A Health Care Appraiser Reviews a Judge-Appraiser's "Report"

by Mark O. Dietrich, CPA/ABV

Introduction

The decision in *Delaware Open MRI Radiology Associates, PA (majority) v. Kessler et al. (minority)*[1] has created a great deal of commotion in the valuation community for a variety of reasons. Not the least of these is that Vice Chancellor Strine (hereinafter "Judge") of the Delaware Chancery Court adopted an S Corp tax effecting scheme based on the difference between the after-tax dividend cashflow in the hands of an S shareholder versus that of a C shareholder, the latter taxed at 15%. There is also a replication of a discounted cash flow (DCF) model based upon the Judge's changes in the underlying assumptions and an oft-scathing critique of the majority's valuation expert. This article does not focus on those issues but rather the failures in the application of the Income Approach, including a discussion of the use of the Industry Risk Premium in lieu of capital asset pricing model's (CAPM) beta in the build-up method.

When using the Income Approach in any business valuation engagement, the appraiser's most critical task is to perform a reasoned analysis of the future revenue and profit prospects for the valuation subject. Industry expertise is required for many valuation engagements in various industries. In the valuation of health care entities in general and the MRI facilities that were the subject of this case in particular, studying industry trends commonly used by the peer group of health care industry valuation specialists is required. As will be seen in the following analysis, either the experts failed to address known industry trends in their reports, legal counsel failed to bring them out in testimony, or the Judge ignored them. Health care industry knowledge can be readily obtained from sources such as the Medicare Payment Advisory Commission (described below).

Timeline of the Case

The merger giving rise to the lawsuit in this matter occurred in January of 2004. This date is critical, as the Medicare Payment Advisory Commission (MedPAC) had already identified high-tech imaging like MRI as a problem spending area in 2003. The first lawsuit was filed in February of 2004.

The Court's Findings on Revenue Growth are directly contradictory to foreseeable changes—foreseen by the majority expert (Mr. Reed), whose testimony was dismissed in the following extract from the Opinion. If, in fact, Mr. Reed failed to cite external sources to give his revenue reduction forecast credibility, it is indeed unfortunate because he had it right.

> I also find that Mitchell (minority expert) made reasonable assumptions regarding the revenues that Delaware Radiology would receive for doing scans. Mitchell began by using the same base reimbursement rates as Reed for Delaware I ($601 per scan) and Delaware II ($571 per scan). Mitchell used those reimbursement rates because they were the numbers the Broder Group provided to Reed for the purpose of performing a valuation, and Mitchell found them reasonable. *Mitchell* [minority expert] *held these rates constant throughout his projection period.* Reed, by contrast, assumed reductions in reimbursement rates of 9% for Delaware I and II in year two, or 2005, and then increased them at 3%, the rate of inflation, annually. Essentially, the basis for Reed's reduction was speculation by Carr, and Reed's own opinion that Delaware reimbursement rates were high relative to neighboring states and that they were likely to fall. But the record is devoid of information from more objective sources to substantiate that viewpoint, which, like other elements of Reed's and Carr's testimony, fits with the self-interest of the Broder Group.

History of MedPAC's Identification of High-Tech Imaging Expense Trends

"The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program."[2] This is the most easily identifiable and readily obtainable source of insight into future health care industry reimbursement. Although it applies specifically to Medicare payments to health care providers, many health insurers link their payment levels to Medicare.

Revenue, of course, is a function of the number of units of service provided and the rate per unit paid. Consider Exhibit 1 from the March 2003 MedPAC Report to Congress, highlighting the rapid growth in MRI services provided to the Medicare population.

> Relatively high growth rates for imaging services were concentrated in several specific categories, all of which involve technology of one kind or another. For instance, nuclear medicine grew by 13.0 percent, computerized automated tomography (CAT) of parts of the body other than the head grew by 15.3 percent, *magnetic resonance imaging (MRI) of parts of the body other than the brain*

[1] Since the case involved suit and countersuit, "majority" and "minority" is more descriptive than plaintiff and defendant.

