# Practice Valuations: What's Your Practice Worth Today?

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## I. INTRODUCTION

This article is designed to enlighten you as to the manner in which we, and many medical practice appraisers, appraise ophthalmology practices. After reading this, you should be capable of determining your practice's approximate value.

There are various methods of appraisal. Appraisers typically employ more than one when appraising a practice. We employ as many as three methods, which are the focus of the discussion below. Because business appraisal is an inexact science, no one method can precisely determine value. Employing multiple methods provides for appropriate checks and balances, each having a somewhat different emphasis in the valuation process.

Certain tenets, however, are universal to all methods of appraisal:

- Practice values come into play for various reasons: Owner buy-sell arrangements (*i.e.,* buy-ins and pay-outs), outright practice sales, practice mergers, divorce proceedings, and the like. But a practice's value shouldn't vary depending on the reason for the appraisal. A practice's value at any given point in time is, quite simply, its value.

- Although all methods rely heavily upon a practice's financial statements of historical operational results, assumptions play a large role. Assumptions are appropriate, however, only when reasonably accurate. Future practice plans (such as opening a new office, hiring a subspecialty surgeon, and the like), should be factored only if the plans are reasonably imminent and if projected results are reasonably certain.

- All methods, despite their heavy reliance on historical numbers, require appraiser discretion in determining revenue or earnings multipliers, discount and capitalization rates – as discussed below. Discretion should have some foundation whether based upon market comparables, appraiser experience or both.

## II. MATERIALS AND INFORMATION

Each appraisal begins with a review of the relevant practice information. We generally ask for, and/or make use of, the following:

1. The practice's federal income tax returns and accountant-prepared financial statements for the most recent three (3) years and interim financial statements for the current year-to-date;

2. A current listing of the practice's "Hard Assets", defined below, and accountant-prepared depreciation schedules;

3. Current accounts receivable report including classification by age and payor, if possible;

4. Fee schedule and practice volume statistics for the most recent year;

5. Operational records and data, including appointment schedules, referral pattern information, and the like;

6. General information regarding supplies on hand and ordering habits;

7. Evaluation of the practice's market area, competition and patient demographics, based in part on a review of area phone directories (physician listings), internet directories such as the American Academy of Ophthalmology's web site, review of Chamber of Commerce information, and Census data;

8. Medical practice industry statistics prepared by the Medical Group Management Association ("MGMA") for the most recent year, including charge and collection data by specialty;

9. Information from the Health Care Group's Goodwill Registry (The Goodwill Registry is a compendium of sales and other transactions which have been tabulated to express the goodwill -- as a percentage of gross revenues -- paid in these transactions.); and

10. Application of our own experience with ophthalmology practice matters to all of the above.

## III. OVERVIEW OF VALUATION METHODS

Three valuation methods are most commonly used in the appraisal of ophthalmology practices (and medical practices in general). This course focuses on these three: The Component Method, the Discounted Cash Flow Method, and the Capitalized Excess Earnings Method.

We start with an overview of each:

1. Component Method. We sometimes refer to this as the "Balance Sheet Approach". Utilizing this method, the appraiser specifically identifies the practice's assets and

liabilities. The assets are individually valued, and the aggregate of such individual asset values constitutes the practice's total asset value. Total liabilities are then subtracted from the total asset value, the result representing the practice's resulting value. Below we discuss the identifiable assets and the valuation technique for each asset classification.

2. Discounted Cash Flow Method. This method focuses on the practice's projected future cash flows from operations, rather than assets and liabilities. Projected future cash flows are ascertained from historical cash flows (typically, the practice's prior year's cash flow) applying reasonable assumptions about future operations (including, for example, growth in revenues and expenses). The projected future cash flows are then discounted to present value by applying an appropriate discount rate. Whereas the Component Method focuses on a practice's Balance Sheet – hence, its assets and liabilities -- this method focuses on a practice's Income Statement (*i.e.,* revenues and expenses). Therefore, we sometimes refer to the Discounted Cash Flow Method as an "Income Statement Approach". The practice's assets and liabilities are not ignored, but rather, they, together with the practice's staff, location, etc. form a going concern that produces cash flow. Hence, in contrast to the Component Method, the Discounted Cash Flow Method values the practice as a going concern.

