

AMERICAN MEDICAL NEWS INTERVIEW
REGARDING: MEDICAL PRACTICE VALUE AND GOODWILL

Ten Questions for:
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1. Does goodwill still exist in physician's practices? Why or why not?

Yes, it still exists, but it is certainly diminishing in many respects, and areas of the country. This has occurred because of the various cost constraint mechanisms we seen in medicine today; as well as the specter of some sort of national healthcare policy and aging domestic demographics. We call this the "commoditization of medicine."

Typically, for clinics and physician practices, the majority of value usually rested in the intangible assets (restrictive covenants, buy-sell agreements, trademarks, brand loyalty, logos and copyrights, intellectual property rights, goodwill, willing and assembled workforce, etc). Furthermore, goodwill is - more than anything else - based on income production. In turn, income is a function of those resources and efforts expended on the part of the physician-executive of the medical practice [business-entity].

You mention two types of goodwill: charisma and reputation, which you say can't be transferred, and business or practice, which can. Does charisma goodwill still exist, for any purpose whatsoever other than improving your own private practice?

Yes, it does and in financial terms. Whenever a doctor receives more reimbursement than average, the excess can usually be attributed to "goodwill."

For example, if the average annual salary of all mature dermatologists is \$274,014, and dermatologist Doctor Smith PC earns \$349,250, then the difference may often be attributed to "goodwill." In other words, the intangible goodwill translates into very tangible financial value. That's why a good "bedside manner" counts more than ever
[\[http://certifiedmedicalplanner.com/MDs.aspx\]](http://certifiedmedicalplanner.com/MDs.aspx)

I can recall another illustration of goodwill when performing a phlebology practice valuation / appraisal in up-state New York a while back. At the time, the average phlebologist earned about 175,000 per year, according to sources and agreed upon by the selling physician. However, although not forthcoming with the information, we determined that he paid himself about \$350,000 and still wanted a "premium in-kind" for the goodwill portion of the practice that was no longer monetarily there.

Of course, our position was that not only did he “spend some of his goodwill” and could not resell it; but his prior skills as a board certified vascular surgeon were not transferable to the naïve associate phlebologist who was considering purchase.

Sadly, in the context of long-term compensation for a lifetime of work, mature practitioners of all types often erroneously focus on the intangible of “goodwill” upon retirement; especially relative to medical practice worth. What they should focus on today is putting some cash back into the practice - unlike our phlebologist client - in order to enhance long-term equity value; rather than high current income [practice “milking” philosophy], which is often squandered on an unsustainable lifestyle, bad investment decisions, divorce, etc.

Two Definition of “Goodwill”

Goodwill is defined as “the ability of a business to generate income in excess of a normal rate on assets due to superior managerial skills, market position, new product technology, etc. In the purchase of a business, goodwill represents the difference between the purchase price and the value of the net assets.” More formally, “goodwill” is the difference between the book value of a company and what an acquirer pays for that company (often as the result of a purchase merger). Yet, there are two types of goodwill; one far more compensable than the other.

1. Physician Goodwill

Personal goodwill results from the charisma and reputation of a specific doctor. Its attributes accrue solely to the individual, are not transferable and can't be sold. They have no economic value. Nevertheless, young uninformed physicians may over-compensate retiring doctors for this non-existent “asset.”

2. Business Goodwill

Medical practice business entity goodwill, on the other hand, may be transferred and is defined as the unidentified residual attributes that contribute to the propensity of patients and managed care contracts (and their revenue streams) to return in the future (*Schilbach v. Commissioner*, T.C. Memo 1991-556).

However, one must appreciate the: (i) impact of a changing environment; (ii) practice transfer activity in a local market which can augment or blunt goodwill value; and the (iii) determination of whether patients or HMOs return because of goodwill or are mandated by contractual obligations. A good medical practice is not necessarily a good business, and retiring doctors can no longer extract excess compensation for this intangible asset. Moreover, astute younger physicians should not over-pay for it either; and mature doctors must realize that the fee-for-service “golden-age of medicine” is gone forever.

2. What were the leading factors causing the change?

Managed care, discounted fee-for-service, capitation reimbursement, women in the workforce, fee transparency, use of the various low-cost non-traditional physician extenders [optometrists, nurse practitioners, Doctor of Nurse Practice (DNP), etc] and new-wave resources [medical tourism, retail clinics, foreign graduates and outsourcing, etc]; and a host of non-fee-for-service compensation arrangements which occurred as medicine shifted from retail to a wholesale – mentality.

For example, a recent Merritt Hawkins & Associates Study reported some nurses, like CRNAs, land higher salaries than primary care doctors. It's no wonder that reports like these, and related physician salary trend summaries, are the most frequently visited articles on the *Executive Post* blog at www.HealthcareFinancials.wordpress.com

Moreover, the Centers of Medicare and Medicaid Services [CMS] itself reduces economic goodwill potential when physicians participate in its various programs, be it Medicare, the Indian Health Care System, Prison Systems, etc. All this is a two edged sword, of course.

On the one hand, all participating doctors get paid essentially the same per CPT code; pretty much regardless of quality [sans liability issues]; and this currently accounts for more than 52% of all provider payments. Thus, experienced doctors may be paid as much as a new practitioner; per unit of care. However, Pay for Performance [P4P] initiatives may address this situation, somewhat in the future.