[2] 2003 Report to Congress.

TABLE 2B-2

Change in per capita use of physician services by beneficiaries in traditional Medicare, by selected type of service, 1999–2002

Type of service	Per capita service use				Average annual percent change		Percent of total service use
	1999	2000	2001	2002	1999–2001	2001–2002	
All services	663.4	691.8	707.9	738.5	3.3%	4.3%	100.0%
Evaluation and management	353.6	359.4	361.9	372.5	1.2	2.9	50.4
Office visits—established patient	127.6	131.2	130.3	133.3	1.1	2.3	18.1
Hospital visit—subsequent	65.0	64.6	64.7	66.7	-0.2	3.1	9.0
Consultations	39.8	41.5	42.6	44.5	3.5	4.4	6.0
Emergency room visit	18.1	19.0	20.1	21.4	5.3	6.5	2.9
Specialist—psychiatry	18.5	18.3	18.2	18.5	-1.0	2.1	2.5
Speciolist—ophthalmology	15.9	16.8	17.5	18.1	4.9	3.5	2.4
Hospital visit—initial	17.6	17.4	17.2	17.2	-1.2	0.3	2.3
Office visits—new patient	15.4	15.5	14.9	14.9	-1.4	-0.2	2.0
Imaging	81.1	88.2	96.1	105.1	8.9	9.4	14.2
Echography—heart	12.6	13.8	14.9	16.5	8.8	10.8	2.2
Standard—nuclear medicine	10.0	11.7	13.6	15.4	16.5	13.0	2.1
Advanced—CAT: other	9.3	10.7	12.3	14.1	14.8	15.3	1.9
Advanced—MRI: other	6.4	7.9	9.4	10.9	21.3	15.9	1.5
Standard—musculoskeletal	8.5	8.8	9.2	9.5	3.9	2.9	1.3
Advanced—MRI: brain	5.1	5.8	6.5	7.4	12.6	14.6	1.0
Standard—chest	6.7	6.5	6.3	6.3	-3.3	0.4	0.9
Advanced—CAT: head	2.7	2.8	2.9	3.0	3.2	4.5	0.4
Imaging/procedure—heart, including cardiac catheterization	1.9	2.1	2.4	2.4	10.4	-0.4	0.3

Exhibit 1

grew by 15.9 percent, and MRI of the brain grew by 14.6 percent. It is noteworthy, however, that none of these technologies are new. Instead, *it appears that use of well-established technologies is increasing.* CAT, for example, was introduced in the 1970s. MRI began to diffuse as a new technology in the 1980s. Thus, the indications for use of these technologies may be changing. (*Emphasis added*)

The March 2004 MedPAC Report to Congress repeated this observation (Exhibit 2).

> Among broad categories of services—major procedures, evaluation and management, other procedures, imaging, and tests—growth rates vary, but all are positive. Imaging and tests grew the most. *From 2001 to 2002, the imaging growth rate is 9.4 percent,* and the growth rate for tests is 11.1 percent. Within these categories, some services grew much faster than others. From 2001 to 2002, we see the highest growth in volume—*approaching 20 percent*—of nuclear medicine, computed tomography, *magnetic resonance imaging*, laboratory tests, and minor procedures which include outpatient rehabilitation. (*Emphasis added*)

And yet again in the March 2005 MedPAC Report to Congress (Exhibit 3). At this time MedPAC formally advised Congress to implement strategies for reducing the volume of MRI and other high-tech imaging. These reductions were announced in August 2005 by CMS[3] and were scheduled to be implemented over two years starting in January of 2006. The Deficit Reduction Act signed in 2006 brought further dramatic reductions to MRI reimbursement in 2007.

