

Chapter AA

## **Do's and Don'ts of Medical and Health Care Facility Leasing**

---

**Gregory G. Gosfield, Esquire**  
Klehr Harrison Harvey Branzburg, LLP  
Philadelphia

**Daniel F. Shay, Esquire**  
Alice G. Gosfield and Associates, PC  
Philadelphia

These materials are updated and reprinted, with permission, from *The Medical & Healthcare Facility Lease: Legal and Business Handbook* (American Health Lawyers Association).



---

# Table of Contents

---

Chapter AA:

**Do's and Don'ts of Medical and Health Care Facility Leasing**.....AA-1

*Gregory G. Gosfield, Esquire*

*Daniel F. Shay, Esquire*

1. Regulatory Issues .....	AA-5
1.1. Health Insurance Portability and Accountability Act (“HIPAA”) .....	AA-5
1.2. American Recovery and Reinvestment Act (“ARRA”).....	AA-9
1.3. Doctor-Patient Privilege and Duty of Confidentiality.....	AA-10
1.4. Torts.....	AA-11
1.5. Anti-Kickback and Stark Laws .....	AA-11
1.6. Exclusions from Participation in Federal Funding Programs.....	AA-17
1.7. Hazardous Materials .....	AA-17
1.7.1. Medical Waste.....	AA-18
1.7.2. Hazardous Chemical Materials. ....	AA-20
1.8. Americans with Disabilities Act of 1990 (“ADA”), Rehabilitation Act of 1973, Fair Housing Act of 1988, and Related Laws (“Disabilities Laws”).....	AA-20
1.9. Compliance .....	AA-22
2. Physical Issues .....	AA-22
2.1. Utilities.....	AA-22
2.2. Maintenance Services .....	AA-23
2.3. Physical and Structural Improvements.....	AA-23
2.4. Practice Groups with Special Locations .....	AA-24
2.5. Signage .....	AA-24
3. Operational Issues.....	AA-24
3.1. Landlord entry .....	AA-24
3.2. Tenant Early Termination .....	AA-24
3.3. Use .....	AA-25
3.3.1. Tenant Permitted Use .....	AA-25
3.3.2. Tenant Prohibited Uses.....	AA-26
3.3.3. Tenant Exclusive Uses .....	AA-28
3.3.4. Landlord Permitted Uses .....	AA-29
3.3.5. Time Block and Time Share Lease Arrangements .....	AA-29
3.4. Common Areas .....	AA-31
3.4.1. ADA .....	AA-32
3.4.2. Health Fairs .....	AA-32
3.4.3. No Obstruction.....	AA-32
3.5. The Hospital as Tenant .....	AA-32
3.5.1. Satellite Services .....	AA-32
3.5.2. Licensure Compliance .....	AA-32
3.5.3. Personnel.....	AA-33
3.5.4. Private Health Information .....	AA-33

3.5.5. Patient Services .....	AA-33
3.5.6. Financial Information .....	AA-33
3.5.7. Signage .....	AA-34
3.5.8 Authority .....	AA-34
3.5.9. Operations .....	AA-34
3.6 Construction Issues .....	AA-34
3.6.1 Plan and Specification Approval [DOH, Joint Commission, Clinical Laboratory Improvements].....	AA-34
3.6.2 Tenant Improvement Allowance.....	AA-34
4. Conclusion.....	AA-35
<i>Slide Outline &amp; Presentation .....</i>	<i>AA-37</i>

## 1. REGULATORY ISSUES

### 1.1. Health Insurance Portability and Accountability Act (“HIPAA”)

The two general purposes of HIPAA encompassed in the Privacy Rule,<sup>1</sup> which creates standards for the use and disclosure of protected patient health information, and the Security Rule<sup>2</sup>, which creates standards for protection of electronic patient health information. HIPAA applies to “covered entities” (“CE”) which includes a health care provider transmitting health information electronically.<sup>3</sup> “Health care provider” is a health care professional or other organization that bills, furnishes or is paid for health care.<sup>4</sup> “Health information” is any information created or received in any format, whether oral, written, or in any medium, by a health care provider and relating to an individual’s health care.<sup>5</sup> “Individually identifiable health information” is health information created or received by a health care provider relating to the health care of an individual which identifies or can reasonably be expected to be able to identify an individual.<sup>6</sup> “Protected health information” (“PHI”) is individually identifiable health information transmitted or maintained in any format. A CE may not use or disclose PHI except in connection with permitted uses. A covered health care provider who transmits PHI in electronic form (“EHPI”) is subject to standards adopted by the US Department of Human and Health Services (“DHHS”).<sup>7</sup>

---

<sup>1</sup> 45 C.F.R. §164.502 See also 65 Fed. Reg 82462

<sup>2</sup> 45 C.F.R. 164.306(a), 744 (Oct 1, 2006)

<sup>3</sup> 74 Fed. Reg. 56123, 56124 (Interim final rule; request for comments Oct 30, 2009)

<sup>4</sup> HIPAA §1171

<sup>5</sup> HIPAA §1171

<sup>6</sup> HIPAA §1171

<sup>7</sup> 45 C.F.R. 164.306(a), 744 (Oct 1, 2006)

A “business associate” (“BA”) is an entity that provides a service to a CE which requires the use or disclosure of PHI.<sup>8</sup> A BA takes PHI subject to the same general privacy rule that apply to a CE as to use and disclosure. “Disclosure” is the release or access to information outside of the entity holding the information.<sup>9</sup> The HITECH Act provides for federal regulatory enforcement of notice by CEs and BAs of a breach of privacy of PHI.<sup>10</sup> In addition, HIPAA covers BAs directly, not just indirectly through business associate agreements.<sup>11</sup>

Intuitively, a landlord would not expect to be governed by HIPAA or any other federal and state laws regulating health information confidentiality requirement because the landlord would not consider itself to be providing a service to the tenant related to the tenant’s PHI. But the text of a lease and the circumstance of the landlord-tenant relationship may result in the landlord being drawn within the ambit of HIPAA coverage.

There are at least three common instances when a landlord may be implicated as a BA for HIPAA purposes because it is not exercising incidental control but actually acting on behalf of the tenant: (1) landlord’s work includes installation of fixtures that provide or secure patient health information during which the landlord must have access to the PHI either to test that the installation works or to confirm the security remains operational and in good repair or replacement; (2) landlord’s services include administering or securing PHI, such as by providing medical suites with common support services, receptionists, or data storage; (3) landlord’s repossession of the leased premises includes retrieval, storage and

---

<sup>8</sup> 45 CFR 160.103; 65 Fed. Reg. 82798, Dec. 28, 2000, as amended at 67 Fed. Reg. 38019, May 31, 2002; 67 Fed. Reg. 53266, Aug. 14, 2002; 68 Fed. Reg. 8374, Feb. 20, 2003; 71 Fed. Reg. 8424, Feb. 16, 2006.

<sup>9</sup> 68 Fed. Reg. 8334, 8374 (Feb 20, 2003)

<sup>10</sup> 68 Fed Reg. 8334, 8358 (Feb. 20, 2003)

<sup>11</sup> Pub. L. No 111-5, §13401, 123 Stat. 260 (2009) [and need cite]

disposal of PHI upon tenant's surrender, abandonment or ejection from the leased premises; landlord's storage may especially create a duty for landlord as acting on behalf of the tenant with respect to its PHI.<sup>12</sup>

The tenant should be mindful that even though the landlord has not risen to the level of a BA, its acts may result in tenant's violation of HIPAA, such as where (1) landlord audit rights could result in disclosure of PHI, such as information related to patient treatments and third party reimbursements; or, (2) landlord's security forces exercise control over PHI upon extraordinary events such as casualty affecting the area where PHI is located.

The general rule is that a mere landlord-tenant relationship does not bring the landlord into the ambit of HIPAA, but the landlord could be a BA if its contractual relationship with the CE provides landlord with more than an incidental control over PHI. If the landlord's engagement with PHI is merely incidental, such as cleaning an area where files are located, the landlord would not be a BA.<sup>13</sup> If, however, the landlord control is material rather than incidental, the landlord would be a BA and the contract between it and the CE must include BA contract provisions required by HIPAA.<sup>14</sup>

Even if the landlord is not a BA, the tenant CE may need to incorporate or at least reconcile the landlord's security system and security plan into the tenant CE's security plan to manage the protection of the PHI in the case of an emergency.<sup>15</sup> Accordingly, a covered entity in a multiple business office structure should acquire a copy of the landlord's building security plan and include it in the covered entity's security plan as an exhibit or appendix item. In the alternative, a landlord may contractually disavow responsibility for providing

---

<sup>12</sup> <http://www.hhs.gov/ocr/privacy/hipaa/faq/safeguards/577.html> (Created 02/18/09).

