling 72-124, shepherded through the National Office of the IRS by a Hanson Bridgett law firm partner, opened the possibility of tax exempt profitable businesses with market priced offerings and with sales staffs to fill the residential units. The dynamic of the industry shifted slowly from cooperative affinity ventures into market driven tax exempt, residential multi-family business undertakings.

Not surprisingly, the change brought about by Revenue Ruling 72-124 allowed the CCRC industry to prosper, grow, and expand. Some CCRC businesses used the opportunity for market pricing to strengthen their balance sheets and to provide the viability protection that people expect of longterm trust enterprises like insurance companies and CCRCs.

Others retained their charitable intent. Monte Vista Grove Homes (MVGH) is an example. It's purpose then and now Is primarily "to provide much needed retirement housing for ministers and missionaries of the Presbyterian Church USA." It got its start with the impetus and support of James Marwick, of the accounting firm that bore his name, now KPMG International, and David Gamble, of Procter & Gamble, the consumer goods behemoth.

Ironically, despite the impetus from those corporate chieftains, MVGH today remains charitable with highly empowered residents, while the faith-originated Lutheran CCRC mentioned earlier is today part of a mega-nonprofit-corporate behemoth with a corporate culture. Paradoxically, this is a common evolution within the CCRC industry.

Thus, it is that the nonprofit industry evolved into a disparate range of ventures from profitable market-based projects committed to growth and profit at one extreme to affordable living projects committed to serving the indigent and dependent on philanthropy and government assistance, e.g., the U.S. Department of Housing and Urban Development.

The Regulatory Conundrum.

It's not surprising that this mélange of responses to age can seem perplexing, leading many regulators to try to avoid having to come to grips with it. Still, when contracts of adhesion are allowed to take advantage of a public which trusts in government to work for the common good and the general welfare, public institutions – including the regulatory authority of the government – are called to right the inequity and to restore justice.

In reality, it's not as complex as it seems. All people, as they near life's end, may come to need a more protective, more responsive, and more supportive living environment. CCRCs do that. The combination, say, of PACE with affordable HUD housing also does that. There is a continuum of needs from the poorest among us to the wealthiest. Old age, decline, and demise know no favorites.

A well-managed, resident-focused, resident-protective, and resident-empowering full-care inclusive (Type A) continuing care retirement community is an approach to meeting these

universal needs. When we write "universal," we don't mean that everyone has the same needs, but everyone approaching age can anticipate the chance that they may eventually have those needs.

Since the needs are universal, they are all met in one way or another. Some unfortunates may die abandoned on the streets and sidewalks of our cities. Others may seek shelter from misfortune in ways that open them to fraud or exploitation by others. When do the practices of a nonprofit or for-profit CCRC that gives enterprise interests priority over customer value rise to exploitation? When do certain practices become unethically exploitative? Those are questions that we've sought to explore in this paper.

The impetus for this paper was the issuance of an RFP by the Washington State Office of the Insurance Commissioner (OIC), an RFP that was difficult to respond to because of timing, inferences in the RFP, and other factors. Still, the initiative that led the OIC to issue the RFP has been long overdue. This paper, therefore, responds to that call for guidance without getting embroiled in the political jockeying that seems to be an undercurrent behind the RFP.

Conclusion.

We conclude that the health and safety, social services, and aging policy elements of CCRCs are now well addressed by various state-level departments ranging from Departments of Social Services, Departments of Public Health, to Departments of Aging. What has been lacking has been effective regulation of financial and contract elements.

Insurance Parallels. The parallels are with the insurance industry which, like the CCRC industry, is an industry with long term contractual obligations; advance payments for deferred future contingent services; the opportunity for unscrupulous persons to divert payments away from mission-related obligations; and with a reliance on public trust for the industry's credibility.

Moreover, because of their history with the insurance industry, and with the support of the National Association of Insurance Commissioners, state insurance departments, generally, and

the OIC specifically, are best positioned to set the CCRC industry on a proper track that will allow it to thrive and better meet the needs of the American public in a trustworthy way.

The Case for Continuing CCRC Consumer Risks. There are those in the CCRC industry, and among its advisors, who are resistant to putting the CCRC industry on a plane with the much older, sounder insurance industry. They fear that the sales offerings will become too expensive. That's a public policy issue to be addressed in the public forum.

Resistors to full financial soundness also fear that requiring financial soundness will force nonprofits to become for-profits so they can access the equity capital markets. There are investment bankers who now specialize in tax exempt debt financings for nonprofit CCRCs. They would have to master new skills to be able to work with the full spectrum of capital markets.

Of course, there is no imperative that for-profits not operate with the same altruistic commitments that the public expects of nonprofits. That deserves repeating. Executives are not inherently more ethical when they work for nonprofits than are those who work for public service investor-funded enterprises. The nonprofit/for-profit distinction has primarily to do with whether the enterprise pays taxes or not. Secondarily, though, it affects accountability with nonprofits having less external accountability than do investor-funded enterprises.

Others object that insisting that entrance fees be matched to the contractual undertakings for which they are consideration would prevent CCRCs from using entrance fees as equity capital. They don't see how nonprofits can get startup or expansion equity capital without diverting entrance fees. Counter to that is the observation that entrance fees are not sold as risky investment securities, nor is it likely that people would sell their homes to be able to invest their home equity in such speculative concentrated investments if they fully understood what they were doing.

Call for Reform and Legislation. Consequently, the deep analysis in this paper points to the need to learn from the insurance industry history and to avoid the pitfalls that insurance encountered in the last decades of the 19th century, continuing into the early years of the 20th century.

There is a need for legislation now. It will be up to the elected legislators and their advisors to determine how far that legislation should go toward rising to the standard that insurance regulation achieved. More than 100 years ago, the States of Massachusetts and New York led in the reform of a life and annuity insurance industry that had become untrustworthy.

The State of Washington can now lead the nation in providing standards to give the public a trustworthy CCRC industry on which people can rely for the safety and security of their latter years. Though it may now seem paradoxical, there is strong evidence that putting customers and prospective customers first is the surest way to achieve business growth and profits. Success can attract capital. By raising the minimum bar, Washington State regulators can lead in helping the industry to thrive so CCRCs can continue to be there for generations to come.

Acknowledgement

Finally, a heartful thank you to all who contributed to shaping the thinking presented in the White Paper. You know who you are, though some of you may not want to be named because of the sensitivity of your employment. Your courage in addressing these salient issues is much appreciated.

Appendices

Catalog of Proposed Standards and Model Laws 2013

See Also https://actionaging.com/ModelLaws.html

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
Governance	CCRC provider Boards of Directors should balance the interests of residents with those of other stakeholders, including executives and employees, in keeping with the purpose and well-being of the enterprise and the composition of the Board should reflect this balance.	Model CCRC Governance Act	***Click here for a lively, impromptu discussion among a group of residents on this topic.***
Financial Guarantee	Residents of CCRCs should have the same financial protection in the event of provider impairment as that which life and annuity insurance policyholders already have. This requires legislation like that proposed here which is adapted from the insurance precedent.	Model Financial Guarantee Act	
Financial Responsibility	Some contracts leave more of the future financial risk with residents than do others. Entering residents are expected to have sufficient assets (in addition to any Entrance Fees) or other guarantees to ensure that they can pay future provider fees as they come due and that resident asset threshold is higher when providers shift risk to residents. This standard and model law establishes benchmarks to ensure that entering residents who do not have care-inclusive (Type A) contracts can afford the added risk they thereby assume.	Model Financial Responsibility Act	
Financial Viability and	Residents in CCRCs and participants in Continuing Care at Home (CCAH)	Model Financial Viability and	

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
Rehabilitation Act	programs are particularly vulnerable to provider financial impairment and other impacts and should have protections similar to those accorded to insurance company policyholders. This resident protection requires legislation like that proposed here which is adapted from the insurance precedent.	Rehabilitation Act	
CCRC Standard Valuation	In order for there to be some assurance that funding for deferred services promised to CCRC residents -- in return for current payments including Entrance Fees -- will be there later when needed, it is important that such commitments be valued currently together with projections of expected future income. For insurance companies analogous valuations are conducted by actuaries. This standard extends to CCRCs a similar standard for financial integrity. This requires legislation like that proposed here which is adapted from the insurance precedent.	Model CCRC Standard Valuation Act	
Prepaid Medical Reserve	Many CCRCs advise their residents that a portion of their Entrance Fees may be currently tax deductible as prepaid medical expenses. There is not now, however, any requirement that those funds be earmarked for the intended purpose. This places the related tax deductions in jeopardy. This standard calls for the CCRC to establish a reserve item for amounts designated for prepaid medical expenses to ensure that such amounts are in fact used for that purpose.	Model Prepaid Medical Reserve Act	
Investment Regulation	Entrance Fee Continuing Care Contracts like single premium annuities bring in cash in return for long deferred promises. That requires	Model CCRC Investment Act	

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
	trust and prudence in the investment of funds. Of course, investment in the Continuing Care facility itself is an appropriate investment, assuming that the facility is operated to ensure a fair investment return. Insurance companies have long had regulated investments to avoid speculative investments that can undermine their risk averse mission. This Model Law extends similar investment protections to Continuing Care contract holders that life and annuity insurance policyholders already have.		
Nonforfeiture	There is no required correlation currently between Continuing Care Contract forfeiture provisions and the value of the services provided thereunder. This standard would correct that imbalance. There has also been controversy about a widespread industry practice in which payments of promised refund or death benefits are dependent on successor residents. This has led to delays in the payments of funds and denial by providers of liability for promised refunds. This standard would apply to CCRCs nonforfeiture principles comparable to those that have long applied to the life and annuity insurance industry. The legislation modeled here is adapted from the insurance precedent.	Model CCRC Standard Nonforfeiture Act	***Click here for further explanation.***
Contracts	Continuing Care Contracts are now written by providers and must be accepted before a person eligible for residence is allowed to move in. The result is that some contracts are one sided and there is a need to balance the interests of residents with those of the executives and of the enterprise	Model CCRC/CCAH Standard Contract Provisions Law	

