Stark Law Dos and Don’ts: Best Practices for your Physician Contracts

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Outline

- What are the main components of best practices for physician contracts?
- Where do physician contract rules come into play with employee physicians?
- How can you determine whether the volume and value of referrals will affect compensation?
- What is a Stark-compliant bonus program? Which programs could lead to trouble?
- What are the restrictions on contracts with physicians for medical directorships?
- What are the chief pitfalls in leasing space to physicians?
Stark Law: The Basics, Briefly Stated
Stark Act
42 U.S.C. 1395nn

• The Stark II Act prohibits a physician from making a **Referral**
  ➢ to an **Entity**
  ➢ for the furnishing of a **Designated Health Service**
  ➢ for which payment may be made under Medicare
  ➢ if the physician (or an immediate family member)
  ➢ has a **Financial Relationship** with the entity
Stark II Act

Proof of Intent is *Not* Required
Penalty

Denial of payment or refund; civil money penalties (up to $100,000) and exclusions from federal and state programs for improper claims or schemes.
What is a Referral?

A referral includes:

- Request for an item or a service by a physician
- Request by physician for consultation with another physician, and any tests or procedures the other physician orders, performs or supervises
- Request for or of plan of care that includes provision of designated health services
What is a Referral?

- A referral is not a DHS personally performed by a physician.
- A referral does not include a request by:
  - Pathologists for clinical diagnostic laboratory tests and pathological examination services
  - Radiologists for diagnostic radiology services
  - Radiation Oncologists for Radiation Therapy
- If the request for such additional services results from a consultation initiated by another physician.
Designated Health Services

- **Designated Health Services** include:
  - Clinical laboratory services;
  - Physical therapy and occupational therapy services;
  - Radiology or other diagnostic services (including MRI, CAT scans);
  - Radiation therapy services;
  - Durable medical equipment;
  - Parental and enteral nutrients, equipment and supplies;
  - Prosthetics, orthotics and prosthetic devices;
  - Home health services;
  - Outpatient prescription drugs; and
  - Inpatient and outpatient hospital services (encompassing almost every type of medical procedure).

- **Note:** *Ambulatory Surgery Centers services are not DHS!"
What Is a Financial Relationship?

A *Financial Relationship* includes:

- Ownership interests
  - Through equity, debt, compensation or other means; and
- Compensation arrangements
  - Includes virtually any form of direct or indirect *remuneration* (i.e., personal service contracts, medical directorships, lease agreements, consulting arrangements, medical service provider arrangements)
What Is a Financial Relationship?

Remuneration is defined (42 CFR§ 411.351) as “any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind …”
Exceptions

- Permitted *Ownership* and Compensation Arrangements:
  - Physician Services
  - In-office Ancillary Services
  - Services to Members of Prepaid Health Plans
  - Academic Medical Centers
  - Implants Furnished by ASC
  - Dialysis-related Drugs Furnished by End Stage Renal Disease Facility
  - Preventative Screening Tests, Immunizations and Vaccines
  - Eyeglasses and Contact Lenses Following Cataract Surgery
  - Intra-family Rural Referrals*

*New Phase II (7/26/04 effective date)
Exceptions

- Permitted *Ownership* Interests:
  - Publicly-traded securities
  - Mutual Fund Investment
  - Rural Provider (75% of DHS to Rural Residents)
  - Hospitals in Puerto Rico
  - Hospital Ownership (whole, not department or floor)
    - Applies only to Physician-owned hospitals up to December 31, 2010 – such hospitals cannot i) Expand physician ownership percentage, or ii) Expand capacity such as patient rooms, procedure rooms, etc.
Exceptions

- Permitted Compensation Arrangements:
  - Rental of Office Space
  - Rental of Equipment
  - Employment Relationships
  - Personal Service Arrangement
  - Physician Recruitment
  - Isolated Transactions
  - Services Unrelated to Provision of Designated Health Services
  - Hospital-affiliated Group Practice Arrangements
  - Fair Market Value Payments Made by Physicians for Items and Services (i.e., clinical laboratory services)
Exceptions

• Permitted Compensation Arrangements:
  ➢ Charitable Donations by Physician
  ➢ Non-monetary Compensation (Benefits) up to $385 Per Year
  ➢ Fair Market Value Compensation
  ➢ Medical Staff Incidental Benefits
  ➢ Risk-sharing Arrangements (i.e., withholds, bonuses, risk pools)
  ➢ Compliance Training
  ➢ Indirect Compensation Arrangements
  ➢ Referral Services
Exceptions

