

**Hospital-Physician
Alignment and Acquisition
Strategies: Addressing
Structural and Valuation
Challenges and Recent
Legal Developments**

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An In-House Counsel's Perspective On Hospital-Physician Alignment Strategies and Practical Advice

Hal McCard, Esq.

The Big Picture

What is driving physician practice acquisitions by hospitals and health systems?

The Big Picture

» Recent Study

– Center for Studying Health System Change

- —Rising Hospital Employment of Physicians: Better Quality, Higher Costs?,” Issue Brief August 2011; O’Malley, Bond and Berenson

– Periodic Site visits to —12 nationally representative metropolitan communities as part of —Community Tracking Survey”; interviews with local health care leaders

– Boston, Cleveland, Greenville SC, etc.

The Big Picture

» Found a combination of factors:

– Physicians:

- Seek better —work/life balance”
- Experiencing —stagnant” reimbursement rates
- Rising costs of maintaining practices
- Difficulty navigating (coming/present) technological changes
- —Seeking Security”

The Big Picture

» Hospitals:

- Pursue Integration Strategies (either in response to ACA or to continue strategies in place)
- Gain perceived advantage in Quality and Service Delivery (in response to CMS initiatives or Managed Care drivers-some efforts new, some ongoing)
- Seeking —market share” in service lines (cardio, IM, FP/Primary Care)
 - Defensive or offensive strategy to develop or protect current position

The Big Picture

- » With more integration between hospitals and referral sources, and the development of different economic integration models, the federal statutes regarding physician self-referral and program fraud are clearly implicated
- » Whither the exceptions and safe harbors?
- » Witness the disappointment of the industry to the ACO proposed regulations as far as the waivers and —“protections” offered for Program abuse were concerned
- » Valuation issues rise to the top in integration and acquisition strategies — Complex and Difficult Analyses

The Big Picture

- » Are we violating or potentially at risk for violating applicable federal law?
- » Are we paying —“too much”?
- » Is our post acquisition structure appropriate for our strategic goals?
- » Will our doctors be happy after we close the deal?

The Big Picture

- » Today we will:
 - Review and discuss common valuation issues at the nexus of the increasing physician and hospital/health system economic integration
 - Review some common economic integration models
 - Discuss some recent Case Law activity that may be relevant
 - Discuss some common issues in acquisitions that may be helpful in evaluating the risk with any potential acquisition

Physician Practice Valuation – *Challenges in Applying Traditional Valuation Methods*

Jason L. Ruchaber, CFA, ASA

Physician Practice Acquisitions Overview

- » Healthcare transactions subjected to significant regulatory scrutiny — especially when acquisition target is in a position to refer
- » Most transactions must be priced at Fair Market Value
- » Appraisers are polarized with respect to use of certain valuation approaches
- » In Physician Practices acquisitions, purchase price directly affected by post-acquisition compensation

Fair Market Value

» Standard Business Valuation Definition:

*“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 **arms-length** in an **open and unrestricted market**, when **neither is under compulsion** to buy or sell and when both have **reasonable knowledge of the relevant facts.**”*

(source: International Glossary of Business Valuation Terms)

Fair Market Value

» Stark (Healthcare) Definition:

*“the value in arm’s length transactions, consistent with the general market value. “General market value” means the price that an asset would bring, as the 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 the 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.”*

“the definition of “fair market value” in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies.” (Phase II - 69 F.R. 16107 – March 26, 2004)

Overview of Valuation Approaches

There are three general approaches to business valuation

- » The **Market Approach** relies on data from comparable transactions (or stock prices) to derive an indication of value.
- » The **Cost (or Asset) Approach** determines value for an asset based on the economic principal of substitution
- » The **Income Approach** determines value by drawing reference to the expected future income generated by the Practice.



Physician Practice Acquisitions

Divergent Valuator Opinions

The central argument among appraisers regarding physician practice valuation is whether or not intangible value can exist in the absence of an income stream which *fully* supports the intangible value.



- » Certain respected appraisers espouse —Cash is king... income is the sole determinate of physician practice value.”
- » Other appraisers identify and value specific intangible assets with no consideration of the income of the practice.

Positions on either end of this spectrum are likely incorrect.