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
	which they lead. Moreover, Continuing Care Contracts can be quite complex and difficult for ordinarily educated people to understand. This can lead to confusion and disappointment. The standard proposed in the accompanying model law applies to Continuing Care Contracts concepts analogous to those governing life and annuity insurance contracts.		
Transfers	Some CCRCs penalize internal transfers by only crediting a transferring resident with the Entrance Fee originally paid for the apartment relinquished and then reselling that same apartment at current market Entrance Fee rates. This discourages internal transfers which can be positive in allowing a resident to adapt to the losses that inevitably accompany aging. This standard and model law encourages transfers as an adaptive mechanism.	Model CCRC Transfer Act	
Continuing Care at Home	There is a movement to encourage Continuing Care at Home (CCAH) programs as an adjunct to CCRCs or in place of CCRC residence. By their nature such programs involve more enterprise risk than do brick and mortar CCRCs, and they verge on becoming very liberal long term care insurance, but without the regulatory oversight applicable to insurance. This standard would limit such programs to what is reasonable given the constructive purposes that such CCAH programs can meet.	Model Continuing Care at Home Authorization Act	***Video Discussion of Continung Care at Home at a NaCCRA Meeting***
Conversion to Enable Resident Ownership	A few CCRCs have an ownership model. The condominium form, which involves fee simple ownership, creates transfer delays and difficulties	Model CCRC Cooperative Conversion Law	***Click here for an Explanatory Paper.***

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
	at the death of a resident. These difficulties can be avoided with specifically tailored cooperative ownership models. Moreover, such models can enable the gradual conversion of existing CCRCs to an ownership model that is more compatible with the large Entrance Fees that are often required. Existing residents can retain their existing arrangements for life if they wish, while those residents who choose ownership, and new residents who may prefer ownership, can purchase an commensurate interest in the cooperative corporation together with a lifetime lease to occupy a specified unit. This law is adapted from laws that have allowed New York City apartments to convert from rental to cooperative ownership.		***Many residents of Entrance Fee CCRCs are confused about Ownership. Click here for a discussion by Bob Nagele of Connecticut of this confusion.***
Self-Certification	Highly detailed, reactive regulatory requirements for advance approval of facilities etc. inhibit providers responsiveness to changing needs and run up costs, though they are intended as a protection for the public. Since capital investment often lies fallow awaiting inspection or approval, excess regulation involves considerable cost for providers which drives up the cost of housing and services provided for the aging. Regulation also inhibits innovation which might otherwise improve the services offered. Such oversight, approval, and inspection is redundant for the most responsible providers who are regularly voluntarily in compliance with all requirements. This legislation would allow a provider to earn a	Model CCRC Self-Certification Act	

Proposed Standard	Purpose and Rationale	Link to Model Law	Elaboration (if any)
	Trusted status facilitating the certification and inspection process by allowing self-certification for those providers who achieve and maintain an exemplary record. While this legislation is proposed at the state level, Federal legislation is also involved because of Federal oversight of Medicare, Medicaid and the Patient Protection and Affordable Care Act of 2010.		
Federal Trusted Provider Status	Because CCRCs are subject to oversight by the Federal Centers for Medicare and Medicaid and other Federal Agencies, Federal legislation is needed to fully implement a targeted oversight program allowing responsible providers to earn Trusted Status. Accordingly this model Federal enactment is included in this portfolio of proposed standards and legislation.	Model Federal Trusted Providers Act	
Federal End of Life Palliation	Once it is clear that the end of life is approaching, care needs shift from restoration to comfort. Recent hospice legislation has moved in this direction. The model law suggested here would clarify personal rights of choice as life's end approaches.	Model Federal End of Life Palliation Act	

Resident Ongoing Financial Responsibility in a CCRC

Typically Continuing Care Contracts are for life, and many require the payment of an Entrance Fee upon acceptance into residency. Continuing Care Contracts are issued in conjunction with Continuing Care Retirement Communities (CCRC) or Continuing Care At Home (CCAH) contracts. Beyond the payment of an Entrance Fee residents (in the case of CCRCs) or participants (in the

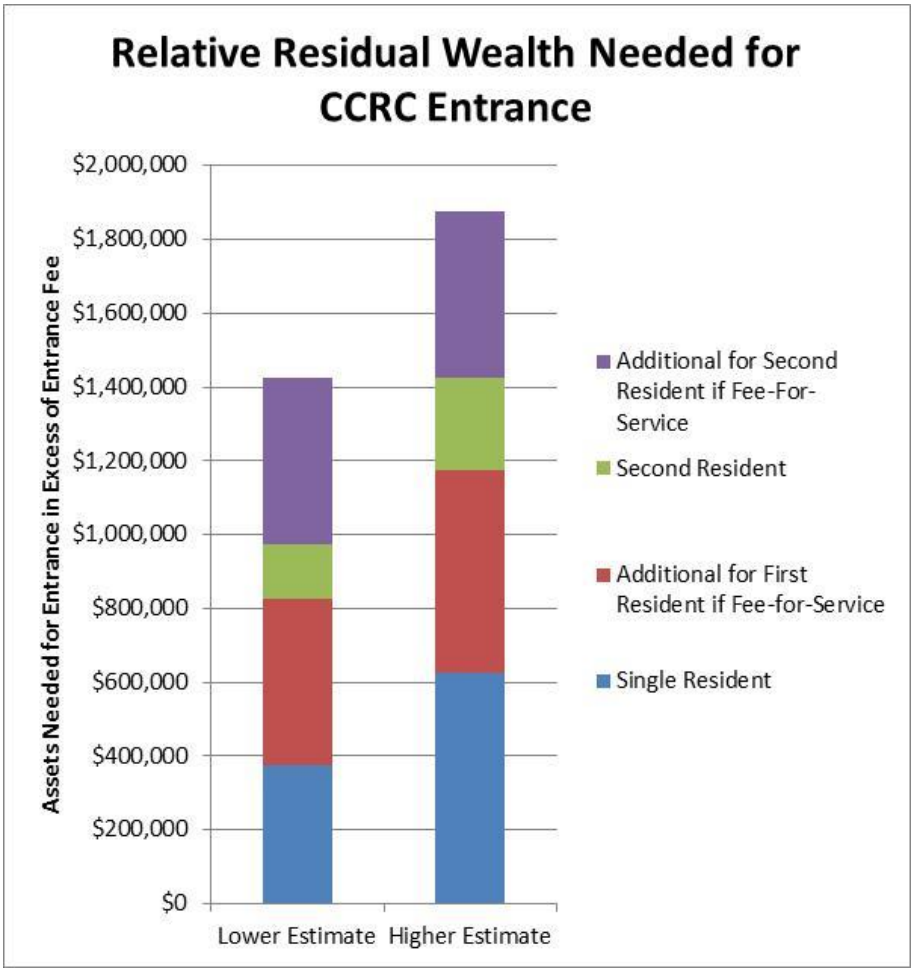
case of CCAH programs) are required to pay recurring monthly costs. Together the Entrance Fee and the Recurring Fees are expected to cover the costs of the services provided.

Many, likely most, CCRCs require proof of financial capacity before an applicant for residence is admitted. Revenue Ruling 72-124 requires nonprofit CCRCs to maintain in residence those whose assets run out. Hence, it's reasonable for providers to manage their exposure to this benevolent care obligation.

The presumptive idea behind the wealth requirement for admission is to ensure that entering residents will be able to afford the future recurring monthly and other charges without outliving their assets. Making that determination is not a simple matter. Many CCRCs simply use an arbitrary financial standard, though there is a financial analysis program, FINAID,[1] which was developed by A. V. Powell and associates and which is used by some CCRCs to provide a more refined standard.

Since predictability of future fees varies with contract type, the asset requirement for entrance should likewise reflect the contract. Let's start with the amount needed to pay basic fees. The requirement depends on economic factors and the expected duration of the residency, so the entrance amount might vary between, say, 150 and 250 times the initial monthly fees, assuming that additional fees are not anticipated for care services over and above the basic fees. This amount is increased if there is a second resident, i.e. if a couple moves in as a unit, or if the CCRC does not offer a full care inclusive (Type A) contract. The chart that follows shows how the asset requirement for entrance mounts with these added considerations. The range from Low to High represents two scenarios for the imponderable future elements implicit in the determination. Examples are future inflation rates, future CCRC policy regarding fee increases, and future investment returns on resident assets.

[1] http://www.avpowell.com/software/finaid/ accessed January 11, 2014.



There are obviously a number of additional assumptions that enter into this chart, starting with an assumed initial monthly fee of $2,500 a month. These elements and assumptions are discussed in the Technical Addendum. Suffice it here to conclude, though, that the assets that a CCRC should require of entering residents need to be specific to the terms offered by the CCRC and cannot be determined by any simple industry-wide "rule of thumb".

It's evident that the asset requirement varies with the term of expected residency and that is affected by factors such as age and health condition at CCRC entrance. Clearly, older people who are already beset with a life threatening condition are not likely to live as long as will younger people with a healthy lifestyle and above average fitness. Since CCRCs do not, typically, take these factors into account in the determination of Entrance Fees, we have omitted them from this analysis of minimum asset requirements but that is not to say that they aren't material;

this analysis simply follows the industry practice to ignore these financially material aspects of new resident evaluation.

From the discussion above the reader will perceive that the review of assets as a basis for resident financial responsibility prior to admission is complex. Ultimately, however, there can be no guarantee concerning future outcomes and developments. Accordingly, simplification is expedient.

Consistent with this bias toward simplification, the Model Law distinguishes solely between CCRC contracts that provide a financial guarantee for future long term care costs, i.e. an extensive care (Type A) contracts, and other contracts that do not (Type B, C, and D contracts). It's thought that existing provider entrance requirements have served adequately for basic fees though we are neither aware of industry studies of adequacy nor of industry standards for such evaluations. In contrast to Type A, care inclusive contracts, Type B, C, and D contracts leave the resident with the risk of providing for all or much of the cost of the resident's long term care if that should become necessary.

Correspondingly, the entrance requirement should be higher for such residents to ensure that residents can pay the cost of this added risk. Otherwise, such at risk residents are more likely to qualify for benevolent care and so present a greater potential burden to the community than do their more fully protected fellow residents. Residents who are subject to unpredictable costs for long term care are more likely to outlive their assets. For nonprofit CCRCs complying with Revenue Ruling 72-124 this risk is transferred back onto the CCRC.

There is no evidence now that CCRCs require such a higher standard of resources at entrance for residents who accept the riskier contracts (Types B or C). Accordingly, the Model Law would require that evidence of such financial responsibility be part of the entrance evaluation. The same reasoning applies to variations in Continuing Care at Home (CCAH) contracts.

The standard proposed in the Model Law is a simplification resulting from a much more complex analysis. The greater complexity arises from a reasoned, statistically based approach. The goal is to determine the assets, over and above the entrance fee, that a new resident must have to provide reasonable assurance that the resident is unlikely to need benevolent care support.