3. Capitalized Excess Earnings Method. Another Income Statement approach, the Capitalized Excess Earnings Method also values the practice as a going concern. Rather than focusing on projected cash flows, however, the Capitalized Excess Earnings Method focuses on the practice's historical earnings, as reported per its income statement. An appropriate capitalization factor is applied to earnings to determine practice value. Appraisers will typically use a weighted average technique, whereby earnings for the prior three-year period are included and subjected to a weight factor that gives increasing consideration to the more recent year.

Each valuation method requires the making of various assumptions. Hence, there is always a fairly significant element of discretion. And so, while appraisals do focus a great deal on numbers, they are not so rigid that there is not subjectivity on the appraiser's part. If assumptions are consistently applied, then the results should be fairly consistent. Thus, the average of the three methods described above should yield an accurate determination of a practice's value.

## IV. METHODS Of VALUATION

1. Component Method.

A. Assets. The primary assets commonly associated with an ophthalmology practice are: (1) Tangible assets, such as furniture, fixtures, equipment and office and medical supplies, often referred to as "Hard Assets"; (2) Accounts Receivable; and (3) Goodwill.

There are generally other assets as well. On any particular valuation date, there may be cash on hand, investments, notes receivable, and the like. There may also be deposits and prepayments. These assets may be lesser in value than the three primary assets, described above, but they should not be ignored.

Some, but not all, of a practice's assets will appear on its books or Balance Sheet. Consequently, while book value represents a good starting point, it does not adequately capture all of a practice's assets. Asset additions or adjustments are necessary.

A practice's books can be kept on a "cash basis" or an "accrual basis". The necessary additions or adjustments will depend upon which accounting method is utilized. On the asset side, cash basis books exclude accrual-based items, accounts receivable being the primary accrual-based asset. Cash basis books also exclude prepayments. Books kept on an accrual basis are inclusive of accrual and accrued-based items and, therefore, more adjustments and additions are required for books maintained on a cash basis.

As previously mentioned, under the Component Method, each of the asset groups is valued independently. The aggregate of the independent asset group values represents the practice's total "asset value".

i) Hard Assets. One way to determine the fair market value of Hard Assets is by appraisal. Most of the tangible assets in medical offices fall into two categories: those items that are nonspecific to medical practices, and those that are peculiar only to medical practices. With regard to the latter, while there is not much of a secondary market for such equipment, there is *some* market. Most vendors of major (*e.g.*, ophthalmic) equipment will provide appraisals of the fair market value of that specialty equipment. As to the former, most such vendors will also provide a valuation, but the market for such industry nonspecific tangibles is less certain, and an appraisal is likely to yield, ultimately, someone's *"*best guess*"* and very little more as to their fair market value.

Another, more common, way is to start with book, or Balance Sheet, value and make adjustments designed to give a more realistic result, designed, of course, to approximate fair value. Some of a practice's Hard Assets – furniture, fixtures and equipment -- are reported on the books (*i.e.,* reported per the Balance Sheet) at cost, which, at the time of purchase is essentially fair market value. Office and medical supplies are not "booked" and, therefore, do not appear on the Balance Sheet. We'll address these separately below. Over time, the assets are depreciated in accordance with financial accounting standards of depreciation. A practice's Balance Sheet will report the accumulated depreciation. The net of cost less depreciation represents "book value" for each Hard Asset.

Once again, book value represents a good starting point, but adjustments are necessary since financial accounting depreciation doesn't accurately reflect economic (*i.e.,* actual) wear and tear. Hence, book value doesn't yield a practical or fair value. 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" methods of depreciation are often used, pursuant to which depreciation is not taken pro-rata, or "straight-line", but rather front-weighted. In using an accelerated method of depreciation, as much as thirty percent (30%) of an asset can be written off in the first year. Some assets may even be fully depreciated in the year of purchase.