Selection of Valuation Approach

» According to Revenue Ruling 59-60

*“A determination of fair market value, being a question of fact, will depend upon the circumstances in each case. **No formula can be devised that will be generally applicable to the multitude of different valuation issues ...** Often, an appraiser will find wide differences of opinion as to the fair market value of a particular stock. In resolving such differences, he should maintain a reasonable attitude in recognition of the fact that valuation is not an exact science. A sound valuation will be based upon all the relevant facts, but the elements of common sense, informed judgment and reasonableness must enter into the process of weighing those facts and determining their aggregate significance.”*

Selection of Valuation Approach

» IRS 1996 CPE Text of Physician Practice Valuation

*“the factual assumptions upon which a valuation is based should be reviewed carefully to ensure that they are realistic, and if the valuation uses the income approach, it should be confirmed, if possible, by the cost and market approaches. **Requiring that multiple approaches be used is consistent with the statement in Revenue Ruling 68-609, supra, that the formula [income] approach may be used for determining the fair market value of intangible assets of a business only if there is no better basis therefore available.**”*

Income Approach

» Arguments FOR

- Intangible value “requires” return on investment
- Income approach ensures post-acquisition physician compensation is accounted for in purchase price

» Arguments AGAINST

- Use of discounted cash flow “values” future referrals
- Assumptions may be easily manipulated
- Carve-out of ancillaries not commercially reasonable
- Intangible value yielded by DCF is not specifically identified

Cost Approach

» Arguments FOR

- Value not tied to —“future referrals”
- Income approach generally yields no value for practice
- Both buyers and sellers recognize intangible value exists

» Arguments AGAINST

- No investor would pay for an asset that generates no return on investment (*i.e.*, no income)
- Assumptions may be easily manipulated
- Paying for —“cost to recreate” not commercially reasonable
- Does not account for post-acquisition compensation

Is the Cost Approach “Recognized”

» 1996 IRS CPE Text on Practice Valuation

a well trained, organized, and efficient work force is a valuable asset in any business. . . . The use of the cost approach is based on the premise that for a potential buyer to re-create the particular practice it has to hire and train a similar workforce; that hiring/training process has identifiable costs – for recruitment, orientation, training and lost salary – that form the basis of the valuation process.”

“Medical Practices have going concern value. The buyer of an existing practice purchases a turnkey operation and receives immediate value from the assembled workforce and other assets needed to operate the business.”

Physician Practice Acquisitions

Divergent Valuator Opinions

- » Types of Intangible assets that may exist in a physician practice:
 - Workforce in Place
 - Medical Records / EMR
 - Trade name
 - Know-how / Clinical Protocols
- » Does the valuation/payment for intangibles cause higher regulatory concern? YES
- » Key issue is to fully support the existence and value of the intangible asset with sound analysis and common sense

Physician Practice Acquisitions

Post-Acquisition Compensation

- » Increased compensation is a form of purchase price consideration (*Derby v. Commissioner*)
- » Determining the —compensation offset”
 - In a DCF, the cash flow can be adjusted to reflect the higher compensation – or – a direct purchase price offset can be computed
 - If the practice value is based on a Cost approach, the compensation offset must be done through a secondary calculation

Physician Practice Acquisitions

Other Issues

- » Valuing ancillaries that depend upon the future referrals of the selling physicians?
- » Services that will be discontinued (e.g., duplicative services or CON assets)
- » Differentiating —“equity value” and —“transaction price”



Employment Agreements

Overview

- » Employment activity has seen a significant uptick in past 12 months.
- » Productivity-based models are in vogue; median compensation per wRVU is a widely viewed metric.
- » Employment agreements have many moving parts... the —terms and features” are critically important.
- » Benefit plans are becoming more robust.

Employment Agreements Using Survey Data

- » Important to understand Surveys and use data appropriately
- » MGMA and other survey data can be misused in a variety of ways, including:
 - Cherry picking from among different tables (e.g., regional data vs. state data)
 - Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation
 - Do regional compensation differences exist?
The grass is always greener...

Employment Agreements

Compensation per wRVU

Example of misuse of MGMA data:

- » For Orthopedic Surgery: General
- » 90th percentile cash compensation - \$876,000
- » 90th percentile wRVUs – 13,977
- » 90th percentile compensation per wRVU - \$103.71

Where is this going?