The FINAID method, referred to above, uses statistics to estimate the probability that any given resident is likely to run out of funds. Thus, based on the assets reported or documented by a prospective resident, the program might show that there is, say, a 5% chance that the resident's funds could run out, say, at age 101. The judgment is left up to the provider to decide if that is an acceptable risk or not. The model is also based on standard mortality and it's also up to the provider to evaluate whether the health condition of the prospective resident is standard or shows deterioration.

A more sophisticated approach would evaluate the probable mortality applicable to a statistically significant cohort of like situated people. This would mean that the mortality assumed for the evaluation would reflect an age, gender, and health profile comparable to that of the entering individual. This is mathematically determinable with sufficient precision for classification purposes using the well-developed techniques that life insurance companies use to assign prospects for insurance to rate classifications. Such a classification process could allow the provider to forecast the expected value of the resident's future cost of residence to ensure a higher probability that the resident's assets would suffice. In addition to these components, the sophisticated analysis, could also include an evaluation of the resident's ability to manage those assets to produce the hypothecated rate of investment return used in the analysis, as well as, the more problematic assessment of the chance that the resident might improperly spend down assets or divest assets to defeat the purpose of the asset evaluation.

We know of no CCRCs that today approach the question of wealth evaluation with this degree of sophistication. Still, it's important that any simplified approach consider these more

sophisticated components of the analysis. The use of a simplified methodology reflects a conclusion on the part of the provider organization that a more sophisticated analysis is not justified and would not provide a materially more valid conclusion. By using a simplified approach the provider makes a business judgment that the evaluation is sufficient to allow the CCRC to assume the risk for the potentiality of benevolent care late in life.

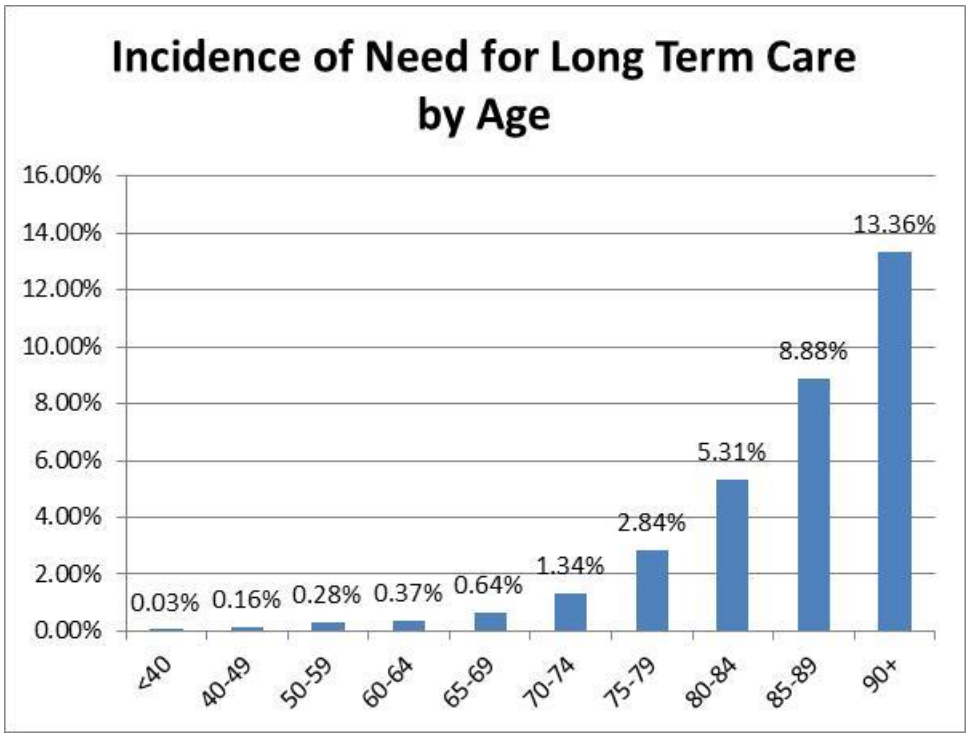
This digression into a refined analysis of financial sufficiency is intended to show the difficulty of the decisions that the provider must make. Moreover, there is no appeal if a provider rejects a resident on financial grounds, so providers may be tempted to do all they can do to shield the CCRC from any possibility of benevolent care. For instance, in a recent case, a couple with substantial assets was required to provide a third party guarantor when the FINAID program showed the discounted value of future benevolent assistance as $707.[2] The provider in this instance did not take into account the obviously impaired health status of the applicant which would have shown a shorter likely residence period if it had been taken into account. It's unlikely that even this miniscule financial exposure would have remained if the health of the applicants had been considered. This is an example of how an excess of caution on the part of a provider functionary can work to the detriment of a resident or prospective resident.

To return to our consideration of the magnitude of assets required for admission to a CCRC, it's evident that the assets needed with a Type C (or minimal Type B) contract, i.e. a fee-for-service arrangement, are much greater than those needed for a life care[3] (Type A) contract. The resident assuming such a risk needs to be prepared for the worst case situation rather than just for the probability that long term care services may be needed. Probability assumes a cohort of like situated individuals sharing risk among them, as is the case with an extensive care Type A contract. Since in a fee-for-service arrangement each individual is on his or her own, the individual has to be ready for the remote possibility that a stroke or other debilitating condition

[2] Personal communication. Names and specifics withheld to protect the privacy of the parties.
[3] The terms "extensive care", "life care", and Type A are often used interchangeably.

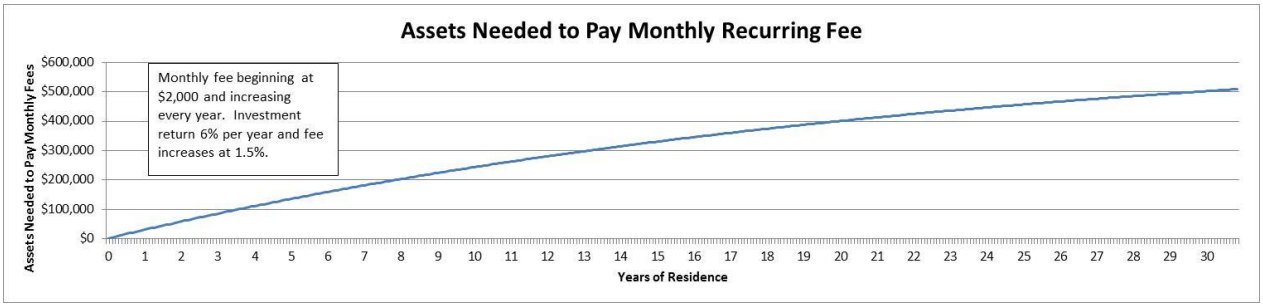
might strike immediately after admission, leaving the resident required to pay out of pocket for the consequent care fees.

Thus the funds that a resident has to have at the ready to meet unanticipated costs for long term care are much higher than the average cost expectancy which is built into provider pricing to cover the added benefits of a Type A contract relative to those for Type C arrangements. An insurance arrangement to spread risk, which is the essence of the difference between a Type A and a Type C contract, substitutes the certainty of a preset cost (the premium or monthly fee) for an uncertain, unpredictable catastrophic cost. If the absence of contractual risk sharing, the resident must be prepared for the eventuality of catastrophic long term care expenses even though the probability may seem small. The following chart shows the incidence of episodes requiring paid long term care by age.[4]

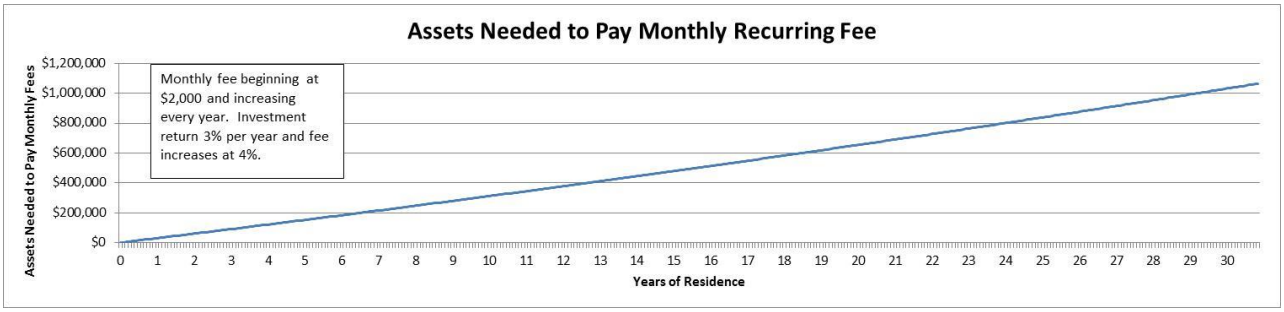


[4] http://www.soa.org/files/research/exp-study/research-ltc-study-1984-report.pdf accessed August 19, 2011.

There are a number of forecast assumptions that must be made to estimate the assets that a resident needs to have. Among these are the amount of future fee increases, what the resident is able to earn on the investment of those funds, and how long the resident is likely to live in residence. For instance, assuming a fairly typical recurring monthly fee of $2,500 a month, if we assume that a resident can earn 6% a year and that fee increases are held to 1.5% a year, then the assets needed for various terms in residence are as follows:



But, if we change the assumptions to assume that the resident earns just 3% a year while fee increases are 4%, then the picture changes to the following:



That's a dramatic difference. For instance, to cover the basic recurring fee exposure a resident expected to be in residence for 15 years needs assets at entrance, with these more conservative assumptions, and after paying the entrance fee, of roughly $500,000 instead of just $340,000 with the more optimistic assumptions. The bend of the curve reflects the relationship between the investment return on the resident's assets and the increase in fees which the assets have to cover. The greater the difference the larger the bend.

Hence, a CCRC with an initial recurring monthly fee of $2,500 might require that after paying the entrance fee the resident have additional assets of between $375,000 and $625,000. If there is

a $1,000 additional monthly charge for a second resident, the additional resident might add another $150,000 to $250,000 to the basic asset requirement. But, for those CCRCs which don't include the possibility of future long term care or skilled nursing in their basic rates, the resident carries more risk of future costs and so must have even more assets at move in.

Based on a judgmental review of statistical data, the additional funds that such a resident should have at entrance over the basic requirement is roughly 1,500 times the CCRC's daily rate for skilled nursing services. Thus, if the CCRC charges $300 a day for nursing care, the additional requirement would be $450,000 per resident.

