November 2015

Ophthalmic Practice Buy-ins/Payouts: A How to Guide for Bringing on a New Partner

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I. Introduction These materials are intended to address the selling an ownership interest in a typical ophthalmic practice, usually referred to as a practice "buy-in". The materials will address the higher profile issues of price and payment terms. They will also address the lesser profile issues which are nonetheless important and which often influence price and payment terms (and which can make a buy-in offer worthy of accepting or rejecting, as the case may be).

II. Making an Offer In a typical ophthalmic practice scenario, the practice looks to bring on a new associate as an employee, and then makes the associate a "partner" two to three years later. Notwithstanding the typical scenario, it is extremely important to recognize that many times "partnership" is not in the cards. Therefore, there should not be an expectation that an associate will automatically be made a partner. Indeed, it is imperative for all parties that they be very careful in deciding even whether to offer ownership at all on the one hand, without regard to price, and accepting, without regard to price, an offer of equity. ***Not everyone is meant to be a partner.*** Even as the trend is toward larger group practices, one "misfit" can create a huge problem—and that goes for those looking to buy-in. Private practice entails a set of very intimate business and personal relationships. The "associateship" period should be used to evaluate whether you can deal comfortably with another person, yes about business matters, but in a way that is comfortable on a personal level that requires a high degree of trust. If you can't accept putting your professional fate into the hands of the person on the other side of the transaction, irrespective of the money, there is no good reason to do a deal.

If you can get past the "gut-check" issues, financial considerations come next. In our experience, the best partnership arrangements are those where a new owner has achieved a level of productivity commensurate with the senior partners, or at least is at such a level that, through whatever buy-in period there is and with whatever compensation plan you adopt, both senior(s) and junior doctors can anticipate being better off. If not, it may not be time for a buy-in. Sometimes there are better alternatives to buying in, such as retaining the employment relationship but changing the compensation methodology. Selling and buying an interest in a practice is, in one sense, for all parties a financial investment in their respective futures.

III. Elements of Value In determining the most appropriate way to structure a buy-in, it is important to first understand the underlying economic issues involved. The purchase price is, without issue, one of the most important terms of the buy-in – to both the selling physician and the purchasing physician. There are two aspects of a medical practice that will determine its value, and thus, the purchase price: 1) tangible assets -- equipment, furnishings, fixtures and supplies; and 2) intangible assets, which can be broken down into accounts receivable and goodwill.

IV. <u>Valuation</u>

A. <u>Tangible Assets</u> While there may be no adequate market for used medical practice equipment, the equipment used in a medical office still has some value to that practice. This is true even if such equipment and other tangible assets have been fully depreciated for tax purposes. Tangible assets may be valued in three ways: (i) appraisal; (ii) adjusted book value; and (iii) simple guessing.

1. <u>Appraisal</u> Most of the tangible assets in an ophthalmic practice fall into two categories—those items that are nonspecific to that particular medical practice, and those that are specific for the practice of ophthalmology or a related subspecialty. While there is not a substantial market for used ophthalmology equipment, there is *some* market. Accordingly, most vendors of major medical equipment will provide appraisals of the fair market value of such equipment. With regard to those nonspecific tangible assets, vendors may also provide an appraisal, but the market for such nonspecific tangible assets is less certain and an appraisal is likely to be nothing more than someone's "best guess."

2. <u>Adjusted Book Value</u> A common approach to valuing tangible assets is to start with the "book value" of the practice's tangible assets, as shown on its financial statements and tax returns (assets less liabilities), which reflects the assets' cost less accumulated depreciation. The book value of the assets does not, however, reflect their fair market value, since depreciation for accounting and tax purposes does not accurately reflect actual wear and tear. For example, an office desk is depreciable over five (5) years. Hence, at the end of this "useful life", the desk retains zero book value. In actuality, the desk may go on to have a practical useful life of 10 years. Furthermore, "accelerated" standards of depreciation are often used meaning that the depreciation taken over such five year period is not pro-rata, or "straight-line", but rather front ended so that, for example, as much as thirty percent (30%) may be written off in the first year. Some assets may even be fully depreciated in the year of purchase.

Therefore, depreciation for each tangible asset is typically restated using a *"straight-line"* method and assuming a 10 to 15-year useful life instead of the useful lives used for accounting and tax purposes. In addition, a floor (or minimum) value for each such item of 15% to 20% of its original cost may be established. This method is intended to approximate the fair value of the equipment and other tangible items.

3. <u>Guessing</u> Although the appraisal and adjusted book value approaches to valuing equipment have their merit, sometimes an educated guess can work just as well. In most medical practices, tangible assets do not constitute the bulk of the value of the practice (the intangibles hold that distinction), so it may not be worth the effort to calculate their actual value. This is particularly true for supplies and inventory, where, for example, a practice may spend a certain amount per year on supplies, and, on average, has a two month supply on hand. Rather than do an exact inventory or appraisal, the supplies on hand may be estimated to be approximately two months' worth, or one-sixth of a year's supply expenditures. Often, the best way in which to value tangible assets will incorporate each of the three methods described above: appraisal for ophthalmology equipment, modified book value for other nonspecific tangible assets and guessing or estimating for supplies.

B. Intangible Assets

1. Accounts Receivable Although in practice sales to large institutional purchasers, accounts receivable are rarely sold (due to both collectibility concerns and the prohibition on the sale or assignment of Medicare and Medicaid receivables), accounts receivable are often part of the valuation and "sale" in the buy-in context. Depending upon the subspecialty, payor mix and collection efforts of a practice, receivables (truly collectible receivables) can constitute 8% to 15% of a practice's annual gross revenues. Accordingly, the valuation of accounts receivable can be very important in determining a buy-in purchase price.

