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# VIEW FROM THE BAR

## HEALTH CARE

SPRING 2008

## A MESSAGE FROM *Barry Mandelbaum*

by Barry R. Mandelbaum



### Dear Clients and Friends:

Nearly four years ago we decided to expand our firm's practice to include health care law. Dennis Alessi and Steven Holt joined us as directors of the firm and co-chairmen of our Health Care Law Department; with Dennis focusing on regulatory issues, particularly as they relate to new business formations for physicians, and representing them in related litigation matters; and with Steven concentrating on corporate and tax law, and asset protection for physicians.

Continuing unfavorable national trends for physicians in the health care industry, combined with recent decisions by the courts in New Jersey, proposed regulations by the Department of Banking and Insurance and by the Board of Medical Examiners, and proposed legislation in the State Senate, all create harrowing times for the future financial wellbeing and clinical autonomy of New Jersey physicians.

This special Health Care edition of our Newsletter includes three articles of our recommendations on how physicians can successfully overcome these perils. We hope you find this information useful and we stand ready to assist you with all the legal and related services necessary to overcome these perils.

### Barry R. Mandelbaum

*Barry Mandelbaum is president and founding member of the firm and chairs its Commercial Real Estate Department. He has forty-six years of legal experience.*



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*The opinions and recommendations expressed in this Newsletter are those of the attorneys at Mandelbaum Salsberg and do not necessarily reflect those of the Medical Society of New Jersey.*

**IS YOUR  
ONE-ROOM  
SURGICAL  
PRACTICE  
PROPERLY  
STRUCTURED**

**Possibly  
Not.**

# The Consequences

There are only two legally correct business structures in New Jersey for non-hospital-based surgery rooms. The first is an ambulatory care center licensed by the Department of Health and Senior Services (the "Department"), which must have a minimum of two surgery rooms. The second is an unlicensed, Medicare-certified one-room "surgical practice," as defined by the Department's regulations.

## DEFINING THE "SURGICAL PRACTICE"

Under the Department's definition, this one surgery room must be an integral component of the "surgical practice" itself, within the same corporate structure as the practice, and use of the room must be limited to those surgeons who are members or employees of the practice. This means that the surgeon must examine the patient, perform whatever diagnostic or pre-surgery testing or other preliminary procedures are necessary, and then must perform the ambulatory surgery, itself, within one business entity; his/her "surgical practice." The surgeon must bill for the professional and technical components and the facility fees, for all these steps of the patient's treatment, only under the "surgical practice's" tax identification number.

Under the Department's definition of a "surgical practice" there is no other health care entity, in which the surgeon or his family has a financial interest, to which this patient can be referred for the ambulatory surgery, or for any other related treatment component of the surgery. This limitation in the Department's definition is necessitated by the Codey Act which prohibits a physician from referring patients from his/her medical practice to any other entity providing health care services in which the physician, or a member of his family, has any financial interest. The only exception provided by the Act is for services that are performed within the physician's "medical office." Hence, the one-room surgical suite must be within the corporate structure of the surgeon's medical practice to fall within this one exception to the Codey Act's otherwise blanket prohibition of self-referrals.

## USE BY MEMBERS OF A "SURGICAL PRACTICE"

The other element of the Department's definition is that use of the surgery room must be limited to the members (i.e., owners and physician employees) of the "surgical practice." The regulation does not include a definition nor a formula for determining when a surgeon is a member of the practice. However, since the Codey Act prohibitions on self-referrals are akin to those similar prohibitions provided by the federal law known as Stark, it is reasonable to assume that regulators in New Jersey, and the insurance industry, will look to the definition provided by Stark for a "group practice" in determining whether a physician is legitimately a member of the "surgical practice."

Under Stark's 75% rule for a "group practice," all the surgeons using the surgery room, both owners and physician employees, when considered in the aggregate, must spend 75% of their total work time working at the "surgical practice" before they will be considered as truly being members of the practice. (We understand that in future litigation insurance carriers will be urging judges to adopt this Stark rule.)

# Could Be Catastrophic!



by Dennis J. Alessi, Esq.