• Permitted *Compensation* Arrangements:
  - Obstetrical Malpractice Insurance Subsidies
  - Professional Courtesy
  - Retention Payments in Underserved Areas
  - Community-wide Health Information Systems
  - Electronic Prescribing Items and Services
  - Electronic Health Records Items and Services
Personal Service Arrangement Exception
(Appplies to Compensation Relationships)

• Remuneration paid under personal service arrangement is not prohibited compensation arrangement if:
  ➢ Arrangement is set out in writing, signed by parties and specifies services covered by arrangement
  ➢ Arrangement covers all services to be provided by physician to entity
    • This condition is met if contract:
      » References all other arrangements; or
      » References master list of contracts that is maintained with historical record of all arrangements
  ➢ Term for at least one year
Personal Service Arrangement Exception
(Appplies To Ownership and Compensation Relationship)

- Services are *reasonable* and *necessary*;
- Compensation to be paid over term of arrangement is set in *advance*, does not exceed *FMV*, is *reasonable* and determined through *arm’s length negations*, and is not determined in manner which *takes into account volume or value of referrals* between parties.
Personal Service Arrangement Exception
(Applies To Ownership and Compensation Relationship)

- Hold over month-to-month following a term of at least one year, assuming all other provisions of the exception are met, continuing on a month-to-month basis for up to 6 months as long as the terms during the hold over period are fair market value will meet the personal service arrangement exception
Bona Fide Employment Exception
(Appplies to Compensation Relationships)

• Employment is for identifiable services;
• Amount of remuneration under employment is:
  ➢ Consistent with *fair market value, reasonable* and determined through *arm’s length negotiations*
  ➢ Not determined in manner which *takes into account volume or value of referrals* by referring physician; and
  ➢ Remuneration is provided pursuant to agreement that would be commercially reasonable *even if no referrals* were made to employer
Bona Fide Employment Exception
(Applies to Compensation Relationships)

- Productivity bonuses can be paid if based on services *performed personally* by the physician (i.e., worked RVUs)
Requiring referrals

An employer *can require* an employee to refer to a particular provider, practitioner or supplier so long as:

- the compensation is set in advance
- the compensation is fair market value
- the referral requirement
  - is in writing signed by the parties
  - is not required if the patient expresses a preference for a different provider
  - does not require physician to refer if patients’ insurance does not cover services at required providers
  - does not require physician to refer if the physician believes that the required referral is not in the patient’s best medical interest

**Bona Fide Employment Exception**

*(Applies to Compensation Relationships)*
Bona Fide Employment Exception
(Applies to Compensation Relationships)

• Requiring referrals (Continued)
  - The required referrals relate solely to the physician’s services covered by the scope of the employment and the referral requirement is reasonably necessary for the legitimate business purposes of the compensation arrangement between the employer and the employee

Bad
Medical Director - Inpatient

Good
Employed Primary Care – Inpatient
Fair Market Value Exception
(Applies to Compensation Relationships)

• Payments that are fair market value are permitted compensation arrangements if:
  - In writing
  - Covers all arrangements between parties
  - Does not have to be 1 year term as long as terms and conditions do not change during 1 year
Fair Market Value Exception
(Applies to Compensation Relationships)

- Compensation set in advance, FMV, and *not related to volume or value of referrals*
- Commercially reasonable and furthers legitimate business interests
- Complies with fraud and abuse provisions

**Note:** Applies to payments by i) DHS entity to physician, and ii) physician to DHS entity. Also cannot base compensation on

- 1) “per click” if physician/owner is source of referral or
- 2) percentage
Other Stark Issues

- Group practice definition
- In-office ancillary services exception
- “Stand in the Shoes”
1) Is compensation a) based upon, or b) varies due to the volume or value of a physician’s referrals?

2) Is the compensation to be paid to the physician commercially reasonable?

3) Is the compensation to be paid to the physician fair market value?

These issues are being litigated: Halifax and Toumey.
Halifax Health

• **Allegations:**
  - Lawsuit brought by the former Director of Physician Services at Halifax Health alleges that contracts with six (6) oncologists violated the Stark law and other relevant Medicare laws.
  - Allegations that Halifax submitted 74,000 false claims to Medicare with potential damages and penalties exceeding $1 Billion.