Obviously, medical practices do not collect every dollar they charge. Medicare and other third party payors greatly discount physician charges and some patient charges are simply never collected, *i.e.*, bad debt. Accordingly, it is important when valuing receivables to discount them to account for these factors. In addition to third party payor discounts and bad debts, a proper valuation of accounts receivable should also account for the costs incurred in billing and collecting them – whether done internally or through an outside billing company. Moreover, as it will generally take anywhere from 30 to 60 days to collect most of the receivables, the "time value of money" concept arguably should be used when determining the value of the receivables

In actuality, however, most buy-ins in which receivables are valued, the valuation methodology will only discount for collectibility and bad debts, and will ignore the existence of collection costs and the time value of money.

A common valuation methodology is to take a practice's existing accounts receivable on which there have been charges or payments within the last 6 months and multiply that total by the practice's gross collection rate. The gross collection rate is the practice's total cash receipts divided by the practice's total billings for some specified period of time, usually 12 calendar months prior to the valuation date, or the most recent fiscal year. While this is not an exact valuation of a practice's accounts receivable, it should be relatively close.

2. Goodwill Goodwill is one of the most elusive concepts and probably one of the most troublesome when valuing a medical practice. Historically, it hasn't been long that people have recognized that medical practices might have some kind of intangible value other than accounts receivable. Indeed, until the late 1970's, there probably *wasn't* much goodwill in medical practices. Goodwill typically exists where there are barriers to entry into a given industry such that it is worth one's while to pay someone, over and above the cost of Hard Assets and accounts receivable, to get into an existing business. However, with increasing start-up costs, explosive competition and other factors, goodwill became a recognized component of many practice purchases starting in the late 1970s and gained momentum throughout the late 1980s and into the early 1990s. Values topped out then and have, on average, gone down somewhat since then—but that's on average.

Like any asset, goodwill can have a great deal of value or have very little value. And, in today's uncertain and changing environment, there is a tendency to regard goodwill, once again, as a nonexistent or a small element in practice purchases and buy-ins. The whole transition to a more results driven, managed care environment, and the uncertainty that comes with it, is what is driving this current view. However, it needs to be clearly understood that there is no logical reason that goodwill does not exist in today's environment. The only question (and, therefore, the reason that people will discount goodwill's existence in today's market) is ***which*** practice is going to have goodwill. In today's environment, those practices that have navigated the changes over the years—adopted good clinical management, have adopted and gone through the transitions with electronic health records and who have adopted cost savings strategies to deal with declining reimbursement or otherwise found ways to grow their bottom line, will have extraordinary goodwill value because, among other things, those practices will be able to predict with a fair degree of certainty what their cash flow is going to be.

Nevertheless, the trend these days is that most physicians attempting to sell their practices, and most people buying in, are placing less value than in prior years on goodwill. There is still recognition, however, that practices have some value, in any event, as "going concerns." That is to say, they have value simply because they have systems, staff and equipment in place and operating. That, in and of itself, is worth something. Beyond that, however, the existence and valuation of goodwill in any given context is difficult. However, those practices that are reasonably well positioned to take on and adapt to changing markets are more likely to be able to command some kind of "goodwill" value in a sale or buy-in.

Assuming that goodwill exists, how does one value it? There are databases that report goodwill values from particular transactions, but one must be exceedingly wary of giving too much credence to those reports. By and large, the samples are small, and the transactions reported vary from buy-ins and payouts to outright sales to distress sales (*e.g.,* sales upon a death or disability) to divorce valuations (which depending on who the appraiser is and whether he or she wanted a high or low valuation, might generate very different numbers). Moreover, inasmuch as these databases tend to report "averages", it is important to recognize that those averages are compiled from a fairly broad range of goodwill values. Relying on an "average" as providing any guidance is about as helpful as trying to purchase a pair of shoes that fit by asking a clerk to bring out an "average" pair.

Notwithstanding those concerns, ophthalmology is fortunate to have generated a fairly sizable database of sale and goodwill information. In that regard, we can give a bit more credence to the "averages".

The Goodwill Registry, published by the Health Care Group, in Plymouth Meeting, Pennsylvania, possesses such a database. The Goodwill Registry cites mean and median goodwill values based on ophthalmology transactions, where goodwill value was included, having occurred during the past 10 – 15 years. The Goodwill Registry reveals that, for ophthalmology, the median goodwill value for ophthalmic transactions reporting goodwill during that period averaged between 25-30% of a year's gross revenues (*i.e.*, goodwill value, expressed as a percentage of annual practice gross receipts). Actually, the Goodwill Registry, which is updated annually, has been tracking transactions for the almost 30 years. During this time, two trends have become clear: (1) that recognition of goodwill values in ophthalmology have declined – for example, approximately 15-20 years ago the mean was almost 40% and has declined since – and, (2) that there is lesser recognition now – for example, whereas 15 years ago 10-15% of ophthalmic sales transactions did not recognize goodwill at all, according to the more recently published editions, this non-recognition percentage increased to 16-18%. It also should be noted, the mean and median percentages represent transactions only were goodwill was recognized. In other words, the 0% goodwill transactions are not included in the mean/median figures. That said, there are obviously a good number of transactions that do recognize some goodwill. The question is whether in any given instance one should be paying for (or getting paid for) something beyond the value of the identifiable tangible assets and accounts receivable.

A practice's goodwill value depends upon various factors that are discussed below. Determining the appropriate goodwill percentage in light of these factors is where virtually all of the subjectivity lies. This is where an evaluator's experience will be most important. Using average as a benchmark, these factors should be considered and will typically influence the goodwill percentage -- positively or negatively, as the case may be, in the appraiser's discretion.

The goodwill factors are:

- Overhead. Valuing goodwill as a percentage of receipts ignores overhead. Consequently, a high overhead warrants a negative adjustment to the benchmark percentage, while a low overhead warrants a positive adjustment.

