Special Issues and Dynamics of the Medical and Health Care Facility Lease for the Commercial Landlord

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Health Care Lease Provisions Rider
Special Dynamics of the Health Care Facility Lease

By: Gregory G. Gosfield, Esq.¹

1. INTRODUCTION

The Health Care Facility Lease (“HCFL”) tenancy has a number of easily identified special issues that can be categorized under the headings of regulatory issues, physical issues, operational issues, and transfer issues. The risks associated with them should be identified and managed either by allocation negotiated between the parties, or by performance to avoid the risks. Summarized below are some of the core points. The balance of this paper will discuss those core points and their consequences in greater detail.

1.1. Regulatory issues.

1.1.1 Licensure. The health care facility tenant, and premises, may need to comply with specific regulatory requirements to preserve local licenses and permits.

1.1.2 Health Insurance Portability and Accountability Act (“HIPAA”) and American Recovery and Reinvestment Act (“ARRA”). Patient records are expected to remain private within the premises of an HCFL. The landlord may become responsible for that privacy when it repossesses or disposes of tenant’s personalty upon a re-entry for repair or for eviction.

1.1.3 Anti-kickback and Stark Laws. The landlord and tenant may be violating the laws if the landlord or tenant is remunerated for referrals linked to federal health care funding reimbursements. For example, time block or time share leasing may violate Anti-kickback or Stark laws if the tenant is receiving excessive remuneration for health care services.

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1.1.4 Medical Waste and Hazardous Chemical Materials. The landlord and tenant may be liable if medical waste and hazardous chemicals are handled improperly.

1.1.5 Americans with Disabilities Act of 1990 ("ADA"). Premises that serve the public require improvement to provide the invitees reasonable accommodation. Patients generally have more acute disabilities; and patients being examined or treated by specialists generally need special accommodations.

1.2. Physical Issues:

1.2.1 Utilities. Health care tenants require greater utility capacity for more intensive use can result in disproportionate allocation of costs to the premises compared to allocations based on square footages.

1.2.2 Maintenance Services. Special services may be required for a health care tenant’s physical security, confidential communications, and general repairs due to the more intensive use and higher standards of care of space than a typical commercial tenant.

1.2.3 Physical and Structural Improvements. Expenses for a health care tenant’s single purpose fit outs or equipment may be required which increase costs for reuse or removal at the end of the term.

1.2.4 Practice Groups with Special Locations. A health care tenant’s practices may have special requirements as to location, such as proximity to hospitals, parking, public transportation or major roadways, or distance from schools or businesses that cater to minors.

1.2.5 Signage. A health care tenant’s signage requirements relating to disclosure of significant information may conflict with building signage restrictions as to location, height, or illumination.
1.3. **Operational Issues**

1.3.1 **Landlord Entry.** The tenant may require that landlord take special efforts for confidentiality, accommodation and convenience of the tenant’s patients, such as allowing operations after business hours and refraining from entry during patient examinations.

1.3.2 **Tenant Early Termination.** Tenants may seek a reduction or elimination of lease obligations upon a change in circumstances such as death of a key employee, loss of admission privileges, loss of licensure, or changes in health care delivery.

1.3.3 **Tenant Permitted Use.** A tenant may seek broader rights of use beyond its core use, but broad uses can hamper a landlord in attracting new tenants.

1.3.4 **Tenant Exclusive Uses.** The tenant seeks to retain exclusive use for its business without competition from other tenants or the landlord.

1.3.5 **Tenant Prohibited Uses.** Landlord may prohibit tenant uses that either would violate other tenants’ exclusive uses, would simply not be appropriate for the tenant mix, or would create a risk of protests, or would violate the religious or moral tenets of the landlord or other tenants.

1.3.6 **Tenant Transfer Requirements.** Tenant may require a landlord to disclose information before landlord makes a transfer, to allow the tenant to disapprove or at least terminate, if the new landlord is incompatible with tenants’ religious or moral tenets, or heightens the risk of regulatory violations.

1.3.7 **Landlord Use Restrictions.** If a landlord master leases or otherwise relies for a large part of its rent on a single tenant, that tenant may wish to restrict the other tenant population to protect the larger health system business, or to create a compatible mix
of tenants who share a common business goal for example due to admission privileges at the same treatment facility.

1.3.8 **Landlord Transfer Requirements.** Tenant may require a landlord to disclose information about a proposed transferee before the landlord makes a transfer, to allow the tenant to disapprove the landlord or terminate the lease, if the new landlord is incompatible with tenants’ religious or moral tenets, or heightens the risk of regulatory violations.

1.3.9 **Tenant Quality Control Compliance.** A landlord will require tenant’s staff’s compliance with accreditation, licensure, professional qualifications, and proper supervision of staff, and admission privileges if linked to a health system.

2. **Economic Issues**

2.1. **Market Issues.**

The economic recession disturbed and disrupted the entire real estate market, roiling the capital formation for HCFL development and operations. But an analysis of the dislocation in the HCFL market provides insight into some of the fundamental components of HCFL capital structures, whether trending up or down. Notwithstanding the impact of the recession, the HCFL fundamental story line remains the same which, simply put, is that the HCFL boasts reliable cash flow from rent. The reliability of rent is based on constant demand from a captive consumer base of patients, with the demand increasing over time as the consumer base ages and becomes more needy. The captive base and increasing demand supports the forecasts that HCFLs should enjoy more steady lease expansions and annual
rent escalations, compared to the comparable office market which is going in the opposite direction in both categories. 2

Improved technology has forced more outpatient treatment for reduced costs and increased efficiencies. 3 Those fundamentals remain true today. One outcome is the adaptive re-use of emptied space. 4 Analysts report that until 2008, functional loan to value ratios were at 95% (80% commercial debt, 10-15% mezzanine debt and/or preferred equity), with interest rates in the mid 5.0s to 6.0s. 5 But then the financial collapse crushed the model, with the recession resulting in loss of capital sources, higher interest on loans, when available, increased capitalization rates, and depressed values. Specifically, commercial mortgage backed securities were shut down, mezzanine real estate financing almost disappeared, and big banks retreated from lending in order to meet government capital requirements under the Troubled Asset Relief Program of the Emergency Economic Stabilization Act 6 and other

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2 “But in many cases, tenants are taking less space than they had before— both because they have fewer employees and because they are able to use space more efficiently. In New York, for example, three of the five largest deals of the second quarter involved tenants either taking the same amount of space or less. "Until tenants shift into expansion mode ... the market will be engaged in a process of musical chairs," states Studley's Second-Quarter Report on New York. The trend bodes poorly for an office market struggling with a national vacancy rate of 17.4%, the highest since 1993, according to real-estate research firm Reis Inc. Concerns are particularly acute for the hundreds of office properties that are in precarious financial condition because they are worth less than the mortgages that were made during the boom years. They need to fill space to boost rental revenue— and values.” By Anton Troianovski, “Office-Leasing Rebound Could Be Deceiving Tenants Signing Commitments Often Take Less Space, Give Less Room To Each Employee”, WSJ.Com, Real Estate August 18, 2010 3.1.


4 “One example of adaptive use of a large retail site is the Vanderbilt Health Care project, located at 100 Oaks Mall in Nashville. About 20 health clinics offering a full range of outpatient and physician services— including women’s health, cardiac care, and imaging— have recently moved into what was a dying mall, filling half the building’s 850,000 square feet (79,000 sq m) of space. The facility offers patients accessible parking, and shopping— as well as medical technology, including magnetic resonance imaging, computed tomography, digital radiography, and mammography. ***The $99 million renovation by Vanderbilt has allowed the system to offer a new campus and a new concept— connecting services for patients to convenient locations that are branded to the system’s name. In addition, the existing shops in the mall, including retail stores, a food court, and a movie theater, have benefited from an increase in foot traffic. Nancy Egan & Paul Nakazawa, Healthcare Development, Vol. 69 URBAN LAND NUMBER 11/12, November/ December 2010, at 51

5 Id.

6 Division A of Pub.L. 110-343, enacted October 3, 2008
economic stimulus programs. The result cleared the landscape for regional and local banks to be more selective about their commercial mortgage loan approvals. Mortgage loan interest rates for HCFLs rose to the mid 6.0s to 7.0s. Values of HCFLs dropped 15-35%. HCFLs that were able to sustain value, meaning a capitalization rate of less than 8.0, as a general rule, were limited to HCFLs that were on-campus of hospitals, in major Metropolitan Statistical Areas, with the majority of the tenancy based on a credit rated health systems, and subject to long term leases.7

Analysts predict the health care systems will likely need to conserve capital in the face of withering investment portfolios and devastated endowment funds. Converting capital assets into cash can help avoid depleting cash on hand and even improve it. Some rating agencies look at cash on hand as one of a number of measures of credit worthiness. Deterioration of a credit rating increases the borrowing costs, further impairing the health care company. Another result of the flight to capital conservation is that the health care systems will attempt to structure HCFL development without committing their own capital. The health care systems may turn even more strongly to using off-balance sheet techniques. That could lead to increased sale-leaseback and similar transaction to monetize illiquid assets.8 These twists and bends in the capital markets will of course face further pressure from the proposed FASB9 revisions to lease accounting rules which are currently expected to

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7 Cushman and Wakefield page 5.
8 CoStar at page 1.
9 “The Boards tentatively decided that a lessor should account for a lease contract on the basis of whether the lessor retains exposure to significant risks or benefits associated with the underlying asset either : 1. During the expected term of the current lease contract; or 2. Subsequent to the term of the current lease contract by having the expectation or ability to generate significant returns by leasing that asset multiple times subsequent to the current contract or by selling the underlying asset.” Financial Accounting Standards Board, Project Update - “Leases-Joint project of the IASB and FASB” (Last Updated on July 29, 2010).
arrive sometime in 2013, and will spread capital lease treatment to most long term leases that currently are characterized as operating leases under the FASB operating lease test.\(^\text{10}\)

2.2. **Rent Issues.**

As discussed below in the Anti-Kickback law and Stark law discussion, fixed rents at fair market value help preserve lease agreements from falling under the bans against fraud and abuse. Operating expenses, and the corresponding need for additional rent, can also be affected by increases to utility charges for extra consumption: specifically water for hygiene increased electricity usage commonly occurs for HVAC and lighting due to patient examination during extended hours and large equipment consumption such as in radiology services, increased water usage arises from the increased attention to frequent hygiene needs. There may also be decreases in landlord operating expenses if the tenant self-cleans, disposes of medical waste, or assumes independent duties to protect patient files.

