Private Practice Management

Changes in the Tax Reform Act of 1976 Which Affect Business Operations

Robert E. McGillivray, PhD, CPA
Arlington, Texas

The changes contained in the Tax Reform Act of 1976 discussed in this article have a direct impact on the operation of a doctor's medical practice. However, not all of the changes contained in this article will have an impact on every medical practice. Certain changes were designed to give benefits to overall business operations; others have an impact only on those practices operating in the corporate form, or others on those practices operating in a non-corporate form.

The first change to be discussed deals with the investment credit. The credit was increased by the Tax Reduction Act of 1975 from seven to ten percent of the purchase price of assets with certain "lives." The Tax Reform Act of 1976 extends this increase from 1976. The Tax Reform Act also increased the amount of used property which can be subject to the investment credit from $50,000, to $100,000 for all tax years through 1980. Other requirements related to the investment credit remain the same as they were before.

The Tax Reform Act also contains a change in the way investment credits would be applied against the tax liability of a business entity. Under the prior law, the credit earned for the current year was applied first, and then the unused credits from prior years were applied. A number of taxpayers would be faced with a situation, from time to time, in which they could not receive the benefit of all of the investment credit they were entitled to because of a limitation in the law which affected the number of years in which they could apply investment credits from prior years. The Tax Reform Act makes a change in this area, in which the taxpayer is now required to use investment credits on a first-in, first-out basis. In computing his tax liability, the taxpayer would first apply investment credits from prior years, then credits earned during the current year, and finally, if there were tax liability available, a carry-back of investment credits earned in future years. In addition, the act provides that the seven-year carry-forward will be increased to a nine-year carry-forward for credits that would expire in 1976.

A second provision which has impact for businesses, is a new special deduction which permits the taxpayer to take, as an expense of the current year, amounts paid up to a maximum of $25,000 per year for the costs of removing architectural and transportational barriers, if the removal of these barriers assists access of the handicapped and the elderly. These expenses may be incurred in altering property either owned or leased by a taxpayer; however, there is a requirement that the removal of the barrier must be in business facilities and must meet standards set by the architectural and transportation barriers compliance board. Thus, the Tax Reform Act permits deduction as expenses of a current year those costs which normally would be capitalized and used as an increase in the depreciable amount of property.

There are now tax incentives contained in the tax law which are designed to encourage preservation of historical buildings and structures. These buildings and structures must be either listed in the National Register of Historic Places, located in a regional historic district and certified by the Secretary of Interior as being of historic significance to the district, or lo-

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cated in a historical district designated by an appropriate state or local government statute that has been certified by the Department of Interior. The incentive is that the taxpayer will be allowed to write off, over a five-year period, the costs of rehabilitating a depreciable historical structure used in his trade or business, or held for production of income. This five-year write-off applies to additions to property made after June 14, 1976, and prior to June 15, 1981. The law also contains some deterrents against destruction of historical property. The deterrent is caused by a provision which prohibits the deduction to the owner or lessee of a historical structure for any amount which is spent in demolition of the structure and prohibits the deduction of any loss which may be sustained because of demolition. Instead, any amounts expended to the cost of the land. This applies to all demolitions after June 30, 1976, and before January 1, 1981. Also, there is a provision which states that if a taxpayer builds new property on a site which was occupied by a historical structure that was destroyed, the individual can only use straight-line depreciation on the new structure. There is also a provision which will permit a taxpayer, who purchases a used, depreciable, historical structure and rehabilitates it, to choose accelerated depreciation methods which normally apply to new depreciable property. There is a requirement that the rehabilitation costs which have occurred during the prior 24 months must either exceed $5,000 or the amount of cost of the building which has not been depreciated at the beginning of the 24-month period. This provision applies to additions to the capital account which occur after June 30, 1976, and before July 1, 1981.

The Tax Reform Act has increased the amount of time a net operating loss may be carried forward to other years and applied against income. This extension now permits a seven-year carry-forward, rather than five years. The prior law permitted the taxpayer to take a net operating loss of one year and apply it against income in three prior years, or to carry it forward for a period of five years. The law now permits that taxpayers may forego the three-year carry-back and use only a seven-year carry-forward, if they so desire.