Many one-room “surgical practices” are not structured as previously described. Rather, the one-room surgery suites are owned by separate business entities from the surgeons’ medical practices; surgeons from multiple practices have ownership interests in these separate business entities and use the surgery rooms; the surgeons initially examine their patients and may perform some pre-surgery diagnostic or other testing procedures at their medical practices; the surgeons then refer their patients for procedures from their medical practices to these other entities which own the surgery rooms; the surgeons bill their professional fees under their medical practices, and these separate surgery entities bill the technical components and facility fees.

This structure clearly does not comply with the Department’s definition of a “surgical practice”; nor does it comply with the Codey Act’s exception, to the prohibition of self-referrals, for services performed in the physician’s “medical office.” This exception to the Codey Act does not apply to this structure precisely because the surgeon is referring the patient from his/her medical practice, for a surgical procedure, to the “surgical practice” in which the surgeon has a financial interest. That the surgeon bills the professional fee for this surgical procedure through his/her medical practice, and not through the “surgical practice,” is another violation of the Codey Act.

## “GRANDFATHERING”

Admittedly, the proposed amendments to the Codey Act, as discussed in a companion article in this Health Care Law Newsletter, do “grandfather” unlicensed, Medicare-certified one-room ambulatory surgery practices as not being in violation of the Act. However, these proposed amendments are silent on eliminating the obligation that such facilities must also comply with the Department’s regulations which clearly apply to them. Therefore, it must be concluded that to fall within the protection of this “grandfathering” provision of the proposed amendments to the Codey Act, a Medicare-certified ambulatory surgery practice must also comply with the Department’s definition of a “surgical practice” in terms of its organizational structure, ownership and business operations.

Any one-room surgery practice which is not organized and operated in accordance with the Department’s definition of a “surgical practice,” as described above, faces the potential of insurance carriers claiming that all the billing, by both the surgeons’ various medical practices and by their separate surgery practices was fraudulent because it was in violation of the Codey Act, and was also in violation of the New Jersey Insurance Fraud Prevention Act. Such a claim would subject all these practices to treble damages for all the payments made to them by the insurance carriers for the prior six years or longer, plus the carriers’ attorneys’ fees and costs of the investigation.

In addition, representatives of the Department have indicated that if surgeons from different, separate practices all have an interest in, and utilize, the “surgical practice’s” one room to perform surgeries, then the Department will require that this practice be licensed as an ambulatory surgical center and will consider it as having previously operated illegally, as an unlicensed center. Such a determination will subject the “surgical practice” and the surgeons to

disciplinary action by the Department and, almost assuredly, by the Board of Medical Examiners, as well as possible civil fraud actions by insurance carriers.

## A RECENT COURT DECISION

Insurance carriers are beginning to bring claims against surgical practices that they are not properly structured under the Department’s definition. In a recent decision, *Endo Surgi Center, P.C. v. Liberty Mutual Insurance Company*, a Union County Superior Court judge interpreted the Department’s definition as requiring that all the surgeons performing procedures at this surgical practice had to be members or employees of it. The judge ruled against the insurance carrier on this point only because he found that all the surgeons at issue were employees. However, the judge did find a violation of the Codey Act precisely because the professional components for the surgeries were billed by the physician’s separate medical practice, while the facility fees were billed by the surgical practice, Endo Surgi Center. The judge declined to order a refund to Liberty Mutual of all the prior paid facility fees, but did order that Endo Surgi Center was not entitled to be paid its outstanding claims for such fees.

While the carrier only partially prevailed in this case, it represents the industry’s strategy of pursuing any health care entity which is even arguably not in compliance with Department and Board of Medical Examiner regulations, and the Codey Act provisions, on the proper business structures for such entities. In these lawsuits the carriers always seek a full refund of all fees previously paid, an order that they do not have to pay any outstanding claims, payment of their attorneys’ fees, and damages of three times the fees that they previously paid. A truly catastrophic result for the entity!

## RECOMMENDATIONS

Any unlicensed, one-room Medicare-certified ambulatory surgery practice, which is not properly organized and operated under the Department’s definition of a “surgical practice,” as described above, should consider reorganizing and restructuring as soon as possible, particularly given the *Endo Surgi Center* decision<sup>1</sup>. In addition, as discussed in a companion article in this Health Care Law Newsletter, if at all practicable these one-room practices should begin the process within the next few months of expanding and becoming licensed by the Department.