> Imaging services have been growing much more rapidly than other services paid under the physician fee schedule. We examined per-beneficiary growth in the volume and intensity, or complexity, of fee schedule services. Between 1999 and 2002, the per-beneficiary average annual growth rate in the use of fee schedule imaging services was twice as high as the growth rate for all fee schedule services (10.1 percent vs. 5.2 percent). Use of the following types of imaging services increased by 15 percent to 20 percent per year: magnetic resonance imaging (MRI) of parts of the body other than the brain, nuclear medicine, computed tomography (CT) of parts of the body other than the head, and MRI of the brain. Between 2002 and 2003, the per beneficiary growth rate for imaging services moderated to 8.6 percent but was still much higher than the growth rate of all fee schedule services (4.9 percent). Although imaging services paid under the fee schedule have been shifting from facilities, such as hospitals, to physician offices, about 80 percent of the increase in the volume and intensity of these services between 1999 and 2002 was unrelated to this shift in setting (MedPAC 2004a). The Secretary should improve Medicare's coding edits that

[3]Centers for Medicare and Medicaid Services of the Department of Health and Human Services.

TABLE 3B-3

Use of physician services in fee-for-service Medicare, for selected services, 1999–2002

Type of service	Percent change in units of service per beneficiary: Average annual 1999–2001	Percent change in units of service per beneficiary: 2001–2002	Percent change in volume per beneficiary: Average annual 1999–2001	Percent change in volume per beneficiary: 2001–2002	Percent of total volume
All services	3.8%	5.1%	4.9%	5.6%	100.0%
Evaluation and management					
Office visit—established patient	2.2	2.8	2.7	4.0	18.3
Hospital visit—subsequent	1.9	2.6	2.1	4.0	8.5
Consultation	4.6	4.2	5.8	6.0	5.9
Emergency room visit	4.1	2.8	6.9	6.6	2.7
Hospital visit—initial	0.3	1.1	0.4	1.8	2.2
Office visit—new patient	0.4	1.2	0.1	0.9	2.1
Nursing home visit	–0.8	1.2	0.3	3.5	1.8
Imaging					
Echography—heart	9.2	9.8	11.0	13.1	2.0
Standard—nuclear medicine	14.7	12.1	18.0	17.1	1.9
Advanced—CT: other	14.5	13.8	16.4	16.5	1.8
Advanced—MRI: other	18.5	15.3	22.3	17.4	1.5
Standard—musculoskeletal	3.5	3.7	5.5	6.5	1.2
Advanced—MRI: brain	19.2	12.3	16.1	13.8	1.0
Standard—chest	–0.4	1.9	–1.1	1.2	0.8
Advanced—CT: head	5.6	5.6	4.9	5.3	0.4
Imaging and procedure—heart, including cardiac catheterization	6.9	3.2	8.8	6.4	0.3

Exhibit 2

TABLE 2B-4

Use of selected physician services per beneficiary in fee-for-service Medicare, 1999–2003

Type of service	Percent change in units of service per beneficiary: Average annual 1999–2002	Percent change in units of service per beneficiary: 2002–2003	Percent change in volume per beneficiary*: Average annual 1999–2002	Percent change in volume per beneficiary*: 2002–2003	Percent of total volume*
All services	**4.3%**	**3.6%**	**5.2%**	**4.9%**	**100.0%**
Evaluation and management	**2.3**	**2.2**	**3.4**	**3.9**	**42.1**
Office visit—established patient	2.4	2.5	3.2	3.9	18.1
Hospital visit—subsequent	2.2	1.8	2.8	3.5	8.4
Consultation	4.5	3.3	5.9	5.0	5.9
Emergency room visit	3.7	1.9	6.8	4.8	2.7
Hospital visit—initial	0.6	1.3	0.9	2.1	2.1
Office visit—new patient	0.7	–1.9	0.4	–1.2	2.0
Nursing home visit	–0.1	1.8	1.4	4.0	1.8
Imaging	**5.4**	**4.2**	**10.1**	**8.6**	**14.8**
Echography—heart	9.4	6.2	11.8	7.6	2.1
Standard—nuclear medicine	13.8	9.1	17.8	13.2	2.2
Advanced—CT: other	14.3	12.9	16.6	14.6	2.0
Advanced—MRI: other	17.4	15.9	19.5	16.5	1.6
Standard—musculoskeletal	3.6	3.6	5.9	4.5	1.3
Advanced—MRI: brain	16.9	8.0	15.5	8.6	1.0
Standard—chest	0.4	0.5	–0.3	0.1	0.7
Advanced—CT: head	5.6	4.6	5.1	4.2	0.4
Imaging/procedure—heart, including cardiac catheterizatian	5.6	1.6	8.0	4.6	0.3