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\(^{10}\) "The criteria for classifying leases set forth in this paragraph and in paragraph 8 derive from the concept set forth in paragraph 60. If at its inception (as defined in paragraph 5(b)) a lease meets one or more of the following four criteria, the lease shall be classified as a capital lease by the lessee. Otherwise, it shall be classified as an operating lease. (See Appendix C for an illustration of the application of these criteria.) a. The lease transfers ownership of the property to the lessee by the end of the lease term (as defined in paragraph 5(f)). b. The lease contains a bargain purchase option (as defined in paragraph 5(d)). c. The lease term (as defined in paragraph 5(f)) is equal to 75 percent or more of the estimated economic life of the leased property (as defined in paragraph 5(g)). However, if the beginning of the lease term falls within the last 25 percent of the total estimated economic life of the leased property, including earlier years of use, this criterion shall not be used for purposes of classifying the lease. d. The present value at the beginning of the lease term of the minimum lease payments (as defined in paragraph 5(j)), excluding that portion of the payments representing executory costs such as insurance, maintenance, and taxes to be paid by the lessor, including any profit thereon, equals or exceeds 90 percent of the excess of the fair value of the leased property (as defined in paragraph 5(c)) to the lessor at the inception of the lease over any related investment tax credit retained by the lessor and expected to be realized by him. However, if the beginning of the lease term falls within the last 25 percent of the total estimated economic life of the leased property, including earlier years of use, this criterion shall not be used for purposes of classifying the lease. A lessor shall compute the present value of the minimum lease payments using the interest rate implicit in the lease (as defined in paragraph 5(k)). A lessee shall compute the present value of the minimum lease payments using his incremental borrowing rate (as defined in paragraph 5(l)), unless (i) it is practicable for him to learn the implicit rate computed by the lessor and (ii) the implicit rate computed by the lessor is less than the lessee's incremental borrowing rate. If both of those conditions are met, the lessee shall use the implicit rate." Statement of Financial Accounting Standards No. 13, Accounting for Leases Page 8 (November 1976)
2.3. Patient Protection and Affordable Care Act ("PPACA")

The March 23, 2010 passage of the PPACA\textsuperscript{11} made the HCFL differences from regular offices more important because the delivery of medical services must be increased to serve the additional patients brought under the expansion of insured health care.\textsuperscript{12} The PPACA is intended to provide access to health insurance for an additional 32,000,000 million patients by 2019.\textsuperscript{13} Some analysts forecast it will result in the need for an additional 60,000,000 square feet of health care facility space\textsuperscript{14} using a theoretical multiplier of 1.9 square feet of health care facility for each new patient in the system.\textsuperscript{15} In addition to that, analysts forecast that currently insured "baby boomers" are going to require more medical treatment as they migrate past middle age. As part of this bulge, some analysts calculate that there will be a need for an additional 13,000 primary care physicians.\textsuperscript{16} An ancillary result of an increase in patient count is expected to be an increase in retail pharmacies. Comparing past history to these future predictions, analysts have also forecasted that whereas production of new health care facility space annually averaged 17,000,000 square feet from 2006 through 2008, production is expected to drop to 8,400,000 square feet in 2010 and 7,300,000 square feet in 2011, and that any return to the pre-recession levels will need to wait until 2013 at the earliest.\textsuperscript{17}

\begin{itemize}
\item 12 Special Research Report, "Health care Reform Holds Positive Implications for Medical Office Space Demand," Marcus & Millichap, First Half 2010., page 1
\item 13 Id.
\item 14 Randy Drummer, "Medical Developers, Hospitals Early winners as Health Care Overhaul Becomes Law," www.costar.com, March 24, 2010, page 2
\item 15 Id.
\item 16 Marcus & Millichap at page 3
\item 17 Id. Page 3.
\end{itemize}
3. **REGULATORY ISSUES**

3.1. **Health Insurance Portability and Accountability Act (“HIPAA”)**

The two general purposes of HIPAA encompassed in the Privacy Rule, which creates standards for the use and disclosure of protected patient health information, and the Security Rule, 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. "Health care provider" is a health

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18 "Uses and disclosures of protected health information: general rules.
(a) Standard. A covered entity may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.
(1) Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows:
(i) To the individual;
(ii) For treatment, payment, or health care operations, as permitted by and in compliance with §164.506;
(iii) Incident to a use or disclosure otherwise permitted or required by this subpart, provided that the covered entity has complied with the applicable requirements of §164.502(b), §164.514(d), and §164.530(c) with respect to such otherwise permitted or required use or disclosure;
(iv) Pursuant to and in compliance with a valid authorization under §164.508;
(v) Pursuant to an agreement under, or as otherwise permitted by, §164.510; and
(vi) As permitted by and in compliance with this section, §164.520 or §164.528; and
(2) Required disclosures. A covered entity is required to disclose protected health information:
(i) To an individual, when requested under, and required by §164.524 or §164.528; and
(ii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity’s compliance with this subpart.
(b) Standard: Minimum necessary — (1) Minimum necessary applies. When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. * * *
(e)(1) Standard: Disclosures to business associates. (i) A covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information." 45 C.F.R. §164.502 See also 65 Fed. Reg 82462

19 Security standards: General rules “General Requirements. Covered entities must do the following: (1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits; (2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information. (3) Protect against reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this Part. (4) Ensure compliance with this subpart by its workforce.” 45 C.F.R. 164.306(a), 744 (Oct 1, 2006)

20 “(a) APPLICABILITY.--Any standard adopted under this part shall apply, in whole or in part, to the following persons: “(1) A health plan. “(2) A health care clearinghouse. “(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1). ***” HIPAA §1172, “Under sections 1176 and 1177 of the Act, 42 U.S.C. 1320d–5 and 6, these persons or organizations, collectively referred to as “covered entities,” may be subject to civil money penalties and criminal penalties for violations of the HIPAA rules.” 74 Fed. Reg. 56123, 56124 (Interim final rule; request for comments Oct 30, 2009)
care professional or other organization that bills, furnishes or is paid for health care.\footnote{21}

“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.\footnote{22} “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.\footnote{23} “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”).\footnote{24}

\footnote{21}“(3) HEALTH CARE PROVIDER.--The term ‘health care provider’ includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.” HIPAA §1171

\footnote{22}“(4) HEALTH INFORMATION.--The term ‘health information’ means any information, whether oral or recorded in any form or medium, that-- “(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and “(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.” HIPAA §1171

\footnote{23}“(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.--The term ‘individually identifiable health information’ means any information, including demographic information collected from an individual, that--”(A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and “(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and--”(i) identifies the individual; or “(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.” HIPAA §1171

\footnote{24}“General Requirements. Covered entities must do the following: (1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits; (2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information. (3) Protect against reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this Part. (4) Ensure compliance with this subpart by its workforce.” 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. 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. The HITECH Act provides for federal regulatory enforcement of notice by CEs and BAs of a breach of privacy of PHI. In addition, HIPAA covers BAs directly, not just indirectly through business associate agreements.

25 “(1) Except as provided in paragraph (2) of this definition, business associate means, with respect to a covered entity, a person who: (i) On behalf of such covered entity or of an organized health care arrangement (as defined in §164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: (A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or (B) Any other function or activity regulated by this subchapter; or (ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.” 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.