<sup>13</sup> 67 Fed. Reg. 53252, Aug. 14, 2002.

<sup>14</sup> 45 C.F.R. § 164.504, 749, 759 (Oct 1, 2007).

<sup>15</sup> 68 Fed. Reg. 8334, 8353 (Feb 20, 2003)

security systems to protect tenant's PHI. Similarly, but less acutely, the landlord's mortgagee should anticipate the risks that inhere in taking over the role of a BA.

A cautious tenant may negotiate for the landlord to take all prudent action to avoid accessing or disclosing PHI, including advising all its employees and contractors providing services to landlord to acknowledge it is subject to the obligations and restrictions (1) to comply with requirements of HIPAA, (2) to maintain the confidentiality of the PHI records, (3) to refrain from entering any tenant space where patient's are being examined, (4) to enter the tenant's space only when landlord is accompanied by a tenant representative, and (5) to indemnify tenant for violations landlord. The tenant may also require the landlord to establish a protocol to limit landlord access to the tenant's PHI space to those landlord parties who sign-in or are otherwise identified or pre-approved, and, if there is no other compelling security, to monitor the PHI location with a security camera. Tenant may seek landlord indemnification for loss; but, the landlord may need to exclude consequential damages, such as tenant being excluded from further federal funding programs. The tenant may also insist that the landlord waive any statutory or contractual liens relating to PHI as tenant's personal property at the leased premises. Tenant should require that the PHI is expressly excluded from any security agreement and from any Uniform Commercial Code financing statement perfecting a landlord lien. In response, the landlord may want a perfected security interest subject to the duty to destroy or relocate PHI. If landlord has no confidence that tenant will pay for relocation, the landlord would choose destruction. Tenant would want that destruction performed in a pre-determined fashion, such as shredding or other commercially reasonable fashion, by a professional disposal company which serves attorneys, physicians and similar professionals with on-going needs to appropriately destroy confidential information.



A cautious landlord may in turn seek to shift the onus of HIPAA requirement back to tenant by requiring all PHI be preserved by the tenant in a secure cabinet, as to papers, and a secure electronic format as to electronic files; that the PHI access points be clearly and conspicuously identified with restrictions such as “THESE CABINETS/COMPUTERS CONTAIN PROTECTED AND CONFIDENTIAL INFORMATION. ANY UNAUTHORIZED ACCESS OR USE MAY RESULT IN VIOLATION OF FEDERAL LAW, FINES AND IMPRISONMENT.” The landlord may further require that the tenant at its cost maintain all PHI tangible files in specific and pre-designated secure areas shown on a lease plan, that the tenant covenant to keep them locked at all times outside of business hours, and that the tenant construct them in a manner that allows them to be easily relocated or destroyed in the case of an extraordinary event, such as a building casualty. The landlord may also require that the tenant identify a security officer to be responsible for PHI and for decisions relating to its treatment during an extraordinary event, including casualty, eviction, or abandonment. The landlord may negotiate for the tenant to pre-approve landlord’s unilateral right to remove and dispose of PHI if tenant’s security officer does not assume responsibility for the PHI in a timely fashion.

1.2. American Recovery and Reinvestment Act (“ARRA”)

The passage on February 17, 2010 of the ARRA, is another new statute affecting HCFL financial structures and HCFL lease provisions. The ARRA includes the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”) to provide stimulus to revamp health information technology. It accentuates the regulation of health data privacy in the electronic medium for data, and it expands the coverage of its regulatory program to cover not only CEs with protected PHI, but also BAs. Failure to comply with

HIPAA can result in civil and criminal liability for CEs.<sup>16</sup> One consequence of the HITECH Act is that BAs, like CEs, may now be liable for civil liability up to \$1,500,000, and cannot defend with the argument that “it did not know.”<sup>17</sup>

### 1.3. Doctor-Patient Privilege and Duty of Confidentiality

Doctor-patient privilege and doctor-patient confidentiality are cognates, but distinguishable. The privilege is deemed to be protected by common law. The confidentiality by statutes. Many would reach back to the Oath of Hippocrates for the first written articulation of the principle: “Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.”<sup>18</sup> The principle of the privilege is sometimes protected by the Federal Rules of Civil Procedure under the Article V “Privileges,” General Rule.<sup>19</sup> Most states also have codified in their statutes some form of doctor-patient confidentiality. The confidentiality is for the benefit of and can be broken by the acts of the patient. If the patient breaches the confidentiality, or undertakes a lawsuit that would pierce the confidentiality, then the confidentiality is ordinarily lost. Until the patient has lost the confidentiality, the tenant health care provider would want to protect the confidentiality for both health and legal reasons.

---

<sup>16</sup> HIPAA rules. 74 Fed. Reg. 56123. 56124 (Interim final rule; request for comments October 30, 2009)

<sup>17</sup> HHS strengthens HIPAA Enforcement, Friday, October 30, 2009

<sup>18</sup> *Oath of Hippocrates*. In: Harvard Classics, Volume 38. Boston: P.F. Collier and Son, 1910.

<sup>19</sup> Fed. R. Evid. 501 (2009)

Consequently, the tenant may insist that landlord exercise any routine right of entry at a time outside of patient examination times. Additional special provisions may include landlord preserving confidentiality, adopting acceptable tenant protocols to safeguard confidentiality, and promulgating written guidelines or adhering to tenant's written guidelines. The landlord may require an increase rent by tenant in exchange for the cost and risk of agreeing to increase its standard of confidentiality, whether subject to the regulatory regime, or as adopted contractually. If so, the lease agreement may need to comport with the requirements of the tenant health care provider's confidentiality protocol.

#### 1.4. Torts

If a landlord prevents a tenant from accessing its PHI, the landlord is interfering with the tenant's business, which may be a tort by landlord suffered by tenant. If a patient suffers injury or deterioration of its condition which was reasonably foreseeable, this may be a tort by landlord suffered by the patient.

#### 1.5. Anti-Kickback and Stark Laws.

If the four essential terms of a lease are parties, premises, period of duration, and rent, then of them, certainly rent is the most contentious and subject to creative argument. Whereas in a hospitality or entertainment venue, rent can be calculated on per capita invitees, federal law forbids that in the health care lease where federal funds are involved. And though a retail landlord can have a rent based on a percentage of revenue, that is not permitted in an HCFL lease subject to federal jurisdiction. Consequently, in constructing an appropriate rent provision, the health care lease can be subject not only to the ordinary exigencies of the marketplace, and the guidelines of the financial accounting standards, but also to health care law specific restrictions to prevent fraud and abuse.

The Ethics in Patient Referrals Act, also known as the Stark law<sup>20</sup> prohibits physicians from (1) making referrals of a Medicare or Medicaid patient (2) to an entity which provides “designated health services,” (3) with which the physician or family members have a financial relationship.<sup>21</sup> For the HCFL lease, this would occur where the HCFL was owned by several doctors or family members, with interests in tenant medical practices or a tenant hospital at which the doctors have admitting privileges and provides services to the doctors’ patients. Another instance is if an HCFL is leased to a hospital and it requires that as a condition of its lease all other tenants have admission privileges only at the hospital. A third instance is if the tenants are those doctors who are owners and cross-refer to each other. Another instance is where the tenants are the doctors, and a hospital at which those tenant doctors have admitting privileges or to which the tenants might refer Medicare or Medicaid business is the landlord.

By comparison, the Anti-kickback law forbids the remuneration for referrals or ordering services which are compensated by a federal health care program.<sup>22</sup> The federal government issued guidance on how the Anti-kickback law can affect health care real estate leases.<sup>23</sup> Suspicious activity was identified as including: (1) rent which is excessive, or tied to non-real estate factors such as patient referrals; (2) companion payments that are not based on expenses for valuable services; or (3) rent for space greater than the tenant’s business needs. Any of these three components could routinely show up in a general office lease, such as by way of example: (1) percentage rent is based on sales rather than real estate

---

<sup>20</sup> Section 1877 of the Social Security Act (“SSA”) 42 U.S.C. 1395.