We've omitted from this analysis the possibility that a CCRC with care inclusive contracts may have a stronger incentive to manage utilization than otherwise. There's some anecdotal evidence that facilities that are predominantly fee-for-service are more likely to encourage the utilization of such services to enhance revenue per resident but we have not taken such incentive effects into account here. The statistically judgmental simplification referred to is derived from the following long term care insurance data.[5]

Figure 6: Percentage Persisting at Least N Days by Age at Incurral

	Incurral Age Group				
Duration (Days)	55-64	65-74	75-84	85-89	90+
1	99.21%	99.65%	99.71%	99.83%	99.90%
2	98.89	99.30	99.40	99.57	99.60
3	98.58	98.81	99.07	99.38	99.39
4	98.19	98.30	98.68	99.10	99.19
5	97.81	97.75	98.30	98.85	98.90
10	95.50	94.93	96.13	97.28	97.66
20	91.68	90.52	92.26	94.19	94.34
30	88.09	86.55	88.69	91.29	91.43
60	79.55	77.72	81.29	84.75	84.22
90	72.83	71.85	76.15	80.00	78.59
120	67.73	67.26	71.76	75.71	73.69
180	59.73	60.54	65.44	69.13	66.13
365	45.82	48.28	52.25	54.18	48.89
730	34.12	34.55	36.28	34.98	28.59
1095	26.77	25.23	24.69	21.70	14.52
1460	19.81	17.47	15.72	12.15	6.91
1825	15.05	12.22	10.30	7.42	3.80

Indicates Highest Percentage Remaining
Indicates Lowest Percentage Remaining

[5] http://www.soa.org/files/research/exp-study/research-ltc-study-1984-report.pdf accessed August 19, 2011.

The judgment is that 1,500 days covers a sufficient percentage of possible needs to meet the standard of financial materiality that is relevant for a CCRC provider facing the burden of Revenue Ruling 72-124 to maintain residents in residence. It's understandable that providers may be skeptical about this standard. After all, Elisabeth Kübler-Ross, M.D. tells us that denial is the first stage for dealing with unpleasant truths. But, the maximum exposure is not inconceivable for a resident.

Consider the case of a husband who moves to a CCRC with a mildly cognitively impaired (though undiagnosed) wife. He has been caring for her and helping to shield others from noticing her impairment. A week after moving in, perhaps as a consequence of the stresses of moving and of meeting many new people, the husband suffers a debilitating stroke leaving him speechless and unable to feed himself. The same stresses, combined with the specter of the loss of her husband's care and support, cause the wife's dementia to suddenly flair into full scale erratic behavior requiring institutionalization. Both husband and wife may now require long term care for the rest of their lives with an unpredictable duration.

Hence, if a single resident moves into a CCRC that offers only a Type C contract, thus requiring the resident to pay additional for assisted living or skilled nursing services, the total assets needed over the entrance fee, staying with our examples, would be $825,000 to $1,075,000. If a married couple is involved, and if the additional monthly payment for the spouse adds $1,000 a month, then, these numbers would be increased accordingly. The assets for the second person would add another $150,000 to $250,000 to the basic requirement, and with a Type C (or similar contract), an additional $450,000 for the spouse. This would bring the asset requirement for couple moving in, over and above the entrance fee requirement, up to a range of $1,425,000 to $1,775,000.

These are big numbers, and many providers are likely to protest that their market area can't afford that kind of entrance requirement. The risk is that the CCRC may have to sustain the residents in residency when their assets run out. An alternative would be to conduct fundraising to provide assistance and many CCRCs today emphasize benevolent care in their fundraising. This could be similar to the kind of scholarship and fellowship assistance that many universities

provide to students who might otherwise be unable to afford the education offered. In other words, charitable assistance might be provided even for residents who don't first become impoverished and indigent. Regardless of how the long term care is financed, the reality remains. The Model Law ensures equity for those residents who keep the financial risk – either of their own volition or by the decision of the provider – to avoid their becoming a financial burden on those other residents who have a CCRC contract that shields them.

U. S. Internal Revenue Service Rulings

Rev. Rul. 72-124, 1972-1 C.B. 145

Requirements that 'homes for the aged' must meet to qualify for exemption under section 501(c)(3) of the Code are explained; Revenue Ruling 57-467 superseded.

Advice has been requested whether an organization that otherwise qualifies for exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 is operated for charitable purposes by reason of the activities described below.

The organization was formed under the sponsorship of leaders of a church congregation in a particular community for the purpose of establishing and operating a home for the aged. Its board of trustees is composed of leaders of the congregation, as well as other civic leaders in the community. It provides housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, useful, and independent lives. Admission to the home is generally limited to persons who are at least 65 years of age.

The organization is self-supporting in that its operating funds are derived principally from fees charged for residence in the home. An entrance fee is charged upon admission, with monthly fees charged thereafter for the life of each resident. Fees vary according to the size of the accommodations furnished.

Because of the necessity of retiring its indebtedness, the organization ordinarily admits only those who are able to pay its established rates. However, once persons are admitted by established policy to maintaining them as residents, even if they subsequently become unable to pay its monthly charges. It does this by maintaining such individuals out of its own reserves to the extent available, by seeking whatever support is available under local and Federal welfare programs, by soliciting members of the church congregation and the general public, or by some combination of these means.

The organization's receipts are used exclusively in furtherance of its stated purposes. Its charges are set at an amount sufficient to amortize indebtedness, maintain reserves adequate to provide for the life care of its residents, and set aside enough for a limited amount of expansion sufficient to meet the community's needs. Net earnings are thus generally used to improve the care provided, retire indebtedness, subsidize any resident unable to continue making his monthly payments, or expand the facilities of the home where the needs of the community warrant such expansion. No part of the organization's net earnings inures, directly or indirectly, to the benefit of any private shareholder or individual. All employees receive no more than reasonable compensation for services rendered.

Section 501(c)(3) of the Code provides for exemption from Federal income tax or organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. Such term includes the relief of the poor and distressed or of the underprivileged.

Providing for the special needs of the aged has long been recognized as a charitable purpose for Federal tax purposes where the requisite elements of relief of distress and community benefit have been found to be present.

Of principal importance are three rulings in which the Internal Revenue Service has given consideration to the tax exempt status of homes for the aged as charitable organizations described in section 501(c)(3) of the Code: Revenue Ruling 57-467, C.B. 1957-2, 313; Revenue Ruling 61-72, C.B. 1961-1, 188; and Revenue Ruling 64-231, C.B. 1964-2, 139.

Revenue Ruling 57-467 holds that a home for aged people that does not accept charity guests and that requires the discharge of guests who fail to make certain required monthly payments is not organized and operated exclusively for charitable purposes and is, therefore, not entitled to exemption from Federal income tax under section 501(c)(3) of the Code.

Revenue Ruling 61-72 holds that, if otherwise qualified, a home for the aged is exempt under section 501(c)(3) of the Code if "(1) the organization is dedicated to providing, and in fact furnishes, care and housing to aged individuals who would otherwise be unable to provide for themselves without hardship, (2) such services are rendered to all or a reasonable proportion of its residents at substantially below the actual costs thereof, to the extent of the organization's financial ability, and (3) the services are of the type which minister to the needs and the relief of hardship or distress of aged individuals."

Revenue Ruling 64-231 holds that an entrance fee paid in addition to a required lump sum life-care payment as a prerequisite to obtaining direct personal services and residence in a home for the aged must be included along with the required lump-sum life-care payments to the home in determining whether the home meets the "below cost" requirement of Revenue Ruling 61-72.

Under the Revenue Rulings referred to above, exemption from Federal income tax under section 501(c)(3) of the Code is conditioned, in effect, upon whether an organization relieves the financial distress of aged persons by providing care and housing for them on a gratuitous, or below cost, basis.

However, it is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in sense that they have special needs because of their advanced years. For example, it is recognized in the Congressional declaration of objectives, Older Americans Act of 1965, Public Law 89-73, 89th Congress, 42 U.S.C. 3001, that such need include suitable housing, physical and mental health care, civic, cultural, and recreational activities, and an overall environment conducive to dignity and independence, all specially designed to meet the needs of the aged. Satisfaction of these special needs contributes to the prevention and elimination of the causes of the unique forms of "distress" to which the aged, as a class, are highly susceptible and may in the proper context constitute charitable purposes for functions even though direct financial assistance in the sense of relief of poverty may not be involved.

Thus, an organization, otherwise qualified for charitable status under section 501(c)(3) of the Code, which devotes its resources to the operation of a home for the aged will qualify for charitable status for purposes of Federal tax law if it operates in a manner designed to satisfy the three primary needs of aged persons. These are the need for housing, the need for health care, and the need for financial security.

The need for housing will generally be satisfied if the organization provides residential facilities that are specifically designed to meet some combination of the physical, emotional, recreational, social, religious, and similar needs of aged persons.

The need for health care will generally be satisfied if the organization either directly provides some form of health care, or in the alternative, maintains some continuing arrangement with other organizations, facilities, or health personnel, designed to maintain the physical, and if necessary, mental well-being of its residents.

The need for financial security, i.e., the aged person's need for protection against the financial risks associated with later years of life, will generally be satisfied if two conditions exist. First, the organization must be committed to the established policy, whether written or in actual practice, of maintaining in residence any persons who become unable to pay their regular charges. This may be done by utilizing the organization's own reserves, seeking funds from local and Federal welfare units, soliciting funds from its sponsoring organization, its members, or the general public, or by some combination thereof. However, an organization that is required by reason of Federal or state conditions imposed with respect to the terms of its financing agreements to devote its facilities to housing only aged persons of low or moderate income not exceeding specified levels and to recover operating costs from such residents may satisfy this condition even though it may not be committed to

continue care of individuals who are no longer able to pay the established rates for residency because of a change in their financial circumstances. See, for example, section 236 of the National Housing Act, P.L. 90-448, 82 Stat. 476, 498 (12 U.S.C. 1715 z-1).

As to the second condition respecting the provision of financial security, the organization must operate so as to provide its services to the aged at the lowest feasible cost, taking into consideration such expenses as the payment of indebtedness, maintenance of adequate reserves sufficient to insure the life care of each resident, and reserves for physical expansion commensurate with the needs of the community and the existing resources of the organization. In case of doubt as to whether the organization is operating at the lowest feasible cost, the fact that an organization makes some part of its facilities available at rates below its customary charges for such facilities to persons of more limited means than its regular residents will constitute additional evidence that the organization is attempting to satisfy the need for financial security, provided the organization fulfills the first condition regarding the provision of financial security. The amount of any entrance life care, founder's, or monthly fee charged is not, per se, determinative of whether an organization is operating at the lowest feasible cost, but must be considered in relation to all items of expense, including indebtedness and reserves.