26 “Disclosure means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information” 68 Fed. Reg. 8334, 8374 (Feb 20, 2003)

27 “We proposed that parties processing data through a third party would be required to enter into a chain of trust partner agreement, a contract in which the parties agree to electronically exchange data and to protect the transmitted data. This final rule narrows the scope of agreements required. It essentially tracks the provisions in § 164.502(e) and § 164.504(e) of the Privacy Rule, although appropriate modifications have been made in this rule to the required elements of the contract. In this final rule, a contract between a covered entity and a business associate must provide that the business associate must— (1) implement safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity; (2) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate safeguards; (3) report to the covered entity any security incident of which it becomes aware; (4) make its policies and procedures, and documentation required by this subpart relating to such safeguards, available to the Secretary for purposes of determining the covered entity’s compliance with this subpart; and (5) authorize termination of the contract by the covered entity if the covered entity determines that the business associate has violated a material term of the contract.” 68 Fed Reg. 8334, 8358 (Feb. 20, 2003)
Intuitively, a landlord would not expect to be governed by HIPAA or any other federal and state laws regulating health information confidentiality requirement. 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 five common instances when a landlord may be implicated as a BA for HIPAA purposes: (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 and disposal of PHI upon tenant’s surrender, abandonment or ejectment from the leased premises;29 (4) landlord audit rights could result in disclosure of PHI, such as information related to patient treatments and third party reimbursements; and, (5) 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

made applicable with respect to covered entities shall also be applicable to such a business associate and shall be incorporated into the business associate agreement between the business associate and the covered entity. , (b) APPLICATION OF CIVIL AND CRIMINAL PENALTIES.-In the case of a business associate that violates any security provision specified in subsection (a), sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to the business associate ,with respect to such violation in the same manner such sections apply to a covered entity that violates such security provision.” Pub. L. No 111-5, §13401, 123 Stat. 260 (2009) [and need cite]

29 "May a covered entity hire a business associate to dispose of protected health information? Answer: Yes, a covered entity may, but is not required to, hire a business associate to appropriately dispose of protected health information (PHI) on its behalf. In doing so, the covered entity must enter into a contract or other agreement with the business associate that requires the business associate, among other things, to appropriately safeguard the PHI through disposal. See 45 CFR 164.308(b), 164.314(a), 164.502(e), and 164.504(e). Thus, for example, a covered entity may hire an outside vendor to pick up PHI in paper records or on electronic media from its premises, shred, burn, pulp, or pulverize the PHI, or purge or destroy the electronic media, and deposit the deconstructed material in a landfill or other appropriate area.” U.S. Department of Health & Human Services, Health Information Privacy. http://www.hhs.gov/ocr/privacy/hipaa/faq/safeguards/577.html (Created 02/18/09).
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. 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.

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30 The Department also clarifies that a business associate contract is not required with persons or organizations whose functions, activities, or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be de minimus, if at all. For example, a health care provider is not required to enter into a business associate contract with its janitorial service because the performance of such service does not involve the use or disclosure of protected health information. In this case, where a janitor has contact with protected health information incidentally, such disclosure is permissible under § 164.502(a)(1)(iii) provided reasonable safeguards are in place.” 67 Fed. Reg. 53252, Aug. 14, 2002.

31 Standard: Business associate contracts.
(i) The contract or other arrangement between the covered entity and the business associate required by Sec. 164.502(e)(2) must meet the requirements of paragraph (e)(2) or (e)(3) of this section, as applicable.
(ii) A covered entity is not in compliance with the standards in Sec. 164.502(e) and paragraph (e) of this section, if the covered entity knew of a pattern of activity or practice of the business associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful:
(A) Terminated the contract or arrangement, if feasible; or
(B) If termination is not feasible, reported the problem to the Secretary.
(2) Implementation specifications: Business associate contracts. A contract between the covered entity and a business associate must:
(i) Establish the permitted and required uses and disclosures of such information by the business associate. The contract may not authorize the business associate to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the covered entity, except that:
(A) The contract may permit the business associate to use and disclose protected health information for the proper management and administration of the business associate, as provided in paragraph (e)(4) of this section; and
(B) The contract may permit the business associate to provide data aggregation services relating to the health care operations of the covered entity.
(ii) Provide that the business associate will:
(A) Not use or further disclose the information other than as permitted or required by the contract or as required by law;
(B) Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by its contract;
(C) Report to the covered entity any use or disclosure of the information not provided for by its contract of which it becomes aware;
(D) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from, or created or received by the business associate on behalf of, the covered entity agrees to the same restrictions and conditions that apply to the business associate with respect to such information;
(E) Make available protected health information in accordance with Sec. 164.524;
(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Sec. 164.526;
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. 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 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.

(G) Make available the information required to provide an accounting of disclosures in accordance with Sec. 164.528;
(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the business associate on behalf of, the covered entity available to the Secretary for purposes of determining the covered entity’s compliance with this subpart; and
(i) At termination of the contract, if feasible, return or destroy all protected health information received from, or created or received by the business associate on behalf of, the covered entity that the business associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(iii) Authorize termination of the contract by the covered entity, if the covered entity determines that the business associate has violated a material term of the contract.
* * *
(4) Implementation specifications: Other requirements for contracts and other arrangements. (i) The contract or other arrangement between the covered entity and the business associate may permit the business associate to use the information received by the business associate in its capacity as a business associate to the covered entity, if necessary:
(A) For the proper management and administration of the business associate; or
(B) To carry out the legal responsibilities of the business associate.
(ii) The contract or other arrangement between the covered entity and the business associate may permit the business associate to disclose the information received by the business associate in its capacity as a business associate for the purposes described in paragraph (e)(4)(i) of this section, if:
(A) The disclosure is required by law; or
(B)(1) The business associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and
(2) The person notifies the business associate of any instances of which it is aware in which the confidentiality of the information has been breached. 45 C.F.R. § 164.504, 749, 759 (Oct 1, 2007).

32 The first Physical Safeguard Standard of the HIPAA Administrative Simplification Security Rule, provides that covered entities in multiple business office structures must implement the standard, taking into consideration, that it “retains responsibility for considering facility security even where it shares space within a building with other organizations. Facility security measures taken by a third party must be considered and documented in the covered entity’s facility security plan, when appropriate.” 68 Fed. Reg. 8334, 8353 (Feb 20, 2003)
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.

3.2. 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.\footnote{Under sections 1176 and 1177 of the Act, 42 U.S.C. 1320d-5 and 6, these persons or organizations, collectively referred to as “covered entities,” may be subject to civil money penalties and criminal penalties for}
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.”

3.3. 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.” The principle of the privilege is sometimes protected by the Federal Rules of Civil Procedure under the Article V “Privileges,” General Rule. 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 violations of the HIPAA rules. 74 Fed. Reg. 56123. 56124 (Interim final rule; request for comments October 30, 2009)

34 “HHS Strengthens HIPAA Enforcement” Section 13410(d) of the HITECH Act strengthened the civil money penalty scheme by establishing tiered ranges of increasing minimum penalty amounts, with a maximum penalty of $1.5 million for all violations of an identical provision. A covered entity can no longer bar the imposition of a civil money penalty for an unknown violation unless it corrects the violation within 30 days of discovery.” HHS strengthens HIPAA Enforcement, Friday, October 30, 2009


36 “Rule 501 General Rule” Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law” Fed. R. Evid. 501 (2009)
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.

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.

3.4. 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.

3.5. 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\(^\text{37}\) 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.\(^\text{38}\) 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.

By comparison, the Anti-kickback law forbids the remuneration for referrals or ordering services which are compensated by a federal health care program.\(^\text{39}\) The federal government issued guidance on how the Anti-kickback law can affect health care real estate

\(^{37}\) Section 1877 of the Social Security Act (“SSA”) 42 U.S.C. 1395.

\(^{38}\) “The Stark analysis: To determine whether the Stark statute applies to a particular arrangement, ask yourself these three critical questions: 1. Does this arrangement involve a referral of a Medicare or Medicaid patient by a physician or an immediate family member of a physician? 2. Is the referral for a “designated health service”? 3. Is there a financial relationship of any kind between the referring physician or a family member and the entity to which the referral is being made?” 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.

\(^{39}\) “Section 1128B(b) of the Social Security Act (the Act) 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. Both parties to an impermissible kickback transaction are liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The OIG may also initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil money penalties for fraud, kickbacks and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act. * * * Some of the arrangements identified as suspect in this Special Fraud Alert may also implicate the Ethics in Patient Referrals Act, also known as the Stark law (section 1877 of the Act). The interpretation of the Stark law is under the jurisdiction of the Health Care Financing Administration (HCFA).” “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"]
leases. 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 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. The interpretation of the Stark law is under the jurisdiction of the

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40 “The questionable features of suspect rental arrangements for space in physicians’ offices may be reflected in three areas: the appropriateness of rental agreements; the rental amounts; and time and space considerations.” Alert at p.2.