<sup>21</sup> Alice G. Gosfield “The Stark Truth About the Stark Law: Part I” Family Practice Management (November/December 2003): 27-45. [Referred to herein as “The Stark Truth”] p. 28.

<sup>22</sup> “Rental of Space in Physician Offices, by Persons or Entities to Which Physicians Refer” Special Fraud Alert of The Office of Inspector General of the United States Department of Health and Human Services Bulletin (February 2000) at p. 2. [Referred to herein as the “Alert”]

<sup>23</sup> Alert at p.2.

comparables, (2) transfer fees, key money charges, and participation in assignor revenues from assignment or subletting are not based on expenses for valuable services, and (3) tenants whose 10 year business plan forecasts future significant expansion or current anomalous staff reductions, may lease more space than it needs for the short term because of the need to plan for the long term. A landlord engaged in that activity in an HCFL may find itself culpable for civil and criminal liability.

The Anti-kickback law is separate and different from the Stark law in the ways they can affect HCFL leases.<sup>24</sup> The interpretation of the Stark law is under the jurisdiction of the Centers for Medicare and Medicaid Services (“CMS”). The Anti-kickback law is policed by the Office of the Inspector General (“OIG”).<sup>25</sup> The Anti-kickback law applies to health care providers and suppliers,<sup>26</sup> including comprehensive outpatient rehabilitation facilities (“CORF”s) that provide physical and occupational therapy and speech-language pathology services in physicians’ and other practitioners’ offices; mobile diagnostic equipment suppliers that perform diagnostic related tests in physicians’ offices, independent diagnostic testing facilities (“IDTFs”); physical and occupational therapy practices; and, suppliers of durable medical equipment, prosthetics, orthotics and supplies (“DMEPOS”) that set up “consignment closets” for their supplies in physicians’ offices. One conspicuous difference is that Stark law violations may be totally innocent, whereas Anti-kickback law prohibits “knowingly and willfully soliciting, receiving, offering or paying anything of value to induce referrals of items or services payable by a Federal health care program.”<sup>27</sup> Another noteworthy difference is, if the arrangement does not fall within the scope of a Stark

---

<sup>24</sup> The Stark Truth at p.29.

<sup>25</sup> The Alert, page 1

<sup>26</sup> Alert, Page 1.

<sup>27</sup> Alert, page 2

exception, it is a violation of the statute. By contrast, an arrangement which falls outside a safe harbor under the Anti-kickback statute is not necessarily a violation; it is not as “safe” as falling within the safe harbors, but some deviation from the safe harbors is permissible. However, a more inconspicuous example of the divergence, is that the OIG defers to the CMS’ jurisdiction in the interpretation of the DMEPOS supplier standards with respect to the appropriateness of “consignment closets.”<sup>28</sup> In each case, the following two conditions must be met before undertaking the analysis: is one of the parties a health care provider, or owned by health care providers, and does it benefit from federal health care program payment.

The prohibitions under the two Acts are congruent but not identical. The usual issues that are suspect under the Anti-kickback law when a lease relationship exists are whether rental amounts reflect market rates, and whether the purported size and duration of the arrangement is an appropriate reflection of the underlying real estate needs. The OIG illustrates a suspect lease relationship as one where a DMEPOS supplier rents a consignment closet at a physician’s office but the storage of the inventory is generally considered an accommodation for the physician’s patients.<sup>29</sup> The OIG characterizes suspect rent calculations as those that do not reflect market value, are not fixed in advance, or are related in some way to referral business between the parties. Though in an ordinary real estate lease rent based on revenue would be otherwise unremarkable, in the health care facility lease with its heightened scrutiny, rent is presumptively suspect if it is based on revenue, as is sublease rent if on a square foot basis if it is in excess of the prime lease rent. Other examples of rent which would be presumed suspect are (1) rent in excess of what a comparable property

---

<sup>28</sup> Alert, page 1. Although the Alert refers to the Health Care Financing Administration, or "HCFA," the agency's name was changed in 2001.

<sup>29</sup> Alert, page 1.

would bear where no referrals were related to the arrangement, (2) rent reset more than once annually, (3) rent based on referral activity, (4) rent based on hourly use without fixing the number of hours to be used, (5) rent based on Federal health care program beneficiaries referred, and (6) rent based on Federal health care program payments.<sup>30</sup> In addition, free rents, and large tenant allowances may be recharacterized as impermissible remuneration if not consistent with tenant concessions in the marketplace. There is little case law construing fair market rental for these regulated concerns.<sup>31</sup> The size of the premises and period of duration are presumptively suspect if they do not conform to the actual needs of the tenant. OIG examples are if a CORF pays rent on the entire space but only uses one examination room, or if it pays rent for a full day, but uses space only for 4 hours, or if a health care provider, such as a nurse practitioner, pays rent when assisting a primary provider, such as a physician, who also pays rent; but the nurse practitioner does not occupy the space separately from physician because the nurse assists the physician.<sup>32</sup> In the case of use of interior or common space, the OIG prescribes a formula for rent for partial users that includes all users in the allocation.

Though the safe harbor exceptions to the prohibition with respect to real estate leases are not identical as between the Stark law and the Anti-kickback law, from a 30,000 foot height, the rules for both safe harbors have the following general requirements: they must be (a) in writing, (b) signed by both parties, (c) specify the leased premises, (d) endure for a term of more than one year, (e) grant premises which are not too spacious for the business being conducted, (f) require rent consistent with fair market value, (g) with no

---

<sup>30</sup> Alert, page 2.

<sup>31</sup> *USA v. McLaren Regional Medical Center*, 202 F. Supp 2d 671, 685 (E.D. Mich. 2002).

<sup>32</sup> Alert, page 3.

corresponding charges for the number or value of referrals, and (h) on terms otherwise commercially reasonable.<sup>33</sup>

The specifics of the safe harbor protection from OIG prosecution requires all of its elements be met. The specific components of the Anti-Kickback Law safe harbor<sup>34</sup> are: (1) the agreement be written; (2) the agreement be signed by the parties; (3) the agreement cover (a) all of the premises rented by the parties (b) for the term of the agreement and (c) specify the premises covered by the agreement; (4) if the agreement is intended to provide the lessee with access to the premises for periodic intervals of time rather than on a full-time basis for the term of the rental agreement, the rental agreement specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals; the term of the rental agreement be for at least one year; and (6) the aggregate rental charge: (a) be set in advance, (b) be consistent with fair market value in arms-length transactions, and (c) be unrelated to the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program. Even then, there may be uncertainty in light of the OIG opinion that a block sublease with a fixed fair rental value may be suspect if it covers up “improper remuneration.”<sup>35</sup>

In the case of equipment rental or personal services provided by staff, the OIG has similar safe harbors<sup>36</sup> (1) the agreement be written; (2) the agreement be signed by the parties; (3) specific equipment or services used should be identified and documented; and (4) payment be limited to the prorated portion of its use.

---

<sup>33</sup> 73 Fed. Reg. 48752 (Aug. 19, 2008) as amended 73 Fed. Reg. 57542 (Oct. 3, 2008)[ Stark]

<sup>34</sup> 42 C.F.R. §1001.952(b) 680, 682 (2009)

<sup>35</sup> 42 C.F.R. 1001.952(b).” *McLaren Regional Medical Center*, 202 F. Supp 673-674.

<sup>36</sup> Id. 683



The OIG may initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil money penalties for fraud, kickbacks and other prohibited activities.<sup>37</sup> Violations of the Anti-kickback law can also be punished as a felony with sanctions of up to \$25,000 in fines, five years of imprisonment, or both.<sup>38</sup> Both landlords and tenants can be subject to the sanctions.