Exhibit 3

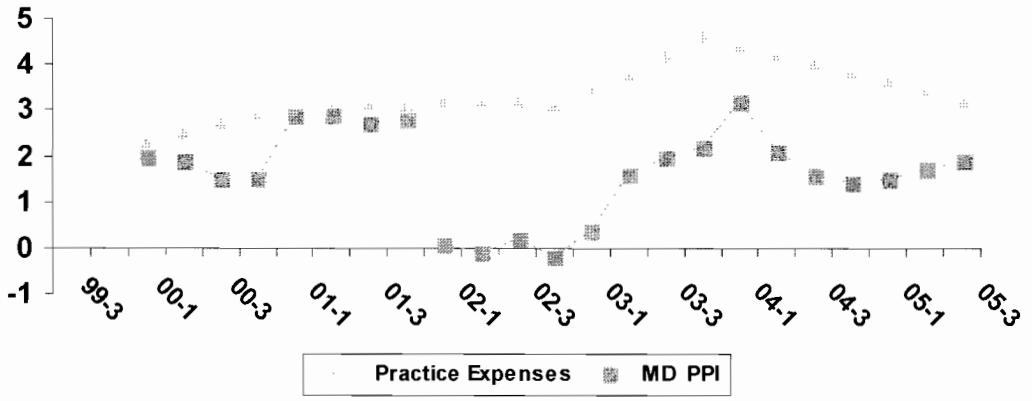

Figure 1
Physician PPI and Practice Expenses

detect unbundled diagnostic imaging services *and reduce the technical component payment for multiple imaging services performed on contiguous body parts.* (*Emphasis added*)

To reiterate, *one place valuation analysts are sure to find insight into future changes in Medicare reimbursement is in the annual MedPAC report released in March of each year.*

The Medicare Conversion Factor

Valuation firms have work codes and rates per hour (unit of service) for their services. Similarly, health care providers have work codes (CPT™ codes or Current Procedural Terminology[4]) for their services. The Medicare program and most health insurers pay for services included in Medicare Part B based upon a unit of service called a Relative Value Unit or RVU (see later discussion) assigned to services under the Resource-Based Relative Value Scale (RBRVS). The rate per RVU from Medicare is known as the Medicare Conversion Factor.

The lack of growth in the Medicare Conversion Factor—which has risen from $36.69 in 1998 to $37.90 in 2007, a compound growth rate of virtually zero—is separate and distinct from this foreseeable response to the enormous growth in imaging utilization and expenditures. For non-Medicare services, the compound rate of growth for the last 11 years based upon the Bureau of Labor Statistics Producer Price Index for physician services is 1.85%.

The Gordon growth model used in the discounted cashflow models of the two experts and the Judge assumed perpetual growth in cashflow to equity (3% for the majority expert and 4% for the minority expert, the Judge choosing 4%). Cashflow to equity is revenue *less* **expenses**! There is no evidence in available industry data to suggest that a 4% perpetual growth rate could be sustained.

The recent history of the relationship between physician practice expenses and the physician producer price index demonstrates that practice expenses are rising much more rapidly than fees (CMS data) (Fig. 1).

As the facts demonstrate, expenses were and are rising more rapidly than per unit costs. This is called an Eroding Profit Margin. The only way to maintain an overall profit would be to perform more and more services at a lower and lower margin—***precisely*** what the MedPAC analysis from 2003 forward indicated was happening and precisely what the government moved to put an end to in 2005!