- » 90th percentile wRVUs x 90th percentile compensation per wRVU = \$1,450,000 – this is nearly double the 90th cash compensation.
- » MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- » Median compensation (per wRVU) is a misnomer; no physician wants to be below the median! (but, by definition, half of them are)

Employment Agreements

“Stacking”

If you label compensation layers by different names, you can stack them higher and higher!

- » Sign-on bonus
- » Productivity bonus
- » Medical directorship
- » Co-management agreement
- » Quality bonus
- » Retention bonus
- » Call pay
- » Tail insurance
- » Excess vacation
- » Relocation costs
- » Excess benefits



Employment Agreements

Perils of wRVU Models

Hospitals implementing wRVU models have been observed to make errors related to:

- “Total” vs. “work” RVUs
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers
- Site-of-service differentials
- CMS changes in wRVUs
- New or discontinued CPT codes



Employment Agreements

Other Issues

- » Can physicians be —made whole” for ancillary profits?
 - Defining —normal” ancillaries
 - Oncology – chemotherapy infusion
 - OB/GYN – Ultrasound tests?
 - Cardiology – Stress tests, Echo?
 - Orthopedic surgery – MRI?
- » Part-time arrangements (*e.g.*, for procedures only)
- » Perils of overly complicated compensation structures
- » Valuing clinical vs. administrative duties

FMV Pitfalls

FMV Pitfalls

Use of Tainted Market Data

- » Generally, any market data used to establish FMV must be —arm’s length.” Healthcare transactions are frequently suspect.
- » A market approach is the preferred valuation approach for many types of compensation arrangements.
- » For certain types of arrangements, virtually no —not tainted” data is available.
- » The valuator must consider alternate approaches.



FMV Pitfalls

Misapplication of a FMV Opinion

Examples:

- » Opinion was valid only over a specified range of outcomes.
- » Misapplied “units”
 - Surgical cases vs. procedures
 - Unrestricted vs. restricted call
 - 24-hour on-call rate applied to a 14-hour call period
- » FMV opinion is ambiguous or conditional.
- » FMV opinion included critical governing assumptions that were not considered in its application.

FMV Pitfalls

An Unreliable FMV Opinion

- » Even with a fair market value assessment, many things can still go wrong:
 - The terms and provisions assumed by the appraiser may not match the agreement.
 - The valuator may have lacked sufficient knowledge of the subject matters.
 - Consider the “shelf life” of the appraisal, and whether there are any post-closing obligations (such as a true-up).

General Models for Hospital-Physician Alignment Transactions

Gary W. Herschman, Esq.

Background on Models

- » Hospitals are increasingly exploring physician alignment strategies in order to position themselves to succeed in the new environment caused by fundamental changes in the healthcare delivery and reimbursement system.
- » There are numerous ways to structure hospital-physician alignment transactions
 - The following is a brief overview of 6 general models involving a hospital aligning with physicians who will continue to practice at the same office locations.
 - Other models and hybrids are also possible.

6 General Models

1. Acquisition of entire Practice and employment of Physicians
2. Employment of Physicians and lease of Practice assets and non-physician staff
3. Employment of Physicians, purchase of ancillary services, and lease of other assets & staff of Practice.
4. Purchase of ancillary service(s) and employment of physician as Medical Director of service
5. Purchase of ancillary service(s) and lease of all other assets and all staff (including Physicians through PSA)
6. Lease of entire Practice (including Physicians)

6 General Models

1. Entire Practice Acquisition
 - » Employment of the Physicians directly by Hospital (or affiliate) with base compensation plus productivity bonus (e.g., per wRVU).
 - » Hospital purchases the tangible assets of the entire Practice.
 - » Hospital assumes all of Practice's space and equipment leases.
 - » Hospital directly employs all non-physician personnel

6 General Models *(Cont'd)*

2. Employment & Practice Lease

- » Employment of the Physicians directly by Hospital (or affiliate) with base compensation plus productivity bonus (e.g., per wRVU).
- » Hospital leases all of Practice's space, equipment, and non-physician personnel

6 General Models *(Cont'd)*

3. Employment & Ancillary Purchase

- » Employment of the Physicians directly by Hospital (or affiliate) with base compensation plus productivity bonus (e.g., per wRVU).
- » Hospital purchases Practice's ancillary service line(s) (e.g., imaging, laboratory, therapy, etc.).
- » Hospital leases all of Practice's space, non-ancillary assets, and non-physician personnel.