1.6. Exclusions from Participation in Federal Funding Programs.

The OIG has developed certain rules that would exclude non-compliant providers from participation in federal funds, directly or indirectly, such as if a provider has been convicted of fraud, patient abuse, licensure infractions, and the like.<sup>39</sup> As a general matter a landlord, without providing other services is not likely to be in the class of regulated providers, and can be paid rent that is from revenue received by a covered health care provider. But it is likely that if the landlord provides health care services, such as leasing medical equipment to the tenant, it may fall within the class of regulated providers.<sup>40</sup>

1.7. Hazardous Materials.

As a general matter, all office users store hazardous substances, whether the solvents to clean stains or the nickels in the President's pocket. The issue is whether the hazardous substances are in concentrations and quantities regulated by law, and if so, does the tenant's use comply with the requirements of applicable law. Common hazardous substances include medical waste,<sup>41</sup> nuclear waste, hazardous chemical substances, needles and similarly medical

---

<sup>37</sup> Social Security Act"1128A(a)(7); 42 U.S.C. 1320a-7a

<sup>38</sup> Alert, page 1.

<sup>39</sup> "The Effect of Exclusion From Participation in Federal Health Care Programs," OIG Special Advisory Bulletin (September 1999), available online at [http://oig.hhs.gov/fraud/alerts/effect\\_of\\_exclusion.asp](http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp)

<sup>40</sup> OIG Advisory Opinion No. 07-17, page 4 (issued December 5, 2007); available online at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-17A.pdf>

<sup>41</sup> World Health Organization Fact sheet No. 253, Reviewed November 2007. <http://www.who.int/mediacentre/factsheets/fs253/en/>

sharps objects, volatile gases (oxygen, vacuum, medical air, nitrous oxide, nitrogen or carbon dioxide),<sup>42</sup> and controlled substances.<sup>43</sup> Controlled substances are regulated by two federal agencies, the Drug Enforcement Administration and the Food and Drug Administration, which determine which substances are added or removed from the various schedules, and expired drugs. Various responses to hazardous substances may arise, based on the circumstances of landlord's concerns and tenant's needs. Sometimes the landlord will allocate all medical waste removal and disposal to the tenant, in which case the operating expense should provide an equivalent reduction. Sometimes the landlord will prohibit disposal of specific chemical products in the building sanitary sewer systems. Sometimes the landlord will require disposal of hazardous materials after business hours to avoid creating unnecessary anxiety in other tenants.

1.7.1 Medical Waste. The World Health Organization suggests that of the total of wastes generated by health-care activities, almost 80% are general waste comparable to domestic waste. The remaining approximate 20% of wastes are considered hazardous materials that may be infectious, toxic or radioactive. Medical waste regulation may occur at the state or federal level. There may be overlap of state acts with the Federal Medical Waste Tracking Act.<sup>44</sup> Under any circumstances the landlord and tenant should have reciprocal representations and covenants covering how they create, release or are otherwise responsible for medical waste. At a minimum they should expect the following controls are in place. The landlord will seek to allocate the risk for medical waste to the tenant generating it. The

---

<sup>42</sup>

<http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm124716.htm>

<sup>43</sup> 21 U.S.C. § 802(6).

<sup>44</sup> The United States Department of Transportation Hazardous Materials Table, 49 C.F.R. §172.101 et seq.

tenant would be responsible for its storage and would be forbidden from allowing and released or disposal of outside the required storage protocol. The tenant should keep all medical waste produced by it or otherwise within its control or possession in proper containers until disposal. The tenant should not permit the mixing, disposal, or release of any medical waste into general office trash, waste, or refuse. Sometimes the landlord will provide medical waste removal as an additional service, especially if the landlord is the hospital or its affiliate, but otherwise and more routinely the landlord disclaims any duty or obligation to remove any medical waste, and expects tenant to both release the landlord from liability to tenant and to indemnify landlord from claims by third parties. As an affirmative covenant, the tenant should agree to separate medical waste from other types of refuse and place the medical waste in a container conspicuously marked with the phrase "Medical Waste" and the skull and cross bones warning symbol for toxic substances. The landlord should require that the container be impervious to the elements, air-tight, puncture resistant, and closed with an air-tight locked cover in such a way that the container prevents any release of the contents in the course of the storage, handling and transportation, whether it maintains its upright position or is violently upset. Not only would landlord require tenant to comply with all laws, but with respect to medical waste that it comply with guidelines and regulations relating to the creation, retention, storage, shipping and disposal of the waste. To the extent the tenant can show a manifest of the laws to which its products are subject, it should include them in its acknowledgment of compliance requirements. The obligation to comply and to surrender the premises free from medical waste and the effects of medical waste should survive the termination of the lease.

1.7.2 Hazardous Chemical Materials. Under the Occupational Safety and Health Act of 1970 (“OSHA”)<sup>45</sup>, the Hazard Communication Standards<sup>46</sup> requires employers to communicate to employees the potential hazards of chemicals and adopt appropriate protective measures, which includes identification of hazardous chemicals, distribution of material safety data sheets to employees, and institute training programs for handling the chemicals.<sup>47</sup> Hazardous materials may include those identified by the United States Department of Transportation.<sup>48</sup>

1.8. Americans with Disabilities Act of 1990 (“ADA”), Rehabilitation Act of 1973, Fair Housing Act of 1988, and related laws (“Disabilities Laws”).

Physical accessibility within HCFLs is governed by two federal statutes, the ADA<sup>49</sup> which prohibits discrimination against individuals with disabilities in everyday activities, such as receiving health care, and Section 504 of the Rehabilitation Act of 1973<sup>50</sup> prohibiting discrimination against individuals based on their disabilities by programs receiving federal financial assistance. The ADA defines a disability as (1) a physical or mental impairment that substantially limits one or more of the major life activities of an individual; (2) a record of such an impairment; or (3) being regarded as having an impairment.<sup>51</sup> The offices of a health care provider are classified as places of public accommodation under the ADA.<sup>52</sup> Local laws, for example the Pennsylvania Human Relations Act (“PHRA”), can prohibit disability

---

<sup>45</sup> Pub. L. No. 91-596, 84 Stat. 1590 (1970).

<sup>46</sup> 29 C.F.R. §1910.1200.

<sup>47</sup> 29 C.F.R. §1910.1200.

<sup>48</sup> 49 C.F.R. §172.101 et seq.

<sup>49</sup> Americans with Disabilities Act of 1990 as amended, ADA Amendments Act of 2008 (P.L. 110-325),

<sup>50</sup> Rehabilitation Law of 1973 (P.L. 93-112)

<sup>51</sup> ADA Amendments Act of 2008, Public Law No: 110-325 (9/25/08). 42 U.S.C.A. §§ 12102 et seq.

<sup>52</sup> <http://www.ada.gov/q%26aeng02.htm> (“ADA web page”)]

discrimination in employment, housing and commercial property, public accommodations and education.<sup>53</sup>

As a general matter, the ADA regulations' requirements for new construction compliance of is tempered to the extent compliance is not "structurally impracticable,"<sup>54</sup> and tempered for alterations to the "maximum extent feasible."<sup>55</sup> The U.S. Department of Justice and Department of Health and Human Services prepared a technical assistance publication<sup>56</sup> ("ADA TAP") to explain their interpretation of those requirements. Generally, existing facilities must remove accessibility barriers if removal is "readily achievable," meaning readily achievable without much expense or difficulty.<sup>57</sup> Accessibility may require adjustable height examination tables or ceiling or floor based lifts. The ADA TAP also advised that staff must be trained in the operation of the accessibility equipment.<sup>58</sup> ADA TAP warns that the tenant and landlord are responsible for the compliance with the ADA and accessibility to the examination room, examination table, waiting room, and toilet facilities.<sup>59</sup> Customary accessibility features include pathways, door width, hardware, lift equipment,<sup>60</sup> water fountains, public telephones and voice systems for elevators and security systems, and clear floor space for maneuvering and side transfers. The need for special ADA access and parking accommodations may also need to be addressed and may be more intensive than might otherwise apply in the case of zoning restrictions.

---

<sup>53</sup> 43 P.S. § 951-963. *See also* PHRC's website at [www.phrc.state.pa.us](http://www.phrc.state.pa.us).

<sup>54</sup> 28 C.F.R. §36.401, 570 (July 1, 2004)

<sup>55</sup> 28 C.F.R. §36.402, 572 (July 1, 2004)

<sup>56</sup> "Americans with Disabilities Act: Access to Medical Care for Individuals with Mobility Disabilities" U.S. Department of Justice, Civil Right Division, *Disability Rights Section* and U.S. Department of Health and Human Services, Office for Civil Rights ([http://www.ada.gov/medcare\\_mobility\\_ta/medcare\\_ta.htm](http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm))

<sup>57</sup> ADA Web Page.