Mandelbaum Salsburg has all the legal expertise, the availability of other consultants, and the resources to assist in obtaining financing for this purpose. Please call Dennis J. Alessi, the co-chair of our Health Care Law Department.

*Dennis J. Alessi is a partner, and the firm’s lead attorney for representing clients in the health care industry.*

<sup>1</sup>As discussed in another article in this newsletter, there are proposed amendments to the Codey Act which do create an exemption under the Act for “surgical practices,” but these amendments have not yet become law. There is a real question if they ever will; and even if they do, these proposed amendments do not appear to eliminate the requirement of compliance with the Department’s definition of a “surgical practice.”

# NEW BUSINESS MODELS FOR PHYSICIANS GETTING THEIR RIGHTFUL "PIECE"

by Dennis J. Alessi, Esq.



For decades, the piece of the health care dollar which physicians have received has continued to shrink, and the trend clearly appears to be continuing in that direction. Insurance carriers are paying less for out-of-network services, causing patients to pay a larger portion of the fees as their co-insurance obligation, and possibly forcing these patients to seek the services of in-network physicians in the future. Carriers are reducing reimbursement levels to participating providers and are engaging in guerilla warfare in the claims/reimbursement process to further forestall and reduce what they

pay physicians for their services. Medicare reimbursement levels are a political football almost every year. Currently for some services, reimbursements are less than the physicians' costs to provide them.

## HOW HAVE PHYSICIANS REACTED TO THIS SITUATION?

Physicians have reacted in a number of ways. Some simply work longer hours, see more patients, and cut operating expenses and other overhead costs to the bone. Others, where practicable, have gone out-of-network; still others do not accept insurance at all. None of these are long-term solutions.

First, physicians can only work so many hours, and see so many patients, before quality of care suffers. Secondly, our experience is that with the current business model which generally prevails, of small group practices with four or five physician members, the economies that can be realized are limited, and most practices reached these limits long ago.

Third, the New Jersey Department of Banking and Insurance ("DOBI") has already proposed regulations to limit, to a multiplier of Medicare reimbursement levels, how much out-of-network physicians can charge. While this attempt was beaten back last year by the Medical Society of New Jersey, you can be certain that the insurance carriers will try again. The Board of Medical Examiners ("BME") has recently proposed two different sets of regulations which would make it more difficult for surgeons to participate in ambulatory surgery centers, and more difficult for them to obtain non-physician investors and financing for these centers. These proposed regulations are also being fought. The Board has also proposed additional regulations which would further restrict the ability of physicians to establish multidiscipline practices with other health care professionals (e.g., nurse practitioners, chiropractors, podiatrists, physical therapists, and the like).

## A MATTER OF CLOUT

In the end, the insurance carriers have more money, more lobbyists, more political clout, and more staying power than organized medicine in the political and regulatory arenas. Consequently, these are not the arenas which hold long-term prospects for the economic wellbeing and clinical autonomy of physicians. Also, every time the physicians find an avenue to enhance their finances, the carriers seek to close it off. Examples are the proposed DOBI "caps" on out-of-network fees and the BME proposed restrictions on physicians in ambulatory surgery centers.

We are satisfied that only by enhancing the economic clout of physicians can the trend of lower reimbursement levels be permanently reversed over

# PHYSICIANS; “PIECE OF THE HEALTH CARE PIE”

the long term; while maintaining and even improving the quality and efficiency of care. When physicians are properly organized into larger “Super Groups,” which they control and which are sensitive to their needs for collegiality, they are able to:

- 1 effect significant economies and efficiencies;
- 2 negotiate higher reimbursement levels with insurance carriers;
- 3 maintain and even improve the quality of care;
- 4 maintain clinical autonomy and the atmosphere of a small group practice.



## “SUPER GROUP” STRUCTURE

A “Super Group” can be structured in two different practice models. One is horizontal integration (e.g., a fairly large number of physicians all in one specialty, such as urology, gastroenterology, or cardiology, within a geographic area form one group.) With so many physicians in one specialty being in one practice, they can negotiate higher reimbursement levels because they command such a large share of the market for their specialty services within their geographic area.