41 “One of the major misunderstandings about the Stark statute is that it is the same as the anti-kickback statute. Not only are they not the same law, they have a very different scope and are in two different titles of the Social Security Act:

• The Stark statute pertains only to physician referrals under Medicare and Medicaid ("physicians" includes chiropractors and dentists but not midlevel providers, such as nurse practitioners and physician assistants); the anti-kickback statute is far broader and affects anyone engaging in business with a federal health care program.
• The Stark statute does not require bad intent (i.e., a tainted financial relationship violates the Stark law regardless of good intentions); the anti-kickback statute requires intent, but it must be specific intent (i.e., not just intent that might merely be inferred from a pattern of behavior).
• The Stark statute exceptions define the boundaries of permissible behavior. The statute is a prohibition that can only be overcome by complying explicitly with an exception. The anti-kickback “safe harbor” regulations describe transactions that may tend to induce referrals but don’t necessarily violate the law. The safe harbor regulations state clearly that transactions that don’t meet a safe harbor don’t necessarily violate the statute; a prosecutor will evaluate the facts and circumstances to make that determination.
• A Stark violation is punishable by civil money penalties; an anti-kickback violation is punishable by exclusion from federal health care programs, criminal penalties of up to $25,000 in fines or up to five years in jail (or both) and a $50,000 civil money penalty for each violation.
Health Care Financing Administration ("HCFA"). The Anti-kickback law is policed by the Office of the Inspector General ("OIG"). The Anti-kickback law applies to health care providers and suppliers, 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; 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." Another more inconspicuous example of the divergence, is that the OIG defers to the HCFA's jurisdiction in the interpretation of the DMEPOS supplier standards with respect to the appropriateness of "consignment closets." 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

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42 The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in the Department’s programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections." The Alert, page 1

43 Alert, Page 1.

44 Alert, page 2.

45 Alert, page 1.
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 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.\textsuperscript{46} 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 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 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.\textsuperscript{47} 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.\textsuperscript{48} The size of the premises and period of

\textsuperscript{46} Alert, page 1.
\textsuperscript{47} Alert, page 2.
\textsuperscript{48} “[6] The Court finds the expert witnesses relied on by the Defendants to be more persuasive and credible, in various respects, than the experts relied on by the Government. Unlike [Prosecutor Government Witness] MacDermaid, Defendants’ experts did not unduly restrict the market area under consideration. Rather, Defendants’ experts considered leases throughout the greater market area of Flint Township. In addition, unlike MacDermaid, Defendants’ experts did not exclude triple net leases from consideration. Rather, they considered both gross and triple net leases from comparable buildings, making adjustments as needed in order to compare triple net leases to McLaren’s gross lease rate. *** The Court also finds persuasive [Defendant Medical Group Witness] Cooper’s testimony that certain adjustments are necessary in order to appropriately compare McLaren’s lease agreement to other lease agreements in the market. Unlike MacDermaid, Cooper considered the unusual way that the square footage in the McLaren lease was calculated.
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. 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 corresponding charges for the number or value of referrals, and (h) on terms otherwise commercially reasonable.

and explained that the square footage stated in the lease must be adjusted in order to directly compare the McLaren lease to other leases in the market area.” USA v. McLaren Regional Medical Center, 202 F. Supp 2d 671, 685 (E.D. Mich. 2002).

§ 411.357 Exceptions to the referral prohibition related to compensation arrangements. For purposes of § 411.353, the following compensation arrangements do not constitute a financial relationship: (a) Rental of office space. Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements: (1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers. (2) The term of the agreement is at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement. (3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee’s pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than
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\textsuperscript{51} 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

\textsuperscript{51}(b) Space rental. As used in section 1128B of the Act, “remuneration” does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following six standards are met—

(1) The lease agreement is set out in writing and signed by the parties.
(2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.
(3) If the lease 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 lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
(4) The term of the lease is for not less than one year.
(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account 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, Medicaid or other Federal health care programs.
(6) “The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. Note that for purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.” 42 C.F.R. §1001.952(b) 680, 682 (2009)

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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.”52

In the case of equipment rental or personal services provided by staff, the OIG has similar safe harbors53: (1) the agreement be written; (2) the agreement be signed by the

52 "The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. ** * In other words, the Requestor may be offering the Urologist Groups impermissible remuneration by giving them the opportunity to obtain the difference between the reimbursement received by the Urologist Groups from the Federal health care programs and the rent and fees paid by the Urologist Groups to the Requestor and the individual Radiologists (i.e., the profit from IMRT ordered by the Urologist Groups.) By agreeing effectively to provide services it could otherwise provide in its own right for less than the available reimbursement, the Requestor and its Radiologists would potentially be providing a referral source - a Urologist Group - with the opportunity to generate a fee and a profit. If the intent of the Proposed Arrangement were to give the Urologist Groups remuneration through the IMRT to induce referrals to the Requestor, the anti-kickback statute would be violated." Department of Health & Human Services OIG Advisory Opinion No. 8-10, Issued: August 19, 2008; Posted August 26, 2008. Cf "Stark II provides that the rental of office space shall not be considered to be a prohibited financial relationship for purposes of the statute if, among other things, “the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.” 42 U.S.C. § 1395nn(e)(1)(A). For purposes of the Anti-Kick-Back Statute, the term “remuneration” does not include any payment made by a lessee to a lessor for the use of premises, if, among other things, “the aggregate rental charge is set in advance, is consistent with fair market value in armslength transactions and is not determined in a manner that takes into account 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.” 42 C.F.R. 1001.952(b)." "Stark II provides that the rental of office space shall not be considered to be a prohibited financial relationship for purposes of the statute if, among other things, “the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.” 42 U.S.C. § 1395nn(e)(1)(A). For purposes of the Anti-Kick-Back Statute, the term “remuneration” does not include any payment made by a lessee to a lessor for the use of premises, if, among other things, “the aggregate rental charge is set in advance, is consistent with fair market value in armslength transactions and is not determined in a manner that takes into account 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.” 42 C.F.R. 1001.952(b)." McLaren Regional Medical Center, 202 F. Supp 673-674.

53 "(c) Equipment rental. As used in section 1128B of the Act, “remuneration” does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following six standards are met—
parties; (3) specific equipment or services used should be identified and documented; and
(4) payment be limited to the prorated portion of its use.

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. 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. Both landlords and tenants can be subject to the sanctions.

(1) The lease agreement is set out in writing and signed by the parties.
(2) The lease covers all of the equipment leased between the parties for the term of the lease and specifies the equipment covered by the lease.
(3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such interval.
(4) The term of the lease is for not less than one year.
(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account 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, Medicaid or all other Federal health care programs.
(6) The aggregate equipment rental does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. Note that for purposes of paragraph (c) of this section, the term fair market value means that the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

54 ** * * ** Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—* * * shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.” §1128(b); 42 U.S.C. 13207a-b; and “commits an act described in paragraph (1) or (2) of section 1128B(b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; or in cases under paragraph (7), $50,000 for each such act). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.” Social Security Act §1128A(a)(7); 42 U.S.C. 1320a-7a

55 Alert, page 1.
3.6. 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.\textsuperscript{56} 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.\textsuperscript{57}


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,\textsuperscript{58} nuclear waste, hazardous chemical substances, needles and similarly medical

\textsuperscript{56} "The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician (42 CFR 1001.1901). This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded."

"The Effect of Exclusion From Participation in Federal Health Care Programs," OIG Special Advisory Bulletin (September 1999), available online at \url{http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp}

\textsuperscript{57} "In this scenario, we believe that the intervening and independent entities (i.e., Newco and its distributors), together with your certifications that you would have no relationship – financial or otherwise – with Newco, would sufficiently attenuate you from any claims submitted to Federal health care programs by downstream providers or suppliers that you would not be indirectly furnishing the Invention or causing claims for it to be submitted to Federal programs in violation of your exclusion." OIG Advisory Opinion No. 07-17, page 4 (issued December 5, 2007); available online at \url{http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-17A.pdf}

\textsuperscript{58} "Medical waste is all waste materials generated at health care facilities, such as hospitals, clinics, physician’s offices, dental practices, blood banks, and veterinary hospitals/clinics, as well as medical research facilities and laboratories.
sharps objects, volatile gases (oxygen, vacuum, medical air, nitrous oxide, nitrogen or carbon dioxide), and controlled substances. 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

The Medical Waste Tracking Act of 1988 defines medical waste as “any solid waste that is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals.” This definition includes, but is not limited to: blood-soaked bandages, culture dishes and other glassware, discarded surgical gloves, discarded surgical instruments, discarded needles used to give shots or draw blood (e.g., medical sharps), cultures, stocks, swabs used to inoculate cultures, removed body organs (e.g., tonsils, appendices, limbs), and discarded lancets.

http://www.epa.gov/osw/nonhaz/industrial/medical. See also, “WASTES FROM HEALTH-CARE ACTIVITIES Health-care activities - for instance, immunizations, diagnostic tests, medical treatments, and laboratory examinations - protect and restore health and save lives. But what about the wastes and by-products they generate? From 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. The wastes and by-products cover a diverse range of materials, as the following list illustrates (percentages are approximate values): Infectious wastes -- cultures and stocks of infectious agents, wastes from infected patients, wastes contaminated with blood and its derivatives, discarded diagnostic samples, infected animals from laboratories, and contaminated materials (swabs, bandages) and equipment (disposable medical devices etc.); and Anatomic - recognizable body parts and animal carcasses. Infectious and anatomic wastes together represent the majority of the hazardous waste, up to 15% of the total waste from health-care activities. Sharps -- syringes, disposable scalps and blades etc. Sharps represent about 1% of the total waste from health-care activities. Chemicals -- for example solvents and disinfectants; and Pharmaceuticals -- expired, unused, and contaminated; whether the drugs themselves (sometimes toxic and powerful chemicals) or their metabolites, vaccines and sera. Chemicals and pharmaceuticals amount to about 3% of waste from health-care activities. Genotoxic waste -- highly hazardous, mutagenic, teratogenic or carcinogetic, such as cytotoxic drugs used in cancer treatment and their metabolites, and Radioactive matter, such as glassware contaminated with radioactive diagnostic material or radiotherapeutic materials; Wastes with high heavy metal content, such as broken mercury thermometers. Genotoxic waste, radioactive matter and heavy metal content represent about 1% of the total waste from health-care activities” World Health Organization Fact sheet No. 253, Reviewed November 2007.
http://www.who.int/mediacentre/factsheets/fs253/en/

59 “COMPRESSED MEDICAL GASES GUIDELINE

INTRODUCTION

This guideline, issued under 21 CFR 10.90, states principles and practices of general applicability that are not legal requirements but are acceptable to the Food and Drug Administration (FDA). A person may rely upon it with assurance of its acceptability to FDA or may follow different procedures. Any person who chooses different procedures may, but is not required to, discuss the matter in advance with FDA to preclude expending money and effort on activity that FDA may later determine is unacceptable. This guideline describes practices and procedures for compressed medical gas (CMG) fillers (including companies engaged in home respiratory services) that constitute acceptable means of complying with certain sections of the current good manufacturing practice (CGMP) regulations for drug products (21 CFR Parts 210 and 211).”
http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm124716.htm

60 “The term ‘controlled substance’ means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V of part B of this subchapter. The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986.” 21 U.S.C. § 802(6).
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.