• **Settlement:**
  - March 2014 – Stark Law Allegations Settled for $85 Million
  - July 2014 – Short Stay (Observation vs. Inpatient Admission) Allegations Settled for $1 Million
• **Arrangement:**
  - Bonus pool would be equal to 15 percent operating margin for the medical oncology program. The payments to individual doctors would be based on each individual oncologist’s personally performed services.
  - Halifax argued that the arrangement met the employment exception under the Stark law since the physicians were employed.
  - Summary Judgment: The bonus was not based solely on personally performed services but also included services provided including revenue from referrals made by the oncologists for DHS.
U.S. ex rel. Drakeford v. Tuomey Healthcare System

• **Allegation:**
  - The government and relator alleged that the part-time employment agreements for roughly 19 physicians in various specialties violated the Stark Law and the Anti-Kickback Statute.

• **Outcome:**
  - Jury originally found that Tuomey violated the Stark Law, but not “willfully and knowingly,” and thus had not violated the FCA.
  - District Court set aside jury verdict and granted judgment in favor of Government. Tuomey ordered to pay $44.9 M for the Stark Law violation.
Subsequently...

- Judge acknowledged he erred when ruling that the deposition of Tuomey’s COO was inadmissible, and ordered a new trial specifically on the FCA issue (not Stark Law).

- July 16, 2010: Tuomey filed an appeal on the determination of the Stark Law violation.

- September 7, 2010: Tuomey filed a petition for permission to appeal the District Court’s order granting a new trial.
October 26, 2010: Fourth Circuit Court of appeals denied Tuomey’s petition to appeal the District Court’s order granting a new trial.


- Gov’t seeks to recover $300 M for the alleged FCA violations.

- New trial ordered by District Court on FCA, in effect, vacated jury’s findings, thus denying Tuomey Seventh Amendment right to jury trial.
- Fourth Circuit focused on facility fee/technical component of referrals while performing services under employment arrangement.
Court held that jury can be instructed on preamble regulations (Phase I-III)

Court rejected Tuomey’s assertion that the technical component of a personally performed service is not a “referral.”

“Taking into account the volume or value of referrals” means anticipated and historical referrals.
May, 2013: (cont.)

- Jury found that Tuomey had violated both the Stark Law and the False Claims Act.
- Tuomey was required to repay $39.3 million plus interest in Medicare payments and up to $337 million in additional penalties.
- The crux of the case focused on the fair market value and commercial reasonableness of the employment contracts.
July, 2014: (cont.)

- Tuomey appealing as representatives of the organization stated that paying the jury verdict amount would effectively bankrupt the organization.
- Court ordered Tuomey to place $40 million in an account to continue the process of appealing the jury verdict.
- Hearing is scheduled in September of 2014 to discuss continuing the case.
U.S. ex rel. Drakeford v. Tuomey Healthcare System

- Contract Analysis
  - 10 year terms
  - Contracts included requirements of only outpatient procedures
  - Exclusive use requirement – all outpatient surgeries at Tuomey
  - Yearly salary based on previous year’s net collections
  - Bonus
    - 80% of net collections of professional fees
    - Additional 7% of productivity bonus for other factors

- Agreement not to compete – prohibited physicians from performing surgeries elsewhere within 30 miles of the hospital (during and post-two years)

- Full time benefits: Including health insurance, malpractice premiums (covered physicians for office and inpatient services), cell phones, journals, CME
Cejka, a valuation firm evaluated the contracts for purposes of the fair market value requirement at inception.

- Analysis indicated productivity levels of physician’s were between the 50\textsuperscript{th} and 75\textsuperscript{th} percentiles
- Compensation level exceeded the 90\textsuperscript{th} percentile
- Evaluation did not include full time benefits

Government expert analyzed the contracts at trial.

- Impossible to ever make profit on these contracts
- Full time benefits for minimal hours per week
- Cejka showed that certain physicians, across the country, received between 49\% and 63\% of net collections, but Tuomey paid, on average, 131\% of net collections
- Non-Compete Agreement locked in referrals
- Reactive to competing ambulatory surgery center and physician groups informing Tuomey they may perform surgeries in their own offices rather than at Tuomey.
Volume or Value

- **Clear Violations:**
  - Physician is paid a fixed amount or percentage for each ancillary service referred to the hospital.
  - Physician is paid at the upper end of the compensation range recognizing that he/she is a high volume referral source.
  - Physician is paid a percentage of the reimbursement received by hospital for every ancillary service referred by physician.
Volume or Value

Unclear Examples:

- Compensation pool increases based upon the volume of ancillary referrals or profit/margin generated from ancillary referrals (i.e., Halifax)
  - Even if compensation pool is divided based upon personally performed services?
- Bonus/compensation pool is fixed but is based upon quality, expense containment, and efficiencies based upon service line or medical department?
- Fixed bonus pool, divided based upon each physician’s productivity, paid based upon financial success of hospital or health system?
What Is Commercially Reasonable?