Vertical integration is when a core group of internists or family practitioners create a single practice together, along with a number of different specialty physicians to whom these primary care physicians most often referred their patients (e.g., a group of internists find that their most frequent referral is to a cardiologist, so they start by hiring a part-time cardiologist for their practice; and then they continue to build a multi-specialty practice around this core of primary care physicians who refer their patients to the various specialty physicians, all within their one “Super Group” practice.) In this model the “Super Group” is built more slowly over time in layers, with part-

time and then full-time specialty physicians in different specialties being added as the core of primary care physicians also increases and, in turn, this increases the numbers and types of referrals they can make within the “Super Group” to a larger, increasingly diverse set of specialty physicians.

Once the “Super Group” reaches a certain volume of patients it can then begin hiring, even on a part-time basis initially, other allied health care professionals and technicians, such as physician assistants, nurse practitioners, physical therapists, various technicians, and the like, all of whom are on salary and do not have an ownership interest in the “Super Group.” Accordingly, these allied health care professionals and technicians become profit makers for the “Super Group,” which is another source of income for the physician owners.

## “SUPER GROUP” FACILITY MODELS

There are also two different facility models for a “Super Group.” One is to house all the “Super Group’s” physicians in one physical location. Obviously, this results in the greatest economies and efficiencies of operations. However, it is not always feasible nor necessarily desirable in a suburban setting where the “Super Group” wants to solicit patients from a larger geographic area. The other facility model is to have a number of satellite offices, like spokes on a wheel, which has a large geographic circumference. This model is less efficient because of the multiple facilities, but economies can still be obtained from centralized billing and other support services. There is also the benefit of each office maintaining its prior atmosphere of a small group practice.

Admittedly, there are health care regulatory, anti-trust and other legal issues, and still other business and personality hurdles which have to be overcome to create a “Super Group.” However, it has already been done in New Jersey, and we can replicate it. We are satisfied that going forward only such “Super Groups” can restore to physicians the rightful compensation they deserve, and the clinical autonomy to which they are entitled as plenary license-holders.

Mandelbaum Salsburg has all the legal expertise, access to other experts and consultants, and the availability of financing to assist in the formation of “Super Groups.” If you have a real interest in doing so, please call Dennis Alessi or Steven Holt, Co-Chairmen of our Health Care Law Department.

# SENATOR CODEY PROPOSES LIMITING PHYSICIAN-OWNED AMBULATORY SURGICAL CENTERS

by Dennis J. Alessi, Esq.



The Codey Act in New Jersey prohibits physician referrals from their medical practices to any other entities providing health care services in which the physicians, or members of their families, have any financial interest. The Act's only exception is for services that are performed in the physician's "medical office." Since 1997 the Board of Medical Examiners has interpreted the Codey Act as not prohibiting a surgeon from referring his/her patients

for procedures to an ambulatory surgical center (ASC) in which the physician has an ownership interest. The rationale for this interpretation is that for a surgeon, the ASC is simply an extension of his/her medical office. As a result of this interpretation there are now nearly 200 ASCs in New Jersey.

The legal validity of this business model was seriously called into question in November 2007 when a Superior Court judge, in the case of *Garcia v. Health Net of New Jersey*, decided that physician-ownership of an ASC, to which they refer patients, violates the self-referral prohibition of the Codey Act. In response to this decision, Senate President Richard Codey has proposed amendments to the law bearing his name.