- Competition. Generally speaking, the more competitive the market, the greater a successful practice's goodwill within the market; the less competitive the market, the lesser the goodwill value. Assume two practices of comparable size, receipts, overhead and the like. Further assume one such practice is located in a dense market and that the other is located in a rural non-competitive market. The practice located in the dense market is less at risk to future competition. Indeed, it has built its practice in the face of competition, its patients/payors having a surplus of choice. Successful practices within a competitive market possess an intangible that enables them to retain the loyalty of their patients and referring sources. This intangible is often a combination of practice name, physician recognition and reputation, location, recognizable staff, patient relationships, referring relationships, and the like. The practice located in the rural area, conversely, is subject to risk of future competition and patient loss – even if it possesses the same intangibles described above. Indeed, it may retain the loyalty of its patients and referring sources in the face of new competition. But there is the risk that it won't, that greater choice will matter, and that there will be a resulting loss to the practice's patient base. This very risk warrants a reduction in goodwill value.

- Specialty Versus Primary Care. Generally, the higher the degree of primary care, the greater the goodwill value; the higher the degree of specialty care, the lesser the goodwill value. The more specialized a practice, the more its goodwill tends to be personal to the physician rather than institutional to the practice. Goodwill is only valuable when it belongs to the group. Thus, the practice that provides medical ophthalmology services, employs optometrists and dispenses through its own optical shop will possess greater goodwill value (expressed as a percentage of revenues) than, for example, a subspecialized retinal practice that provides none of the foregoing. In primary care, intangibles such as location, staff recognition and relationships matter more. Simply put, a patient is far more likely to seek a referral and travel to see a surgeon for a surgical procedure than they are for a routine office visit.

- Non-Compete Agreements. The practice that binds its physicians with non-compete agreements is likely to be more valuable than a comparable practice that does not (or cannot due to state prohibition). The existence of non-compete agreements provides security against the potential loss of patients due to the competition by a practice's departing physician(s).

- Contracts. Diversity of a practice's patient base is also important. The smaller the payor mix, the less valuable a practice's goodwill. The reason, again, is risk of loss to the practice's patient base. Similarly, as with a subspecialty group, the lesser the number of contracts, the greater the risk of loss. Assume, for example, that 50% of a retina group's patients are referred under one contract with a medical ophthalmology group. How strong/tenuous is that relationship? What are the chances the non-retina group will hire its own retina specialist?

- Miscellaneous. Every practice is different, each having its own characteristics and circumstances. So there may be other reasons warranting an adjustment to the average goodwill factor (capitation, potential litigation, and the like).

All things considered, goodwill percentages will generally range from as low as 15% to as high as 55%.

C. Alternative Valuation Methods It should be noted that there are additional alternative methods for valuing practices -- the discounted cash flow method and the capitalization of earnings method. In the discounted cash flow method, practice revenues are projected for a number of years (usually four to five). Then subtracted from those revenues are the costs of operating the practice (including the cost of paying a physician to operate and run the practice). Added back to that difference (*i.e.*, net profit) is depreciation. This is merely a paper deduction and therefore does not affect cash. Subtracted from that total is the yearly cost of any capital improvements, which does not affect taxes, but does affect cash. Profit left over is projected out into the future for that four- to five-year period with a separate calculation performed to value the profit stream from years five on into infinity. A discounting factor is then used to account for risk/reward and the time value of money to arrive at a value for the entire practice. Subtracted out from this value are the values for tangible assets and accounts receivable--leaving goodwill.

There are a number of concerns in valuing practices in this fashion, not the least of which is trying to get a handle on how much one should factor in for appropriate compensation for operating the practice. Physician compensation is typically a function of how hard an individual is willing to work within his or her specialty, among other things. Accordingly, it is very difficult to ascribe the "average" compensation to be derived from any particular practice. Moreover, making assumptions about future revenues is always dicey, as is the case with any expenses and discount rates used to value profit streams. That said, it is useful to use this kind of valuation methodology because, at the end of the day, cash flow from an investment really is the bottom line. By looking at a number of scenarios as far as projected revenues are, and by looking at a variety of compensation possibilities, one can develop a range of "healthy" outcomes where the buyer and the seller can both do well.

The second alternative valuation technique is one commonly used by Wall Street—namely, the capitalized excess earnings method. Like the discounted cash flow method, it looks at historical profits and losses, again "normalizing" those profits and losses by assuming some "standard" physician compensation to get a true "earnings" picture. However, since the earnings method is not strictly cash-flow oriented, it does not subtract out capital expenditures from the bottom line and add back in depreciation. The idea, rather, is to get a "true" picture of "profit" or "corporate earnings." Once "earnings" have been calculated, a multiplier is assumed, and the product of earnings and this multiplier yields the value of the practice. The range, typically, for ophthalmic practices is 4.5 to 6 times "earnings," although the multiples in some transactions can be as high as 8 times earnings.

Ultimately, a good valuation will take into account all of the different valuation techniques so as to balance out each one's strengths and weaknesses.

D. <u>Other Values/Entities</u> Values attributable to the ownership of optical shops, real estate, ambulatory surgery centers (ASCs) and the like, should be considered separately from the medical practice buy-in. Because of kickback and self-referral prohibitions, optical shops more often than not, are owned within the practice's legal entity. Conversely, tax and liability issues often dictate that ownership of interests in real estate or ASCs should be maintained separately from the medical practice entity.

Regardless, the first buy-in related consideration is whether the junior physician will be offered an opportunity to buy-in to "separate" businesses, such as these. Often times, the junior physician is permitted to complete the medical practice buy-in before buying into ancillary businesses as the combination of buy-ins can be prohibitively expensive. Other times, the junior physician is required to complete the medical practice buy-in before being offered an interest in these other businesses, as the senior physicians wish to defer the dilution of their interests. On occasion, the junior physician is not offered the opportunity at all. Particularly as to ownership in real estate and ASCs, there seems to be no one preferred manner. Optical shops, on the other hand, are more integrally related to the business of the medical practice and, therefore, if there is a trend, it would be that the optical shop is bought into contemporaneously with the medical practice buy-in.