Figure 2 shows the recent history of Medicare payments for an MRI scan of the chest (CPT code 71552), one of the most frequently performed MRI services. Note that the bottom drops out in 2007. No future increases could be expected to offset such a dramatic drop so as to generate a 4% terminal growth rate. The decrease in another common MRI procedure were less dramatic, but nonetheless wholly inconsistent, with a 4% terminal growth rate.

The previous graphs are the *per unit* of service payments only (Fig. 3). They do **not** illustrate the effect of the implemented recommendation from MedPAC in its 2005 Report that the "*payment for multiple imaging services performed on contiguous body parts*" be reduced, which had a dramatic effect on many MRI providers.[5]

Reduction in the Relative Value of MRI Services

As if this is not compelling enough evidence that explosive growth in service volume leads to forceful countermeasures, on June 29, 2006, CMS published in the Federal Register notice of a plan to re-value physi-

[4]Copyrighted by the American Medical Association.

[5]Medicare estimated the cuts at 8% of revenue for the affected scanning procedures.

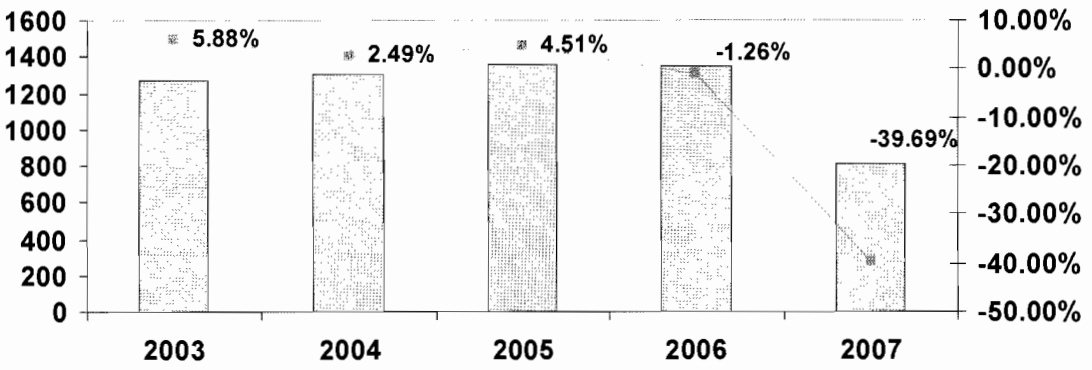

Figure 2
Medicare Payment for Chest MRI

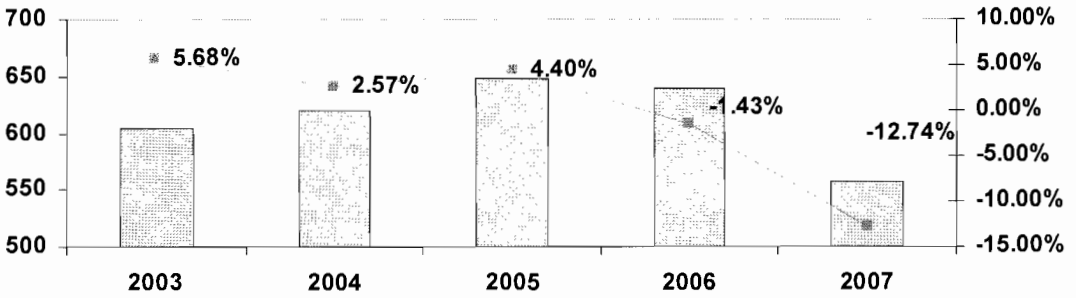

Figure 3
Medicare Payment for Brain MRI

cian services under the Resource-Based Relative Value Scale; the plan was adopted in August 2006. Less one think this only affects Medicare, many insurers follow Medicare's lead—particularly when it gives them an excuse to cut expenses. The changes followed closely on the heels of a suggestion by MedPAC in its March 2006 report that Evaluation and Management services (typically, face to face physician–patient encounters) had declined in value, in large part to the benefit of high-tech imaging services. The changes would cut radiology reimbursement 5% as of January 2007.