6 General Models *(Cont'd)*

4. Ancillary Purchase & Medical Directorship

- » Hospital purchases Practice's ancillary service(s).
- » Hospital leases space from the Practice for the ancillary service and directly employs the ancillary service clinicians (e.g., imaging techs, therapists, etc.).
- » One of Practice's physicians enters into an employment agreement with Hospital (or affiliate) to provide directorship services for the ancillary service.
- » The Physicians continue to practice medicine through their existing Practice.

6 General Models *(Cont'd)*

5. Ancillary Service Purchase & Lease of Practice

- » Hospital purchases the Practice's ancillary service line(s).
- » The Physicians continue to be employed by Practice, but are "leased" to Hospital through a professional services agreement (PSA).
- » Hospital leases all of Practice's space, non-ancillary assets, and non-physician personnel.

6 General Models *(Cont'd)*

6. Lease of Entire Practice

- » The Physicians continue to be employed by Practice, but are leased to Hospital under a PSA in exchange for compensation.
- » Hospital leases all of the Practice's space, ancillary and non-ancillary assets, and non-physician personnel in exchange for compensation.

Regulatory Issues with Models

- » Models involving a higher level of *integration* are more likely to be viewed as bona fide, legitimate and reasonable business arrangements.
- » Models involving the direct full-time employment of physicians generally involve a lower degree of risk under the federal Stark Law and Anti-Kickback Statute (assuming the terms are FMV).
 - The foregoing also assumes that the employed physicians will be subject to centralized & standardized policies, procedures, quality assurance activities, IT, etc.

Regulatory Issues *(Cont'd)*

- » Models involving —leasing an entire practice” could have higher risk (especially if the intent is to seek the Hospital’s higher rate of reimbursement for services)
- » Such risk may be reduced if the model nevertheless involves substantial integration with the Hospital, for example, if the physicians are contractually required:
 - to follow the Hospital’s operational policies and procedures,
 - to adopt the Hospital’s medical records and IT systems, and
 - otherwise integrate the physicians’ day-to-day medical practice into the Hospital (*e.g.*, through standardized & centralized clinical protocols, quality metrics, best practices, coding programs, etc.).

Regulatory Issues *(Cont'd)*

- » Models involving the purchase of ancillary services:
 - Could be viewed as creating a captive referral base for the Hospital with respect to the ancillary services (and thus, should always be supported as fair market value);
 - But may demonstrate a greater commitment to the integration of services with the Hospital.

Regulatory Issues *(Cont'd)*

- » In all models, it is crucial for compliance purposes that ALL components of compensation paid to the Practice and Physicians be:
 - fair market value (and NOT determined in any manner that takes into account the volume or value of referrals),
 - commercially reasonable, and
 - confirmed as such in a written valuation report from an independent and reputable healthcare valuation firm.

**Impact of the *Bradford* Decision
and the *Tuomey* Case
on Structuring Transactions**

The *Bradford* Case — Background

- » Pennsylvania Federal District Court
- » FCA Claim
 - Whistleblowers = competing physicians
- » Government declined to intervene
- » Court's ruling issued on cross-motions for summary judgment

Significance

- » In-depth discussion of and ruling on:
 - Whether an arrangement meets the Stark Law definition of “fair market value” — even if a written valuation report is obtained
 - How compensation — even if fixed — may be deemed to “take into account” the volume or value of physician referrals for purposes of Stark Law exceptions

Key Facts

» Sublease

- Pursuant to a written agreement, the hospital (Bradford) subleased a GE Nuclear Camera from the physician group (internists)
- The physicians agreed not to compete with Bradford with respect to nuclear imaging services during the term of the Sublease

Key Facts *(Cont'd)*

» Lease Fee

- Pass-through of monthly amounts due under prime lease; PLUS
- \$23,655 per month for “all other rights” under the sublease (including non-compete)