3.7.1 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. 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 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

61 The United States Department of Transportation Hazardous Materials Table, 49 C.F.R. §172.101 et seq.
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.

3.7.2 Hazardous Chemical Materials. Under the Occupational Safety and Health Act of 1970 (“OSHA”)\textsuperscript{62}, the Hazard Communication Standards\textsuperscript{63} 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

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\item\textsuperscript{63} 29 C.F.R. §1910.1200.
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chemicals.\textsuperscript{64} Hazardous materials may include those identified by the United States Department of Transportation.\textsuperscript{65}


Physical accessibility within HCFLs is governed by two federal statutes, the ADA\textsuperscript{66} which prohibits discrimination against individuals with disabilities in everyday activities, such as receiving health care, and Section 504 of the Rehabilitation Act of 1973\textsuperscript{67} 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.\textsuperscript{68} The offices of a health

\textsuperscript{64} "(a)(2) This occupational safety and health standard is intended to address comprehensively the issue of evaluating the potential hazards of chemicals, and communicating information concerning hazards and appropriate protective measures to employees, and to preempt any legal requirements of a state, or political subdivision of a state, pertaining to this subject. Evaluating the potential hazards of chemicals, and communicating information concerning hazards and appropriate protective measures to employees, may include, for example, but is not limited to, provisions for: developing and maintaining a written hazard communication program for the workplace, including lists of hazardous chemicals present; labeling of containers of chemicals in the workplace, as well as of containers of chemicals being shipped to other workplaces; preparation and distribution of material safety data sheets to employees and downstream employers; and development and implementation of employee training programs regarding hazards of chemicals and protective measures. Under section 18 of the Act, no state or political subdivision of a state may adopt or enforce, through any court or agency, any requirement relating to the issue addressed by this Federal standard, except pursuant to a Federally-approved state plan." 29 C.F.R. §1910.1200.

\textsuperscript{65} 49 C.F.R. §172.101 et seq.


\textsuperscript{67} §12102. Definition of disability. As used in this chapter ***(3)*** (A) An individual meets the requirement of 'being regarded as having such an impairment' if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity ***(4)*** RULES OF CONSTRUCTION REGARDING THE DEFINITION OF DISABILITY - The definition of 'disability' in paragraph (1) shall be construed in accordance with the following: (A) The definition of disability in this Act shall be construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act. (B) The Term 'substantially limits' shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008. (C) An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability. (D) An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. (E)(i) The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as - (I) medication, medical supplies,
care provider are classified as places of public accommodation under the ADA.\textsuperscript{69} Local laws, for example the Pennsylvania Human Relations Act ("PHRA"), can prohibit disability discrimination in employment, housing and commercial property, public accommodations and education.\textsuperscript{70}

As a general matter, the ADA regulations' requirements for new construction compliance of \textit{is} tempered to the extent compliance is not "structurally impracticable,"\textsuperscript{71}

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\textsuperscript{69} Q. What are public accommodations?

A. A public accommodation is a private entity that owns, operates, leases, or leases to, a place of public accommodation. Places of public accommodation include a wide range of entities, such as restaurants, hotels, theaters, doctors' offices, pharmacies, retail stores, museums, libraries, parks, private schools, and day care centers. Private clubs and religious organizations are exempt from the ADA's title III requirements for public accommodations. \url{http://www.ada.gov/q%26aeng02.htm} ("ADA web page")

\textsuperscript{70} 43 P.S. § 951-963. See also PHRC's website at \url{www.phrc.state.pa.us}.

\textsuperscript{71} § 36.401 "New construction. (a) General. (1) Except as provided in paragraphs (b) and (c) of this section, discrimination for purposes of this part includes a failure to design and construct facilities for first occupancy after January 26, 1993, that are readily accessible to and usable by individuals with disabilities. *** (c) Exception for structural impracticability. (1) Full compliance with the requirements of this section is not required where an entity can demonstrate that it is structurally impracticable to meet the requirements. Full compliance will be considered structurally impracticable only in those rare circumstances when the unique characteristics of terrain prevent the incorporation of accessibility features. (2) If full compliance with this section would be structurally impracticable, compliance with this section is required to the extent that it is not structurally impracticable. In that case, any portion of the facility that can be made accessible shall be made accessible to the extent that it is not structurally impracticable. (3) If providing accessibility in conformance with this section to individuals with certain disabilities (e.g., those who use wheelchairs) would be structurally impracticable, accessibility shall nonetheless be ensured to persons with other types of disabilities (e.g., those who use crutches or who have sight, hearing, or mental impairments) in accordance with this section. (d) Elevator exemption. (1) For purposes of this paragraph (d)— (i) Professional office of a health care provider means a location where a person or entity regulated by a State to provide professional services related to the physical or mental health of an individual makes such services available to the public. The facility housing the "professional office of a health care provider" only includes floor levels housing at least one health care provider, or any floor level designed or intended for use by at least one health care provider. *** (2) This section does not require the installation of an elevator in a facility that is less than three stories or has less than 3000 square feet per story, except with respect to any facility that houses one or more of the following: (i) A shopping center or shopping mall, or a professional office of a health care provider. *** (3) The elevator exemption set forth in this paragraph (d) does not obviate or limit, in any way the obligation to comply with the other accessibility requirements established in paragraph (a) of this section. For example, in a facility that houses a shopping center or shopping mall, or a professional office of a health care provider, the floors that are above or below an accessible ground floor and that do not house sales or rental establishments or a
and tempered for alterations to the “maximum extent feasible.” The U.S. Department of Justice and Department of Health and Human Services prepared a technical assistance publication (“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. Accessibility may require adjustable height examination tables or ceiling or floor based lifts. The ADA TAP also

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§ 36.402 “Alterations. (a) General. (1) Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, shall be made so as to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs. (2) An alteration is deemed to be undertaken after January 26, 1992, if the physical alteration of the property begins after that date. (b) Alteration. For the purposes of this part, an alteration is a change to a place of public accommodation or a commercial facility that affects or could affect the usability of the building or facility or any part thereof. (1) Alterations include, but are not limited to, remodeling, renovation, rehabilitation, reconstruction, historic restoration, changes or rearrangement in structural parts or elements, and changes or rearrangement in the plan configuration of walls and full-height partitions. Normal maintenance, reroofing, painting or wallpapering, asbestos removal, or changes to mechanical and electrical systems are not alterations unless they affect the usability of the building or facility. (2) If existing elements, spaces, or common areas are altered, then each such altered element, space, or area shall comply with the applicable provisions of appendix A to this part. (c) To the maximum extent feasible. The phrase “to the maximum extent feasible,” as used in this section, applies to the occasional case where the nature of an existing facility makes it virtually impossible to comply fully with applicable accessibility standards through a planned alteration. In these circumstances, the alteration shall provide the maximum physical accessibility feasible. Any altered features of the facility that can be made accessible shall be made accessible. If providing accessibility in conformance with this section to individuals with certain disabilities (e.g., those who use wheelchairs) would not be feasible, the facility shall be made accessible to persons with other types of disabilities (e.g., those who use crutches, those who have impaired vision or hearing, or those who have other impairments).”

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Q. What are examples of the types of modifications that would be readily achievable in most cases? A. Examples include the simple ramping of a few steps, the installation of grab bars where only routine reinforcement of the wall is required, the lowering of telephones, and similar modest adjustments. Q. Will businesses need to rearrange furniture and display racks? A. Possible. For example, restaurants may need to rearrange tables and department stores may need to adjust their layout of racks and shelves in order to permit access to wheelchair users.” ADA Web Page.
advised that staff must be trained in the operation of the accessibility equipment. 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. Customary accessibility features include pathways, door width, hardware, lift equipment, 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.