Whenever buy-ins to separate businesses occur, they should be valued, and bought-into, separately from the medical practice. For example, if the practice's office building is owned by the practice owners in a separate real estate partnership then, in addition to the junior physician's purchase of an interest in the medical practice, he or she would purchase an interest in the real estate partnership. The underlying property, the building, would be valued for this purpose at fair market value – typically by appraisal. Some would argue that the values for an optical shop or ASC used in connection with the practice should be "baked into" the medical practice valuation. We disagree. While these businesses do usually derive their income from the medical practice, there are often other sources of referrals and income and, as such, they do have values separate and distinct from the medical practice. In valuing these businesses, we typically apply the discounted cash flow or capitalized excess earnings methodology.

V. <u>Structuring a Buy-In</u> As discussed above, the assets involved in a buy-in can be valued in a variety of different ways. Regardless of the valuation method selected, most buy-ins are structured by dealing separately with the tangible assets and the intangible assets. The tangible assets are usually acquired through the purchase of an equity interest in the entity through which the medical practice is conducted, such as a professional corporation. The intangibles (accounts receivable and goodwill) are acquired by means of an "earn-in."

A. <u>Equity Purchase</u>

1. <u>Equal Ownership</u> The sale of an equity interest in the practice entity is usually accomplished by a sale of an equity interest from the senior physician(s) the junior physician *directly*, and not from the entity to the junior physician. This makes it more economical for the junior physician. Many times, the junior physician is offered an ownership interest that makes him or her equal to the other partners. This is, perhaps, considered a little risky for the senior physician(s); however, typically there are protections that are built into the arrangements so that equal ownership is not worrisome to the senior physician(s). Indeed, equal ownership (with protections for the senior physician(s)) tends to be a healthy thing. It is also easier from an administrative standpoint than having an associate purchase equity over a number of years.

2. Senior Physician Protections Senior physician protections come in many forms. Generally speaking, these can be broken down into two categories: (1) outright control in the form of stock options, post-dissolution entitlements and voting privileges, and (2) financial disincentives for the junior physicians to make certain decisions against the interests of the senior physician(s).

Probably the easiest and most straight-forward way for a senior physician to maintain control is in the form of the stock option. The stock option grants the senior physician the ability to purchase a junior physician's stock in the corporation at any time for any reason. In the event of irreconcilable differences, the stock option gives the senior physician a way to divorce the junior physician from the practice without having to go through the time, cost and complexity required to go through the corporate framework, possibly resulting in the liquidation of the corporate entity.

Another very typical senior physician protection is the senior physician's ability to force a liquidation of the practice unilaterally in the event of irreconcilable differences. In such an event, the senior physician then has the ability to retain the practice name, telephone numbers, medical records and other accouterments of the practice, as well as the ability to practice at the practice's main office location upon liquidation of the practice. Unlike the stock option, the senior physician cannot avoid the split up of the practice, but he or she can retain much of the practice's going concern value in such an event.

The third way of maintaining outright control is through the use of voting privileges. This often takes the form of making the senior physician the managing partner of the group practice, and delegating to him or her the authority to make certain day-to-day decisions unilaterally. In addition, certain decisions can be designated as requiring the affirmative consent of the senior physician, such as the opening or closing of an office location, the making of any major capital expenditure, the termination of key employees, etc.

When a senior physician or senior physicians brings on more than one junior physician as co-owners of the practice, there is always the concern that the senior physician will be forced out by the junior physicians. Short of having the ability to always maintain control of the practice in the form of a stock option or retention of the practice going concern values in the event of a split-up, a senior physician can be protected by financial disincentives for the junior physicians to make decisions adverse to the senior physician's interests. For example, similar to the liquidation rights discussed above, the senior physician can have the option to maintain the office location, practice name, telephone numbers, medical records and all other accouterments of the practice in the event his or her employment is terminated by the other physicians. In addition, some practices provide that in addition to maintaining all of the accouterments of the practice, the terminated senior physician is still entitled to his or her pay-out from the practice, notwithstanding his or her continued practice in the area. This creates a significant disincentive for the other partners in a group practice to "gang-up" on and fire the founding member.

As a general matter, some senior physician protections should be incorporated into a co-ownership arrangement, but in most cases should endure for only a limited period of time –in some instances for the length of the buy-in, and in others a bit longer. Although in a closely held organization it is important to provide the founding physician with certain rights, these rights are often viewed as antithetical to the nature of a group practice or partnership. That is why, before getting into the financial issues, it is imperative to know you can trust your future partner. Many junior physicians feel that once the buy-in is complete, all owners should be treated equally, and that perpetual senior physician protections are inequitable in a group practice. Therefore, it is important in structuring co-ownership arrangements that the senior physician consider carefully what rights are important in light of the composition of the group, and tailor the senior physician protections to address those needs, and not more. At some point, the junior(s) will have paid their dues.

3. <u>Financing Over Time</u> Even though in most instances the tangible assets in medical practices are the assets of least value being sold and acquired, the junior physician may not have sufficient cash to pay for his or her equal share right away. Accordingly, many times the senior physician acts as the bank and lends the junior physician the money, by means of a promissory note, to acquire the stock. Typically, there is a down payment of 10% to 20%, with the balance of the loan being financed over a four- to five-year period, with interest at prevailing rates.

B. <u>Income Discounting</u> Buying into the intangibles, however, is a different story. This is usually handled in a "pre-tax" fashion, and there are two distinct ways of handling it. They are the "exact" method and the "inexact" method.