Key Facts *(Cont'd)*

» FMV Report

- Bradford obtained a report prepared by an accountant (not a healthcare valuation firm)
- Compares the revenues Bradford expected to generate with Sublease vs. without Sublease
- Projections were based on the assumption that the physicians would refer nuclear imaging services to Bradford

The Court's Analysis

- » The court acknowledged that the compensation under the Sublease was fixed, BUT
- » The court was concerned that the fixed payment took into consideration the value of the physicians' **anticipated** referrals

The Court's Analysis *(Cont'd)*

- » The accountant's report provided evidence that the payments for the non-compete were based, in part, on anticipated referrals of the physicians
- » Other facts showed that the non-compete payments = anticipated profits to physicians from the GE Camera, and thus, the compensation paid was based on anticipated referrals from the physicians.

Counter-Argument

Bradford and the physicians argued that the Sublease met a —brightline rule” referenced in the preamble to the 2001 Stark II Phase 1 final rule:

—A compensation arrangement does not take into account the volume or value of referrals...if the compensation is fixed in advance and will result in fair market value and the compensation does not vary over the term of the arrangement in any manner that takes into account referrals.”

The Court's Conclusion

- » The compensation did not satisfy the Stark definition of —fairmarket value” because the FMV analysis was based on anticipated referrals; and
- » The —brightline rule” did not apply because even though fixed, the compensation took into account anticipated referrals
- » Thus, there was an —indirect compensation arrangement,” and no exception was satisfied

Issues to Consider

1. FMV Reports

- To what extent can FMV reports be based on assumptions related to anticipated referrals?
 - Valuation principles for the “income approach” require an assessment of the volume of future services and corresponding revenues
- FMV reports must be based on “fair market value” — the amount that would be paid for a similar arrangement with a party not in a position to generate referrals

Issues to Consider *(Cont'd)*

2. Structure of the Transaction

- Would the court have ruled differently **if Bradford had acquired** the physician group's imaging service line, as opposed to subleasing the GE Camera?
- Stark preamble: in the case of a physician practice acquisition, it may be permissible to consider the value of DHS if:
 - The DHS fit into an exception prior to the acquisition, and
 - The transaction is not contingent upon future referrals

Issues to Consider *(Cont'd)*

3. Non-Compete

- Stark preamble states that non-competes in leases may be problematic. [69 FR 16088]
- Stark preamble suggests that non-competes are acceptable in purchase agreements, so long as there is no requirement to refer [66 FR 787-89, 69 FR 16094]
- Stark exceptions allow “requirement to refer” in employment agreements and PSAs (subject to certain exceptions) [42 CFR 411.354(d)(4)]

The *Tuomey* Case — Background

- » South Carolina Federal District Court
- » Jury verdict found that the hospital (Tuomey) violated the Stark Law
- » \$45 million judgment
- » Tuomey appealed to the 4th Circuit
 - Appellate briefs filed earlier this year
 - Oral arguments expected later this year

Significance

- » In appellate briefs, the government makes arguments with respect to the Stark Law that, if adopted, could substantially impact how hospitals and physicians structure their arrangements
- » The government (and *qui tam* plaintiffs) may continue to pursue the theories argued in *Tuomey* in other courts across the country

Key Facts

» Part-Time Employment Agreements

- 10 year term
- Offered to physicians practicing in local specialty groups (gastro, orthopedic, etc.)
- Physicians would perform outpatient procedures exclusively at Tuomey
- Generally, physicians acted as employees **only** when performing surgical procedures
- Testimony re: —“phantom ownership” in outpatient surgery center, and OK to have loss

Key Facts *(Cont'd)*

» Compensation

– Base salary = — “Tired”

- \$5,000 for personally performed collections up to \$185,000;
- \$5,000 for each additional \$25,000 of personal collections

– Productivity bonus = 80% of collections

– Quality measures = 5.6% of collections

» *Note: total compensation on average was 19% higher than professional fee collections (some even higher!)*

Key Facts *(Cont'd)*

» Compensation Consultant

- In developing a benchmark for physician compensation, calculated the value of potentially lost referrals per physician practice, divided by the number of physicians in the practice
- Stated that compensation was justifiable if it did not exceed 150% of 90th percentile

Tuomey's Position on Appeal

- » Stark Law does not apply
- » The only potentially applicable financial relationship between Tuomey and physicians is —indirect
- » No —indirect compensation arrangement” exists because physicians were paid only for their personally performed services

Government's Position on Appeal

- » The physicians' compensation varied with the volume and value of referrals because the physicians only earned money for services that simultaneously generated a facility fee (DHS).
 - Every time a surgery was performed:
 - The cash component of physician's salaries increased; and
 - The volume of DHS referrals to the facility increased.