Therefore, we restate depreciation for each Hard Asset using a *"*straight-line*"* (*i.e.,* ratable) method and assuming a 10 to 15-year useful life instead of the useful lives used for financial 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. With respect to any individual Hard Asset, this restatement may yield a higher or lower fair value than, perhaps, may be appropriate. But such inequities are generally washed out (*i.e.,* the overvaluations washing with

the undervaluations). Although *"*rough justice*"* in its own sort of way, this technique yields a fair and practical result that is, in our experience, seldom disputed.

We should also mention that when restating depreciation in the manner described above, one must be certain to include among the Hard Assets those assets which are (i) expensed for book and tax purposes, and (ii) those which are purchased under capitalized leases (financing leases, for example, where title to a piece of equipment transfers to the practice for $1 at the end of a lease term).

As mentioned, clinical and office supplies are expensed for tax and book purposes rather than "booked" as assets given their consumable nature. Notwithstanding their treatment as non-assets, a practice will, at any given time, have an inventory of unused clinical and office supplies. These, when paid for, have a value that is best measured by cost. There are two ways to value supplies. First, an actual hand-count can be performed. The cost of those on-hand supplies represents their value. Here, once again, this may be a precise, though not a practical, approach. The second, more practical, approach is to estimate the value of supplies on hand by determining the total cost of supplies purchased during the one (1) year period preceding the valuation date and then dividing such cost by twelve (12), yielding a monthly average cost. Practices generally carry 2 to 3 months' inventory. So, applying a 2.5 multiple (representing 2½ months) times the monthly average cost produces a reasonable estimated value of supplies on hand. The precise multiple for use in any appraisal will depend upon the practice's ordering habits.

ii) Accounts Receivable. There are a couple of similar techniques used to value accounts receivable.

The first step to valuing accounts receivable under any method, however, is to purge, or write off, those accounts that are uncollectible. What's uncollectible? Well, any account balances aged over 180 days for which the practice has no intention of pursuing collection should clearly be written off. Unless uncollectible amounts are purged, accounts receivable value will be inflated. However, it can be time-consuming to determine which accounts to purge on an account-by-account basis. A rule-of-thumb approach is to purge accounts that have had no activity (*i.e.,* neither a charge nor payment) for 180 days or more, excepting old balances that are outstanding for a reason and where collection is still anticipated.

Of course, purging uncollectible accounts doesn't guaranty collection of the remaining "live" accounts. What ultimately is collected can be reasonably predicted by applying historical collection ratios. Collection ratios are generally derived by dividing actual collections received for a given period – one year is a sufficient period – by the charges generated to produce such collections. However, this requires a matching up of charges and collections for the same services. An easier, less precise, determination is to divide collections for the determination period by the charges during such period. Collections and charges are not matched per the service using this technique, but assuming the volume of services in the months leading up to the determination period are consistent with the volume rendered thereafter, then collections and charges during the determination period will be reflective of continuous operations during the valuation period. Hence, the resulting ratio should be reasonably accurate.

Another, perhaps more scientific, technique is to apply different collection ratios to accounts categorized by age. This recognizes that current accounts have a higher probability of collection than, say, accounts dated 90 days, and so on. For example, a collection ratio of 95% might be applied to current accounts; 90% to receivables aged between 30 and 60 days; 75% to

those aged 60 to 90 days, and so on, down to 5% for those receivables aged 180 days or older which have not been purged (because if they've not been purged, there presumably remains some possibility of collection).

Obviously, there is no guarantee that any formula will provide a "to the dollar" valuation of accounts receivable; however, most will come reasonably close. The greatest danger is that, particularly in a marketplace where fees are being discounted more and more, old collection ratios may overstate what one can expect in the future. However, given that the bulk of receivables are collected within a 60 to 90-day period, one's collection ratio should not alter dramatically in such a short period of time.

iii) 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 20 to 25 years ago, 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.