Under the exact method, the accounts receivable and goodwill values are totaled and the junior physician purchases a specific share of that total. Thus, for example, if accounts receivable in a practice are $300,000 and goodwill is $200,000, and the junior physician is purchasing a one-half interest, his or her purchase price for those assets might be $250,000. Over a four- to five-year period, the junior physician will "pay" for that $250,000 interest in intangibles by reducing his or her share of income from the practice by some amount (and increasing the others' shares accordingly) over a four- to five-year period, for example, $50,000 for five years. Some groups will add an interest factor onto the intangibles value to account for the time value of money, so that, instead of reducing the junior partner's salary by $50,000 a year for five years, they will instead reduce the salary by $60,000 for five years (the additional 20% being the cumulative interest factor).

An alternative way of accomplishing an "earn-in" to the intangibles is the "inexact method." Under this approach, accounts receivable and goodwill are not separately valued, totaled and then taken out of an income share over a defined period of time. Rather, the junior physician "earns" his or her way into a full share of income (described below) by taking a smaller specified percentage of a "full" income share over a period of time. Typically, if income were to be divided equally, the junior physician would be entitled to less than a full equal share of income in the first year of the "earn-in." Rather, he or she would be entitled to a *percentage* of a full income share -- very often as low as 60% of full income share. (The net result in a two-doctor practice when the junior physician receives 60% of a full partner's share is that the income is divided 70% in favor of the senior physician and 30% in favor of the junior physician.) Then, very typically, the junior physician will receive 70% of a full income share in the second year of the "earn-in." In the third year, he or she would receive 80% of a full income share, and in the fourth year, 90% of a full income share. Thereafter, he or she would receive a full income share.

For a number of reasons, the inexact method of buying in may be preferable. First, since goodwill and accounts receivable don't have to be separately valued, one can sidestep a great many arguments about whether goodwill exists and even what the value of receivables is. An inexact buy-in can also be regarded as no more than the practical reality of a junior physician not being quite as valuable to a practice as a senior physician during the early years of co-ownership. Instead, over time, the junior earns the right to make as much money from the practice as the senior physician who has been there longer and who is, therefore, more valuable to the practice by virtue of his or her contacts, reputation and the like. In addition, to the extent that "goodwill" might be considered a capital asset, it is arguably inappropriate to buy that asset by means of a pre-tax income shift. However, since the inexact method does not specify that anything is being purchased (rather there is simply an income phase-up), no such "purchase" takes place. In that fashion, the inexact method is, arguably, safer from a tax standpoint.

It should be noted, however, that before one can reduce a junior partner's share (and accordingly increase the senior physicians' shares), one has to define "income" to a practice and "income" from a practice to its physician owners. It may seem fairly easy to define income to a practice, and for the bulk of the revenues flowing to a practice, there really is not much of an issue. Practice income, obviously, incorporates revenues collected from patient encounters and procedures, co-pays, capitation payments, and revenues from ancillary services. However, many groups also allow their physician members to act as expert witnesses in civil litigation matters for which they receive remuneration. Other groups have physician members who write and publish books and articles for which they are paid or who teach and receive stipends. Still others perform administrative duties for hospitals, IPAs and the like and receive remuneration for those services. Finally, others invent and create devices and systems to generate royalties and other monies.

Once income to a practice is determined, one must consider income from a practice. In the context of small professional corporations, one cannot simply consider profit, because profit is too easily manipulated by its members. Money can flow out to the owners of a professional corporation as salary, fringe benefits, retirement plan contributions, and even "semi-personal" expenses (expenses which are legitimate from a tax standpoint, but which are, nevertheless, inherently personal, *e.g.,* automobile expenses). Accordingly, when one talks about income shares, one must talk about all of the many different ways in which money can come out of a professional corporation to its owners. This includes the salaries, bonuses, retirement plan contributions, fringe benefits and "semi-personal" expenses payable to the physicians. It is the sum total of these items that is shared among the owners, and it is on this basis that the junior partner's "earn-in" to the intangible values takes place.

C. Income Division The source of many serious problems in group practices is often their income division arrangements. Close attention must be paid to this issue to ensure that the group members are contributing the right efforts to make the compensation arrangement fair, and that the perception of fairness is retained. We typically recommend that group practices periodically review their compensation arrangements, evaluate their continued appropriateness and the perceptions of the group members, and assess each individual's continuing commitment to the arrangement.

An appropriately structured income division arrangement must meet several criteria. First, it must be perceived as fair. That is, the members ought to believe they are being reasonably compensated for what the group demands of them, as well as their own efforts. Second, the income division arrangement must be flexible. It must be able to accommodate both subtle and acute changes in circumstances. This is where we find most group income division formats fail. Third, the arrangements should be simple to apply. Income division arrangements should not be so complicated that they fall under their own weight. The more complex the arrangement, the more we have seen partners argue that the arrangement is not fair.

When addressing its income division arrangement, it is necessary for the group to fully understand the factors that lead to the practice's success. The most obvious factor considered by groups is production. The more productive group members are, the more revenue there likely will be. Productivity can be measured in a number of different ways: collections, charges, RVUs, patient encounters or time worked.

In addition to productivity, other factors contribute to a practice's success and are worthy of consideration.

1. Executive or Administrative Efforts While these do not directly lead to dollars flowing into the practice, they are extremely important to a practice's success. Management in medical practices is often given short shrift both in terms of actual performance and in terms of compensation for such performance. The fact of the matter is, many medical group practices have succeeded despite failing to pay attention to the importance of such efforts and compensating them appropriately. However, in today's highly competitive managed care environment, executive efforts are becoming increasingly important in determining the overall success of ophthalmology practices. These efforts include, among others, the day-to-day management (budgeting, controlling expenses), integration of technology, contract negotiations, networking, referral building and the like.