<sup>58</sup> *Id.* at 4.

<sup>59</sup> *Id.* 4.

<sup>60</sup> *Id.* 5.

Because the construction guidelines contained in the ADA Accessibility Guidelines (“ADAAG”) take into account the fact that alterations to existing facilities are not held to the same standard as new construction, there may be latitude for the regulated party. The ADAAG requirements for alterations reiterate the exception of “maximum extent feasible”.<sup>61</sup> Similarly, the section of ADAAG dealing with exception expands on the meaning “technically infeasible”.<sup>62</sup> These give a small breather to the regulated party.

#### 1.9. Compliance.

Because of the highly regulated nature of the health care enterprise, the landlord and tenant will each want the other to maintain regulatory compliance. That would frequently take the form of a covenant with stronger remedies, such as termination and damages, if the covenant is violated. The landlord may negotiate for the tenant to covenant that all health care services will be provided by licensed professionals in good standing, that delivery of health care services will be under the supervision of a licensed professional, and that services shall be provided in compliance with the practice guidelines established by the respective specialty’s oversight association. The landlord may require the tenant represent that it has all required current and valid permits, licenses, and certificates, and covenant to deliver copies to landlord upon request.

## 2. **PHYSICAL ISSUES.**

#### 2.1. Utilities.

Utility expense can be one of the highest cost components of occupancy. Medical practice tenants often have higher utility usage than standard office tenants because many medical tenants have equipment and hygienic requirements which consume large amounts of

---

<sup>61</sup> ADAAG § 4.1.6 (j)

<sup>62</sup> Id.

utility service. They may consume extra water from examining rooms with sinks. They may consume extra electricity from diagnostic or therapeutic equipment that utilizes more electricity than standard office equipment. Some medical uses such as surgery centers, require the continuous presence of uninterruptible power supply and consequently the extra expense of both back-up power generation and data transmitters. The landlord may need to refine the capital improvements component of its operating expense invoice as well as re-weight the usage formula to properly allocate a tenant's excess usage.

## 2.2. Maintenance Services.

Medical uses often will restrict or require specialized janitorial and waste removal services. Special attention may be given to medical and infectious waste maintenance and storage. These issues may sometimes focus on the procedure for isolating medical waste and used equipment, the kinds and qualities of waste containers, and the procedure for removal and disposal of such waste.

## 2.3. Physical and Structural Improvements.

Tenants will frequently have more intensive water and electric needs. Special machinery may require special floor/pad requirements. Equipment may also require special fixturing and buildout. If the tenant expects to retain ownership of the equipment at termination of the lease, it will need to obtain landlord's waiver of rights to the equipment. If tenant has financed the cost of equipment; it will also need landlord's waiver of any lien or security interest in equipment which is owned by or pledged to tenant's equipment financing and a right for the tenant's lender to have access to and the right of removal of its leased or furnished equipment. If tenant intends to abandon the property, then the landlord has to anticipate the cost of removal, such as equipment and improvements, as well as incidental additional costs, if there are hazardous materials involved, such as occurs in laboratory and

radiology services. The examination rooms in a health care facility may also be good only for the single use of the health care tenant, with no likelihood of a second use by a subsequent tenant. The landlord should factor in those exit costs as well. Equivalent issues apply to extra work needed to install and remove ADA accommodations.

#### 2.4. Practice Groups with Special Locations.

Some special practices may require special improvements. Ambulatory surgical centers may need to be on the first floor. Maternity and birthing centers may need closest proximity to reserved parking. Psychiatric centers may need separate and secured access. Plastic surgery clinics may prefer separate and less visible accessways.

#### 2.5. Signage.

The tenant would need confirmation that it at least had directory, directional and door signs. Depending on its size, it may also be entitled to a place on a monument or pylon sign. Signage is itself a valuable right, and the landlord may try to charge for it.

### **3. OPERATIONAL ISSUES**

#### 3.1. Landlord Entry.

The confidentiality and privacy of patient examinations would require tenants to restrict the landlord's right of entry. In some instances, they could diagram areas which could not be entered during certain times of the day, or simply require any entry by landlord be only outside of business hours, except for emergencies.

#### 3.2. Tenant Early Termination

As in any office lease, a tenant would negotiate for early termination rights based on various events outside of its reasonable control. Typical events would include: death of the primary practitioner, changes in the reimbursement environment that would eliminate the profitability of the practice, changes in the certification and independence of the specialty



due to the pre-eminence of competing specialties, and the hospital's decision to eliminate the practice from admission program whether due to a change in its own business model or conflicts with the practitioners or their staff. The landlord, fearing the contempt of its lender, would not be willing to accommodate that unless there were a sufficient cushion of time and money to avoid impairment of its cash flow while it sought to find a substitute. That would usually take the form of several months rent plus the anticipated expense of refurbishment, free rent and similar concessions that may be required in the future. On the other hand, if the tenant is an important practice for the hospital, it might be induced to "master lease" the space and take the risk of replacement of the practice group individuals. A master lease is similar to a ground lease in that the tenant does not actually occupy the space, but rather signs the lease because it has the requisite creditworthiness, and then it in turn subleases to the space occupants, in this case the desired health care provider.

### 3.3. Use.

Ordinarily, a landlord has broad rights to confer upon its tenants as to future uses. But to attract a tenant, a landlord may significantly limit its otherwise broad use rights; and a tenant may similarly agree to significantly limit its potential use rights so as to be entitled to a reciprocal use restriction against uses of other tenants. A landlord can agree to prohibit uses that are incompatible with an HCFL, which would be to the benefit of all tenants. The landlord can agree to limit a particular use to be the exclusive right of that tenant. Prohibited uses, exclusive uses, permitted uses can solidify the HCFL's brand and profile in the community.

3.3.1 Tenant Permitted Use. In describing a tenant's permitted uses, the landlord will customarily describe an intended use, and then restrict it with a clause like "and no other use." The landlord is driven by several goals. One is to confine the tenant to a

narrow use so that the landlord can market other exclusive uses to other tenants. Second, the landlord wants to create a distinctive profile for the HCFL by limiting it to similar or at least compatible users. For example, the landlord may not want a detoxification center near a school for adolescents. Third, the landlord may have accepted the tenant based on underwriting criteria which rely on a narrow business plan and would be undercut by a change in use from the original underwriting. The tenant is driven by the need to be sure the description of the use is sufficient to cover future changes brought on by changes in the market place, in the payment for services, in the advances in the science of the practice, and in the other forces that may subvert current assumptions. The tenant may use comparable practices as the measure so that it can change its use in a manner similar to comparable practices identified by function, size, affiliation, location or patients served.

Restrictions on tenant's use can be a relatively straightforward description of the tenant's core practice, such as "ambulatory surgical care" or "general medical and physician's offices."<sup>63</sup> But even in a facially straightforward provision, issues may emerge, such as whether tenant's change in use is within the scope of the permitted use. One court used as a touchstone whether the change would result in a use that would be certified differently for licensure purposes or would cause the original approved use to lose its current licensure certification.<sup>64</sup>

3.3.2 Tenant Prohibited Uses. In addition to permitted use, even if a use might otherwise be permitted, a landlord, or the affiliated hospital, may further scale back tenant's uses by naming specific prohibited uses. As a general matter prohibitions are usually imposed to preserve those exclusive rights of another practice group in the hospital. An

---

<sup>63</sup> *Tenet Healthsystem Surgical, L.L.C. v. Jefferson Parish Hospital Service District No. 1*, 426 F.3d 738, 742 (5th Cir. 2005)

<sup>64</sup> *Id.*

example of those restrictions include express limitations on diagnostic or therapeutic testing which requires sophisticated technology, such as fluoroscopy, x-ray, radiography, computerized tomography, ultrasound and magnetic resonant imagery. In any event, the tenant would expect to reserve the right to perform core elements of its practice if it was part of the quality of use or core service a patient would be best served to receive, even though they are in competition with other practice groups. In addition, the tenant would negotiate for the expanded use if the expansion was a service that was incidental to quality of care, but other practitioners like the tenant provide it in the ordinary and customary delivery of those kinds of core services tenant provides.