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

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75 "To provide medical services in an accessible manner, the medical provider and staff will likely need to receive training. This training will need to address how to operate the accessible equipment, how to assist with transfers and positioning of individuals with disabilities, and how not to discriminate against individuals with disabilities. Local or national disability organizations may be able to provide training for your staff. This document and other technical assistance materials found on the ADA Website (www.ada.gov) can be used in conjunction with live training to train medical staff. The U.S. Department of Justice ADA Information Line is another resource. Anyone can call the Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY) to speak with an ADA Specialist to get answers to questions about the ADA. Additionally, when preparing to assist a patient with a disability, it is always best to ask the patient if assistance is needed and if so, what is the best way to help. If the provider is unsure of how to handle something, it is absolutely O K to ask the patient what works best." Id. at 4.

76 "If I lease my medical office space, am I responsible for making sure the examination room, waiting room, and toilet rooms are accessible? Yes. Any private entity that owns, leases or leases to, or operates a place of public accommodation is responsible for complying with Title III of the ADA. Both tenants and landlords are equally responsible for complying with the ADA. However, your lease with the landlord may specify that, as between the parties, the landlord is responsible for some or all of the accessibility requirements of the space. Frequently, the tenant is made responsible for the space it uses and controls (e.g., the examination rooms and reception area), while the landlord is responsible for common space, such as toilet rooms used by more than one tenant." Id. 4.

77 The features that make this possible are: • an accessible route to and through the room; • an entry door with adequate clear width, maneuvering clearance, and accessible hardware; • appropriate models and placement of accessible examination equipment (See Part 4 for detailed discussion of accessible examination equipment.); and • adequate clear floor space inside the room for side transfers and use of lift equipment. New and altered examination rooms must meet requirements of the ADA Standards for Accessible Design. Accessible examination rooms may need additional floor space to accommodate transfers and for certain equipment, such as a floor lift. The number of examination rooms with accessible equipment needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One such exam room may be sufficient in a small doctor’s practice, while more will likely be necessary in a large clinic. Id. 5.
ADAAG requirements for alterations reiterate the exception of “maximum extent feasible”. Similarly, the section of ADAAG dealing with exception expands on the meaning “technically infeasible”. These give a small breather to the regulated party.

3.9. 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.

4. Physical Issues.

4.1. 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

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78 "EXCEPTION: In alteration work, if compliance with 4.1.6 is technically infeasible, the alteration shall provide accessibility to the maximum extent feasible. Any elements or features of the building or facility that are being altered and can be made accessible shall be made accessible within the scope of the alteration.” ADAAG § 4.1.6 (j)

79 "Technically Infeasible. Means, with respect to an alteration of a building or a facility, that it has little likelihood of being accomplished because existing structural conditions would require removing or altering a load-bearing member which is an essential part of the structural frame; or because other existing physical or site constraints prohibit modification or addition of elements, spaces, or features which are in full and strict compliance with the minimum requirements for new construction and which are necessary to provide accessibility.” 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.


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.

4.3. 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.

4.4. 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.

4.5. 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 itself a valuable right, and the landlord may try to charge for it.

5. Operational Issues

5.1. 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.

5.2. 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.

5.3. 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.

5.3.1 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 marketplace, 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.” 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.

5.3.2 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

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80 Tenet Healthsystem Surgical, L.L.C. v. Jefferson Parish Hospital Service District No 1, 426 F.3d 738, 742 (5th Cir. 2005)

81 “The express restriction to use the premises solely for general dentistry precluded use for an orthodontic practice. In this case, there was no similar evidence that an occupational medicine clinic did not fit within the category of a ‘general medical and physician’s offices, including related uses.’” Id.
imposed to preserve those exclusive rights of another practice group in the hospital. An 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.

5.3.3 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.

5.3.4 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.

5.3.5 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.\footnote{See Section 3.5 above.} 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 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.
6. **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.
Health Care Lease Rider of Illustrative Specialty Provisions

1. Regulatory Issues

1.1 General Licensure Compliance.

Tenant and the Premises shall comply with all federal, state and local licensing and other laws and regulations applicable to the operation of a Facility in compliance with the [License] as well as with the certification requirements of Medicare and Medicaid (or any successor program), if applicable. Further, subject to Force Majeure events, Tenant shall ensure that the Premises continues to be operated as a [ ] bed licensed facility, all without any revocation, or decertification of such license.

1.2 Protected Health Information.

1.2.1 Landlord Covenant for Privacy Rule Compliance.

Landlord agrees to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including, but not limited to, Privacy Rule (45 CFR Parts 160 and 164), as such are implemented and revised from time to time, including, without limitation, the American Recovery and Reinvestment Act ("ARRA") and the objectives of the guidelines establishing privacy standards as adopted by any federal regulatory agencies having jurisdiction over Tenant's affairs (the "Privacy Guidelines").

Landlord further agrees that it will: (i) not use or disclose Protected Health Information as defined in HIPAA ("PHI") obtained or accessible by it as a result of this Lease other than as permitted or required by this Lease or applicable law; (ii) use appropriate safeguards to prevent use or disclosure of such PHI except as permitted by this Lease and applicable law; (iii) mitigate, to the extent practicable, any harmful effect known to Landlord of a use or disclosure of PHI by Landlord in violation of the requirements of this Lease or applicable law; (iv) report to “Tenant's Compliance Officer” (defined below) or the party to receive
notice on behalf of Tenant under this Lease, and if required by applicable law, to regulatory authorities within two (2) days of discovery of any use or disclosure of PHI not provided for in this Lease; (v) report to Tenant’s Compliance Officer or the party to receive notice on behalf of Tenant under this Lease, and if required by applicable law to regulatory authorities, within two (2) days of discovery of any security breach relating to PHI; (vi) ensure that any agents, including employees, consultants and subcontractors, who obtain or have access to PHI, agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI; (vii) not present access to PHI to the individual who has a right of access under applicable law; (viii) to the extent in Landlord’s control, make PHI available for amendment and incorporate any amendments to PHI; (ix) to the extent in Landlord’s control, make available information required to provide an accounting of disclosures as required by applicable law; and, (x) make its internal practices, books and records relating to the use and disclosure of PHI received or obtained from Tenant, or created or received by Landlord available to the Secretary of the Department of Health and Human Services and other authorities with competent jurisdiction for determining Landlord’s compliance with Federal regulations.

1.2.2 Landlord Covenant for Security Regulations Compliance.

To the extent this Lease involves the transmission of PHI using electronic media, Tenant and Landlord agree to comply with the requirements contained in the HIPAA Security Rule (45 CFR Parts 160, 162, and 164), as amended from time to time. So long as PHI is transmitted using Landlord’s electronic media, Landlord shall protect the integrity, privacy and availability of such PHI by implementing appropriate and commercially reasonable administrative procedures, physical safeguards, technical security services and technical security mechanisms with respect to Landlord’s facilities, software and systems, all
as required by, and more specifically set forth in, the HIPAA Security Rule and related
requirements. To the extent PHI is transmitted using Tenant’s electronic media, Landlord
shall not present or interfere with it.

1.2.3 Tenant Covenant for Notice of Privacy Practices Permissions
and Restrictions.

Tenant will provide Landlord with the notice of its Privacy Guidelines and any other
privacy practices that Tenant produces, including those in response to 45 CFR 164.520, as
well as changes to such notice. Tenant will provide Landlord with any changes in, or
revocation of, permission by the individual to use or disclose PHI of which Tenant is aware,
if such changes affect Landlord’s permitted or required uses and disclosures. In addition,
Tenant will notify Landlord of any restriction to the use or disclosure of PHI that Tenant
has agreed to in response to 45 CFR 164.522, to the extent that such restriction may affect
Landlord’s use or disclosure of PHI.

1.2.4 Landlord Security Measures.

Landlord shall collaborate with Tenant on Landlord’s security plans and protocols
for the Building with respect to treatment of PHI in the case of events requiring the
undertaking of security measures. Landlord shall timely provide Tenant in a commercially
reasonable manner a written description of Landlord’s security measures designed to meet
Privacy Guidelines, provided that: (i) Tenant shall provide Landlord with updated copies of
such Privacy Guidelines, along with written notification and description of any amendments;
(ii) Landlord shall have a reasonable period of time to implement changes to its security
program necessary to comply with the requirements set forth in the Privacy Guidelines
(“Requirements”); and (iii) Tenant shall be responsible for payment of Landlord’s
incremental fees and costs to implement the Requirements to the extent they are materially
different from the Requirements of the Privacy Guidelines as promulgated at the commencement of Lease. “Landlord Entry” shall mean Landlord’s rights to access and entry upon the Premises for any reason, including, without limitation, for janitorial maintenance, inspection, repair, marketing, leasing, and repossession.

1.2.5 Tenant Covenant to Secure PHI; Landlord’s Exculpation.

Tenant shall preserve all PHI in a secure cabinet, as to papers, and a secure encrypted electronic format as to electronic files. Tenant shall clearly and conspicuously identify PHI receptacles and access points with written restrictions stating: “THESE CABINETS/COMPUTERS CONTAIN PROTECTED AND CONFIDENTIAL INFORMATION. ANY UNAUTHORIZED ACCESS OR USE MAY RESULT IN VIOLATION OF FEDERAL LAW, FINES AND IMPRISONMENT.” Tenant at its sole cost, shall maintain all PHI tangible files in specific and pre-designated secure areas shown on the attached Exhibit [ ]. Tenant covenants to keep tangible PHI receptacles locked at all times outside of business hours, and to construct them in a manner that allows them to be easily relocated or destroyed in the case of an extraordinary event, such as Building casualty. Tenant shall identify a security officer to be responsible ("Tenant Compliance Officer") for PHI and for decisions relating to its treatment during an extraordinary event, including casualty, eviction, or abandonment. Tenant hereby agrees that Landlord shall have the right in its sole, unfettered discretion, to remove and dispose of PHI if Tenant’s Compliance Officer has not assumed responsibility and taken possession of for the PHI.