As originally drafted, the most important features of the bill are that:

1. currently licensed ASCs, and those under development, and existing, unlicensed Medicare certified one-room ambulatory surgical practices, are all "grandfathered" as not violative of the Codey Act;
2. all prior billings by these entities to insurance carriers are granted protection from claims by the carriers to recoup these billings as having been paid in violation of the Act;
3. non-physician ownership of ASCs will be permitted to continue
4. existing ASCs can expand in the future and ownership interests in them can be sold or otherwise freely transferred;
5. no new ASCs owned by surgeons referring to them would be permitted. (Although the proposed amendment does not specifically address the issue, it does appear that new "surgical practices" with an unlicensed one-room surgical suite, as defined by the Department of Health and Senior Services regulations, will be permitted to open in the future as being within the Codey Act exception for services provided in the physician's "medical office.")<sup>1</sup>

## CERTAIN CONDITIONS APPLY

The bill also establishes several conditions which have to be met for the ASC or the surgical practice to fall within the protections of these "grandfathering" provisions. These are: (1) the physician who refers the patient to the ASC, or within the surgical practice, must also actually perform the surgery; (2) the physician's remuneration as an owner of, or an investor in, the ASC or surgical practice is directly proportional to his ownership interest in it; (3) his/her remuneration is not proportional or otherwise related to the volume of patients the physician refers to the ASC or within the surgical practice; and (4) the surgeon discloses his/her ownership interest to the patient and whether the fees for the surgery will be billed out-of-network.

What all this means is that except for the few ASCs currently under development, no new ones owned by physicians will be opening for at least two years, and possibly longer, if these amendments to the Codey Act become law. Surgeons will have only two options going forward. They can either purchase an interest in an existing ASC, the price for which will obviously escalate, or they can combine with other surgeons to create a "surgical practice" with a one-room surgical suite certified by Medicare.

## RECOMMENDATION

Because there will be no new ASCs opening in the near future in which surgeons can have an ownership interest and refer their patients to them, the existing ones will only increase in value; particularly as medical science advances and increasingly more procedures are performed on an ambulatory basis. Accordingly, we recommend that if it is at all feasible, one-room surgical practices should convert to become licensed ASCs. There is, at most, **a window of opportunity until September 1, 2008**, under the current proposed amendments to the Codey Act, in which this conversion can be accomplished before the amendments to the Act may become law and surgical practices will be precluded from so converting.

If your surgical practice is interested in becoming licensed, please call Dennis J. Alessi, co-chair of our Health Care Law Department. Mandelbaum Salsburg has all the legal expertise, relationships with other experts and consultants, and access to financing, to assist in every aspect of a one-room surgical practice expanding and becoming licensed.

<sup>1</sup> A new draft of the amendments would place a two-year moratorium on the issuance of licenses for new ambulatory surgical centers, beginning September 1, 2008, and would establish a task force from several regulatory agencies to determine if the moratorium should be continued beyond September 1, 2010.



# THE ASSET PROTECTION TRUST:

*A Popular Way  
to Protect Assets  
from  
Creditor's Claims*

by Steven Holt



As our society has become more litigious, professionals, business owners, corporate officers and others continue to search for ways to protect assets from creditors' claims. Using trusts for this purpose is becoming increasingly popular.

Until recently, the only way to use a trust to potentially shelter personal assets from creditor claims was to create a trust in an offshore jurisdiction. The use of this very effective strategy is often hampered by the complexities posed by unfamiliar foreign laws, foreign judicial systems, geographic remoteness, political uncertainties, and potentially punitive changes in U.S. tax laws, including possible liability for advisors.

The states of Alaska, Nevada and Delaware have adopted legislation allowing for the creation of domestic asset protection trusts as an alternative to offshore trusts. Witness the the state of Delaware, which in 1997, enacted the "Delaware Qualified Dispositions in Trust Act". This legislation allows an individual, known as the Grantor, to create an irrevocable Delaware-sited trust, the assets of which, if properly structured, will not be reachable by creditors. Most importantly, the Grantor may continue to benefit from the assets transferred to the trust.

In general, asset protection trusts shield assets from claims of creditors when the claims result from actions or conduct occurring after the establishment of the trust. Asset protection trusts are

particularly attractive to physicians and others engaged in high risk professions who may face potential future litigation.

The individual who creates an asset protection trust, along with designated family members, may receive income or principal from the trust at the discretion of the trustee or a trusted family advisor. They also retain the right to receive current income distributions or retain the right to receive income and principal for certain defined needs such as for health and education.

The professional trustee serving as trustee of an asset protection trust will normally provide such services as trust administration; trust investment management; trust reporting to beneficiaries; trust accounting and record keeping; custody of assets; and tax services.