2. Seniority and Special Qualifications (*e.g.*, special credentials) These achievements can be important factors to a practice's success. Longevity of certain members in the practice contributes to a greater sense of strength and stability, and in many cases, leads referral sources to continue their referral patterns. This cannot be overstated. The presence of a "senior statesman" physician has the potential of being a significant contributing factor to financial gain. Similarly, someone with stellar credentials -- *e.g.,* having graduated from a prestigious school, having published a number of articles, or otherwise being seen as an “expert” in a particular area -- will often lead to increased referrals and, as a result, increased revenues.

3. <u>Clinical Quality</u> Another factor contributing to practice success is clinical quality. After all, without an emphasis on quality, a practice could develop a bad reputation that, ultimately, could lead to a loss of patients, referrals and revenues.

Once one understands what contributions have led and continue to lead to the practice's success, there must then be a reconciliation of personal and overall group goals. In most instances, individuals will, more than likely, be motivated to maximize their own financial well being as opposed to that of the group. However, it is the group’s goals that must take precedence. Thus, a group may want to foster production, but a compensation model that relies solely on production might create an environment that is too competitive. Individual physicians within such a group, if they are so inclined, might look for ways to “game” the system, insuring that they get the better paying surgeries and procedures at the expense of their colleagues, and perhaps, more importantly, at the expense of quality care. On the other hand, an income division model that does not promote production in some fashion could result in certain individuals letting the other members do more than their fair share of work.

The key then, if one can be said to exist, is to create a common “corporate culture” where one perhaps did not exist before, or solidify one that already does exist. This culture, defined by values of the organization, will play the greatest role in determining just what kind of compensation system will be developed.

D. <u>Compensation Models</u> There obviously is a myriad of different compensation models that are presently being used by ophthalmology groups throughout the country. Understanding how other groups handle their compensation arrangement, and the alternatives available, can be extremely helpful in evaluating your own compensation arrangements. Thus, a brief overview of the most common compensation models employed by ophthalmology group practices is as follows:

1. <u>One Hundred Percent Equal Allocation</u> Under this approach, 100% of the available practice "net income" (*i.e.,* after all expenses have been paid, what is left for the partners to take as salary, bonuses, retirement plan contributions, dividends and certain agreed upon semi-personal expenses) is allocated equally among those members sharing in the arrangement. Groups that successfully utilize an equal split for a long period of time tend to attribute its success to a strong sense of "trust" among their members. In these practices, there is also a great sense of being part of a "group practice".

The members in these groups also tend to produce (however production is defined) at approximately the same level. However, in groups that maintain successful equal splits where there are significant differentials in production, there usually is a recognition that there are different kinds of non-revenue producing contributions that lead to the overall success of the group practice, such as administrative responsibility, hospital positions, academic positions and shared on-call and schedule responsibilities. Most groups that split income on an equal basis typically are concerned about the negative aspect of a production-based arrangement. That is, many believe productivity arrangements create unhealthy competition, which undermines the group's overall goals and objectives.

Some groups that maintain an equal income division will often adopt certain trigger mechanisms or a "threshold production level" that will provide an automatic adjustment to the equal arrangements if a member's production decreases too significantly. For example, a group might agree that if a member's production falls below 75% or 80% of the average production of the other members of the group, then his income share will automatically be calculated in part, or even entirely, based on production. The concept of the "fail safe" is to establish, at the outset, certain standards in order to avoid an uncomfortable confrontation when a member's production falls off significantly, for whatever reason. It should be noted that groups that maintain a successful equal income split will often run various production reports for their members to track the data. This data is helpful in continuing to confirm that production has remained relatively equal despite perceptions to the contrary. Also, it can provide for an early indication of possible problems that can be addressed before developing into more significant problems.

2. <u>One Hundred Percent Production Allocation</u> A number of ophthalmology groups adopt an income allocation formula that is based 100% on individual production. The approach is fairly straightforward in that, at least theoretically, the harder one works, the more money one will make. The emphasis in this method is on meeting patient demands and providing the clearest of incentives for group members to be productive. (Obviously, groups must be very careful in understanding what is meant by "productivity" -- *i.e.,* whether it means charges, collections, RVUs or some combination of these items.) A productivity approach also embraces the concept that the more productive the group members are, the more successful the overall group will be.

On the other hand, personal ambition can be a potential pitfall in that it can create unhealthy competition among members for the available work. Of course, this is not the case in all groups, and the potential for a negative outcome really depends on the individuals within the group.

There are other disadvantages to a pure productivity arrangement. Basing a group's compensation entirely on a production basis disregards those other significant contributions that are so integral to a group's overall success. For example, time spent by a group's managing partner, unless separately compensated, is not recognized under a pure productivity arrangement. Indeed, it penalizes that member's management responsibilities as such responsibilities take away from production time. In a heavily managed care market, arrangements that emphasize production may be seen as inappropriate because the emphasis is on more care rather than <u>appropriate</u> care.

3. <u>Two-Tiered Allocation</u> Probably one of the most common income division formats for ophthalmology practices is the "two-tiered" approach in which a portion of the practice net income is divided on a production basis and the other portion is divided equally. Under this methodology, groups attempt to gain the benefits of both the production and the equal income splits. In this manner, each member has a strong incentive to make the overall group as successful as possible (regardless of which doctor actually sees more patients or performs more work) as well as a personal incentive to produce. Because both group loyalty and individual ambition should be well-accepted as desirable attributes, the formula combining both the equal and production components is often a workable solution. Variations on the two-tiered combinations are limitless. For example, some groups divide 50% of the net income equally and 50% on a production basis. Other groups will go with a smaller productivity split (perhaps 20%-30%) and the balance on an equal basis (70%-80%) as a way to recognize some production differences within the group while preserving the "group culture". The right allocation for a group will depend, of course, on the culture and philosophy of the group and its individual members.