The Tax Reform Act also has made a change in the requirements related to condemnation of real estate. The prior law stated that if a taxpayer owned property which was condemned by a governmental agency, he could postpone the taxation of any gain received on the property by replacing the property with "similar kind" within a two-year period after the close of the first taxable year in which any gain was realized. The Tax Reform Act makes a change in that it extends the two-year period to a three-year period for real property which has been condemned. The two-year provision still applies to all property which may be lost through condemnation that is not classed as real estate.

The Tax Reform Act of 1976 extended the reduction in corporate tax rates which was introduced by the Tax Reduction Act of 1975 for years 1976 and 1977. The corporate tax rate for 1976 and 1977 will be 20 percent of the first $25,000 of corporate taxable income, 22 percent on the next $25,000 of corporate taxable income, and 48 percent on all taxable income over $50,000 for the corporation. There was a provision in the Tax Reduction Act of 1975 which would require a fiscal year corporation to prorate the income earned in certain years in order to calculate the tax, based upon the assumption that this reduction in corporate tax would not be continued. The requirements for this proration of income have been eliminated due to the extension of the corporate tax reduction.

There were several changes made by the Tax Reform Act which relate to Subchapter S corporations. The Subchapter S corporation is a corporation operating under normal corporate laws but which receives special tax consideration. The special tax consideration received by a Subchapter S corpora-

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Book Excerpts

The following articles have been selected by the Publisher from its new book, *Psychopharmacology in the Practice of Medicine,* edited by Murray E. Jarvik, MD, PhD, in the hope that they will have immediate usefulness to our readers who otherwise might not have had access to them.

Psychotherapeutic Drugs in Childhood and Adolescence

Robert O. Friedel, MD
Carl Eisdorfer, PhD, MD

In this article the use of psychotherapeutic agents is discussed for the treatment of most common childhood behavioral disorders presented to the practicing physician – hyperactive child syndrome (minimal brain dysfunction), enuresis, school phobia, affective disorders, night terrors, and anxiety states. Most physicians will recognize the need for other forms of therapeutic interventions, such as parental and teacher counseling, for all children manifesting symptoms of these disorders. However, since it is beyond the scope of this article to deal with these additional treatment modalities comprehensively, the reader will be referred to other sources for this information, when appropriate.

The effective use of psychotherapeutic agents in children presents the practicing physician with at least four problems in addition to those commonly encountered in treating adults with these medications. (a) Criteria for the diagnosis of psychiatric disorders in children are not as clearly defined as in adults; children present with a vast variety of physical symptoms, some of which are thought of mask underlying emotional conditions. (b) Due to pharmacokinetic effects, only one of which is a function of body size, therapeutic dose ranges are more variable in children than in adults. (c) Even when the diagnostic picture is fairly clear, some of the drugs commonly used in adolescents and adults are not approved for use in children by the Food and Drug Administration. (d) There is concern that drug use in children will increase subsequent drug-abuse tendencies and will act to produce a population of adolescents and adults who use medications far too liberally to solve ordinary life problems (Lennard et al 1971). Although there are no data substantiating these fears and there are some refuting them (Beck et al 1975), they are still most likely a major determinant in the development of treatment plans for behaviorally disturbed children. Hopefully, additional information and a realistic and supportive approach to parents with these concerns will reduce the impact of these latter factors.

Prevalence of Psychotherapeutic Drug Use in Children and Adolescents

Parish (1971) surveyed the records of 13,259 patients aged 15 to 92 years seen by general practitioners in England and Wales from May 1967 to April 1968. Of those aged 15 to 20 years, 8 percent of the males and 34 percent of the females received psychotropic medications, the most commonly prescribed being antidepressants and tranquilizers. Rowe (1973a, b) reviewed more than one million prescriptions for antidepressant drugs written by general practitioners in Australia during a nine-month period in 1971 and found that 4.1 percent of the prescriptions were written for males and 3.3 percent were written for females 14 years and younger. In a cross-national study (excluding the United States) Balter et al (1974) found that between 4.0 percent and 13.5 percent of the males and between 5.3 percent and 17.2 percent of the females between 15 and 24 used antianxiety/sedative drugs during the years prior to their study. Rowe (1973a, b) also found that these medications were prescribed for the treatment of mental disorders in 2.8 percent and 2.2 percent of the male and female patients under 14 years of age by 796 general practitioners surveyed in Australia. In general, then, the data indicated that psychotherapeutic agents are prescribed by general practitioners for children and adolescents in significant amounts in other parts of the world and that it is relatively safe to assume that a similar pattern exists in the United States (Parry et al 1973).