Normally, the Grantor is permitted to designate a "Trust Protector", a trusted family member or advisor, in the trust agreement. Since an asset protection trust is an irrevocable trust, this right allows for flexibility as the Grantor's or his family's circumstances change. Broad powers enable the Trust protector to "manage" the trustee and many of the trustee's decisions, including distributions decisions. The Trust Protector can change the trustee and even effectively terminate the trust.

## WHY SHOULD YOU ESTABLISH YOUR ASSET PROTECTION TRUST IN DELAWARE?

While Alaska and Nevada law allow for domestic asset protection trusts, Delaware law offers several specific advantages. It expressly protects the qualified trustee, trust advisor or "any person involved in the counseling, drafting, preparation, execution or funding of a trust that is the subject of a qualified disposition" from liability, reducing fiduciary risk for these persons.

Delaware does not impose a tax on capital gains or income accumulated within an irrevocable trust managed for a non-Delaware resident. This can result in significant savings and the potential for enhanced growth of the trust principal for the benefit of the ultimate beneficiaries.

Delaware law allows for Dynasty Trusts, which, if properly structured, can help avoid Generation Skipping and Estate taxes, while protecting the interests of multiple future generations from creditors. It can also guard against irresponsible spending, and possibly provide protection in the event of divorce.

Delaware law allows for "direction trusts," through which a Grantor can separate administrative duties of the trustee from the investment duties of a separate trust advisor.

Delaware does not levy a personal property tax.

*(Continued on back cover)*

# WHAT EVERY PHYSICIAN NEEDS LEASING OFFICE

by Gary S. Poplaski, Esq. and Dennis J. Alessi, Esq.



Most medical practices lease their office space. Yet, few physicians take the time to review the lease and, when they do, they often do not know the pitfalls. This article addresses what to look for in a commercial lease for physicians renting office space.

The following list of items should be included in the lease. This is not intended to be an all-inclusive list; rather, it focuses on the “Hot Button” items that should be in every commercial lease for space that is to be occupied as a physician’s office.

- The lease should not be in the physician’s name; it should be in the name of the physician’s business entity (corporation, partnership, LLC, etc.).
- The term (or length) of the lease should be clearly spelled out and may, in rare occasions, also include an “opt-out” provision which allows the physician to terminate the lease after a certain period of time. The opt-out provision would allow the physician to opt-out of the lease after the lapse of a certain period of time, but prior to the expiration of the term, for any reason or for no reason whatsoever.
- Parking is an integral provision of the lease. The parking may include the exclusive use of assigned spots, the non-exclusive use of a general parking area, or public or municipal parking that is in close proximity to the demised space to accommodate incapacitated or handicapped patients.
- Maintenance and repairs of the demised premises should be spelled out clearly, specifying the party that is responsible to maintain and/or repair specific items or features of the demised space (roof, structure, internal systems, etc.), and even down to the most minor of details such as who is responsible for changing light bulbs. Typically, the landlord will be responsible for maintenance and repairs of the structural components, the common areas of the premises, if any, and the roof. But all maintenance items must be negotiated and documented before the lease is signed.
- Janitorial services should be provided at least every evening due to the high volume of traffic in most medical offices. The janitorial services should be negotiated between the landlord and the tenant, and should be clearly reflected in the lease indicating the scope of the services and the frequency of them. That the practice is responsible for the proper disposal of all medical waste should be clearly stated.
- The lease should also include the ability of the tenant to assign or sub-lease the demised premises. It is customary in the lease to require the landlord’s consent to such assignment or sub-lease. However, the lease should include language which states that the landlord’s consent shall not be unreasonably delayed or withheld. It is important to note that the assignment language in the lease should be less restrictive when the assignment is pursuant to, or in connection with, the sale of the practice.
- The tenant should also have the ability to remove all medical equipment, and personalty installed in the premises, at the end of the term of the lease, if he/she so desires. However, the tenant would typically be responsible for repairing any damage that is caused by the removal of such medical equipment unless the lease states otherwise.
- The lease should also include language that the physician will be able to install appropriate signage to the demised premises with the landlord’s written consent. The lease should state that the landlord’s consent shall not be unreasonably delayed or withheld. The lease will also indicate that the signage must be in conformance with all local and municipal ordinances. The lease may further dictate that the signage must be in conformance with other signage that exists at the property at the time



# POINTS TO KNOW ABOUT SPACE

the tenant takes possession of the demised premises. The tenant should make sure that the lease permits the tenant to install conforming signage on any pylons or office directories that exist, or will be installed in the future.