Many of the exceptions under the Stark Act require the payment to “be commercially reasonable even no referrals were made” between the parties.
What Is Commercially Reasonable?

To be commercially reasonable, both the **SERVICES** and **PAYMENT** must be commercially reasonable.
What Is Commercially Reasonable?

• The following services may not be commercially reasonable:
  ➢ Two medical directors over a department when only one is needed.
  ➢ Paying the physician for questionable consulting services.
  ➢ Renting a piece of equipment full-time when only used once a month (assuming rental for one day is less than full-time rental).
  ➢ Purchase of physician’s medical office building with no intention to use building.
What Is Commercially Reasonable?

- Hospital/physician specific indicators:
  1) Does the physician require a physician of a particular specialty?
  2) Can the service be performed by a non-physician provider?
  3) Does the physician have sufficient knowledge, experience, and training for the position (i.e. Medical Informatics)?
  4) Are the duties and responsibilities necessary from both a medical and business perspective?
External Factors that Impact Commercial Reasonableness:

1) Do the specific market conditions support the level of compensation to be paid (i.e., high demand but low supply for specialty, trauma center versus non-trauma center)?

2) Is the compensation paid consistent with other similarly situated hospitals (i.e., call compensation, payment for indigent care)?
Fair Market Value
WHAT IS FAIR MARKET VALUE?

I want MORE!

Fair market value is fine!
“What do you mean by FMV?”

• In the healthcare context, there are essentially 3 basic views on the meaning of FMV:
  • “Person on the street” perspective
  • Professional appraisal perspective
  • Legal/regulatory perspective
• Unfortunately, these 3 basic views frequently conflict.
• Parties can get “dazed and confused” when these 3 competing views meet to complete a transaction.
“The Street” View of FMV

- “What everyone is getting paid in the market”
- “What the hospital down the street is paying”
- “Incremental cost plus a profit margin”
- “What’s in a survey book”
- “What it’s worth to one party to the transaction”
Professional Appraisal View of FMV

- “The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under a compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.”

- (International Glossary of Business Valuation Terms)
Professional Appraisal View of FMV

- Based on the “hypothetical-typical” buyer concept
- FMV contrasts with investment value or strategic value
- Determination of FMV is based on 3 approaches to value:
  - Cost
  - Income
  - Market
- Formal body of knowledge and professional standards governing the appraisal practice for real estate and business valuation (“BV”)
- *No current body of knowledge or standards for compensation valuation (“CV”)
Legal/Regulatory View of Fair Market Value

According to the Stark Act, *fair market value* is “the value in arm’s-length transactions, consistent with the general market value.”
Legal/Regulatory View of Fair Market Value

“General Market Value” means the price that an asset would bring as a result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as a result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.

42 C.F.R. § 411.351
Legal/Regulatory View of Fair Market Value

The Stark Act also defines *Fair Market Value* as the market price at which bona fide sales have been consummated for like type assets in a particular market.
For real estate, the Stark Act states that **fair market value** is “the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee.”
A Fair Market Value Safe Harbor for *hourly rates* was developed under Stark in the Phase II regulations.

Safe harbor deleted in Phase III regulation. However, OIG stated that safe harbor methodology is still a prudent documentation process.
Fair Market Value
Safe Harbor Deleted

An *hourly rate* is deemed to be fair market value if it meets one of the following two tests:

1) Hourly rate is less than or equal to the average hourly rate for emergency room physician services in the market provided there are at least three hospitals providing emergency room services in the market.
2) Hourly rate is determined by averaging the 50 percentile national compensation level with the same physician specialty in at least four of the following survey, and dividing by 2000.

- Hay Group - Physician’s Compensation Survey
- Hospital and Health Care Compensation Services - Physician Salary Survey Report
- Medical Group Management Association (MGMA) - Physician Compensation and Productivity Survey
- ECS Watson Wyatt - Hospital and Health Care Compensation Report
- William M. Mercer - Integrated Health Networks Compensation Survey
Legal/Regulatory View of FMV

• Stark regulations state that the definition of FMV “is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies.”