1.2.6 Effect of Termination.

Upon termination of this Lease for any reason, Landlord, if feasible, will return or destroy all PHI received from, or created or received by Landlord on behalf of Tenant that Landlord still maintains in any form and will retain no copies of such information or, if such
return or destruction is not feasible, shall notify Tenant of the condition that makes the return or destruction of PHI not feasible and shall extend the protections of this Lease to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible for so long as Landlord maintains such PHI. This provision shall survive the expiration or termination of this Lease.

1.2.7 Landlord Waiver of Liens.

Landlord hereby waives any statutory or contractual liens relating to PHI and expressly excludes PHI from any security agreement and from any Uniform Commercial Code financing statement perfecting a landlord lien in property at the Premises. Landlord agrees that if it obtains possession of any PHI due to foreclosure of any security interest, eviction or other exercise of repossession, that it shall treat the PHI in compliance with applicable laws and shall return PHI to Tenant, to the extent practicable, or if impracticable, shall destroy the PHI in a secure fashion without disclosing PHI to third parties, by a professional disposal company which serves attorneys, physicians and similar professionals with on-going needs to appropriately destroy confidential information, as if the Lease were terminated.

1.3 Tenant Antikickback and Stark Law

Tenant represents that it is currently a participant in good standing with the following third party payors [ ] (“Participants”), and covenants to notify Landlord at any time there is a change in its relationships with Participants, including without limitation, upon cessation or suspension of eligibility to participate in any third party payment program with such Participants or upon any change in the identity of such Participants. Tenant represents that it is not currently a “sanctioned person” under the Social Security Act, Section 1128, and covenants to notify Landlord at any time it becomes subject to any
investigation which could result in Tenant becoming a “sanctioned person”. Tenant represents it has not received notice that its billing privileges have been suspended with respect to any third party payor, and Tenant covenants that it shall notify Landlord at any time it receives such notice.

1.4 Tenant Medical Waste Handling.

(a) Tenant, at Tenant’s sole cost and expense, shall be responsible for “Medical Waste” (defined below) maintenance and storage. Tenant shall not cause or permit the release or disposal of any Medical Waste, on or about the Premises or the Building. “Medical Waste” means all surgical, pathological, biological, infectious, or chemotherapy waste; laboratory waste that has come in contact with pathogenic (disease-carrying) organisms; the dead bodies, bedding or wastes from research animals exposed to pathogens; any human tissues, organs and/or other body parts removed during surgical operations of any nature, obstetrical procedures and autopsies, sharp instruments, including, without limitation, needles, syringes and scalpel blades, or other medical instruments capable of causing punctures or cuts or coming into contact with any pathogenic organisms; and, laboratory cultures and stocks of infectious agents and any associated biological materials such as microbiological wastes; and any other materials defined as medical waste under the applicable law.

(b) Tenant shall keep all Medical Waste produced by Tenant, Tenant’s agents, employees, invitees and patients on the Premises, in the manner specifically set forth below in proper containers until disposal of such Medical Waste. Tenant shall not permit the mixing or disposal of any Medical Waste with the general office refuse; and, Landlord shall have no duty or obligation to remove any Medical Waste from the Premises.
(c) Tenant agrees that it will, promptly upon the production or generation of any Medical Waste immediately cause Medical Waste to be separated from other types of refuse and placed in a container or vessel (the “Container”) which shall be prominently marked with the warning “Medical Waste”. The Container shall 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 thereof.

(d) Tenant agrees that it will obtain and maintain during the Lease Term all permits and licenses necessary for its use of Medical Wastes required by all federal, state and local laws, rules, regulations and ordinances, and will contract with an appropriately licensed Medical Waste company which operates in compliance with all federal, state and local laws, rules, regulations and ordinances for the proper removal and disposal of the Medical Waste.

1.5 American with Disabilities Act and State Human Relation Acts.

1.5.1 Landlord Warranties. Landlord represents and warrants all common areas of the Property referred to above are in material compliance with the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.) (the “ADA”) and with all applicable state and local represents for accommodating disabilities (“Disabilities Laws”). Landlord shall not knowingly permit, commit or suffer to exist within the common areas of the Property any condition which is a material violation of the Disabilities Law.

1.5.2 Tenant Covenants. Tenant represents and covenants is obligated pursuant to its lease it is in compliance with the Disabilities Law within its Premises. Tenant will indemnify and hold Landlord harmless from and against any loss, cost or
damage arising by reason of breach of the warranties and covenants set forth in this Certification.

2. **Physical Issues**

   2.1 **Utilities and Uninterrupted Power Source.**

   Landlord shall provide one or more roof-mounted emergency generators shall provide back-up power for selective control of elevators, building emergency smoke control system, building life safety systems, building lighting for emergency egress and tenant’s operating room.

   2.2 **Operating Expenses.**

   Tenant agrees that its share of the cost of its use of hot water, electricity and the heating and ventilation systems compared to other tenants in the Building would not be fairly reflected by its share of rentable square footage in the Premises compared to all rentable square footage in the Building ("RSF Share"). The parties agree that Tenant’s share of these variable costs shall be charged either (a) by submetering of the amount of service consumed by Tenant for such utility, or (b) in the absence of submetering, fraction of the RSF Share multiplied times [1.10].

3. **Operational Issues**

   3.1 **Tenant’s Restriction on Landlord Access.**

   Except as otherwise required in the case of emergency or otherwise in accordance with the terms of this Lease, Landlord agrees for the benefit of Tenant (1) to refrain from entering the Premises when patients are being examined, (2) to enter the Premises only when Landlord is accompanied by a Tenant representative, (3) to indemnify Tenant for claims of patients due to acts or omissions of Landlord, (4) to establish a protocol to limit Landlord access as to the portion of the Premises housing PHI to those Landlord parties who sign-in
or are otherwise identified or pre-approved by Tenant, and (5) to monitor the PHI location with a security camera.

3.2 Tenant Permitted Use.

Tenant shall use and occupy the Premises for procedures and general medical and physician’s offices, including related uses and for other purposes reasonably acceptable to Landlord.

3.3 Tenant Exclusive Use.

(a) Landlord agrees that during the Term of this Lease, no other tenant or occupant of the Building shall be engaged primarily in providing (i) the [ ] services (“Tenant’s Services”), or (ii) any services ancillary to Tenant’s Services (including, without limitation, laboratory, diagnostic or therapeutic health care services, or other diagnostic tests for invitees who are not patients of Tenant), or any other related services. Nothing in this provision shall prohibit any other tenant from using up to [ ] square feet in connection with providing services of Tenant’s Services.

(b) Landlord covenants and agrees that during the Term, Tenant shall have the “exclusive right“ (defined below) within the Building [or medical campus] to engage in providing Tenant’s Services (“Tenant’s Exclusive Use Right”) and other services typically provided in conjunction with Tenant’s Services.

(c) Notwithstanding the foregoing, Tenant’s Exclusive Use Right shall not apply to such services provided by (i) the [Hospital]; or (ii) pre-existing tenants who either had been providing such services, or had the right to provide such services at the commencement of the Term.

(d) Notwithstanding anything to the contrary construed in this Lease, if Tenant ceases engaging in providing Tenant’s Services at the Premises for a period of
[twelve (12)] months] (other than as a result of casualty, condemnation, remodeling, renovation, or Force Majeure), then Tenant’s Exclusive Use Right shall be deemed expired and of no force or effect.

(e) To the extent that any other lease of the Building gives Landlord the legal right to enforce restrictions of this provision against such existing tenants, Landlord shall do so. By way of example, if another tenant’s lease does not include any express reference to Tenant’s Exclusive Use Right, but such lease restricts such tenant to a particular use which is different than and does not overlap with Tenant’s Exclusive Use Right, then Landlord will prohibit such other tenant from violating Tenant’s Exclusive Use Right.

(f) Landlord acknowledges that the covenants and warranties contained in this Paragraph are a material inducement to Tenant entering into this Lease and agrees that Tenant shall have the right to enforce the provisions of this Section by appropriate injunctive or other equitable relief in addition to any and all remedies at law, provided that Landlord shall reimburse Tenant for all reasonable expenses incurred by Tenant in enforcing Tenant’s Exclusive Use Right, including reasonable attorney’s fees. In the event that a violation of Tenant’s Exclusive Use Right continues for thirty (30) days after Tenant’s notice to Landlord, Tenant shall be entitled to abate Rent and other charges due hereunder until such time as such violation ceases; provided, however, if the violation occurs by virtue of another tenant violating the terms of its lease, the thirty (30) day period shall be extended to one-hundred eighty (180) days provided the Landlord promptly commences its efforts to cause the offending tenant to cease its violation (which efforts shall include the filing of litigation). If such violation has not ceased within one-hundred eighty (180) days, Tenant shall notify Landlord in writing within three (3) business days after the expiration of such one hundred eighty (180) day period that it has elected to either: (i) terminate this Lease,
whereupon neither party shall have any further rights, duties or liabilities hereunder; or (ii) not terminate this Lease, whereupon Tenant shall no longer be entitled to abate Rent and other charges due hereunder, and Tenant shall pay all past due Rent and other charges and continue to pay future ones as they become due under the Lease.