- The lease will also typically include an insurance provision which dictates that the tenant must carry a certain amount of premises liability or “All Risk” coverage, as well as property damage coverage for the demised premises. The limits for the coverage would be dictated by the size of the space, but are customarily in the \$1,000,000 to \$3,000,000 range for a typical commercial space.
- The lease should also spell out what the condition of the premises will be at the time that the tenant takes possession, and what improvements the landlord will make, if any, prior to the tenant taking possession. The lease should also spell out who will facilitate, and who will pay for, the installation of plumbing and electrical.
- The lease may also dictate that all governmental approvals will be the responsibility of the tenant, including, but not limited to a Business Certificate of Occupancy (BCO) or any other type of approval that the specific municipality may require.
- The lease may also include an option to renew for additional term(s). It is preferable to have a shorter initial term (3-5 years), with several options to renew, as opposed to a long term (10-20 years), in case the practice must be terminated for any reason. It is also important to note that any lease with renewal options must include clear language on rent increases and how any increases will be calculated (percentage, CPI, fair market value, etc.).
- The lease may also indicate that the tenant will be responsible for a proportionate share of Common Area Maintenance (CAM) and/or property taxes for the demised premises. There may also be a tenant electric charge which is typically charged per square footage and/or an HVAC charge which may allow the usage on business days between certain hours. There may also be an additional charge for usage on weekends. This is an item that should be negotiated between the parties, particularly for practices that have evening and weekend office hours.
- The tenant should also seek several months of free rent from the landlord to allow the tenant to do the “fit-up” of the property, so that the property is in condition to commence business at the time when the first rent payment is actually due. The free rent term is something that should be negotiated between the parties and should include language which states that the rent will not begin before a certain number of days, perhaps 60 or 90 days, have passed after the tenant has taken possession; or, in the alternative, the rent will not begin until the time that the tenant is ready to open for business.

## CONCLUSION

It is critical that a commercial lease include at least the foregoing provisions for the leasehold tenancy to begin and continue in a proper fashion. The tenant should negotiate these terms with the landlord to insure that the tenant receives every consideration. Most importantly, the tenant should have the lease reviewed by an attorney experienced in commercial leasing prior to accepting possession, prior to tendering any deposit or security, and prior to the signing of any formal lease agreement.

*Gary Poplaski is an associate specializing in commercial and residential real estate transactions.*



# VIEW FROM THE BAR

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Delaware's "Prudent Investor Rule" permits the trustee to use a portfolio approach, instead of an asset-by-asset approach, to determine if trust assets are prudently invested, thus increasing investment flexibility.

Delaware places a premium on confidentiality and values privacy. If you have an existing irrevocable trust, certain circumstances can allow you to move the trust to Delaware and qualify the trust under the asset protection trust statute.

## HOW ARE YOUR ASSETS PROTECTED?

Under Delaware law, any attempt to reach the protected trust assets to satisfy creditor claims must be brought in the Delaware Court of Chancery within the four year period after the assets are transferred to the trust. If the claim arose after the transfer, then the creditor must bring suit within four years after the transfer, and must show that the creation of the trust was fraudulent. Any action brought after that time is barred by Delaware's statute of limitations.

## DELAWARE'S REQUIREMENTS FOR ESTABLISHING AN ASSET PROTECTION TRUST

A Delaware asset protection trust must be an irrevocable trust that contains "spendthrift provisions." Spendthrift provisions prohibit any beneficiary from alienating his or her beneficial interest in the trust. The trust must be governed by Delaware law, and the trustee must be an individual, bank or Trust Company resident in Delaware.

*Steven A. Holt is a partner specializing in the areas of sophisticated estate and family wealth transfer planning asset protection planning and federal and state income taxation.*



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155 Prospect Avenue, West Orange, NJ 07052

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