• **Stark example:**
  Exclusion of market comparables between parties in position to refer

• **Stark example:**
  FMV can be established by “any method that is commercially reasonable.”

• OIG Anti-kickback statute example:
  Footnote 5 to Advisory Opinion 09-09 cautioning the use of the Discounted Cash Flow (DCF) method for an ASC valuation
Benchmark Data

Typical third party surveys include:

• **Sullivan, Cotter & Associates, Inc.** - Physician Compensation and Productivity Survey;

• **HayGroup** - Physicians Compensation Survey;

• **Hospital and Healthcare Compensation Service** - Physician Salary Survey Report;

• **Medical Group Management Association** - Physician Compensation and Productivity Survey;

• **ECS Watson Wyatt** - Hospital and Health Care Management Compensation Report

• **William M. Mercer** - Integrated Health Networks Compensation Survey
Benchmark Data

Data Example 1:

- Single Tier Model with a Guaranteed Cash Compensation of $175,000 with additional incentive compensation of $40 per RVU above 4,500 RVUs work.
- Base Compensation, RVU production and compensation per RVU all benchmarked at 50th percentile.

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Cash Compensation</th>
<th>RVUs</th>
<th>Compensation per RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>125,000</td>
<td>3,500</td>
<td>$35</td>
</tr>
<tr>
<td>50</td>
<td><strong>175,000</strong></td>
<td><strong>4,500</strong></td>
<td><strong>$40</strong></td>
</tr>
<tr>
<td>75</td>
<td>225,000</td>
<td>5,500</td>
<td>$41</td>
</tr>
<tr>
<td>90</td>
<td>300,000</td>
<td>6,500</td>
<td>$46</td>
</tr>
</tbody>
</table>
Benchmark Data

Data Example 2:

- Multiple Tiered Model
- 100% RVU Production

<table>
<thead>
<tr>
<th>RVUs worked</th>
<th>Compensation per RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,500 and below</td>
<td>$30</td>
</tr>
<tr>
<td>4,501 – 5,500</td>
<td>$35</td>
</tr>
<tr>
<td>5,501 – 6,500</td>
<td>$40</td>
</tr>
<tr>
<td>6,501 and above</td>
<td>$42</td>
</tr>
</tbody>
</table>
Benchmark Data

• Be careful with the compensation per wRVU benchmark data.

➢ 90\textsuperscript{th} percentile physicians, based upon productivity, do not earn compensation per wRVU at the 90\textsuperscript{th} percentile.

➢ For most specialties, compensation per wRVU should remain approximately at the 50\textsuperscript{th} percentile.
## Specialty: Orthopedic Surgery

<table>
<thead>
<tr>
<th></th>
<th>50&lt;sup&gt;th&lt;/sup&gt;</th>
<th>75&lt;sup&gt;th&lt;/sup&gt;</th>
<th>90&lt;sup&gt;th&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs*</td>
<td>7,981</td>
<td>10,723</td>
<td>13,795</td>
</tr>
<tr>
<td>x $63.54 (50&lt;sup&gt;th&lt;/sup&gt;)*</td>
<td>$507,113</td>
<td>$681,339</td>
<td>$876,534</td>
</tr>
<tr>
<td>x $105.18 (90&lt;sup&gt;th&lt;/sup&gt;) *</td>
<td>$839,442</td>
<td>$1,127,845</td>
<td>$1,450,958</td>
</tr>
<tr>
<td>Benchmark Range*</td>
<td>$520,119</td>
<td>$682,541</td>
<td>$943,059</td>
</tr>
</tbody>
</table>

* Based upon 2012 Physician Compensation and Production Survey from the Medical Group Management Association
Productivity-Based Incentive Measures

The most commonly used productivity measures, in order, are the following: wRVUs, collections, net income, and patient visits.¹

¹2011 Physician Compensation and Productivity Survey by Sullivan, Cotter & Associates, Inc. Of those that use productivity based incentive measures, 74% use work RVUs.
Exceed Benchmark Data Range

- Fair market value is based upon the specific financial arrangement being entered into by the parties. Factors that can cause compensation to exceed 90\textsuperscript{th} percentile include:

  - Extremely high productivity
  - High demand/low supply for specialty
  - Thought leader in specialty
  - Historic compensation above 90\textsuperscript{th} percentile for \textit{personally performed services} (do not include revenue from ancillary services or midlevel providers)
  - Super sub-specialization or multi-specialty
  - Nationally renown program
Compensation Stacking

- Aggregate compensation versus each component of compensation.
- Benchmark data includes all sources of compensation from respondents.
- When analyzing fair market value compensation, understand all sources of compensation.
- Can one physician really be more than a 1.0 FTE?
- Focus on number of hours worked by physician.
Employment vs. In-Office Ancillary Services Exceptions

- Under employment exception, compensation cannot vary based upon volume or value of referrals and bonuses are limited to personally performed services.
- Greater flexibility under in-office ancillary services exception because profits from DHS can be divided amongst the physicians in the group practice.
Medical Directorships
Medical Director

• Medical directorships are for administrative services, not clinical services.

• Medical director benchmark data exists.

• Clinical benchmark data can be used if the administrative services requires a) a physician, and b) a physician of a specific specialty.

• Structure of compensation (and underlying fair market value documentation) may depend upon legal status: Employee vs. independent contractor
Medical Director

Independent Contractor:

1. Hourly payment (with maximum number of hours in contract)

2. Annual payment (determined by projected number of hours multiplied by Fair Market Value hourly rate)
| DUTIES | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|--------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| A. Provide program assistance, guidance, and recommendations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Provide medical guidance and direction. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Provide educational inservices and/or conferences | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Administrative duties. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Be available to discuss and review treatment. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Be a physician liaison. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Meet regularly with Clinic staff. Attend meetings as requested. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**GRAND TOTAL:** __________________________

______________________________  __________________________
Approved by: __________________________

* In addition to the above, please generally describe the services performed this month.

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Example Included as Exhibit A.
Medical Director

If Annual Payment method is used, need to track hours to make sure consistent with contract.
<table>
<thead>
<tr>
<th>Last Name</th>
<th>Current Hrly Pay</th>
<th>Contract Hrly Pay</th>
<th>Contract Weeks</th>
<th>Actual Total Hrs. Wrk</th>
<th>Prorated Hrs.</th>
<th>Contracted Annual Hrs.</th>
<th>Contract Start Date</th>
<th>Contract Expire Date</th>
<th>Total Annual Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Kilroy</td>
<td>$102.42</td>
<td>$114.00</td>
<td>17</td>
<td>65.5</td>
<td>59</td>
<td>180</td>
<td>09/01/05</td>
<td>08/31/06</td>
<td>$20,520.00</td>
</tr>
<tr>
<td>Dr. Bombay</td>
<td>$117.85</td>
<td>$102.56</td>
<td>26</td>
<td>68</td>
<td>78</td>
<td>156</td>
<td>07/01/05</td>
<td>06/30/06</td>
<td>$16,000.00</td>
</tr>
<tr>
<td>Dr. Doctor</td>
<td>$142.12</td>
<td>$111.00</td>
<td>43</td>
<td>201.5</td>
<td>258</td>
<td>312</td>
<td>08/01/05</td>
<td>07/31/06</td>
<td>$34,632.00</td>
</tr>
<tr>
<td>Dr. I.M. III</td>
<td>$139.54</td>
<td>$137.80</td>
<td>4</td>
<td>79</td>
<td>80</td>
<td>1040</td>
<td>08/01/05</td>
<td>07/31/06</td>
<td>$143,310.40</td>
</tr>
<tr>
<td>Dr. Feelgood</td>
<td>$134.77</td>
<td>$97.87</td>
<td>26</td>
<td>321</td>
<td>442</td>
<td>884</td>
<td>07/01/05</td>
<td>06/30/06</td>
<td>$86,520.00</td>
</tr>
</tbody>
</table>

*Current Hourly Pay*: Current hourly rate based upon total hours documents

*(Total Annual Compensation/52 X Contract Weeks)/(Actual Total Hours Worked)*

*Contracted Hourly Pay*: (Total Annual Compensation)/(Contracted Annually Hours)

*Contract Weeks*: Number of weeks into current annual contract cycle

*Total Hours Worked*: Number of hours of services documented by physician during current term based upon time sheets approved

*Prorated Hours*: Average hours physician would have worked if hours evenly distributed throughout contract term.