The organization described in the instant case is relieving the distress of aged persons by providing for the primary needs of such individuals for housing, health care, and financial security in conformity with the criteria specified above. Accordingly, it is held that the organization is exempt from Federal income tax under section 501(c)(3) of the Code as an organization organized and operated exclusively for charitable purposes.

Revenue Ruling 57-467 is hereby superseded. Revenue Rulings 61-72 and 64-231 provide alternative criteria for charitable qualification of homes for the aged which are primarily concerned with providing care and housing for financially distressed aged persons. To the extent that a home for the aged can satisfy those criteria, those Revenue Rulings continue to remain in effect. However, Revenue Rulings 61-72 and 64-231 do not constitute the exclusive criteria for exemption from Federal income tax under section 501(c)(3) of the Code and any organization which meets the criteria set forth in this Revenue Ruling may also qualify for exemption under section 501(c)(3).

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the

principal place of business or principal office of the organization. See section 1.501(a)-1 of the Income Tax Regulations.

H. RENTAL HOUSING FOR THE ELDERLY UNDER IRC 501(c)(3)

Introduction:

This topic has been selected for the EOATRI because of its significance in the exempt organization area. This significance is manifested by the recently published ruling, Rev. Rul. 79-18, 1979-3 I.R.B. 8 (see Attachment 1), as well as by the recurring questions the National Office receives for both technical assistance and advice.

Although this topic deals with housing, it is only one of the problems facing the elderly. Their problems have been rising as our attentions remain focused more on the problems of youth. However, as the expected life span of Americans has increased, the elderly have begun to demand headline attention which is clearly evident from a cursory reading of the daily newspapers. Besides housing projects, today's projects for the elderly include: food programs, sales and real estate tax benefit programs, free transportation, social and recreational programs, free health clinics and legal aid. A review of this area reveals that these programs have been organized, funded and administered not only on the Federal level, but also on the local levels through churches, social organizations, fraternal orders, self-created elderly groups and state and county governmental agencies.

The trend towards new programs or benefits for the elderly continue. For example, in P.L. 95-600, 1978-3 (Vol. 1) C.B. 119, IRC 4942 was amended to provide a special private operating foundation classification for long-term care facilities. See the Legislative Development section of this EOATRI for information on this change.

This topic will briefly trace the legal background of organizations providing housing and auxiliary services to the elderly, in the context of exempt status, leading up to publication of Rev. Rul. 79-18. It will also discuss the standards that homes for the aged, and, in particular, rental housing projects for the elderly, must meet in terms of specially designed housing units, age of residents, financial security and health care in order for such organizations to qualify for recognition of exemption as charitable organizations.

To assist in case development, some workable definitions for commonly used generic terms and descriptions of some Federal funding programs relating to the elderly and their institutions are listed in Attachments 2 and 3, respectively.

1. Background

It wasn't too long ago that the Service did not consider the elderly to be a charitable class, nor the relief of their distress to be a charitable activity per se. Our earlier position was that only those elderly persons unable to provide care for themselves without undue financial stress were proper objects of charity. See Rev. Rul. 57-467, 1957-2 C.B. 313, which held that a home for the aged which did not accept charity guests and which required the discharge of guests who failed to make the required monthly payments, did not qualify for recognition of exemption as a charitable organization. This position was based on the theory that the charitable purpose of these institutions was to relieve the distress of elderly persons who were suffering financial hardship. It was consistent with the traditional view of the law of charity as it related to this area. For example, in the case of Oregon Methodist Homes, Inc. v. Horn, 360 P. 2d 293 (1961), one of the factors determinative of the charitable status of an old age home was:

> whether there [was] a charitable trust fund created by benevolent and charitably minded persons for the needy or donations made for the use of such persons.

By this view, old age, per se, was not equated with need.

It was also the Service's position that a nonprofit home for the aged would be eligible for exemption as a social welfare organization under IRC 501(c)(4), if it could not meet the requirements of Rev. Rul. 57-467. The theory behind exemption under IRC 501(c)(4) was that the activity of operating an old-age home on a nonprofit basis is one which reasonably qualifies as a service beneficial to the community. See Fredericka Home for the Aged v. San Diego County, 221 P. 2d 68.

The next publicized development in this area was Rev. Rul. 61-72, 1961-1 C.B. 188. Here the Service publicized a more liberalized approach, that is, charitable status was extended to a home which did not attempt to provide care entirely free-of-charge or at less than the established monthly charge in cases of those unable to pay. Rev. Rul. 61-72, states that charity is not limited to free care of indigent persons. In this Rev. Rul. the Service recognized that charity may also be dispensed in the form of services below cost as in the case of some hospitals. (See Rev. Rul. 56-185, 1956-1 C.B. 202; and also, Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 79-17, 1979-3 I.R.B. 7). An extensive discussion on Health Care

organizations under IRC 501(c) may be found in this EOATRI Textbook at p. 184-233.

It should be noted that the facilities of the organization described in Rev. Rul. 61-72 were not lavish, nor were they more than required to meet the reasonable needs of senior citizens of limited means. One of the essential objectives of the home was to insure security and care over an indefinite period.

The basic principles we looked for to determine the charitable status were:

a. the organization must be dedicated to providing and, in fact, furnish relief of the distress and hardship of old age by ministering to the particular needs of the elderly;

b. the organization must offer care and housing to its entrants substantially below cost, or offer them free to a substantial number of individuals, to the extent of its financial ability, and;

c. the organization must render these services to those elderly persons unable to provide for themselves without distress.

Rev. Rul. 64-231, 1964-2 C.B. 139, added another dimension in the area of treating homes for the aged as charities. This Rev. Rul. held that entrance fees should be computed in the below cost test of Rev. Rul. 61-72, and that such fees may be amortized over the remaining life expectancy of the residents.

The basic position that the elderly are not a charitable class per se remained the Service position through the 1960's. See Rev. Rul. 66-257, 1966-2 C.B. 212.

In 1966, the Service began an in-depth review of the exempt status of old-age homes primarily as a result of the sociological and economic developments occurring in the 1960's. These developments of the 1960's were manifested by passage of the Older Americans Act of 1965, Public Law 89-73, 79 Stat. 218; 42 U.S.C. 3001. The Senate Report No. 247, accompanying this Act stated that the Government at all levels has a responsibility to help older people solve their problems.

Revenue Ruling 72-124, 1972-1 C.B. 145, (see Attachment 1), long in the making, was the final result of this review. It superseded the Service's longstanding

position regarding the qualification of homes for the aged, as expressed in Rev. Ruls. 57-467 and 61-72.

Rev. Rul. 72-124, recognized that the elderly as a class are susceptible to forms of distress other than financial. It set forth new guidelines under which a home for the aged could qualify for charitable exemption. That is, it must operate in a manner designed to satisfy the three recognized primary needs of aged persons: 1) housing, 2) health care, and 3) financial security. It also states as requisite elements; relief of distress and community benefit.

The organization described in Rev. Rul. 72-124 was formed under the sponsorship of leaders of a church in a particular community. It provides housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, careful, and independent lives.

With the publication of Rev. Rul. 72-124, the Service recognized the relief of the distress of old age as a charitable purpose no longer based on financial considerations alone. Rev. Rul. 72-124 was to be the revenue ruling to clear up any uncertainties caused by the prior revenue rulings. However, issues concerning rental housing were to be treated in a follow-up revenue ruling (published as Rev. Rul. 79-18, see Attachment 1).

Since publication of Rev. Rul. 72-124, the following revenue rulings have been published. These revenue rulings, for the most part, reinforce the principle in Rev. Rul. 72-124, that the elderly as a class are proper beneficiaries of charitable activity regardless of their income or net worth.

Rev. Rul. 75-198, 1975-1 C.B. 157, held that senior citizen centers may qualify for charitable status. The center offered recreation activities and counselling services relating to health, housing, finances, etc., for the elderly residents of a particular community.

Rev. Rul. 75-385, 1975-2 C.B. 205, held that a vacation home for the elderly poor may qualify for charitable status. The purpose of this organization is to provide poor elderly people with two-week vacations in the country. These brief vacations helped to relieve the distress of being poor as well as aged.

Rev. Rul. 76-244, 1976-1 C.B. 155, held that home delivery of meals to the elderly and handicapped may be considered a charitable activity. This organization delivers nutritious meals to persons, who, by reason of advanced age or a handicap

cannot prepare meals for themselves. Although a reasonable fee is charged, service is not denied if the recipient cannot pay.

Rev. Rul. 77-42, 1977-1 C.B. 142, held that a nonprofit organization, that sets up closed circuit radio transmitting equipment in multiple residence structures such as nursing homes, rest homes, and convalescent homes to provide the elderly residents an opportunity to listen to free, non-commercial and educational broadcasts concerning their special needs such as employment, financial security, health and legal care, as well as cultural and recreational needs, is relieving their distress and qualifies for charitable status.

Rev. Rul. 77-246, 1977-2 C.B. 190 held that low cost transportation to senior citizens and handicapped persons in a community where public transportation is unavailable or inadequate qualifies as a charitable activity. In this case the organization was substantially staffed by volunteers and dependent upon public and private contributions and grants.

Finally, in 1979 Rev. Rul. 79-18, (see Attachment 1) covering rental housing was published. This ruling was the result of a follow-up review of this area initiated after publication of Rev. Rul. 72-124. Rev. Rul. 79-18 and a counterpart ruling relating to special housing for the physically handicapped, Rev. Rul. 79-19, 1979-3 I.R.B. 9, made it patently clear that the "... requisite elements of relief of distress and community benefit..." as stated in Rev. Rul. 72-124, could be met by a rental housing project as long as it could meet the standards delineated in Rev. Rul. 79-18 and as long as the project provides its facilities and services at a charge within the financial reach of a significant segment of the community's elderly persons.

2. Standards

It is vitally important that our elderly citizens have access to housing which is adequate but low cost, is modest in size and easy to maintain, and so designed that it will help them avoid accidents. The housing could be close to public transportation and adequate shopping facilities so that normal activity is sustained. It could be near recreational and cultural facilities, church and community centers so that the elderly residents can remain active in the community.

> "To most older Americans, a high degree of independence is almost as valuable as life itself. It is their touchstone for self-respect and dignity..." Poverty and the

Older American Report #1287 by the Special Committee on Aging, U.S. Senate 89th Cong., 2nd Sess., (June 20, 1966) page 7.

It has been stated many times that the mere fact that a group has been described as a charitable class does not mean that any activity undertaken on its behalf would be treated as a charitable activity. The activity must be reasonably calculated to relieve the specific form of distress which causes the group to be described as a charitable class.