Some prohibitions may be to address other issues that concern the landlord. Prohibitions on physical therapy may be to reduce the burden on limited parking at the location. Prohibition on surgery, birthing, or laboratory studies may be to reduce the cost for compliance with medical waste requirements. There may be prohibitions on overnight stay to avoid the need for broader compliance as to local land use permits, safety and security, hygiene, food and nourishment issues. Prohibition on dispensing drugs may be to avoid competition with the hospital's pharmacy.

There may also be prohibitions to avoid conflict with the affiliated health system's moral or religious mission, such as prohibitions against abortions or euthanasia, or general adherence to specific ethical or religious doctrines. The restricted party would negotiate for the termination of these prohibitions upon the termination of the relationship with the health system. In addition, the restricted party would negotiate to limit its liability in the event it failed to enforce or comply with the prohibition. But if the tenant is the health system, it might need the right to terminate rather than remain in an inimical environment. The landlord may, however, act to exclude uses which like any office landlord, may be more

provocative or a nuisance, that the landlord wishes to address. On that basis it may exclude controversial therapies, practices that are targets of activists, schools with large numbers of students, uses which increase the costs of environmental compliance, foreign and local governmental entities which may be protected from their bad acts by sovereign immunity, or users which require significant alterations to improvements both at the commencement and completion of the lease term.

3.3.3 Tenant Exclusive Uses. The lease may also protect the tenant by providing it with the sole right to conduct its own permitted use, and make its permitted use a prohibited use as to all other tenants. Definitions of that use, and reconciling them with other exclusive uses by other tenants in the HCFL requires careful coordination. First, the tenant may want to violate the exclusives of other tenants so long as the violation is an incidental service but is directly related to its core practice. Second, the tenant may want to adopt a new use with exclusive privileges or to preserve the right to expand its exclusive use to other uses, if the other uses do not expressly conflict with any other tenant's currently existing reservation of an exclusive use either at the commencement of the Lease, or at the commencement of tenant's broader use. The landlord, on the other hand, may have already given away the right by the time the tenant would have wanted to exercise it, so landlord will frequently allow an expansion of an exclusive use only if there is no competing use or prohibition on that expansion at the time of the expansion. Violations of the exclusive use are frequently permitted if there is a *de minimis* consequence. Sometimes, it is based on the number of square feet in which the violation occurs. In addition, if the HCFL is part of a hospital campus, the hospital may be permitted to violate the exclusive use. A careful landlord counsel will also carve out pre-existing tenants whose uses were not limited from engaging in the exclusive use, so that if they undertake an exclusive use, the landlord is not

liable for a lease default. Sometimes a landlord will build in a sunset provision so that the tenant's option to expand its exclusive use expires when the protected tenant does not use the option for a specific period of time, such as 12 continuous months. As to the enforcement of the exclusive, the landlord may negotiate for exculpation from liability for failure to successfully impose it, but as a counter measure, the tenant may seek the right of enforcement if landlord does not. The landlord's concern is that the tenant acting to enforce a separate lease may be too aggressive or may create new liabilities for the landlord by creating new claims from the tenant who allegedly violated the exclusive, but is claiming its own grievances based on the enforcement effort of the tenant with the exclusive.

3.3.4 Landlord Permitted Uses. In the case of a hospital campus HCFL, the hospital would impose restrictions on a third party landlord to enhance the benefit of the HCFL to the hospital. Sometimes, a third party restricted tenant will limit the hospital's rights to impose restrictions only to the period where the hospital provides a benefit to the landlord. One example would be the hospital's restriction on the landlord that the landlord lease only to tenants who have admission privileges at the hospital. That, of course, has complications if the tenant health care provider has more than one hospital affiliation, and some physicians do not have admission privileges at the hospital imposing the restriction. The landlord may try to confine the duration of the restriction to a period that the hospital or its staff are tenants of some significant portion of the HCFL and during a significant period of time.

3.3.5 Time Block and Time Share Lease Arrangements. The time block or time share lease arrangement allows a medical practice to use fully furnished facilities, personnel services, or equipment, for discontinuous blocks of time. However, the government reimbursement providers have identified these arrangements as prone to be

disguised sources of abusive kickback and over-utilization. The design of that abuse is to have the medical practice block lease specific equipment or services, directly bill its patient for the equipment or service with a steep mark-up over the cost to the medical practice. The abuse is compounded if the vendor/lessor charges the medical practice on a per-patient or per-click basis for use of the asset, and the abuse is further increased where the vendor/lessor is owned by the medical practice personnel. Similar to the vendor/servicer block or shared lease to a medical practice are “under arrangements.” There, the front-line expert joint ventures with a health system or medical group, and the joint venture, licenses or contracts with the medical group so that the joint venture functionally provides the service, but the medical group bills it at its own rate. Heightening the risk is the recent OIG opinion that even a block sublease based on a fixed fair rental value, which would have been considered a safe harbor, may now be suspect as a sham relationship if it results in “improper remuneration” to the subtenant by allowing excessive mark-ups to patients.<sup>65</sup> Because the risk of abuse is related to health care costs, if the joint venture provides real estate or landlord services, but does not provide clinical services, it may avoid being a suspect arrangement. If a commercial landlord is underwriting a tenant’s wherewithal to pay rent under the prime lease, to the extent block leasing is the source of revenue, a prudent commercial landlord would need to analyze the reliability of that revenue source, as well as its compliance with restrictions on reimbursements under federal and state law. The landlord may further require an appraisal to justify the rent is at fair market value, a key federal requirement for reimbursement.

The medical group is drawn to this structure because it reduces upfront investment compared to a “full time” lease, while providing penetration of a strategic location or

---

<sup>65</sup> See Section 3.5 above.

geographical footprint. The time block or share lease is also attractive to a medical practice that seeks to offer subspecialty services, but does not have the patient volume to justify the investment on a full time platform. The time share lease model assumes the aggregate of the individual medical practices create an entity which can operate a full time facility with personnel and equipment, and each practice can share its amenities, whether in specific time slots or on a first-come first-serve basis. The medical practices share operating expenses plus a fee to the manager of the technical operations and the business itself. The allocation of costs is usually related to the amount of use. Another variant is where leasing is borne by a health system under a master lease. By guaranteeing the availability of the leased assets, the health system seeks to attract more medical groups and their patients. The solvency and ultimate credit worthiness of a health system or hospital may be more attractive to a commercial landlord.

One technical issue for the landlord is whether to enter into a non-disturbance agreement with the “subtenant”. First, if the arrangement, whether time share or time block violates federal or state law , it will not be enforceable. Second, the sublandlord duties may be broader than the commercial landlord is able or willing to undertake, such as management of day-to-day operations of the sophisticated equipment, premises and the business. Third, the lease function may be dependent on equipment or other special services that are provided by third parties outside of landlord’s control. Lastly, the landlord’s mortgagee may be unwilling to approve a lease that is dependent on time share or time block for its viability.

#### 3.4. Common Areas.

The Tenant may have concerns about the use and impairment of common areas affecting its business.

3.4.1 ADA. The Tenant would need the Landlord to create sufficient public access to the Premises by ramps, and sufficiently wide entry doors for both the Building and elevator service.

3.4.2 Health Fairs. The Tenant may want to reserve the right to conduct health fairs, fundraising events, or publicity in the common areas.

3.4.3 No Obstruction. The Tenant may seek to preserve access roads, parking and sidewalk areas as free from use by others, whether as temporary staying areas during construction or loading and turn-around areas used by neighbor.

3.4.3.1 Scaffolding. If the Tenant exterior is an important part of its branding to the public, or amenities for staff such as picture windows, the Tenant would want to restrict Landlord's obstruction of it when raising scaffolding.

3.5. The Hospital as Tenant.

A hospital expanding into an off-site facility may need to consider how the location and the patient services will be integrated with the main location. The following information and documentation may be required in connection with the provider-based site that will be located off-campus from hospital (the "Hospital):

3.5.1 Satellite Services. The Hospital should have a detailed description of the services that will be provided at the satellite site so that the necessary staffing, monitoring, administration and integration is modeled and planned for in advance. A proper plan can also create efficiencies in design and construction of the physical plant. This is important for integration of the satellite's operations with those of the main offices of the Hospital.