Enuresis

The frequent occurrence of enuresis in children makes this a common problem in general practice. Meadow (1970) estimated that between 10 and 15 percent of five-year-olds, five percent of ten-year-olds, and one percent of 15-year-olds wet their bed at night. A recent survey (WHO, unpublished data) revealed similar findings with 13 percent of six and seven-year-olds and three percent of 13 and 14-year-olds still reported to be wetting their beds more than once a month. Thorne (1944) reported that one in 50 Army draftees in World War II were still enuretic at age 18. Boys are more likely to have this problem than girls, the ratio being about 3:2 to 2:1. Approximately two-thirds of enuretic children have never achieved a dry period and are called "primary" enuretics. The remaining one-third, having experienced a dry period at some point prior to the onset of recurrent wetting, are designated "secondary" enuretics. Andersen and Petersen (1974) proposed that these two subtypes be further divided into those without and those with behavioral disturbances. Their data suggest that boys are more likely to present with primary enuresis without behavioral disturbances, whereas girls predominate in the other three subtypes. Girls

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more commonly present with enuresis of a diurnal nature and with symptoms of urinary tract infection. The associated symptom of encopresis was found to be twice as common in boys as in girls by these authors. Ritvo and co-workers (1969) describe two subgroups of children with enuresis on the basis of sleep electroencephalogram derived events, terming them arousal and nonarousal enuretics. Subjects with arousal enuresis showed increased evidence of neuroticism, a history of sporadic wetting, and no family history of enuresis. Subjects with nonarousal enuresis had minimal evidence of maladjustment, a history of regular wetting, family history of enuresis, and a better response to imipramine.

Feldman (1973) lists eight theories of the etiology of enuresis that have been proposed at one time or another. Among these are: small bladder capacity, failure of conditioning, noctural epilepsy, obstructive uropathy, spina bifida occulta, food allergy, and psychologic factors. The relative prevalence of these different proposed causes of enuresis has not been clearly determined, but relatively few are attributable to organic lesions.

Treatment

As one might surmise, no single treatment program has gained universal acceptance. Some authors recommend a complete history, physical examination, laboratory studies, including urinalysis, urine culture, and urologic investigation consisting of intravenous pyelograms and voiding cystourethrograms. Others consider this approach too heroic to be employed routinely and opt for a more conservative program relying on radiologic procedures only in those cases refractory to the more commonly used therapeutic approaches.

In addition to counseling and psychotherapy, the two interventions that have received the most attention have been the electric alarm system and drug treatment with a tricyclic antidepressant, most commonly imipramine. The proponents of the alarm system (Young and Morgan 1973) feel that with the full cooperation of parents this system is highly effective, although it does not lend itself readily to controlled studies. In spite of reported high success rates, it is suggested (Fraser 1972) that buzzer training not be undertaken until a urinary tract infection has been excluded (psychiatric assessment has been requested when several symptoms of emotional disturbance are present in addition to the symptom of enuresis), until waking the child in the late evening or early morning has been tried; and a course of extended treatment with tricyclic antidepressants and chlordiazepoxide has been attempted. When all of these approaches have failed and the alarm system has been unsuccessful, many practitioners feel that more extensive urologic and psychiatric evaluation should then be pursued.