To relieve the distress of the elderly in a charitable manner a housing organization must do more than furnish four walls and a roof. It must offer facilities and services that relate to the totality of the needs of the elderly, such as, health care, recreation, good nutrition and financial security.

The Service has recognized charitable status for homes for the aged based on the charitable concept of relief of the distress of old age. Financial considerations are no longer the only basis. But a charitable home, whether it is one which provides medical or nursing care, or domiciliary care, must provide services which minister to the special needs of its residents.

Nursing homes are designed for persons who are in need of continuous medical attention and/or a controlled and protective environment. Residential care facilities or congregate housing facilities are designed for persons, normally well and ambulatory, who prefer residential accommodations but need some assistance in day-to-day living. Rental housing units are designed for independent living with the organization either directly providing for the basic needs of its residents or making arrangements with other providers on behalf of its residents.

a. Housing Units

To satisfy the need for housing an organization must provide residential facilities specifically designed to meet some combination of the physical, emotional, recreational, social, religious, and similar needs. The home should be designed with safety features such as grab bars by bathtubs and toilets, wide entrance-exit doorways, ramps and elevators for wheelchair use, floors designed to help prevent slips and falls, conveniently located electrical outlets and cabinets to avoid strenuous bending or stretching, lower windows to enable those confined to wheelchairs a view of the surroundings, emergency 24-hour alarm system; and should be constructed with fire-resistant materials.

Although a rental housing project should not have to provide day-to-day assistance to qualify as charitable, it should have a recreational and/or social program. The home should be operating with the intent of providing something more than just housing. The project should have a counselor or trained manager to either coordinate or assist the residents to coordinate social and recreational activities.

b. Age of Residents

The Service in Rev. Rul. 72-124, Rev. Rul. 75-198, and Rev. Rul. 79-18, has directly ruled that the aged constitute a charitable class with special needs. These Revenue Rulings describe organizations that provide for the needs of senior citizens primarily aged 65 and over in a particular community. These Revenue Rulings were based on the Federal public policy (delineated in the Older Americans Act of 1965), that the elderly have special needs apart from financial distress. Satisfaction of these needs may in the proper context constitute charitable purposes or functions. See the Older Americans Act of 1965, Section 101, 42 U.S.C. section 3001 (Supp. VI, 1969).

The Older Americans Act was first enacted by the 89th Congress in 1965 and thereafter, it was revised in 1967 and 1969. A certain portion of the funds was allotted to the various states based on their population aged 65 or over. In 1972, an act to amend the Older Americans Act was enacted by Congress and signed into law by the President. In discussing eligibility in this amendment the House Report No. 92-726 states the following:

> "Any minimum age limitation applied to participants is perforce arbitrary. Nonetheless, the Committee determined on the basis of evidence before it with respect to this bill, and other evidence that it has considered relating to the problems of the elderly, that an age limit of sixty is more reasonable than age sixty-five..." U.S. Cong. and Adm. News, page 2092 (1972).

The following year, the Older Americans Comprehensive Services Amendments of 1973, was enacted into law to strengthen, improve and expand on the programs promoted by the Older Americans Act. See 42 U.S.C.A. section 3000; 87 Stat. 30. Funding under this act used a ratio formula which takes into consideration the population aged 60 or over.

Although in Revenue Rulings 72-124 and 79-18, admission to the housing project is generally limited to persons who are at least 65 years of age, congressional mandate would seem to prevent us from denying or revoking Federal income tax exemption to an organization on the basis that it is not serving a charitable class if benefits are extended to those between the ages of 60 and 65. Although in the revenue rulings the class being served consists mainly of those age 65 and over, there should be no objection by the Service if any organization allows its benefits to those between 60 and 65.

Although statistics relating to the elderly population are quite limited, we do know that the average age of nursing home patients is 82. Ninety-five percent are over 65, and seventy percent are over 70. It is safe to presume that the average age would fall and the percentages mentioned above decrease for homes with less nursing care and more independent type living environment, such as a rental housing project.

Applications received from senior citizens organizations which allow benefits to flow to those as young as 55 should be carefully developed to insure that the class of individuals receiving its benefits is composed principally of the elderly, or as an alternative, that those younger aged individuals qualify as a charitable class in some way other than by age. Keep in mind that statistics seem to support that these organizations should have little difficulty substantiating that most residents are 65 or older.

c. Health Care

It is well recognized that the aged are highly susceptible to certain forms of distress because of their advanced age and that they are in need of special care. However, unlike hospitals and nursing homes (skilled nursing facilities or extended care facilities), the primary function or role of a home for the aged (residential care facility or intermediate care facility), or a rental housing project is a domiciliary one. Consequently, it is not necessary that a home for the aged or a rental housing project provide on its premises the degree of care characteristic of a hospital or nursing home. Although residents of senior citizen apartment (rental housing) projects presumably have less immediate need for health care than those who have entered institutions which offer nursing care and a regulated environment, they should be able to reside there with the assurance and comfort of knowing that if they should fall sick or ill, the mechanism for care is readily available.

The particular means used to meet the unique health needs of the elderly may vary from case to case. However, the senior citizen apartment project must demonstrate that the health needs of its residents are being met. The mere referral of residents to other health care organizations by itself is not sufficient. To satisfy the health care needs of the elderly and to meet our standards, the senior citizen apartment project must provide some form of definitive health program for its residents.

An acceptable program should include a scheme in which someone, such as the resident manager, will be responsible in all cases of emergency to take whatever steps are necessary to render aid and ensure that emergency assistance is provided by qualified medical personnel. In addition one or more of the following could be provided as a part of an acceptable health program:

(1) Annual medical examinations and free transportation for any follow-up treatment.

(2) An examination room on the premises available for the residents' private physicians. The examination room could contain at least the minimum equipment necessary to perform an adequate physical examination. The following equipment would meet minimum requirements:

(a) a comfortable table with stirrups,

(b) adequate lighting (floor lamp) for the examination of the nose and throat,

(c) a blood pressure machine,

(d) a stethoscope,

(e) an otoscope,

(f) an opthalmo scope,

(g) a percussion hammer, and

(h) tongue blades.

(3) A written arrangement with other organizations such as a hospital, a medical clinic or visiting nurses association to provide needed medical care and attention either on the premises or with free transportation to the more specialized or equipped institutions.

d. Financial Security

To satisfy the need for financial security two conditions must exist. First, the home must be committed to an established policy of maintaining in residence any persons who become unable to pay their regular charges. This may be done by utilizing the organization's own reserves and seeking funds from private and governmental units or the general public. However, note the exception to this for state or federally supported housing projects in Rev. Rul. 72-124.

Secondly, the home must operate so as to provide its services to the elderly at the lowest feasible cost. While the Service no longer requires that a home accept charity residents or operate below cost, it does require that the home's policy is such that it will help alleviate the fear of declining income and rising charges. By operating at the lowest feasible cost, it is expected that residence in such a home will be available to a reasonably broad economic segment of the elderly persons in a community. Review Rev. Rul. 79-18 which holds that admission should be within the financial reach of a significant segment of the community's elderly persons.

Operating at the lowest feasible cost is a relative condition with which will vary from case to case. Generally, it means that a home must offer its services to the elderly, who as a group have a large percentage of financially distressed persons, for the least possible expense. Advertising through church bulletins, seeking the aid of other charitable organizations, soliciting contributions and volunteer help, and applying for federal or state financial aid are methods by which an organization could attempt to meet the requirement of operating at the lowest feasible cost.

Conclusion

As can be perceived by reading the above, there is no reason why rental apartment units cannot fulfill the housing needs of the elderly. It should be understood that the limitation on age for admission to a charitable housing project is meant only as a general guide and not as an absolute requirement. The health care provided by a charitable rental housing project does not have to meet the

degree of care characteristic of a hospital or nursing home. However, such projects must make provisions for ensuring that the special health care needs, (especially, emergency needs) of its residents are being met.

Financial considerations alone are no longer the only basis for exempt status as a charitable organization. However, it is vitally important that our elderly citizens have access to housing which is adequate to meet their special needs, but is low cost, is modest in size and easy to maintain, and so designed that it will help them avoid accidents. While the Service no longer requires a housing project for the elderly to accept charity residents or to operate below cost, the Service does require that such organization's policy is such that it will help alleviate the fear of declining income and rising charges. Residence in a rental housing project should be available to a reasonably broad economic segment of the elderly persons in its community. Finally, elderly housing projects must be committed to an established policy of maintaining in residence any persons who become unable to pay their regular charges to the extent the organization is able.

Attachment 1
Key Revenue Rulings Involving Housing for the Elderly

Rev. Rul. 72-124

Advice has been requested whether an organization that otherwise qualities for exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 is operated for charitable purposes by reason of the activities described below.

The organization was formed under the sponsorship of leaders of a church congregation in a particular community for the purpose of establishing and operating a home for the aged. Its board of trustees is composed of leaders of the congregation, as well as other civic leaders in the community. It provides housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, useful, and independent lives. Admission to the home is generally limited to persons who are at least 65 years of age.

The organization is self-supporting in that its operating funds are derived principally from fees charged for residence in the home. An entrance fee is charged upon admission, with monthly fees charged thereafter for the life of each resident. Fees vary according to the size of the accommodations furnished.

Because of the necessity of retiring its indebtedness, the organization ordinarily admits only those who are able to pay its established rates. However, once persons are admitted to the home, the organization is committed by established policy to maintaining them as residents. even if they subsequently become unable to pay its monthly charges. It does this by maintaining such individuals out of its own reserves to the extent available, by seeking whatever support is available under local and Federal welfare programs, by soliciting members of the church congregation and the general public, or by some combination of these means.

The organization's receipts are used exclusively in furtherance of its stated purposes. Its charges are set at an amount sufficient to amortize indebtedness, maintain reserves adequate to provide for the life care of its residents, and set aside enough for a limited amount of expansion sufficient to meet the community's needs. Net earnings are thus generally used to improve the care provided, retire indebtedness, subsidize any resident unable to continue making his monthly payments, or expand the facilities of the home where the needs of the community warrant such expansion. No part of the organization's net earnings inures, directly or indirectly, to the benefit of any private shareholder or individual. All employees receive no more than reasonable compensation for services rendered.

Section 501(c)(3) of the Code provides for exemption from Federal income tax of organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. Such term includes the relief of the poor and distressed or of the underprivileged.

Providing for the special needs of the aged has long been recognized as a charitable purpose for Federal tax purposes where the requisite elements of relief of distress and community benefit have been found to be present.