3.5.2 Licensure Compliance. If the Hospital's intent is to operate the provider-based site under the Hospital's license and control, an analysis of the breadth and



conditions of the license should be analyzed to confirm the undertaking is within the corporate mandate of the Hospital.

3.5.3 Personnel. As part of the planning, the Hospital should identify the personnel necessary to undertake the engagement, and then match the staff needs to prospective individuals who can provide the necessary services at the satellite site. This may affect when and how the site would need to be expanded and related issues for amenities such as parking privileges and for shifts in patient care hours.

3.5.4 Private Health Information. A correlative of patient services is how the medical records and the billings at the provider-based site will be integrated with the main Hospital location. The storage and retrieval process can be the same for both sites but may be different. This could affect the kinds of electronic services that are needed, truck loading areas, and staffing for patient records management.

3.5.5 Patient Services. Along with staff treatment and private health information, patient services and health care access should be examined as an integrated offering. The plan of how the outpatient services at the satellite site will be physically integrated with the inpatient and outpatient services of the Hospital, including emergency services can affect physical layout and amenities at the satellite location.

3.5.6 Financial Information. The landlord may ask for a segregated financial statement of the satellite location for purposes of underwriting the viability of the tenant paying rent. The landlord may ask for a copy of the portion of the Hospital's detail trial balance that will show the revenues/expenses for the cost center in which the satellite site will fall, a copy of the portion of the Hospital's cost report showing the line item which will include the satellite site, and a reconciliation between the Hospital's trial balance and the Hospital's cost report.

3.5.7 Signage. The Hospital may need conspicuous signage at the building entry and the premises entry. If the Hospital intends to sublease to independent but affiliated physician practices, separate signage for them may also be needed.

3.5.8 Authority. The landlord will seek clarification of who has the authority to represent the Hospital, and how final approvals will be achieved.

3.5.9 Operations. If there are management arrangements, time block or timeshares, or other subleases, landlord would expect a description of how it will be operated what equipment lease and financing will apply. If the Hospital provides joint venture opportunities to the practice groups, that would also be important for the landlord to understand control issues.

3.6. Construction issues.

3.6.1 Plan and Specification Approval [DOH, Joint Commission, Clinical laboratory Improvements].

If patients are being examined or treated, the state's department of health may have regulatory review power over the physical layout as to safety and hygiene issues. Similarly, if the Premises houses business operations of a hospital, the Joint Commission may need to approve plans, and in the case of laboratory work, the Department of Health may need to review that as well. If that is the case, Tenant may need to provide early access to the regulators, or postpone rent commencement until they are given timely access.

3.6.2 Tenant Improvement Allowance.

The Tenant Allowance can have issues relating to its enforcement, administration and tax consequences.

3.6.2.1 Deemed Income under IRC 110. The Internal Revenue Code Section 110 permits "retail" tenants conducting business with the public to disregard

tenant allowance as taxable income. If this alternative is available to the Tenant it would need to require that the Landlord file tax returns with the same treatment of tenant improvements as are reported on Tenant's tax returns. If the Tenant is a not-for-profit entity and does not qualify or landlord refuses to cooperate to sue IRC 110 treatment, then the Tenant may need to consider if the Tenant Allowance is taxable as unrelated business taxable income. Some suggest language like the following:

Landlord's Treatment of Expenditures. For federal income tax purposes, Landlord will treat the cost of Landlord's Work as nonresidential real property of the Landlord pursuant to section 110(b) of the Internal Revenue Code of 1986, as amended ("IRC") and will furnish to the Secretary of the Treasury the information required by IRC section 110(d) and related regulations at the appropriate time and manner prescribed therein.

3.6.2.2 Insurance for betterments. The Tenant may look to separately insure upgrades and betterments that might otherwise be considered part of the Building and therefore covered by Landlord's insurance, if there is a risk that the Landlord's insurance has unacceptable deductibles, co-insurance, or is underinsured.

3.6.2.3 Monitoring Payments. Because the Tenant Allowance is tenant's money, there should be a process for Tenant to review and approve disbursements so they are not squandered or excessive or defective requests for payment.

3.6.2.4 Guarantor/Equity for Shortfalls. Landlords will seek credit enhancements to backstop the tenant if there is an overrun that Tenant is obligated to pay but cannot. If the hospital guaranties a physician practice group lease, the Landlord needs confirmation it is not outside of that hospital's authority.

#### **4. CONCLUSION**

The special dynamics of the health care facility lease require an appreciation of the capital sources needed to establish the transaction and the expected cash flow resulting from

the transaction. Not only does the analysis help identify negotiating strengths and weaknesses, it also uncovers special motivations that might otherwise be overlooked. Within that framework, the landlord and tenant need to specify how the tenant's use is integrated with the other uses at the property, how transfers of interests will be affected, and what supervising restrictions are required due to health care regulations imposing anti-kickback rules, confidentiality rules, and medical license rules. Preparation for these issues allows the negotiation to proceed more efficiently and therefore more quickly and less costly. If the commercial landlord does not address these requirements, it may be inadvertently violating applicable laws or duties to its tenants' patients, even without contractual privity.

## **Do's and Don'ts of Medical and Health Care Facility Leasing** (Slide Outline)

1. Economic Issues
  - 1.1. Market Issues
  - 1.2. Rent Issues
  - 1.3. Patient Protection and Affordable Care Act (“PPACA”)
2. Regulatory Issues
  - 2.1. Licensure
  - 2.2. Health Insurance Portability and Accountability Act (“HIPAA”) and American Recovery and Reinvestment Act (“ARRA”)
  - 2.3. Doctor-Patient Privilege and Duty of Confidentiality
  - 2.4. Torts
  - 2.5. Hazardous Materials
    - 2.5.1. Medical Waste
    - 2.5.2. Hazardous Chemical Materials
  - 2.6. Americans with Disabilities Act of 1990 (“ADA”)
  - 2.7. Rehabilitation Act of 1973
  - 2.8. Fair Housing Act of 1988,
  - 2.9. Related Laws (“Disabilities Laws”)
  - 2.10. Compliance
3. Special Dynamics of the Health Care Lease - Joint Venture Issues
  - 3.1. Development Structure
    - 3.1.1. Hospital as Developer
    - 3.1.2. Third Party Developer
    - 3.1.3. Medical Practice as Developer

### 3.2. Basic concepts:

#### 3.2.1. Stark/Anti-kickback Statute

- Generally prohibits certain referral relationships Can be highly nuanced
- There are exceptions, including for lease agreements
- How space is used may be impacted by Stark/AKS issues (e.g., “shared facilities”)

#### 3.2.2. Medicare enrollment/payor credentialing

- “Keys to the kingdom,” and how Centers for Medicare and Medicaid Services (CMS) “locks the front door”
- Time-consuming. CMS has lax deadlines under best circumstances
- Sometimes cannot get credentialed until already occupying space

#### 3.2.3. Scenario 1 – Solo Practitioner

- Stark/AKS not an issue if no referrals from landlord
- Medicare enrollment/payor credentialing (to ensure tenant cash-flow)
- Timeframes for compliance
- Physicians can only estimate enrollment and when the cash flow starts
- Proof of licensure? Certificates? How detailed should landlord be in what it requests from tenant?
- Evidence of Medicare compliance plan?

#### 3.2.4. Scenario 2 – Physician Group (PG) with Hospital Privileges

- Similar issues to the solo physician
- Should they prove they have privileges? What about competition between PG and Hospital? What if PG members are thrown off of the medical staff? Does it matter to landlord?

- Depends on specialty and its dependence on access to the hospital, and whether cash-flow suffers. Primary care, not so much. Interventional cardiology, yes.
- Proving that Hospital won't go after PG is unusual
- Does it matter to landlord if PG is employed by the hospital?