However, 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 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 a managed care 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 a highly mature managed care market, those practices that have managed care contracts with significant numbers of covered lives will have extraordinary goodwill value because, among other things, those practices will be able to predict with a great deal of certainty what their cash flow is going to be. Even though a practice may lose a contract, practices that have contracts are clearly far better off than those practices that don't have contracts.

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 survive in a managed care environment 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 disconcertingly 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. 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 years 1999 and 2008. The Goodwill Registry reveals that, for ophthalmology, the median goodwill value for ophthalmic transactions reporting goodwill during that period was 26.48% and the mean was 28.95% (*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 past 24 years. During this time, two trends have become clear: (1) that recognition of goodwill values in ophthalmology are on the decline – for example, approximately 10 to 12 years ago the mean was 36.9% and has steadily declined since – and, (2) that there is lesser recognition now – for example, whereas 10 to 12 years ago 13% of ophthalmic transactions did not recognize goodwill at all, according to the most recently published edition, this non-recognition percentage is up to 16%. (It 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).

However, a practice's true 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 the appraisers 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:

a. 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.

b. 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.

c. 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.

d. 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).

e. 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?

f. 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 considered, goodwill percentages will generally range from as low as 15% to as high as 35%.

iv) Other Assets. There are other assets, as mentioned, some of which are not reported on a cash basis Balance Sheet.

a. Cash or Cash Equivalents. At any given time, a practice will have a cash balance in its accounts. Cash should be included in the valuation.

b. Securities and Investments. Occasionally, a practice owns securities and other investments. These should be included in the valuation at their market value.

c. Prepaid Assets. At any given time, a practice is likely to have prepaid assets – *i.e.,* payments which have been made for a future benefit. For example, assume a practice pays its malpractice insurance premiums in January of every year. For a valuation date of June 30th, the practice would have a prepaid asset equal to one-half of a year's malpractice coverage (valued at cost). Even if the practice doesn't pay its premiums in

their entirety at the beginning of a year, there is usually some prepaid value, since most insurers require 25% to 30% up-front payment.

d. Deposits. Security deposits, such as under real estate leases, should be included in the assets.

e. Managed Care Withholds, Bonuses, Refunds. Amounts receivable by a practice are considered an asset, unless receipt (or the amount) is in question. For example, unless the practice has a legal entitlement to a specific amount, then that amount is speculative and not deemed an asset.

f. Loans Receivable. Any loans receivable by the practice are considered assets to the extent of the principal amount outstanding.

g. Purchased Goodwill. Occasionally, a practice which is being appraised will have previously purchased another practice and the goodwill paid in that transaction is booked as an asset on the appraised practice's Balance Sheet. In these situations, we generally ignore the purchased goodwill so as not to inflate the appraised practice's goodwill value. Since revenues derived from the purchased practice are inherent in the appraised practice's results, the goodwill percentage when applied will capture the entire goodwill value.

h. Insurance Cash Surrender Values. Cash surrender value under insurance policies, whether held for investment or to fund future ownership buy-outs, are practice assets and should be included at their surrender value.

B. Liabilities. A practice's liabilities can also be ascertained in large part from the Balance Sheet. There are essentially two kinds of liabilities: Current and long-term. Current liabilities are those practice obligations which are payable within the upcoming year. Long-term liabilities are payable in greater than one-year. Oft times, an accountant will classify the current portion of a long-term liability under current liabilities and the remainder under long-term liabilities.

