Wade • Goldstein • Landau • Abruzzo
A Professional Corporation
Attorneys-at-Law
61 Cassatt Avenue
Berwyn, Pennsylvania 19312
Telephone: (610) 296-1800
Fax: (610) 296-1802

Website: http://www.wadegold.com
E-Mail: mabruzzo@wadegold.com
Writer's Direct Line: (610) 296-1800 x210

Negotiating Your Buy-In to a Medical Practice and Practice Valuation

by Mark Abruzzo, Esq.

This article addresses the matter of one's purchasing an ownership interest in a typical medical 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 lesser profile issues which are nonetheless important and which often influence price and payment terms—issues which can make a buy-in offer worthy of accepting or rejecting, as the case may be.

I. Assessing The Offer

In a typical 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, practices are often critical in making a decision to offer ownership to an associate. The counter to that is that the associate should be very critical of accepting any offer. Sometimes there are better alternatives to buying in, such as remaining an employee or leaving the practice altogether. Buying an interest in a medical practice is, in one sense, a financial investment in one's future. But it goes beyond the financial. I could also suggest it is like getting married. Indeed, having a business partner is akin to having a spouse. My representation of a physician who is buying in often begins with them sending me the draft "buy-in" contracts which have been prepared for their review and asking me if I can assist them. I routinely review buy-in agreements for physicians who are buying in. And, I routinely draft these for group practices who are offering partnership. Still, at this stage – even with knowledge of purchase price and payment terms, I am in no position to opine as to whether a buy-in offer is a good one and should be accepted or a bad one and should be rejected and negotiated. Without more, there's just too much I don't know.

A. Financial Information The first thing we generally want to see are *both* practice *income tax returns* and accountant prepared *financial statements* for the three most recently completed fiscal years and also for the practice's current year-to-date (in the case of the year-to-date, financial statements will suffice as tax returns are completed only after the completion of a practice's fiscal year). By "financial statements" I mean:

(i) "*Balance sheet*" which is a statement of the practice's assets, liabilities and partner equity at a given time;
(ii) "*Profit and loss statement*" which is a statement of the revenues and expenses for the stated period;

(iii) "*Depreciation statement*" statement of accumulated depreciation on existing assets, dates placed in service and cost at a given time;
(iv) "Accounts receivable summary" which generally contains, at a given time, a statement of outstanding charges, with and without payor adjustments, by age (e.g., "current", "30 to 60 days", "60 to 90 days", etc.); and
(v) Breakdown of Physician productivity showing charges and collections for the most recent 12 months.

With this information, we can place a value on the practice and then, in turn, evaluate the buy-in price within that context (and in view of the various other intangible factors which are discussed below). As will be discussed below, practice "value" is not solely about the collective value of a practice's assets. It is also about the total amount of liabilities a practice has.

We can also assess the financial health of the practice. It's quite one thing for debt to appear on the balance sheet if it can be traced to the purchase equipment, the opening of a satellite office, etc. But it's quite another thing when debt appears on the balance sheet which was incurred to help fund overhead or fund partner salaries. Except in start-up situations, this can be a sign of financial distress.

Having a few years' worth of financial data is important because this allows us to look for trends. Is the practice growing? Is it losing volume? Are liabilities being repaid? This is all part of the general assessment of health and can influence the decision to buy-in even where the buy-in price is "reasonable".

B. Assessment of Leverage Important *before* commencing any negotiation is an honest assessment of one's negotiating leverage (*i.e*., bargaining power). Usually leverage is with the practice when negotiating the buy-in. If the physician is unhappy with the offer and does not accept it, then what will happen? The practice may allow him/her to remain an employee. This may not suit the physician who eventually may quit his/her employment. The possibility that the unhappy physician may leave employment is a factor the practice should consider. If the physician is valued, their potential departure as a result of an unreasonable buy-in offer can create some leverage in the physician (but only if the practice perceives departure as legitimate possibility). However, if the physician's employment agreement contains a non-compete clause, employment termination would mean having to relocate outside of the restricted area. Working experience benefits aside, relocating outside of the practice community can be like taking a step or two backward career-wise. Clearly, the existence of a non-compete clause in the physician's employment agreement figures to reduce the likelihood the physician would voluntarily leave their employment. In a handful of states, however, non-competes are not permitted. In such states, leverage can shift to the physician. Perhaps not entirely, but the playing field sure seems more level. In these states, if the physician doesn't care for the offer, there is the option of quitting employment and remaining in the community. As such, the practice could lose not only the physician but patients as well. Of course, even in a state where non-competes are permissible, it is possible a physician's employment agreement won't contain one. Not probable, but possible. But I digress. The lesson here is that the absence of a non-compete clause can create additional leverage for the physician. Not coincidentally, buy-ins generally tend to be more reasonable in states where employee non-competes are forbidden or in situations where the physician is otherwise not subject to one regardless of the state in which they practice. Precedence also can create leverage, usually for the practice however. By "precedence" I mean the physician who is buying an interest in a group practice where other physicians have previously bought in. For better or worse, in these situations, the group is unlikely to change the "deal" for the new incoming partner. It's difficult to negotiate change to the buy-in terms in situations where others have been forced to accept them (or worse where they neglected

to). Unfortunately, precedence is usually for worse. I say this only because buy-in values ("goodwill" values (discussed below) in particular) have been slowly but surely decreasing over the years. As a result, outdated buy-in terms often result in overpayment. There may be other factors that create leverage, such as a highly productive physician or a near retirement aged senior partner. The key is identifying these and using them wisely.