Prior to treatment with imipramine, children with organic heart disease, hyperthyroidism, glaucoma, diabetes, kidney or liver disease should be excluded by careful history, physical examination, and routine laboratory tests. Patients receiving treatment with monoamine oxidase inhibitors should also be excluded. Imipramine is approved for use in children of six and over suffering from enuresis. An oral dose of 25 mg given one hour before bedtime is the recommended starting dose. If improvement has not been noted after one week, the dose is increased to 50 mg nightly. In children over 12 years of age an additional increase of 25 mg to a total of 75 mg per night may be attempted in those who do not respond after the second week of treatment. Improvement frequently takes one to two weeks to occur, and both patients and parents should be alerted to this response pattern. Once a successful response has occurred, it is recommended that the child be maintained on the medication for a three to six-month period, since it appears that exacerbation of symptoms frequently occurs when shorter time periods are employed. The evidence is not clear that rapid cessation of medication after the treatment program is complete results in a greater rate of exacerbation of symptoms than a gradual tapering of medications. However, the latter course is to be preferred until conclusive data are available.

Adverse Reactions

Side effects do not appear to be common in children treated with imipramine for enuresis. When reported, they include anticholinergic effects, tremors, anorexia, and diarrhea.

There is a growing concern about the increasing incidence of sublethal and lethal poisoning in children with tricyclic compounds (Brown et al 1971). Such medications now rank second to salicylates as a cause of childhood death due to self-poisoning (Bain 1973). Goel and Shanks (1974) report that 60 percent of 60 children admitted over a seven-year period were receiving treatment for enuresis. The most prevalent symptoms are convulsions, coma, cardiac arrythmias, and vascular collapse. Treatment is difficult. In addition to supportive measures, intravenous physostigmine (Rumack 1973), potassium chloride

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Books Received

Books received by *The Journal of Family Practice* are acknowledged in this column. Those that appear to be of particular interest to our readers will be reviewed as space permits.

A Coursebook in Health Care Delivery. *Sidney Shindell, Jeffrey C. Salloway and Colette M. Oberembt. Appleton-Century-Crofts, New York, 1976, 603 pp., $20.50.*

Reviews in Perinatal Medicine (Volume 1). *Emile M. Scarpelli and Ermelando V. Cosmi (eds). University Park Press, Baltimore, 1976, 396 pp., $24.50.*

Psychology of Deafness for Rehabilitation Counselors. *Brian Bolton (ed). University Park Press, Baltimore, 1976, 156 pp., $14.50.*

Diabetes Explained: A Layman's Guide. *Ira J. Laufer and Herbert Kadison. Saturday Review Press, New York, 1976, 177 pp., $7.95.*

Basic Child Psychiatry (2nd Edition). *Philip Barker. University Park Press, Baltimore, 1976, 274 pp., $14.50.*

Hyperactive Children: Diagnosis and Management. *Daniel J. Safer and Richard P. Allen. University Park Press, Baltimore, 1976, 239 pp., $8.50 (paper).*

Helping Ourselves: Families and the Human Network. *Mary C. Howell. Beacon Press, Boston, 1975, 231 pp., $8.95.*

Antimicrobial Drug Therapy (Volume VIII in the series Major Problems in Internal Medicine). *Abraham I. Braude. W.B. Saunders Company, Philadelphia, 1976, 218 pp., $12.00.*

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Innovative Medical-Psychiatric Therapies. *Richard M. Suinn and Richard G. Weigel (eds). University Park Press, Baltimore, 1976, 302 pp., $19.50.*

The Laboratory in Clinical Medicine: Interpretation and Application. *James A. Halsted (ed). W.B. Saunders Company, Philadelphia, 1976, 866 pp., $32.50.*

Applied Pharmacology (1st American Edition). *Walter Modell, Heinz O. Schild, and the late Andrew Wilson. W.B. Saunders Company, Philadelphia, 1976, 925 pp., $19.50.*

Child in Sport and Physical Activity (International Series on Sport Sciences — Volume 3). *J.G. Albinson and G.M. Andrew (eds). University Park Press, Baltimore, 1976, 233 pp., $16.50.*

The Management of Cerebrovascular Disease (3rd Edition). *John Marshall (ed). J.B. Lippincott Company, Philadelphia, 1976, 224 pp., $25.00.*

Common Symptoms of Disease in Children (5th Edition). *R.S. Illingworth. J.B. Lippincott Company, Philadelphia, 1976, 375 pp., $17.00.*