(g) Landlord covenants that it shall not hereafter grant to any other tenant or occupant of the Building (an “Other Tenant”) any exclusive right to any engage in providing one or more of the following specific services, (“Restricted Uses”) except in accordance with this Section. The term “exclusive right” shall have the meaning of such term generally accepted in the health care industry and includes provisions that would prohibit other tenants from using their space for the “principal” or “primary” purpose of engaging in the particular protected business or from using more than a specified number of square feet in providing the particular protected service. If at any time during the Term, Landlord grants an exclusive right to any Other Tenant for a Restricted Use, then from and after the date of the granting of such exclusive right for a Restricted Use, no single tenant or occupant within the Building (including but not limited to the premises of such Other Tenant) shall utilize more than [ ] square feet of space in the aggregate for the services related to Restricted Uses. The use restriction described in this Section is herein referred to as “Springing Exclusive”. Notwithstanding any provisions in this Section to the contrary, (i) the foregoing restrictions under the Springing Exclusive shall not apply to any leases, or to any renewals or extensions thereof, with such Tenants in effect as of the date of this Lease, unless Landlord has the right under such existing lease to restrict the use thereunder without violating the terms thereof; and (ii) in no event shall the Springing Exclusive arise by virtue of any use restrictions which do not constitute a Restricted Use.

3.4 Tenant Prohibited Use: Religious/ Moral Tenet Restrictions.
As a covenant and condition of this Lease, Tenant agrees for itself and its employees, agents, representatives, contractors, consultants and invitees (i) they shall not commit or permit to be committed, any act that would violate the canons, teachings, or tenets of the [   ] or the Ethical and Religious Directives for [   ] Health Facilities, as adopted by the United States Conference of [   ], and (ii) shall observe the Religious Guidelines for [   ] (the “Guidelines”), copies of which have been provided to Tenant. These Guidelines shall apply as long as [   ] is a tenant of the Building. Landlord may also adopt in its rules and regulations the right to specifically enforce compliance with the Guidelines. Landlord may enforce the Guidelines against the other tenants in the Building, but has no duty to Tenant for such enforcement. If Landlord fails to enforce such Guidelines within ten (10) days of written notice by Tenant, Tenant shall have the right, in addition to any other remedies for Landlord’s default under this Lease, to enforce such Guidelines in Landlord’s name, and Landlord shall reimburse Tenant upon written demand for all costs and expenses incurred by Tenant, including reasonable attorneys fees, in connection with such enforcement actions; provided, however, Tenant shall indemnify Landlord from any loss or claim arising from Tenant’s enforcement of such Guidelines.

3.5 Tenant Transfer Restrictions.

During the Term, Tenant shall not directly or indirectly “transfer” (defined below) either (i) the Premises or any legal or beneficial interest in the Premises or (ii) control of the Tenant’s entity to any individual, corporation, general or limited partnership, limited liability company, limited liability partnership or other business entity, trust or fiduciary and any successor or assign thereof (a “Person”) if such transferee is directly or indirectly engaged in providing medical or other health care services which compete with the medical or other
health care services then being provided by Operator, Landlord or other tenants of the Building at the time of such transfer. Tenant’s governance documents, or other agreements governing its entity, shall expressly prohibit any transfer to such prohibited transferee.

For purposes of this Lease “Transfer” shall mean the direct or indirect (a) sale, exchange, assignment, conveyance, lease, license, easement, “master management” for participation in profits rather than fixed fees, or transfer in one or more transactions or events, of the Premises or any legal or beneficial interest in the Premises, or (b) the pledge, mortgage, encumbrance or grant of any security interest in and to the Premises, except to a lender providing financing to Tenant to the extent secured by no more than Tenant’s trade fixtures, equipment or accounts receivable. Transfer shall include the following events: (i) the sale or liquidation of any assets not in the ordinary course of business, (ii) the merger, acquisition or consolidation of the transferor or any person or entity controlling transferor, directly or indirectly, (iii) any sale, exchange, transfer, pledge or redemption of any stock, membership interest, or any other change in the ownership of the transferor which in any one or more transactions exceeds forty-nine (49%) percent of its controlling interests, or rights in capital, or both, (iv) a change of control or other material change in the structure of the transferor, and (v) the direct or indirect transfer of any beneficial interest, ownership interest, membership interest or rights of management in Tenant or any member or manager of Tenant and their constituent entities or Persons.

3.6 Landlord Restriction Use.

So long as [ ] (“Operator”) operates the [ ] facility (“Facility”) and Operator is leasing at least ___ square feet of space in the Building, Landlord shall lease space in the Building only to a physician or medical practice group which contains physicians who have staff privileges at the Facility (whether by active member status, provisional active member
status, courtesy status, or provisional courtesy status) and shall limit the use and occupancy of the Building to a physician’s, surgeon’s, dentist’s, or other professional health care provider’s office practice, including physicians, surgeons, and dentists, and other personnel providing medical and health care services and products for patients examined at the Premises. Landlord shall not lease or permit the use or occupancy of the Building for any other medical service including, but not limited to, laboratory, diagnostic or therapeutic health services, or other diagnostic tests for invitees who are not patients of tenants, but may otherwise be customers of those providers of such medical or health care services, or which otherwise are services provided at the Hospital. Notwithstanding the foregoing, these restrictions shall not apply to Operator and its occupancy of any space in the Building.

3.7 Landlord Transfer Restrictions.

During the Term, Landlord shall not directly or indirectly “Transfer” (defined below) the Building or any legal or beneficial interest in the Building to any individual, corporation, general or limited partnership, limited liability company, limited liability partnership or other business entity, trust or fiduciary and any successor or assign thereof (a “Person”) which is directly or indirectly engaged in providing medical services which compete with the medical services then being provided by Operator or Tenant, or any Person affiliated with or related to Operator or Tenant within the Building. Landlord’s governing documents or other agreements governing its entity shall expressly prohibit any Transfer to a competitor in accordance with this provision.

For purposes of this Lease “Transfer” shall mean the direct or indirect (a) sale, exchange, assignment, conveyance, lease, license, easement, “master management” for participation in profits rather than fixed fees, or transfer in one or more transactions or events, of the Building or any legal or beneficial interest in the Building, or (b) the pledge,
mortgage, encumbrance or grant of any security interest in and to the Building, except to a construction or permanent lender providing financing for the construction or ownership of the Building. Transfer shall include the following events: (i) the sale or liquidation of any assets not in the ordinary course of business, (ii) the merger, acquisition or consolidation of the transferor or any person or entity, (iii) any sale, exchange, transfer, pledge or redemption of any stock, membership interest or any other change in the ownership of the transferor which in any one or more transactions exceeds forty-nine (49%) percent, (iv) a change of control or other material change in the structure of the transferor, and (v) the direct or indirect Transfer of any beneficial interest, ownership interest, membership interest or rights of management in Landlord or any member or manager of Landlord and their constituent entities or Persons.

3.8 Tenant Quality Control.

(a) Professional Supervision. Each medical and other health care service provided at the Premises shall at all times be conducted under the supervision of a duly licensed health care professional with licensure and competence in the area of practice being supervised and, except with Landlord’s prior written consent, which may be withheld in Landlord’s sole and absolute discretion, Tenant shall not (a) allow any other person or entity to purchase, lease, license, manage, or operate medical or other health care service at the Premises, or (b) conduct medical or other health care service at the Premises while serving as an agent or employee of any other person or entity.

(b) Professional Qualifications. All physicians, surgeons, dentists, nurses and other health care professionals who engage in providing medical services and related activities at the Premises must be and remain appropriately licensed and in good standing with the state licensing board and any applicable federal, state or local certification or
licensing agency or office, without restriction, and not subject to any sanction, exclusion order, or other disciplinary order with respect to his or her participation in any federal or state health care program.

(c) Professional Standards. Tenant acknowledges that the Operator has relied on the Tenant’s covenant to continuously operate and provide Tenant’s Services at this Premises in compliance with Professional Standards, and Landlord’s obligations to Operator requires such continuous operation of Tenant’s Services in compliance with Professional Standards. If Tenant fails to provide continuous operations of Tenant’s Services in accordance with this Lease, which failure is not cured within thirty (30) days after written notice by Landlord, Landlord shall have the right to terminate this Lease without Tenant having any further right to notice or to cure. For purposes of this Lease “Professional Standards” shall mean medical and other health care services which (a) are in compliance with the American College of [ ] Practice Guidelines and Technical Standards and all other regulatory bodies as appropriate to meet the standard of care in Tenant’s Services, (b) are in compliance with all certifications, participation conditions, standards, rulings and regulations of Medicare and all federal, state and local government agencies, (c) are provided by health care professional which maintain Professional Qualifications, and (d) are subject to a continuous quality improvement program.