4. <u>Multi-Tiered Approach</u> Under the multi-tiered approach, in addition to production and/or equal split components, groups establish a tier or tiers to recognize other contributions of their members, such as management and administration, clinical quality, seniority, credentials, teaching and speaking, etc. In so doing, however, the group must determine both what contributions lead to practice success (besides production) as well as what activities the group wants to promote or encourage among its members. In addition, the group must then agree upon the weight to give each contribution or tier. The greater the number of activities and contributions that are recognized, the more difficult this system will be to administer, and groups should try to limit the number of categories, or combine contributions into groupings. Further, the more contributions that are recognized, the more frequently the arrangements will have to be revisited to ensure the proper weight is allocated to each.

5. <u>Base Salary Plus Incentive</u> This method is similar to the multi-tiered approach described above. The difference is that the group establishes, in advance, each physician's base salary and then, if there is any money remaining after the practice's expenses (including the physicians' base salaries) such amount (the "incentive pool") is allocated among the physicians based on production, management contributions, or a combination of these, and/or other factors. This methodology can be effective if the group is willing to set base salaries at a level that will make the incentive pool large enough to be meaningful. This is often difficult, as group members considering this approach tend to attempt to secure as high of a guaranteed base salary as possible.

There are different variations that groups have adopted and comfortably implemented. In some groups, the base salary is determined equally, thus giving each member a "worker's share" for, presumably, certain equal contributions each member makes. Other groups choose to set the base salary based on production, entitling each member to a percentage of his or her collections as base salary. In determining the base salaries, groups should attempt to ensure that amounts will be available to be allocated under the incentive allocation.

A new emerging approach involves the recurring negotiation of base salaries. That is, members will have their base salaries set by annual agreement. The underlying concept of this method is to attempt to evaluate each member's actual contribution to the group. This type of negotiated component is, of course, extremely difficult to successfully implement and certainly is not right for all groups. It takes the right mix of personalities and individuals to be able to work through and trust one another as well as very specific data to carry out the process in an equitable manner.

Finally, in a base salary plus incentive or a multi-tiered approach, a certain portion of the incentive pool or net income might be paid out at the discretion of the group. This allows a group to "fine tune" its compensation scheme by compensating members who have contributed to the overall growth and prosperity of the group, but whose contributions are not otherwise adequately addressed by the income division arrangement. Group members often are uncomfortable with this method, because, ultimately, much of their resulting income is determined in the discretion of others. It does, however, have the potential to recognize and reward those contributions which can be overlooked in the more traditional equal/production income division approaches. It is advisable for groups considering this approach to allocate only a small portion of the available net income on this discretionary basis during the early years of the arrangement. As the group becomes more comfortable with this approach, the amount of the discretionary pool can increase.

VI. <u>Buy-Outs</u> We'd be remiss not to discuss partner buy-outs in these materials. A major inducement to offering partnership to an associate physician is legally binding the new partner to buy-outs of the remaining interests owned by the existing partners. Under most group arrangements, a partner's buy-in is not his or her only purchase of a partnership interest. Of course, the buy-out arrangements (often referred to as "buy-sell" arrangements) generally apply to the new partner as well. Therefore, when assessing a partnership buy-in offer, it is important to understand under what circumstances one's interest will be repurchased and other circumstances one will be required to participate in future purchases (and upon what terms).

A. <u>Equity Repurchase</u> The partner departing a group will have his or her stock (or in the case of a partnership, his or her capital account) repurchased using the same valuation formula used for the new partner's buy-in. The members of a group practice should have a shareholders' agreement in place that requires the corporation (or the shareholders) to repurchase a departed member's shares for an agreed-upon purchase price or a specific manner pursuant to which the purchase price would be determined, in either case fairly reflecting tangible asset value. As discussed above, the stock purchase price might be tied to the practice's book value (assets minus liabilities) calculated as of the last day of the month preceding the payout date, with the following adjustments:

1. All tangible assets (except for cars) will have depreciation recalculated on a "straight-line" basis over a ten- or twelve-year useful life. In addition, fully depreciated assets still in use will each have a minimum (on floor) value of 20% of original cost;

2. Any leased equipment that is not listed as an asset on the practice's balance sheet but which will be purchased at the end of the lease arrangement might be added to book value;

3. Items that have been expensed but are still in use (including supplies) should be added to book value; and

4. Certain prepaid expenses not included on the practice's balance sheet, such as security deposits and prepaid malpractice insurance, should be included in the calculation.

This valuation approach will make the purchase price approximately equal to the practice's tangible asset values minus any debts related to them. The repurchase of an owner's stock or ownership interest is not deductible by the practice for income tax purposes. On the other hand, the selling owner's gain from the sale of his or her stock would be taxed at capital gain rates.

In most cases, a departing owner will be paid for his or her stock or ownership interest over a period of time, perhaps three to five years.

B. **<u>Deferred Compensation</u>** There should also be a payout to recognize a departing owner's interest in the accounts receivable. This interest is typically paid out as continued compensation (or "deferred compensation"). Deferred compensation will be taxable as ordinary income to the recipient but should be tax-deductible by the entity making the payments, thus making it more affordable to the ongoing practice. Deferred compensation is paid in lieu of including the receivables interest in the purchase price of the stock or ownership interest.

The payout of the accounts receivable needs to be carefully structured from a tax standpoint. To avoid IRS scrutiny or attack on the tax-beneficial character of the deferred compensation in a corporate setting, it is best to avoid computing deferred compensation by direct reference to accounts receivable. Instead, the deferred compensation can be computed as a number of months of continued salary. For example, an owner might be entitled to three months of continued salary upon his or her termination from the practice for any reason.