A cash basis Balance Sheet will include the usual obligations – *e.g.,* bank term loans, amounts owed pursuant to a line of credit and the like. But, a cash basis Balance Sheet will ignore accrued liabilities, which are reported only on accrual basis Balance Sheets. It is important to ensure that all obligations are captured.

i) Accounts Payable. Just as accounts receivable are included in the practice's assets, amounts due under invoices received, but not yet paid, must be included in the liabilities. An example would be an invoice for supplies that have been ordered and received but not yet paid.

ii) Accrued Liabilities. Obligations that have accrued and are payable at some later date should also be included. One example is payroll and associated payroll taxes. For example, if the valuation date is December 31st, and the practice makes a payroll on that date, then there would be no accrued payroll obligation – all employees would have been fully paid through the valuation date. However, if the practice's most recent payroll was on December 20th and the next payroll is scheduled for January 3rd, then as of the valuation date (December 31st), 11/14ths of the total payroll obligation should be considered a liability, since this amount is fixed and due.

Often, the largest accrued liability is payroll related – retirement plan contributions. Practices that have defined benefit or defined contribution retirement plans often make large contributions for their employees on an annual basis. The contribution, however, isn't usually fixed until the final day of the plan year. Furthermore, it is not payable until the plan's tax return is due. Therefore, often a practice has a fixed obligation to contribute a large sum at some future date. This obligation becomes a liability the moment it is fixed, and it is extinguished the moment it is paid. If the valuation date occurs after the liability is fixed, but before payment is made, then the liability must be included in the valuation.

iii) Capitalized Equipment Leases. We mentioned above that the value of capitalized equipment leases should be included among a practice's assets. Accordingly, future obligations under such equipment leases should be included with the practice's liabilities (if not already booked as such on the Balance Sheet).

iv) Physician Loans/Bonuses. Any amounts that are payable to shareholders or physicians by way of compensation or repayment of loans are to be considered liabilities to the extent not already booked as such – again, though, only to the extent such amounts are fixed and not contingent.

2. Discounted Cash Flow Method. The Discounted Cash Flow Method determines the value of a practice based upon such practice's projected future cash flows over a five-year period and a sixth, terminal reserve year. It then brings those projected future cash flows to present value using an appropriate discount rate. Projections are based upon historical operational results. Consequently, a historical "Base Year" must be established. The practice's cash flow for the Base Year must be accurately determined. Inaccuracies in the Base Year will have a compounding effect on future projected cash flows and, in turn, the resulting valuation.

Determination of the Base Year cash flow starts with a practice's most recent year's Income Statement (commonly referred to as "Profit and Loss", or "P&L" statement). Conversely, if the valuation date is more than midway through the practice's current year, its current results can be annualized to a full year. However, given that revenues may fluctuate greatly from season to season and certain major expenses may be incurred during a particular part of the year, one must be careful when annualizing current year results.

The Income Statement, in itself, is not a statement of cash flows. First, not all book or tax "expenses" represent actual cash outflows. Depreciation expense is a good example of an expense for Income Statement purposes for which there is no actual cash outflow. Second, not all cash outflows are "expenses" on the Income Statement. For example, payments made on debt principal and for capital purchases are not "expenses" for Income Statement purposes, but they certainly affect cash flow. Thus, the Base Year Income Statement must be converted into a Base Year Statement of Cash Flows.

A. Conversion Adjustments. The typical adjustments necessary to convert an Income Statement into a Statement of Cash Flows ("Conversion Adjustments") are:

i) Depreciation. Depreciation expense taken during the Base Year should be eliminated, since it does not represent an actual cash outlay.

ii) Principal Repayments. Amounts paid in repayment of loans during the Base Year, which are not deductible as expenses, should be included as cash outlays.

iii) Capital Payments. Amounts paid for capital expenditures during the Base Year (which are booked as assets and, hence, are not considered deductible expenses on the Income Statement), should be included.

Once the Base Year Income Statement is converted to a Statement of Cash Flows, cash flows must be projected for five years into the future plus a sixth, terminal reserve year. This calls for further adjustments and the making of various assumptions. The further adjustments are often referred to as "Normalization Adjustments".