*Contracted Annual Hours*: Number of hours required by contract on annual basis

*Contract Start*: Effective Date of current annual term

*Contract Expiration*: Expiration date of current annual term

*Total Annual Compensation*: Total amount of annual compensation per contract
Real Estate
Real Estate

Fair market value v. Commercially Reasonable: Is there a difference?
Real Estate

Fair market value: A Box is a Box is a Box. So, I can charge what the Hospital down the street charges. Right?
Real Estate

**Fair market value:** Is the physician paying occupancy costs that are consistent with arm’s length relationships in comparable properties in local market?
Real Estate

Commercially Reasonable: Is hospital establishing rental rates in amounts sufficient to generate positive cash flows and a rate of return consistent with i) risk and ii) other local real estate investors?

Is this space of an amount that is needed by the physician?
Real Estate

**Commercially Reasonable:** What a reasonable real estate investor will require as a rate of return.

10%? 15%? 20%?
Real Estate

To be *commercially reasonable*, unless extenuating circumstances exist, real estate should generate a reasonable rate of return.
Real Estate

Commercially Reasonable: (Amortized Cost of Building + interest + expenses) - rent receipts = 10%+ [Market reasonable rate of return]
Real Estate

• **Things to consider:**
  - Tenant Improvements ("TI")
  - New Space (higher TIs)
  - Rehab (Presumption - lower TIs)
  - Standard TIs
  - Enhanced TIs
    - Pay up front
    - Prorate with lease payments with interest
Real Estate

• **Things to consider** (Continued):
  - Leasing Costs
  - Amenities (Parking, Security, Internet, etc.)
  - Total Cost (Design, Construction, Land, Financing, HVAC, Taxes, Janitorial, Legal, etc.)
Real Estate

Quality of Building must be evaluated. Class A, B or C Building?
Real Estate
Shared Space

- Must allocate all costs to set FMV rental rate
  - Rental of space (Half or Full Day Slots)
  - Vacancy Rate (Project 20% vacancy?)
  - Supplies
  - Utilities
  - Staff (Registration, Nursing, etc.)
  - Equipment
Real Estate
Shared Space
(Example)

Assume the following:

• $18 gross per square foot rental (exclusive use)
• 30% projected vacancy
• 1,000 square feet in suite
• Building has 6,000 square feet, with 1,000 square feet for common area (5,000 square feet usable space)
• Suite capable of being leased in half day increments (8:00 A.M. – Noon; 1:00 P.M. – 5:00 P.M.)
Real Estate
Shared Space
(Example)

- Furniture and equipment in suite determined to be leaseable at $2,000 per year using independent third party leasing company.
- Miscellaneous medical/office supplies projected to be used in suite is approximately $5,000 annually if suite leased 70% of the time.
Real Estate
Shared Space
(Example)

$18 (exclusive use rate) + 30% (vacancy) = $25.71 per square foot ($18 ÷ .7 = $25.71)

1,000 square feet (suite) ÷ 5,000 square feet (building not including common area) = 20% (percentage of suite’s usable space in building’s usable space)

1,000 square feet (common area) x 20% (suite to building)

= 200 square feet (common area allocated to suite)
Real Estate
Shared Space
(Example)

1,200 square feet (suite plus allocated common area)
x $25.71 = $30,852

$30,852 + $2,000 (furniture and equipment) + $5,000
(medical/office supplies) = $37,852

$37,852 ÷ 52 (weeks) = $728 (weekly rate)

$728 ÷ 5 (business days in week) = $146 (daily rate)

$146 ÷ 2 = $73 (half day rate)
Real Estate
Shared Space
(Example)
Example becomes more complicated if:

• Part of suite is leased (as opposed to full suite)
• Staff is provided by landlord/hospital
• Specialized equipment is used
• Non-standardized supplies are used by a tenant
Real Estate Complexities: Office Space Rates

- Square foot measurement
- Real estate appraisals
- Gross lease v. triple net lease
- Payment of increases in operating expenses
- Tenant improvements
- Holdover Rent
- Exclusive use
- No percentage-based leasing arrangement
- No per click rental for referrals from lessor
Time Share Issues

Time Share leases issues

• Specific Days, # of Days
• What is Exclusive Use? What must be used exclusively?
• Is Lease Required?

  ➢ Hospital patients – Can Hospital arrange for specialists to see Hospital’s patients in Hospital space?

  ➢ If Hospital schedules the patient but does not bill provider-based can Hospital charge the physician the technical fee?
Questions

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