#### 3.2.5. Scenario 3 – Health System as Tenant, PG as Sub-Tenant

- Health system has the primary risk for compliance purposes, not landlord
- Cash-flow still an issue for landlord. If PG collapses, hospital can replace it
- Guarantee agreement? Could violate Stark/Anti-kickback Statute – nonmonetary remuneration to the PG. They get lease that they might not otherwise get, thanks to Health system's guarantee

#### 3.2.6. Scenario 4 – Hospital, Owned by Health System, As Tenant

- If the space is operated under hospital's license, needs to be approved by JCAHO and state Dept. of Health
- Which tenant: Hospital or Health System?
- What about emergency protocols? PHI? Fire suppression? Lighting?
  - Landlord should not have risk
  - Hospital or Health System has the risk
- Must meet the Medicare conditions of participation

#### 3.2.7. Fraud and abuse still an issue – for cash-flow purposes

### 4. Physical Issues

#### 4.1. Utilities

#### 4.2. Maintenance Services

#### 4.3. Physical and Structural Improvements

- 4.4. Practice Groups with Special Locations
- 4.5. Signage
- 5. Operational Issues
  - 5.1. Landlord Entry
  - 5.2. Tenant Early Termination
  - 5.3. Tenant Permitted Use
  - 5.4. Tenant Exclusive Uses
  - 5.5. Tenant Prohibited Uses
  - 5.6. Tenant Transfer Requirements
  - 5.7. Landlord Permitted Use
  - 5.8. Landlord Use Restrictions
  - 5.9. Landlord Transfer Requirements
  - 5.10. Tenant Quality Control Compliance
  - 5.11. Time Block and Time Share Lease Arrangements
  - 5.12. Common Areas
    - 5.12.1. ADA
    - 5.12.2. Health Fairs
    - 5.12.3. No Obstruction
  - 5.13. The Hospital as Tenant
    - 5.13.1. Satellite Services
    - 5.13.2. Licensure Compliance
    - 5.13.3. Personnel
    - 5.13.4. Private Health Information
    - 5.13.5. Financial Information
    - 5.13.6. Signage



5.13.7. Authority

5.13.8. Operations

6. Construction Issues

6.1. Plan and Specification Approval :DOH, Joint Commission, Clinical laboratory Improvements

6.2. Tenant Improvement Allowance



## Do's and Don'ts of Medical and Health Care Facility Leasing

Gregory G. Gosfield, Esquire  
Klehr | Harrison | Harvey | Branzburg  
1835 Market St • Philadelphia, PA 19103  
Tel: 215.569-4164 • Fax: 215.568.6603 •  
ggosfield@klehr.com

Daniel F. Shay, Esquire  
Alice G. Gosfield and Associates, P.C.  
2309 Dolancy Pkwy • Philadelphia PA 19103  
Tel: 215-735-2384 • Fax: 215-215-735-4778 •  
dshay@gosfield.com

---

---

---

---

---

---

---

---

## Economic Issues

- Market Issues
- Rent Issues
- Patient Protection and Affordable Care Act (“PPACA”)

---

---

---

---

---

---

---

---

## Regulatory Issues

- Licensure
- Health Insurance Portability and Accountability Act (“HIPAA”) and American Recovery and Reinvestment Act (“ARRA”)
- Doctor-Patient Privilege and Duty of Confidentiality
- Torts

---

---

---

---

---

---

---

---

## Regulatory Issues

- Hazardous Materials
  - Medical Waste
  - Hazardous Chemical Materials
- Americans with Disabilities Act of 1990 (“ADA”)
- Rehabilitation Act of 1973
- Fair Housing Act of 1988,
- Related Laws (“Disabilities Laws”)
- Compliance

4

---

---

---

---

---

---

---

---

## Special Dynamics of the Health Care Lease - Joint Venture Issues

- Development Structure
  - Hospital as Developer
  - Third Party Developer
  - Medical Practice as Developer

5

---

---

---

---

---

---

---

---

## Special Dynamics of the Health Care Lease

- Basic concepts:
  - Stark/Anti-kickback Statute
    - Generally prohibits certain referral relationships  
Can be highly nuanced
    - There are exceptions, including for lease agreements
    - How space is used may be impacted by Stark/AKS issues (e.g., “shared facilities”)

6

---

---

---

---

---

---

---

---

## Special Dynamics of the Health Care Lease

- Basic concepts:
  - Medicare enrollment/payor credentialing
    - “Keys to the kingdom,” and how Centers for Medicare and Medicaid Services (CMS) “locks the front door”
    - Time-consuming. CMS has lax deadlines under best circumstances
    - Sometimes cannot get credentialed until already occupying space

7

---

---

---

---

---

---

---

---

## Special Dynamics of the Health Care Lease

- Scenario 1 – Solo Practitioner
  - Stark/AKS not an issue if no referrals from landlord
  - Medicare enrollment/payor credentialing (to ensure tenant cash-flow)
  - Timeframes for compliance
    - Physicians can only estimate enrollment and when the cash flow starts
  - Proof of licensure? Certificates? How detailed should landlord be in what it requests from tenant?
  - Evidence of Medicare compliance plan?

8

---

---

---

---

---

---

---

---

## Special Dynamics of the Health Care Lease

- Scenario 2 – Physician Group (PG) with Hospital Privileges
  - Similar issues to the solo physician
  - Should they prove they have privileges? What about competition between PG and Hospital? What if PG members are thrown off of the medical staff? Does it matter to landlord?
    - Depends on specialty and its dependence on access to the hospital, and whether cash-flow suffers. Primary care, not so much. Interventional cardiology, yes.

9

---

---

---

---

---

---

---

---

### Special Dynamics of the Health Care Lease

- Scenario 2 – Physician Group (PG) with Hospital Privileges
  - Proving that Hospital won't go after PG is unusual
  - Does it matter to landlord if PG is employed by the hospital?

10

---

---

---

---

---

---

---

---

### Special Dynamics of the Health Care Lease

- Scenario 3 – Health System as Tenant, PG as Sub-Tenant
  - Health system has the primary risk for compliance purposes, not landlord
  - Cash-flow still an issue for landlord. If PG collapses, hospital can replace it
  - Guarantee agreement? Could violate Stark/Anti-kickback Statute – nonmonetary remuneration to the PG. They get lease that they might not otherwise get, thanks to Health system's guarantee

11

---

---

---

---

---

---

---

---

### Special Dynamics of the Health Care Lease

- Scenario 4 – Hospital, Owned by Health System, As Tenant
  - If the space is operated under hospital's license, needs to be approved by JCAHO and state Dept. of Health
  - Which tenant: Hospital or Health System?

12

---

---

---

---

---

---

---

---

### Special Dynamics of the Health Care Lease

- Scenario 4 – Hospital, Owned by Health System, As Tenant
  - What about emergency protocols? PHI? Fire suppression? Lighting?
    - Landlord should not have risk
    - Hospital or Health System has the risk

13

---

---

---

---

---

---

---

---

### Special Dynamics of the Health Care Lease

- Scenario 4 – Hospital, Owned by Health System, As Tenant
  - Must meet the Medicare conditions of participation
  - Fraud and abuse still an issue – for cash-flow purposes

14

---

---

---

---

---

---

---

---

### Physical Issues

- Utilities
- Maintenance Services
- Physical and Structural Improvements
- Practice Groups with Special Locations
- Signage

15

---

---

---

---

---

---

---

---

## Operational Issues

- Landlord Entry
- Tenant Early Termination
- Tenant Permitted Use
- Tenant Exclusive Uses
- Tenant Prohibited Uses
- Tenant Transfer Requirements

16

---

---

---

---

---

---

---

---

## Operational Issues

- Landlord Permitted Use
- Landlord Use Restrictions
- Landlord Transfer Requirements
- Tenant Quality Control Compliance
- Time Block and Time Share Lease Arrangements

17

---

---

---

---

---

---

---

---

## Operational Issues

- Common Areas
  - ADA
  - Health Fairs
  - No Obstruction

18

---

---

---

---

---

---

---

---



**Operational Issues**

- The Hospital as Tenant
  - Satellite Services
  - Licensure Compliance
  - Personnel
  - Private Health Information

19

---

---

---

---

---

---

---

---

**Operational Issues**

- The Hospital as Tenant
  - Financial Information
  - Signage
  - Authority
  - Operations

20

---

---

---

---

---

---

---

---

**Construction Issues**

- Plan and Specification Approval :DOH, Joint Commission, Clinical laboratory Improvements
- Tenant Improvement Allowance

21

---

---

---

---

---

---

---

---