Of principal importance are three rulings in which the Internal Revenue Service has given consideration to the tax exempt status of homes for the aged as charitable organizations described in section 501(c)(3) of the Code: Revenue Ruling 57-467, C.B. 1957-2, 313; Revenue Ruling 61-72, C.B. 1961-1, 188; and Revenue Ruling 64-231, C-B. 1964-2, 139.

Revenue Ruling 57-467 holds that a home for aged people that does not accept charity guests and that requires the discharge of guests who fail to make certain required monthly payments is not organized and operated exclusively for charitable purposes and is, therefore, not entitled to exemption from Federal income tax under section 501(c)(3) of the Code.

Revenue Ruling 61-72 holds that, if otherwise qualified, a home for the aged is exempt under section 501(c)(3) of the Code if "(1) the organization is dedicated to providing, and in fact furnishes, care and housing to aged individuals who would otherwise be unable to provide for themselves without hardship, (2) such services are rendered to all or a reasonable proportion of its residents at substantially below the actual cost thereof, to the extent of the organization's financial ability, and (3) the services are of the type which minister to the needs and the relief of hardship or distress of aged individuals."

Revenue Ruling 64-231 holds that an entrance fee paid in addition to a required lump sum life-care payment as a prerequisite to obtaining direct personal services and residence in a home for the aged must be included along with the required lump-sum life-care payment to the home in determining whether the home meets the "below cost" requirement of Revenue Ruling 61-72.

Under the Revenue Rulings referred to above, exemption from Federal income tax under section 501(c)(3) of the Code is conditioned, in effect, upon whether an organization relieves the financial distress of aged persons by providing care and housing for them on a gratuitous, or below cost, basis.

However, it is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in the sense that they have special needs because of their advanced years. For example, it is recognized in the Congressional declaration of objectives, Older Americans Act of 1965, Public Law 89-73, 89th Congress, 42 U.S.C. 3001, that such needs include suitable housing, physical and mental health care, civic, cultural, and recreational activities, and an overall environment conducive to dignity and independence, all specially designed to meet the needs of the aged. Satisfaction of these special needs contributes to the prevention and elimination of the causes of the unique forms of "distress" to which the aged, as a class, are highly susceptible and may in the proper context constitute charitable purposes or functions even though direct financial assistance in the sense of relief of poverty may not be involved.

Thus, an organization, otherwise qualified for charitable status under section 501(c)(3) of the Code, which devotes its resources to the operation of a home for the aged will qualify for charitable status for purposes of Federal tax law if it operates in a manner designed to satisfy the three primary needs of aged persons. These are the need for housing, the need for health care, and the need for financial security.

The need for housing will generally be satisfied if the organization provides residential facilities that are specifically designed to meet some combination of the physical, emotional, recreational, social, religious, and similar needs of aged persons.

The need for health care will generally be satisfied if the organization either directly provides some form of health care, or in the alternative, maintains some continuing arrangement with other organizations, facilities, or health personnel, designed to maintain the physical, and if necessary, mental well-being of its residents.

The need for financial security, i.e., the aged person's need for protection against the financial risks associated with later years of life, will generally be satisfied if two conditions exist. First, the organization must be committed to an established policy, whether written or in actual practice, of maintaining in residence any persons who become unable to pay their regular charges. This may be done by utilizing the organization's own reserves, seeking funds from local and Federal welfare units, soliciting funds from its sponsoring organization, its members, or the general public, or by some combination thereof. However, an organization that is required by reason of Federal or state conditions imposed with respect to the terms of its financing agreements to devote its facilities to housing only aged persons of low or moderate income not exceeding specified levels and to recover operating costs from such residents may satisfy this condition even though it may not be committed to continue care of individuals who are no longer able to pay the established rates for residency because of a change in their

financial circumstances. See, for example, section 236 of the National Housing Act, P.L. 90-448, 82 Stat. 476, 498 (12 U.S.C. 1715 z-1).

As to the second condition respecting the provision of financial security, the organization must operate so as to provide its services to the aged at the lowest feasible cost, taking into consideration such expenses as the payment of indebtedness, maintenance of adequate reserves sufficient to insure the life care of each resident, and reserves for physical expansion commensurate with the needs of the community and the existing resources of the organization. In case of doubt as to whether the organization is operating at the lowest feasible cost, the fact that an organization makes some part of its facilities available at rates below its customary charges for such facilities to persons of more limited means than its regular residents will constitute additional evidence that the organization is attempting to satisfy the need for financial security, provided the organization fulfills the first condition regarding the provision of financial security. The amount of any entrance life care, founder's, or monthly fee charged is not, per se, determinative of whether an organization is operating at the lowest feasible cost, hut must be considered in relation to all items of expense, including indebtedness and reserves.

The organization described in the instant case is relieving the distress of aged persons by providing for the primary needs of such individuals for housing, health care, and financial security in conformity with the criteria specified above. Accordingly, it is held that the organization is exempt from Federal income tax under section 501(c)(3) of the Code as an organization organized and operated exclusively for charitable purposes.

Revenue Ruling 57-467 is hereby superseded. Revenue Rulings 61-72 and 64-231 provide alternative criteria for charitable qualification of homes for the aged which are primarily concerned with providing care and housing for financially distressed aged persons. To the extent that a home for the aged can satisfy those criteria, those Revenue Rulings continue to remain in effect. However, Revenue Rulings 61-72 and 64-231 do not constitute the exclusive criteria for exemption from Federal income tax under section 501(c)(3) of the Code and any organization which meets the criteria set forth in this Revenue Ruling may also qualify for exemption under section 501(c)(3).

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or principal office of the organization. See section 1.501(a)-1 of the Income Tax Regulations.

Rev. Rul. 79-17

Advice has been requested whether the nonprofit organization described below, which otherwise qualifies for exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954, is operated exclusively for charitable purposes.

The organization, known as a "hospice," operates on both an inpatient and outpatient basis to assist persons of all ages who have been advised by a physician that they are terminally ill to cope with the distress arising from their conditions. It utilizes and coordinates the professional skills of physicians, nurses, therapists, social workers, the clergy, counselors, and lawyers in a planned effort to alleviate the physical and mental distress of dying persons. It does not seek cures through extensive medical treatments that may not significantly alter terminal illnesses, but rather focuses on lessening the distress, pain, and physical difficulties generally experienced by dying persons.

Although the organization operates a facility to supply temporary accommodations to those dying persons in need of specialized housing, the thrust of its program is to provide care and counseling in the patients' homes. The organization also provides information and advice concerning the care and problems of dying persons to relatives of such persons and to interested individuals. Its financial support is derived from reasonable fees charged for its services and from donations by the public.

Section 501(c)(3) of the Code provides for the exemption from federal income tax of organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense, and includes the relief of the distressed.

By alleviating the mental and physical distress of persons terminally ill, the organization described above relieves the distressed within the meaning of section 1.501(c)(3)-1(d)(2) of the regulations. Accordingly, it is operated exclusively for charitable purposes and, thus, qualifies for exemption from federal income tax under section 501(c)(3) of the Code.

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Application for Recognition of Exemption, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. See sections 1.501(a)-1 and 1.5081(a) of the regulations. In accordance with the instructions to Form 1023, the application should be filed with the District Director of Internal Revenue for the key district indicated therein.

Rev. Rul. 79-18

Advice has been requested whether the nonprofit organization described below, which otherwise qualifies for exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954, is operated exclusively for charitable purposes.

The organization was formed to meet the housing needs of the elderly by building and operating an apartment rental complex designed especially for them. It was formed under the sponsorship of community leaders to meet a community need for such a facility. Its board of directors consists of civic leaders and other individuals with a particular interest in the problems of the elderly.

The complex consists of apartment units that are designed, constructed, and equipped in such a way as to meet the special needs of its elderly residents. It is constructed with fire-resistant materials and is equipped with safety features such as grab bars by bathtubs and toilets, wide entrance-exit doorways, ramps and elevators for wheelchair use, floors designed to help prevent slips and falls, conveniently located electrical outlets and cabinets to avoid strenuous bending or stretching, windows at eye level for residents confined to wheelchairs, and an emergency 24-hour alarm system.

The complex has an employee on duty 24 hours a day who gives temporary aid in emergencies, contacts professional help (doctor, ambulance service, etc.) and ensures that the steps necessary to render aid are carried out. The complex also provides transportation for medical examination and follow-up treatment.

The complex contains a lounge and indoor and outdoor recreation areas. The resident manager coordinates a recreational and social program for the residents.

Admission to the complex is generally limited to persons who are at least 65 years of age.

While the initial funds for building and equipping the facility were provided by both governmental and foundation grants, the organization is self-supporting in that its operating funds are derived principally from fees charged for residence in the facility. The organization admits as tenants only elderly persons who are able to pay the full stated rental charges. The rental charges are set at a level within the financial reach of a significant segment of the community's elderly persons. However, once persons are admitted to the facility, the organization is committed by established policy to maintaining them as residents, to the extent it is able, even if they subsequently become unable to pay its monthly charges. It effectuates this policy by maintaining such individuals out of its own reserves, by seeking whatever support is available under local and Federal

welfare programs, by soliciting contributions from the general public, or by using some combination of these means.

The organization provides services to its elderly residents at the lowest feasible cost. Its receipts are used exclusively in furtherance of its stated purposes. Its charges are set at an amount sufficient to maintain reserves adequate to pay for the life care of any of its residents who may require it, and to enable it to set aside enough for limited amount of expansion sufficient to meet the community's needs. Net earnings are thus generally used to improve the specialized services and facilities provided, to subsidize any resident unable to continue making his monthly payments, or to expand the facility where the needs of the community warrant such expansion. No part of the organization's net earnings inures, directly or indirectly, to the benefit of any private shareholder or individual. No employee receives more than reasonable compensation for services rendered.

Section 501(c)(3) of the Code provides for exemption from federal income tax of organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. Such term includes the relief of the poor and distressed.

Revenue Ruling 72-124, 1972-1 C.B. 145, sets forth requirements that homes for the aged must meet in order to qualify for exemption under section 501(c)(3) of the Code. The Revenue Ruling makes clear that a home for the aged will be deemed "charitable" if it meets the special needs of the elderly such as the need for health care, financial security, and residential facilities designed to meet specific physical, social, and recreational requirements of the elderly. Such a home need not provide direct financial assistance to the elderly in order to be "charitable," since poverty is only one form of distress to which the elderly as a class are particularly susceptible.