A Quantitative Analysis of the Court's Excessive Terminal Growth Rate

Returning to the Court's conclusion that the terminal growth in cashflow (profit) should be pegged at 4%, the following sort of quantitative analysis must have been missing from the experts' reports:

Table 1 presents a "base case" scenario with no growth in volume of services. A 'profit margin' of 44% (close to that determined by the Court) is used in the illustration. Note that the Compound Growth rate in cashflow continues to decline at an ever-increasing amount.

Table 2 presents what the growth in annual volume would have had to have been to maintain the constant 4% growth rate in cashflow through the 5th year as determined by the Court. The key assumption is that total unit expenses grow as rapidly as the units provided. The lower the profit margin, the greater the annual growth in units of service required to maintain the 4% cashflow growth rate. By Year 5, growth in units of service would have to be 7.26%. By year 15, to maintain a constant growth rate of 4%, the units of service would have to grow more than 13.00% per annum—and that rate would *increase* in each subsequent year *into perpetuity*. **Clearly, this is an unrealistic assumption that violates professional standards as well as common sense.**

The Broader Revenue Picture in the Health Care Industry

The cutback in imaging is not an isolated occurrence.

The same thing happened with outpatient physical, occupational, and speech therapy, on which Medicare has imposed an annual limitation per beneficiary of only $1,790 (with some limited exceptions). This was done to rein in explosive growth in the cost of outpatient physical therapy in particular, as noted in this quote from a December 30, 2004 MedPAC letter to the Vice President of the United States.

> Amount of medically unnecessary PT services: The Office of Inspector General (OIG) of the Department of Health

Table 1
Base Case Scenario

Year	0	1	2	3	4	5
Revenue	$100	101	102	103	104	105
Minus: Expense	56	58	60	62	64	67
Equals: Cash Flow	$44	43	42	41	40	39
Compound Growth in Cash Flow		−2.18%	−2.27%	−2.37%	−2.48%	−2.59%
Revenue Growth		1.00%	1.00%	1.00%	1.00%	1.00%
Expense Growth		3.50%	3.50%	3.50%	3.50%	3.50%

Table 2
Growth in Annual Volume Required to Maintain Constant 4% Growth Rate in Cashflow

Year	0	1	2	3	4	5
Revenue	$100	107	116	125	135	146
Minus: Expense	56	62	68	75	83	92
Equals: Cash Flow	$44	46	48	49	51	54
Compound Growth in Cash Flow		4.00%	4.00%	4.00%	4.00%	4.00%
Revenue Growth Per Unit		1.00%	1.00%	1.00%	1.00%	1.00%
Revenue Growth Units		6.32%	6.52%	6.74%	6.99%	7.26%
Expense Growth per Unit		3.50%	3.50%	3.50%	3.50%	3.50%
Expense Growth Units		6.32%	6.52%	6.74%	6.99%	7.26%
Constant Growth per Court		4.00%	4.00%	4.00%	4.00%	4.00%
Target Growth in Cash Flow		46	48	49	51	54

and Human Services examined the provision of outpatient physical and occupational therapy services provided in skilled nursing facilities (SNFs) and found considerable and widely varying shares of medically unnecessary services. One study found that from 5 to 26 percent of services was unnecessary, depending on the patient diagnosis. Another OIG study found that three quarters of the contractors hired to review and process claims for payment commonly found medically unnecessary and excessive therapy claims. The services were medically unnecessary because:

- the services were not skilled,
- the treatment goals were too ambitious for the patient's condition, and
- the frequency of the service provision was excessive given the patient's condition.