C. Financial Return What exactly does ownership of a partnership interest entitle the physician to? Generally, not all that much in terms of dollars and cents. In most cases, partnership net income is not distributed based in any way according to percentage ownership. Instead, it is usually distributed based on individual productivity. Or, at least largely based on individual productivity. Some groups maintain a tier-based system where a smaller portion of the practice net income is distributed according to productivity and some equally. Regardless, one can't possibly evaluate the buy-in offer without knowledge of the return. And, as indicated, in this case, "return" is based on how the partners compensate themselves. Or, more specifically, how the physician will be compensated once his buy-in begins. Because most group partner compensation arrangements are based entirely or largely according to individual productivity, then the level of the physician's productivity at the time of the buy-in and beyond is crucial. Often, at the time of the buy-in, a physician's productivity isn't sufficient enough to allow him/her to be successful under the compensation arrangement. Sometimes it's not sufficient to provide a raise in pay all from the last year of employment. Does it make sense to incur a buy-in to make less or nominally more compensation than one was earning as an employed physician? Usually not. This doesn't necessarily mean the buy-in amount is unreasonable, however. It often means only that the Physician is not ready for partnership. In such circumstances, the best course may be deferring the buy-in date until the physician is capable of buying in. Regardless, there is a direct relationship between buy-in price and partnership compensation. Without a complete understanding of the latter (compensation), one cannot effectively evaluate the purchase price. By this, I mean not just the formula or method pursuant to which compensation will be determined, but a good and honest assessment of the physician's potential for increased productivity in future years if productivity is a concern at the time of buy-in. There is always hope that the physician's productivity will increase. But often hope is not enough. Sometimes circumstances outside of physician's control need to change for the partner to be successful under the partner compensation arrangements. For example, the retirement or cut back in schedule of another group partner. Or the retirement of another physician within the community. The opening of a satellite office. The practice's purchase of a retiring doctor's practice. What's worse than a bad buy-in offer? Accepting it and buying into a bad situation.

D. The Extent of the Offered Interest More times than not, the offer is for an equal ownership interest. However, this is not always the case. Often the offer is for a minority interest (meaning less than equal). So, for example, 49% in a two person partnership where the senior partner will retain 51%. Or in a three person partnership, 24.5% where one of the existing partners owns 24.5% and the senior partner intends to retain 51%. Or in a two person partnership 20% where the senior partner intends to retain 80% and sell off additional interests down the road. These are but a few examples. In all such cases, it is clear the offer is for a minority interest where voting control of the practice is retained by the senior partner. Is this a bad thing? Well, if the physician desires to be a "true" partner and have equal say and equal management of the practice, then yes. If not, then *maybe* no. Some physicians desire to become partners for financial reasons only. As indicated above, usually partner compensation is not tied to partnership percentages. So if compensation is not affected, and if it follows that a lesser interest means a lesser purchase price, then the offer of a minority interest may be a good thing. That is, if the practice is well managed by the senior, controlling partner; if the physician, as a minority partner, will still be

consulted and have say (albeit not equal) on important issues; and if they are respected as partners by the senior partner.

E. Partner Personalities Two or three years is generally sufficient time for the physician to get to know the personalities of his or her future partners and the dynamic between them. In some cases, the personality is known, but there is no existing dynamic. For example, the physician who is buying into a sole owner (who has never had a partner) may know that owner's personality. But what isn't known is how the owner will respond to having a partner. The physician in this case needs to ask him or herself why they believe the owner is offering partnership. What's the owner's incentive? Is it to secure a buy-in and future buy-out of their remaining interest? Is it…well, because two years are up and its time regardless of the situation or relationship? Are they genuinely excited at the prospect of having you as their partner? As I've said, partnership is a lot like marriage. The longer the period of engagement, the better one truly understands their future spouse and his or her likes and dislikes, the less likely it is the marriage will succumb to martial issues. Partnership is the same way. What do you know about the partner before buying in? Is he/she hands-on when it comes to management? Or are they hands-off? Do they have a penchant for spending on the latest and greatest when it comes to equipment? Or do they spend only when absolutely necessary? Were they a good boss or a bad boss? (Bad bosses generally make bad partners too). I counsel practices that they shouldn't offer associates just because the requisite 2 or 3 year period has passed. There have to be redeeming qualities. The physician is sufficiently productive, will make a good partner, is well-liked, etc. The same is true on the flip-side. If the owner isn't someone who you feel you can be partners with, then don't. This may mean remaining employed or leaving the practice, but not getting married is better than getting into a bad marriage. The alternatives will depend, in part, upon the owner's intentions. For example, if the owner is nearing retirement age, it may be best to remain employed and then buy him/her out entirely when they are ready to leave (assuming the period is fairly certain, not too distant and you are fairly compensated during the remaining employment period).