Focus on Learning in Family Practice. *W.E. Fabb, M.W. Heffernan, W.A. Phillips, et al. Royal Australian College of General Practitioners, Melbourne, 1976, 252 pp., price not available.*

Primary Care in a Specialized World. *Philip R. Lee, Lauren LeRoy, Janice Stalcup, et al. Ballinger Publishing Company, Cambridge, Massachusetts, 1976, 220 pp., price not available.*

An Inventory for Primary Health Care Practice. *Archie S. Golden. Ballinger Publishing Company, Cambridge, Massachusetts, 1976, 146 pp., price not available.*

Basic and Clinical Immunology. *H.H. Fudenberg, D.P. Stites, J.L. Caldwell, et al (eds). Lange Medical Publications, Los Altos, California, 1976, 653 pp., $12.50.*

Review of Medical Pharmacology (5th Edition). *Frederick H. Meyers, Ernest Jawetz, and Alan Goldfien. Lange Medical Publications, Los Altos, California, 1976, 740 pp., $12.50.*

Medical Directives for the Use of the Nursing Staff of the Frontier Nursing Service, Inc. (7th Edition). *Frontier Nursing Service, Inc., Wendover, Kentucky, 1975, 150 pp., $5.25.*

The Practice of Medicine. A Self-Assessment Guide. *Simeon Margolis, A. McGehee Harvey, Richard J. Johns, et al (eds). Appleton-Century-Crofts, New York, 1976, 397 pp., $11.50.*

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Beck's Obstetrical Practice, Resident Level (10th Edition). *E. Stewart Taylor. Williams and Wilkins Company, Baltimore, 1976, 639 pp., $38.50.*

Contact Lenses and Corneal Disease. A Programmed Course. *Antonio R. Gasset. Appleton-Century-Crofts, New York, 1976, 403 pp., $20.00.*

Congestive Heart Failure. Mechanisms, Evaluation and Treatment. *Dean T. Mason. Yorke Medical Books, New York, 1976, 448 pp., $35.00.*

Community Mental Health. Target Populations. *Ann Wolbert Burgess and Aaron Lazare. Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1976, 276 pp., $10.50.*

Hypnosis in the Relief of Pain. *Ernest R. Hilgard and Josephine R. Hilgard. William Kaufmann, Inc., Los Altos, California, 1975, 262 pp., $12.50.*

Topics in Family Practice. *Frank J. Cozzetto and H.R. Brettell (eds). Symposia Specialists, Miami, Florida. Released through Stratton Intercontinental Medical Book Corporation, New York, 1976, 398 pp., $21.95.*

Moral Dilemmas in Medicine (2nd Edition). *Alastair V. Campbell. Churchill Livingstone, New York, 1975,212 pp., $5.75.*

Current Pediatric Diagnosis and Treatment (4th Edition). *C. Henry Kempe, Henry K. Silver and Donough O'Brien. Lange Medical Publications, Los Altos, California, 1976, 1,053 pp., $15.00.*

Management of the Unconscious Patient. Volume 1 of Current Concepts in Emergency Medicine. *William R. Darmody. The C.V. Mosby Company, St. Louis, 1976, 120 pp., $9.50.*

Profiles in Human Development. *George Kaluger and Meriem Fair Kaluger. The C.V. Mosby Company, St. Louis, 1976, 250 pp., $5.95.*

Behavioral Methods for Chronic Pain and Illness. *Wilbert E. Fordyce. The C.V. Mosby Company, St. Louis, 1976, 248 pp., $9.50.*

Urology in Primary Care. *Stephen N. Rous. The C.V. Mosby Company, St. Louis, 1976, 277 pp., $11.75.*

Textbook of Basic Emergency Medicine. *Robert H. Miller (ed) in collaboration with James R. Cantrell. The C.V. Mosby Company, St. Louis, 1975, 248 pp., $7.95.*

Physical Examination of the Spine and Extremities. *Stanley Hoppenfeld. Appleton-Century-Crofts, New York, 1976, 276 pp., $16.50.*

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