The appropriateness of care provided at CORFs[6] and ORFs[7] has also prompted examination. In its study of ORFs, the OIG found that about 40 percent of the claims reviewed were for services that were not reasonable and medically necessary for the conditions of the patient. The Government Accountability Office (GAO) examined CORFs in Florida and found that on a per patient basis, Florida CORFs' payments were two to three times higher than payments to other facility-based therapy providers and that the differences were not explained by patient characteristics such as diagnosis. These studies indicate that unnecessary therapy is frequently provided and that the current requirements alone do not eliminate unnecessary service provision, even in settings supervised by physicians, such as SNFs and CORFs. The studies may also reflect low levels of physician oversight provided in some institutional settings. It is possible that unnecessary services are provided more frequently in settings where there even less physician supervision. Finally, the findings may illustrate a poor understanding of Medicare coverage by physicians and physical therapists.

Another recent case of significance in the health care valuation arena—*Caracci*—found the 5th Circuit[8] throwing out the Tax Court's decision that a home health care agency that had never made a profit had an asset value well in excess of its liabilities. The Tax Court had acknowledged that the government was planning a changeover to a Prospective Payment System (PPS)[9] at the time the *Caracci* case arose, but rather than focusing on the Income Approach to value the taxpayer, the Tax Court used the IRS' expert's *Market* Approach, primarily based upon Guideline Public Companies that were in dissimilar lines of business. The changeover to the PPS resulted in total Medicare spending on home health falling by 52% in two years! It is difficult indeed to see how a business

[6]Comprehensive Outpatient Rehabilitation Facility.
[7]Outpatient Rehabilitation Facility.

[8]Correctly in the author's view.
[9]Simply stated, a PPS establishes a standard fee schedule for services, rather than basing the fee on a retrospective settlement, such as one based upon the actual cost of providing those services.

Table 3
SIC Code 801

AmSurg Corp.	Surgery center operator
Coventry Health Care, Inc.	Managed care products
Health Grades, Inc.	Provides ratings of hospitals and physicians
IntegraMed America	National network of fertility/infertility clinics
Metropolitan Health Networks, Inc.	Provides health care benefits to Medicare Advantage members in Florida
NovaMed Eyecare, Inc.	Surgery center operator
Sight Resource Corp.	Manufactures, distributes, and sells eyewear and related products

losing money (i.e., expenses in excess of revenues) could make more money if revenues dropped by 52%.

There are numerous examples across all sectors of the health care industry to conclusively prove that the government and private insurers will move to defeat excessive utilization and cost. In the hospital sector, outlier payments for inpatient services—those where the patient's length of stay exceeded a defined limit for the underlying Diagnosis Related Group (DRG)—were a major cost problem for the government. In a June 29, 2006 press release, the Department of Justice Civil Division and U.S. Attorney for the Central District of California in Los Angeles announced that Tenet Healthcare Corporation, the nation's second-largest hospital chain, had agreed to pay a fine of more than $900 million for "alleged unlawful billing practices." Of the $900 million settlement amount, the agreement requires Tenet to pay more than $788 million to resolve claims arising from Tenet's receipt of excessive "outlier" payments (payments that are intended to be limited to situations involving extraordinarily costly episodes of care) resulting from the hospitals' inflating their charges substantially in excess of any increase in the costs. A fine of nearly $250 million was levied against the University of Medicine and Dentistry in New Jersey for similar outlier issues—and that is a tax-exempt state-owned institution.

An Observation on the Industry Risk Premium

An analysis of *Ibbotson Stocks Bonds Bill and Inflation Industry Premia Company List Report for 2003* indicates that the companies used in the determination of the Industry Risk Premium are not comparable to an MRI operator. The SIC codes of some of these companies were likely assigned at a point in their history when they were engaged in some other line of business (Table 3).