B. Normalization Adjustments.

i) Generally. When projecting the Base Year cash flows forward, it is important to adjust out items of revenue or expense that are non-recurring or extraordinary in nature, but which are included in the Base Year. For example, assume that in the Base Year a practice spent $100,000 on lawyer fees. Further assume, in prior years, the practice had spent in the range of $15,000 annually in lawyer fees. Also assume that the additional $85,000 was attributable to a litigation matter that has since been resolved. It would be appropriate to eliminate the "extraordinary" lawyer fees of $85,000 because they were neither normal nor recurring in nature (assuming, of course, that there are no similar legal matters anticipated). It would also be appropriate to project legal fees of $15,000, subject to annual growth in accordance with cost-of-living adjustments.

ii) Shareholder Compensation. The most difficult adjustment, and the one having the single biggest impact on the valuation is the Normalization Adjustment for owner compensation. Most medical practice owners receive the bulk of practice net income during each year in the form of compensation. The question is: What part of the owner-physician take-home pay represents compensation versus profit? Generally speaking, the physician-owner receives what he/she earns through personal service and, hence, it is appropriate to consider that compensation. Nonetheless, the appraiser must attempt to distinguish compensation from profit, or the Discounted Cash Flow Method will yield very little value because there is very little cash flow after physician compensation. Therefore, physician compensation must be imputed in place of what a practice's physician actually receives during the Base Year.

It is very difficult to ascribe the *"*average*"* compensation to be derived from any particular practice. In our experience, however, a professional salary component of anywhere from 35% to 40% of collections is the norm. Generally, the larger the practice, the higher the overhead and, hence, the lower the physician compensation component. This isn't to say that the physicians in a large, successful practice are paid less; rather, their compensation is less as a percentage of the practice's gross receipts. Gross receipts of a large successful practice are higher, of course, and so physician compensation, while lesser as a percentage of revenues, is usually higher on a dollar per doctor basis. But we typically impute physician compensation on average at about 37.5% for purposes of a valuation. By making the adjustment to compensation, profit is created, which is taxable.

iii) Taxes. Some appraisers impute a line item for income taxes. This doesn't seem unreasonable in light of the adjustment to compensation noted above. However, while payment of income taxes may be the norm for most businesses, professional service "C" corporations typically zero out through year-end bonusing and, as a result, pay very little in the way of income taxes. Professional "S" corporations, limited liability companies and partnerships generally do not pay income taxes. Therefore, to impute income tax artificially skews cash flow and yields an inaccurate result. The appraisal will be accurate only if projected cash flows are real.

C. Assumptions. As one can see, assumptions are required just in making Normalization Adjustments. However, more assumptions are necessary to properly forecast future cash flows. Assumptions must be reasonable and have some foundation. Here are some typical assumptions:

i) Growth in Revenues. It is difficult these days to assume any growth in revenues, all things being unchanged. However, an associate physician might be expected to continue to increase his/her generation of revenues. Circumstances in the marketplace may also impact future revenues. It's worth reiterating, however, that assumptions must have some basis in fact. So, the fact that a practice *may* hire an oculoplastic surgeon in one year doesn't warrant an assumption that there will be an increase in revenues. However, if the practice *will* hire a physician to do the same and *can* reasonably ascertain current revenues referred to outsiders for those surgeries now, then a specific revenue increase can and should be assumed.

ii) Increasing Costs. Revenues may not increase. Expenses (*i.e.,* cash outlays), however, will almost certainly increase. However, not all expenses necessarily increase at the same levels. Most expenses, it is reasonable to assume, will rise at least in accordance with the cost of living increases (2% to 3% annually) -- utilities, supplies, and the like, are good examples. However, growth in a practice must also be factored in. For example, the practice may be purchasing *more* supplies at a *higher* cost. Or, the practice may be paying more wages for a greater number of employees at annually increased rates. Other costs are of a fixed nature, and will grow neither in accordance with the cost of living nor in accordance with revenues. For example, loan repayments or office rents are fixed per agreement and should increase accordingly. Of course, practice expansion might require additional office locations and additional borrowings. The point here is that each cash outflow line item must be analyzed separately.

iii) Capital Purchases. Assumptions must be made with respect to capitalization. That is, a Discounted Cash Flow should include an annual line item for nondeductible acquisitions of equipment, computers, etc.