Many groups also recognize goodwill as an additional intangible value that a departing owner is leaving behind. Thus, for example, a departing owner could receive additional months of continued salary to recognize his or her interest in *both* the receivables and goodwill: perhaps twelve months' total salary (three months for receivables and nine months for goodwill). Some groups elect to increase the entitlement based on the number of years of service with the practice, while some groups will want to pay less. (It is important not to be stymied over what is the "right" answer in comparison to what other practices do, but rather to decide what is "right" -- and affordable -- for the particular practice.) The rationale behind deferred compensation is that it is important to pay owners for their efforts, and for what they are leaving behind. Indeed, if there is not some kind of payment above and beyond the value of receivables, arguably the practice (and the remaining physicians) receives a windfall. If all (or most) of a retiring physician's practice stays with the group upon his or her retirement, the group's revenues will be unaffected by his or her departure. The practice may need to hire an associate to work at the practice, but the cost of that associate will, typically, be far less than what the retiring owner received as his or her compensation package.

In any event, it is preferable to base a deferred compensation arrangement on a number of months' or years' salary. As noted above, for example, a physician might be entitled to twelve months of his or her average W-2 compensation over the preceding two years, with such amount paid in sixty (60) monthly installments. One concern about structuring the deferred compensation in this fashion is that it may or may not directly vary with the practice's accounts receivable or goodwill values. Salaries might fluctuate in certain practices, and thus this method tends to be a little less precise than some partners may desire. An alternative approach, therefore, is to state the deferred compensation as a fixed percentage of the most recent year's practice gross receipts. For example, if, based on the valuation of a two person practice, the total accounts receivable and goodwill values are 60% of one year's gross revenue, then a partner might be entitled to deferred compensation equal to 30% of the most recent year's gross income, paid in sixty (60) equal monthly installments.

Another issue that needs to be addressed is whether the deferred compensation should be based on an ownership right (*i.e.,* in a two-doctor practice, 50% of the total intangible values) or on the doctor's production share of such income. The rationale for providing deferred compensation equally is that the members are equal owners of the hard assets and the income assets of the practice. Thus, the retiring doctor's deferred compensation should recognize the size and profitability of the practice that he or she has helped build and is leaving behind as an *owner*. On the other hand, the theory behind basing deferred compensation on production (*i.e.,* months of salary if the practice is dividing the income, at least in part, on a production basis) is that the accounts receivable and goodwill values are contingent upon each partner's practice activities, similar to the considerations that go into the income division arrangement. In essence, if goodwill and receivables are income assets, they should arguably be paid out based on the practice's normal income division (recognizing production if the practice's income division formula does so).

C. <u>Protections for the Ongoing Group</u> The first priority in payout arrangements is to protect the ongoing practice. The following limitations should be included in any payout arrangements:

1. <u>Percentage of Gross Income</u> Partners in group practices are often afraid that very generous payout arrangements will not be affordable. This concern can usually be addressed by imposing a maximum ceiling on the amount of deferred compensation that can be paid out in any one quarter. For example, the arrangement should include a provision that the total deferred compensation payments shall not, in any fiscal quarter, exceed 4% of that fiscal quarter's corporate gross income. Thus, if the group's activity should significantly falter after a partner's departure, the total payout obligation would not be more than a modest overhead item (4%). The amount not paid because of the limitation is usually deferred to the next quarter when it can be paid. Any amounts that remain unpaid because of the percentage cap after seven years could be forfeited.

2. **<u>Competitive Practice</u>** A departed partner should not be entitled to funds representing the practice's ongoing earning power (goodwill value) if he or she leaves and practices and becomes competitive with it. Were that to occur, he or she would have taken earning power in the form of patients and referral patterns. A departed partner who enters into competitive practice and who continues to receive his or her payout would actually be receiving an improper doubling-up of benefits upon his or her departure. For this purpose, "competition" may be broadly defined. Note that this does not preclude a partner from leaving and competing with the practice (absent any restrictive covenant). It merely deprives him or her of the right to the goodwill portion of the payout. Some agreements provide for *total* forfeiture of separation pay -- loss of the accounts receivable payout as well as the goodwill value -- as a form of a penalty for the decision to compete. Some practices view such competition as so serious an offense that they require a former partner, who waits a year or two before entering into competitive practice, to repay any separation pay he or she previously received.

3. **<u>Reduction for Short Notice</u>** Some groups feel a partner should not be entitled to as much deferred compensation if he or she voluntarily withdraws without giving advance notice to the group to plan for the departure. The physicians remaining should be given enough time to recruit for a replacement physician. A common approach is to reduce a member's right to deferred compensation by one-sixth for each month less than six months that notice of the decision to voluntarily withdraw is given. (The penalty would not apply, of course, in a case of someone's death or disability.)

4. **<u>"Bad Boy" Clause</u>** Another limitation some groups implement is that upon a physician's employment being terminated on account of being expelled, suspended or otherwise disciplined by a hospital, facility or professional organization as a result of professional misconduct, that physician's deferred compensation entitlement is forfeited. In addition, some groups also provide for forfeiture of deferred compensation in the event the physician is convicted of a felony or criminal offense involving moral turpitude.

5. **<u>Post-termination Liabilities</u>** Another limitation some groups have adopted relates to certain post-termination liabilities that arise relating to events that occurred prior to the termination. There are two basic philosophical approaches to this issue. First, the argument can be made that when a physician leaves, there should be a "clean break"; if any Medicare, tax or other liabilities arise after the date of termination, that physician should not bear any responsibility. This is consistent with the idea that, since a departed physician is not going to be sharing in any of the profits or benefits of the ongoing practice, he or she should not bear any of the liabilities or responsibilities. In the second approach, the group can keep the physician "on the hook" for certain liabilities, depending on their nature and origin. If the physician was involved in setting the policy for the corporation which led to the creation of such liability (no matter when the liability is actually incurred by the corporation), that physician should be responsible for his or her pro-rata share of such liabilities, or at least to the extent of any deferred compensation which he or she may be receiving.