Thus, when an organization that otherwise qualifies for exemption under section 501(c)(3) of the Code provides specially designed housing as described above that is within the financial reach of a significant segment of the community's elderly persons, and when the organization commits itself to operating such housing at the lowest feasible cost (consistent with its maintaining the reserve described above) and to maintaining in residence those tenants who become unable to pay its monthly fees, such organization is operated to relieve the major forms of distress to which the elderly are susceptible. Accordingly, it qualifies for exemption from federal income tax under section 501(c)(3) as an organization operated exclusively for charitable purposes.

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Application for Recognition of Exemption, in order to be recognized by the Service as exempt

under section 501(c)(3) of the Code. See sections 1.501(a)-1 and 1.508-1(a) of the regulations. In accordance with the instructions to Form 1023, the application should be filed with the District Director of Internal Revenue for the key district indicated therein.

Rev. Rul. 79-19

Advice has been requested whether the nonprofit organization described below, which otherwise qualifies for exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954, is operated exclusively for charitable purposes.

The organization was formed to meet the housing needs of the physically handicapped by building and operating an apartment rental. complex designed especially for them. It was formed under the sponsorship of community leaders to meet a community need for such a facility. Its board of directors consists of civic leaders and other individuals with a particular interest in the problems of the handicapped.

The organization has designed, constructed, and equipped the complex in such a manner as to enable the handicapped to achieve a greater degree of living independence and mobility, and to make daily living easier for them.

The complex consists of a one-story facility with no stain. Efficiency, one bedroom, and two bedroom apartments are offered. All units of the complex are interconnected by glass-enclosed walkways. All curbs and approaches are ramped. Windows are designed to be at eye level for the large number of residents who are confined to wheelchairs. Kitchen appliances and bathroom fixtures, as well as all switches and wall plugs, are located at levels accessible to residents in wheelchairs. Each unit has an alarm button for residents needing emergency assistance. The complex contains lounge facilities, a dining facility, office space for visiting doctors, a recreation room, indoor and outdoor swimming pools, and a wheelchair sports area. The organization provides transportation for handicapped residents to work, medical care, shopping, and entertainment facilities.

In order to qualify for admission, an individual must demonstrate that he or she needs specially designed facilities in order to live a reasonably comfortable and secure life. Physically handicapped individuals who are able to live adequately in facilities without specially designed features are not eligible for admission.

While the initial funds for building and equipping the facility were provided by governmental and foundation grants, the organization is self-supporting in that its operating funds are derived principally from fees charged for residence in the facility. The organization admits as tenants only handicapped persons who are able to pay the full stated rental charges, which are within the financial reach of a significant segment of the community's handicapped persons. However, once persons are admitted to the facility, the organization is committed by established policy to maintaining them as residents, to the extent it is able, even if they subsequently become unable to pay its monthly charges. It effectuates this policy by maintaining such individuals out of its own reserves, by seeking

whatever support is available under local and federal welfare programs, by soliciting contributions from the general public, or by using some combination of these means.

The organization provides its services to the physically handicapped at the lowest feasible cost. Its receipts are used exclusively in furtherance of its stated purposes. Its charges are set at an amount sufficient to maintain reserves adequate to pay for the life care of any of its residents who may require it, and to enable it to set aside enough for a limited amount of expansion sufficient to meet the community's needs. Net earnings are thus generally used to improve the specialized services and facilities provided, to subsidize any resident unable to continue making his monthly payments, or to expand the facility where the needs of the community warrant such expansion. No part of the organization's net earnings inures, directly or indirectly, to the benefit of any private shareholder or individual. No employee receives more than reasonable compensation for services rendered.

Section 501(c)(3) of the Code provides for exemption from federal income tax of organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. Such term includes the relief of the poor and distressed.

Revenue Ruling 72-124, 1972-1 C.B. 145, sets forth requirements that homes for the aged must meet in order to qualify for exemption under section 501(c)(3) of the Code. The Revenue Ruling makes clear that a home for the aged will be deemed "charitable" if it meets the special needs of the elderly such as the need for health care, financial security, and residential facilities designed to meet specific physical, social, and recreational requirements of the elderly. Such a home need not provide direct financial assistance to the elderly in order to be "charitable," since poverty is only one form of distress to which the elderly as a class are particularly susceptible.

Similarly, the physically handicapped as a class are subject to "distress" in that they may experience frustration and require substantial assistance in dealing with standard design living, recreational, and transportation facilities. Moreover, they may have greater need for financial security than nonhandicapped persons because their employment opportunities may be more limited or because they may be required to live on fixed incomes.

Thus, when an organization that otherwise qualifies for exemption under section 501(c)(3) of the Code provides specially designed housing as described above that is within the financial reach of a significant segment of the community's handicapped persons, and when the organization commits itself to operating such housing at the lowest feasible cost (consistent with its maintaining

the reserve described above) and to maintaining in residence those tenants who become unable to pay its monthly fees, such organization is operated to relieve the major forms of distress to which the physically handicapped are susceptible. Accordingly, it qualifies for exemption from federal income tax under section 501(c)(3) of the Code as an organization operated exclusively for charitable purposes.

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Application for Recognition of Exemption, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. See sections 1.501(a)-1 and 1.508-1(a) of the regulations. In accordance with the instructions to Form 1023, the application should be filed with the District Director of Internal Revenue for the key district indicated therein.

Attachment 2
Definitions of Commonly Used Terms Concerning Elderly

The definitions that follow are meant to be descriptive only and are intended to be used only as an aid in case development and for general information. They have been compiled by using various sources such as, Senate Reports, HUD regulations and pamphlets and other materials relating to the elderly. They should not be cited.

1. Nursing Home - is an elderly care facility in which at least 50% of the residents receive nursing care. At least one full time registered nurse (RN) or licensed practical nurse (LPN) is employed.

2. Personal Care Home (with nursing) - is a home for the elderly in which less than 50% of the residents receive nursing care. At least one full time RN or LPN is employed.

If a full time nurse is not employed, this institution either: a) provides for the administration of medicines, or b) provides assistance with three or more daily activities, such as bath or shower, shopping, correspondence, walking, and eating.

3. Skilled Nursing Facility (SNF), or Extended Care Facility (ECF) is an elderly care facility that provides continuous nursing service on a 24-hour basis for convalescent patients. This type of facility emphasizes medical nursing care and physical therapy.

4. Intermediate Care Facility (ICF), or Residential Care Facility is a home for the elderly that provides regular medical nursing services and social services. The level of care provided is generally less than the care provided in a SNF or ECF.

5. Apartment dwelling (rental housing) units - are designed for independent living. Such a project usually consists of an efficiency and one bedroom apartments with kitchen, bath and storage. Generally, they contain a central lounge and other rooms for social and recreational activities. Such projects may include central dining facilities.

6. Congregate housing units - are designed for elderly residents, normally well and ambulatory who prefer residential accommodations but need or desire some assistance with day-to-day living. Generally, such projects have: a) a central dining room serving three meals a day; b) emergency room service; c) common areas for

lounges, recreation, and special activities; and d) limited housekeeping and laundry services. Most projects have an infirmary with personnel to administer medications.

7. Nursing Care - involves nursing procedures requiring the professional skills of a registered nurse (RN) or a licensed practical nurse (LPN). This care includes the taking of temperature, pulse, respiration and blood pressure; full bed bath; catheterization; injections; nasal feeding; and oxygen therapy.

8. Personal Care - involves services such as help in walking, eating, correspondence; bathing, and dressing.

9. Residential Care - involves general supervision with a protective environment and a planned program for social and religious needs.

10. Handicapped Person - A person who has a physical impairment which: a) is expected to be of a long-continued and indefinite duration; b) substantially impedes his ability to live independently; and c) is of such a nature that his ability to live independently could be improved by more suitable housing conditions.

Attachment 3
Federal Funding Programs

The programs as described below may have changed. For up to date information you might wish to contact the nearest local HUD office or the Director, Multifamily Division in Washington, D. C., telephone number (202) 755-5866. For a more detailed description of these and other related Federal programs you should consult the Catalog of Federal Domestic Assistance which is published annually by the Office of Management and Budget.

1. Section 236 of the National Housing Act, Public Law 90-448; U.S.C. 1715 -- Rental and cooperative housing for lower-income families. Under this program, nonprofit, limited-dividend and cooperative organizations may obtain a HUD-insured mortgage at the market interest rate. To bring the monthly rent down to a level tenants can afford, HUD makes a monthly payment to the lender reducing the interest cost as low as one percent. Tenants pay either the basic rental or 25 percent of their adjusted income, whichever is greater. Those who can afford it pay the fair market rental.

2. Section 221(d)(3) of the Housing and Urban Development Act of 1965; Public Law 89-117; 12 U.S.C. 1701 - Mortgage insurance for low and moderate income housing at market rate interest with rent supplement. Market-rate mortgage insurance is provided for the construction or rehabilitation of rental or cooperative housing of five or more units for persons whose incomes are determined by HUD to be low or moderate. The housing may be primarily for the elderly, or it may combine elderly and family housing. Section 221(d)(3) housing projects may include commercial services, recreation and social areas, and infirmaries.

3. Section 235 of the National Housing Act; Public Law 90-448; 12 U.S.C. 1715 - Home ownerships for lower income families. HUD makes monthly payments to the mortgagee to reduce interest rate costs to as low as one percent. The homeowner must pay at least 20 percent of the adjusted monthly income on the mortgage. Amounts of subsidies vary according to the homeowner's income and the total amount of the mortgage payment at the market interest rate. Families, handicapped individuals, and persons 62 or over are eligible for assistance if their incomes and assets fall within HUD prescribed limits.

4. Rental Supplement Program provides monthly payments for low income housing owned by nonprofit, cooperative, or limited-dividend organizations. A payment amounts to the difference between 25 percent of tenant's gross income

and the FHA - approved rental, but may not exceed 70 percent of the rental. Approximately 25 percent of all rent supplement tenants are elderly.

5. Section 106 of the Housing and Urban Development Act of 1968; Public Law 90-448 -- Interest-free 80 percent loans are made to nonprofit sponsors of low or moderate income housing to cover preconstruction costs involved in planning and financing a proposed project.

6. Section 231 of the National Housing Act; Public Law 86-372; 73 U.S.C. 654; 12 U.S.C. 1715(u) - Mortgage insurance for housing for the elderly. Mortgages are insured by HUD - FHA to finance new or rehabilitated rental housing of eight or more dwelling units specifically designed for persons over 62 or those who are handicapped.

7. Section 221(d)(4) of the National Housing Act - Mortgage insurance for low and moderate income rental housing of at least 5 units. This housing is intended for low and moderate income families, persons age 62 or over and handicapped persons.