D. Present Valuing The Projected Results. Once all Conversion and Normalization Adjustments and assumptions are made and the five year period and the sixth, terminal reserve year, are forecasted, the projected future cash flows must be discounted to present value. Discount rates are typically in the range of 15% to 22%. The precise discount rate must be determined after due consideration is given to the goodwill factors discussed under the Component Method.

E. Terminal Reserve Value. Application of the discount rate to the projected cash flow for each of the five years plus the terminal reserve year yields a "discounted cash flow" for each of the six periods. A capitalization rate must be applied to the discounted

cash flow for the terminal reserve year to determine projected cash flows for indefinite periods ("Terminal Reserve Value"). The Terminal Reserve Value is determined by dividing the terminal reserve cash flow by a capitalization rate (*i.e.,* terminal reserve cash flow/capitalization rate = Terminal Reserve Value). The capitalization rate is determined by subtracting from the discount rate the growth rate percentage assumed on revenues for the terminal reserve year. Thus, if the discount rate is 18% and the assumed growth rate on revenues for the terminal reserve year is 3%, then the capitalization rate would be 15% (*i.e.,* discount rate – terminal revenue growth rate percentage = capitalization rate).

F. Determining Discounted Cash Flow Value. The discounted cash flow value is determined by adding the discounted cash flow for each of the five years plus the Terminal Reserve Value.

3. Capitalized Excess Earnings. Perhaps the easiest of the three methods discussed is the Capitalized Excess Earnings Method. This method capitalizes historical excess earnings from the Income Statement. This can be performed with respect to the practice's prior year's earnings or can be performed on a weighted average basis with respect to the prior 3 years' earnings. We generally prefer not to use a weighted average approach for two reasons: First, if prior year earnings are similar, using a weighted average will have little effect. Second, the most recent year's earnings best reflect current operations and, therefore, according any weight to previous earnings seems pointless. However, if there are significant fluctuations in earnings over a given period, then the weighted average approach may be appropriate.

As indicated, excess earnings are capitalized under this method. There is no need to convert to cash flows. However, certain normalization adjustments may be appropriate to eliminate extraordinary items. Furthermore, physician compensation must be imputed in the same manner as discussed under the Discounted Cash Flow Method. This, essentially, is what will create earnings.

Excess Earnings, once determined, are capitalized. This is accomplished by dividing excess earnings by a capitalization rate – which can be determined in the same manner as the discount rate is determined under the Discounted Cash Flow Method. Most appraisers use this method to determine intangible (*i.e.*, goodwill) value, adding the value of Hard Assets to determine total practice value.

4. Optical Shops and Surgery Centers. Most times, optical shops are owned and operated within the practice entity, while surgery suites are owned and operated separately. Either way, we appraise them separately from the practice. If those businesses are included in the practice, and their assets, liabilities, income and expenses reported on the practice's books (*i.e.,* Balance Sheets and Income Statements), then it is crucial that the books be modified for their exclusion when performing the practice's appraisal. In essence, a separate set of books should be created for the optical shop or ambulatory surgery center. Very often, it should be noted, the practice accountant creates separate and consolidated financial reports as a way of separately tracking operational results. In this case, the work is already done. However, it is nonetheless important to review the separate books to ensure that any internal allocations of expense between the separate businesses are appropriate and reasonable.

How are optical shops and surgery centers appraised? Typically, some multiple of earnings (currently in the range of 3 to 6) are applied to earnings. That is, the earnings from the optical shop or surgery center is determined and then multiplied by a number, currently in the range of 3 to 5. As with the Capitalized Excess Earnings Method, some normalization adjustments may need to be made, but typically there is no need for an adjustment for owner compensation.