An analysis of *Ibbotson Stocks Bonds Bill and Inflation Industry Premia Company List Report for 2004*[10] in SIC Code 807 indicates that only three of the companies (Alliance, Primedex, and Miracor) used in the determination of the Industry Risk Premium is arguably comparable to an MRI operator (Table 4). The betas of these stocks would have been a better indicator of industry risk.[11]

Outside the community of health care appraisers, there seems to be an assumption that all providers are paid in a similar fashion. Nothing could be more factually inaccurate. This leads to such errors as the use of inappropriate and irrelevant comparables for obtaining betas and market transactions. Physicians, non-hospital-based imaging providers such as Delaware Open MRI, podiatrists, and a host of others are paid from Medicare Part B using the RBRVS as previously described. Hospitals are paid from Medicare Part A using a methodology based upon Diagnoses Related Groups (DRGs), which bundle hospital services based upon an expected length of stay for the patient's diagnosis. Home health care agencies are paid in yet another fashion, as are surgery centers and skilled nursing facilities. Most private health insurers follow a similar construct, but the rates of payments vary radically from state to state and even market areas within states.

Perhaps the most fundamental valuation mistake in the health care industry is failure to differentiate the risk of a small entity operating in a single state (Delaware) in a single line of business (MRI) with a few dominant health insurers[12] from the risk of large public entities operating in multiple states in multiple lines of business with multiple health insurers paying for the cost of services. Use of the Industry Risk Premium in the Build-up Method compounds this typical error.

Conclusions

As Valuation Experts, we can only fault the Court if: a) we do not provide adequate compelling evidence, b) legal counsel does a poor job on direct and/or cross-examination or, c) the Court decides to ignore the evidence and rule on some other basis, the

[10]The only match for the −4.51% negative risk premium cited in the case is SIC 807 in Ibbotson's 2004 yearbook, the publication of which post-dates the merger/valuation date of January 2004.

[11]An interesting exercise is to plot the prices of these stocks against the S&P 500 in this time period; they are quite volatile!

[12]See Government Accounting Office's *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market.*

Table 4
SIC Code 807

Alliance Imaging Inc.	Medical diagnostic imaging
Array BioPharma Inc.	Biopharmaceutical company
Bio-Imaging Technologies, Inc.	Medical image management for clinical trials
Bio-Reference Laboratories, Inc.	Clinical laboratory in the greater New York area
Enzo Biochem, Inc.	Research and development, manufacturing, and marketing of biotechnology and molecular biologic products
LabOne, Inc.	Medical laboratory operator (now part of Quest)
Laboratory Corporation of America	Medical laboratory operator
MedCath Corporation	Cardiac hospital operator
MEDTOX Scientific, Inc.	Specialty laboratory testing services
Miracor Diagnostics Inc.	Medical diagnostic imaging
National Dentex Corporation	Dental laboratory operator
Orchid BioSciences Inc.	DNA testing
Primedex Health Systems, Inc.	(Now part of Radnet: diagnostic imaging services)
Psychemedics Corp.	Detection of abused substances
Quest Diagnostics Incorporated	Medical laboratory operator
Sagemark Companies, Ltd.[13]	Management and operation of positron emission tomography centers
Specialty Laboratories Inc.	Medical laboratory (now part of Ameripath)

[13] Unlike MRI, Positron Emission Tomography (PET) was not covered by the Stark laws at this time (although it now is), giving it a much different cashflow profile.

expert testimony notwithstanding. Like newspaper reporters trying to write stories on complex economic matters without adequate research, judges need lots of input in understandable terms, which must be coupled with a desire and willingness to be educated when making decisions on health care valuation. Most of the traditional valuation rules fail in health care because of the substantive and repetitive interference by government regulators that make historical performance nothing more than yesterday's news.

A unit growth analysis is a critical part of the determination of the reasonableness of a perpetual growth rate for a health care entity. Due to the statutory construct of Medicare Part B reimbursement, providers drawing revenue from that program face fixed or declining per unit revenue even as costs increase more rapidly than the generic rate of inflation. Entities limited to a single service line—such as Delaware Open MRI—have no ability to respond by expanding services, unlike large health care entities that operate in multiple lines of business. Even those large entities face numerous problems, as witnessed by the fines levied against Tenet.

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