Government's Position on Appeal *(Cont'd)*

- » The physicians' compensation took into account the volume or value of their referrals
 - The compensation was designed to exceed collections for the physicians' personally performed professional services
 - The compensation included an amount that represented a portion of the facility fee from their anticipated referrals

Issues to Consider

» Type of Compensation

- Compensation which varies based on the professional component of services (e.g., collections, wRVUs, etc.) could implicate the Stark Law if the underlying services involve the referral of a designated health service
- What if not all of the services performed by the physicians under the arrangement result in a referral of DHS? (E.g., Full-time cardiologist, internist or surgeon, etc.)

Issues to Consider *(Cont'd)*

» Amount of Compensation

- May be inference that compensation in excess of collections for personally-performed services violates the “volume or value” standard
- Consider capping compensation for clinical services at under 100% of expected collections (except for safety net hospitals with substantial indigent patients).
- On-call and medical director services should be analyzed separately
- If possible, avoid “~~ie~~ring” compensation models

What to Do About Existing Arrangements that “May” Not Be Compliant

What to Do for “Potentially” Non-Compliant Arrangements

General Plan of Action:

1. Immediately correct going forward
 - Put terms into signed agreement
 - Signed letter of extension for expired agreements/leases
 - Signed amendment to reflect changed terms
 - Adjust to FMV

What to Do for “Potentially” Non-Compliant Arrangements *(Cont’d)*

General Plan of Action *(Cont’d)*:

2. Assess risks and options for what to do about past compliance issues
 - Bona fide arguments of compliance?
 - Pros and cons of self-disclosure?
 - Must report/disclose if clear fraud/violation
 - Very complicated and fact-dependent

Specific “Problems” & What To Do

1. No signed agreement

- Threshold issue: Is there an argument that there is no “indirect compensation,” and that no exception was needed?
 - December 2007 and before if physician owners of a medical practice
 - Maybe beyond if only physician employees of a group are involved

Specific “Problems” & What To Do

No Signed Agreement *(Cont'd)*

- Else, what documents & signatures exist?
- Look to State law regarding whether there is a binding agreement?
- May not need a single document (Villafane)
- Temporary Noncompliance
 - Very limited
 - 90 days – inadvertent
 - 30 days – not inadvertent

Specific “Problems” & What To Do

No Signed Agreement *(Cont'd)*

– What to look for:

- Exchange of letters, emails, etc.
- Job descriptions, reports of services, etc.
- Invoices, payment requests, check requests, etc.
- Checks, check stubs, endorsed checks, etc

Specific “Problems” & What To Do

2. Expired Contracts and Leases

- Any argument that there is no “indirect compensation”? (At least up to 12/07)
- If not, are there any written indications of extension or continuation of terms?

Specific “Problems” & What To Do

Expired Contracts and Leases *(Cont'd)*

- Implied extension based on course of dealing?
 - May depend on State law?
 - Not if new services or terms (Kosenske)
 - May be limited by 6 month holdover provision
- Possible argument — extension of arrangement that is still reflected in a signed writing

Specific “Problems” & What To Do

3. New or Changed Duties/Hours

- Look for anything in writing confirming new or different duties or hours
- Exchange of letters, emails, etc.
- Job descriptions
- Reports of services, etc.
- Invoices, payment requests, check requests
- Minutes of meetings
- Equal swap? Same Hours? Higher value?

Specific “Problems” & What To Do

4. No FMV Assessment; Stale Assessment
 - Conduct internal assessment or re-assessment to —“back” figures
 - Preferably, use outside FMV consultant
 - \$__k or more per year?
 - Extensive/complicated arrangements
 - Cost considerations
 - Letter from local commercial real estate broker regarding space leases
 - Look for any bona fide arguments that arrangement was FMV