F. Legal Control It should be understood that even if a physician is offered *equal* ownership, often the senior partner will somehow retain control of the practice. Sometimes this retained control endures for the buy-in period only. Other times it endures beyond that for some period or until the senior partner, in her discretion, chooses to relinquish it. There are various control-retention methods. The following, for the sake of simplicity, assume a two partner partnership. One method is for the senior, selling partner to sell off 49% until the buy-in period is completed then giving the physician an opportunity to purchase the additional 1% for a nominal price. Another method is for the selling partner to sell a full 50%, but retain the right to repurchase the physician's interest at any time during the buy-in period. Sometimes this right is for any reason, other times it is relegated to a situation where the partners have irreconcilable differences. Another method is for the selling physician to sell off 50%, but retain "contractual control". That means although the partnership is 50/50, the partnership agreements contain clauses that empower the selling partner, giving him/her managing authority over daily operations and, often, authority over major decisions as well. Where the selling physician contractually retains authority over both daily management and major matters, this is akin to 51%/49%. The key where the selling partner desires to retain legal control of the practice, is negotiating the degree or control. So, for example, giving them authority over only daily management. Or if they have control over major issues, as well, limiting this to only certain matters. In all cases, the physician might desire to negotiate their own security. This would mean, for example, having veto power over a decision by the senior partner to terminate their employment. Or, for example, having veto power over the incurrence of any major liability, particularly one which the partners will be required to personally guarantee on the

practice's behalf. This is all discussed in somewhat more detail below.

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. Valuation
A. Tangible Assets 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. Appraisal Most of the tangible assets in a medical practice fall into two categories—those items that are nonspecific to that particular medical practice, and those that are specific for the particular subspecialty. While there may not always be a substantial market for used subspecialty equipment, there is generally *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. Adjusted Book Value 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. Guessing 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 subspecialty 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 60 to 90 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 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.

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 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:

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.

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. Other Values/Entities Values attributable to the ownership of 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, some activities (such as optical shops in the context of an ophthalmic practice), 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.

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. Structuring a Buy-In 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. Equity Purchase

1. Equal Ownership The sale of an equity interest in the practice entity is usually accomplished by a sale of an equity interest from the senior physician to 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 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 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. 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 narrowly tailor the senior physician protections to address those needs.

3. Financing Over Time 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. Income Discounting 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. Clinical Quality 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. Compensation Models There obviously is a myriad of different compensation models that are presently being used by 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 is as follows:

1. One Hundred Percent Equal Allocation 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. One Hundred Percent Production Allocation A number of 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 appropriate care.

3. Two-Tiered Allocation 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. Multi-Tiered Approach 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. Base Salary Plus Incentive 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. Buy-Outs 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. Equity Repurchase 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. Deferred Compensation 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. Protections for the Ongoing Group The first priority in payout arrangements is to protect the ongoing practice. The following limitations should be included in any payout arrangements:

1. Percentage of Gross Income 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. Competitive Practice 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. Reduction for Short Notice 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. "Bad Boy" Clause 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. Post-termination Liabilities 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.

Mark D. Abruzzo, Esq.
mabruzzo@wadegold.com
610.296.1800 x210

Mr. Abruzzo counsels health care providers and other business organizations on all areas of business, corporate and partnership law. He has considerable expertise in areas involving formations, mergers, consolidations, and acquisitions and sales of provider practices and business organizations.

Mr. Abruzzo also has an extensive tax background, having been employed as a tax consultant for a worldwide accounting firm.

He is a consultant to several publications serving physicians and administrators and was the legal editor for *Managed Care Magazine* and *Today’s Health Care*. Mr. Abruzzo is a contributor to numerous publications, including *Argus*, *California Physician*, *The Resident* (Series), *Journal of Commercial Lending*, *Commercial Lending News*, *Today’s Health Care*, *Managed HealthCare News*, *Ophthalmology Review*, *Physicians’ News Digest*, and *Young Physician.*

Mr. Abruzzo addresses national and state specialty associations on a regular basis. Among these are the American Academy of Ophthalmology, Delaware County Medical Society, Philadelphia County Medical Society, Bucks County Medical Society, Bucks County Society of Financial Planners, American Gastroenterology Association, Association of University Professors of Ophthalmology, Vitreous Society, American Society of Cataract & Refractive Surgeons, and residency programs at Pennsylvania Society of Medical Residents, University of Pennsylvania Department of OB-GYN, University of Pennsylvania Department of Orthodontics, Temple University Department of Ophthalmology, Philadelphia College of Osteopathic Medicine, Medical College of Philadelphia, Wills Eye Hospital, Abington Hospital Department of Internal Medicine, and Temple University School of Dentistry.

A graduate of the University of Pittsburgh School of Law, Mr. Abruzzo also holds a Masters of Law in Taxation from Villanova University School of Law. Mr. Abruzzo earned his bachelor of science degree from St. Joseph’s University.

Honors and awards: American Academy of Ophthalmology’s Senior Achievement Award