We call this phenomenon “reputation-equivalency.” Such a system is actually a compliment to the quality of American healthcare, in that the education and training of our physicians is considered equally uniform. However, this gives the appearance that, in effect, “a doctor-is-a-doctor-is a doctor” in-so-far as goodwill and compensation is concerned. This interchangeable commoditization does not bode well for excessive goodwill. In economic terms, the situation approaches a “perfect market competition scenario.” There is little opportunity for differentiation in a third-party payer system that pays the same to all. Now, it’s mostly about volume; the number of procedures, tests, interventions, surgeries, etc.

Moreover, patients rarely select physicians anymore, as they simply see the doctor closest to home or work, and/or who are on their “covered” managed care plan or list of employer provided contracted providers. And, “patient relationship forming time”, the *sine-quo-non* of branding and traditional good-will development, is almost no longer existent in many large cities.

For example, in Atlanta, there are about 4 million of us. The census bureau suggests that the average “hot-Atlantian” moves about every 2.7 years. If this is correct - and my heuristic gut does seem to suggest we are indeed a city “on the move” - then there are few long-term brand-name physician-patient relationships; as goodwill has less time to develop.

And, if you don’t think that medicine is becoming a commodity; think again. At the recent American Hospital Association [AHA] meeting in Las Vegas, last month, Richard Umbdenstock president and CEO sounded the alarm when he said the healthcare itself should be viewed as a “national resource”, and not simply as a business or a commodity. Moreover, even hospitals are not immune to commoditization as radical changes in healthcare will no longer place them at the center of the delivery system - and as consumers take charge - “patient-centric” care emerges as the move toward hospital/practice/doctor charge transparency increases.

3. Can physicians still negotiate for more money for their practice, or is it the buyers holding all the cards now?

Rarely does one “hold all the cards” in any buy-sell situation, as there are too many known and unknown factors to consider. But, there is little doubt that buyers began holding an increasing share of them during the last decade. Of course, effects of the recent sub-prime mortgage fiasco have not yet been discerned, but borrowers will be surely hurt short-term, and the diminution of practice value is likely to continue; if only because fewer loans will be made to fewer purchasers.

But, if you or your medical practice does something different, better, faster, less costly, more original, unique or with better outcomes than similar practices in your community, you will be blessed with increased goodwill value. This is why it is so important to have your practice valued by an independent fiduciary, at an arm’s length distance, for the protection of both buyer and seller.

Are there any physicians in better situation than others? What about equipment, modernization of offices, specialties?

Equipment and office modernization are tangible assets, not intangible ones like goodwill. Tangible assets are sometimes referred to as “hard assets” and include furnishings, fixtures, medical equipment, medical supplies and any leasehold improvements applicable. Some specialties require more or less of each asset class.

However, to a certain extent, any asset [tangible or intangible] may indeed tempt patients to favor one doctor over the other, and hence increase goodwill value. But, this is likely a short-term phenomenon until neighboring competitors acquire same, provide popular new procedure or update their facilities, etc. We call this a “perceived”, rather than “real competitive advantage.” But, the latter is more advantageous than the former, as it is not usually sustainable.

Now, the subject of medical specialties is interesting. Obviously, some specialties pay better than others, as the hotly contested pay disparity between “thinkers” and “doers” is well known.

Yet, *ceteris paribus* or all-things-being-equal among same specialties, the above concepts remain remarkably similar for third-party compensated specialists and their resulting reduced ability to earn good will. Of course, the competition really heats up outside the third party arena. Private pay specialties like plastic surgery, cosmetic dentistry, weight loss centers and concierge medical practices can achieve significant personal and business goodwill values through enhanced business acumen, management practices, marketing, advertising, and best-of-breed outcomes. Of course, as non-participating providers, their business model may be radically different than those with traditional compensation mechanisms.

4. What does this mean for retiring physicians?

Increasingly, more may not achieve full-value for their current practices, or anywhere near what they had hoped for upon commencing practice decades ago. This theme was carefully developed and presented in the second edition of our best selling book: *The Business of Medical Practice: Advanced Profit Maximizing Techniques for Savvy Doctors* [now available at Amazon].

How much less money are they looking at for their practice compared to high-flying period during the 90s?

Well, I was intimately involved in a merger roll-up [“pooling-of-interests” accounting model] Physician Practice Management Corporation [PPMC] in the Mid-West, that ultimately did not launch, in 1998. Our conservative business model was based on debt, rather than equity, with 8-12% management fees. In other words, the doctors had to offer their practices as collateral and continue practicing medicine; rather than retiring and selling-out to Wall Street for riches they did not rightly deserve; but a few did receive. No wonder such equity Ponzie schemes collapsed on the backs of additional 15-20% management fees.

At that time, I saw general medical - primary care and internal medical practices - that were seeking and receiving up to five times gross, top-line, annual revenues upon sale. Talk about excess!

Today, the number is more like 1-2 times gross top-line revenues and/or .5-1 X net, bottom-line, income [assuming 50% overhead costs - which are increasing - just as reimbursements are decreasing].

Does it mean they might not be able to retire as quickly as they thought?

Yes or no; it all depends more on their current and future lifestyle, consumer habits, outside savings and investments and, most of all, marital status. As physician focused health economists and financial advisors, we suggest that doctor's plan on 100-125% of their pre-retirement income needs especially in the early and later retirement years; with a 3-6 % corpus withdrawal rate depending on either a wealth-preservation or wealth-utilization philosophy regarding their heirs.

Again, we were involved in an economic study performed by *Physician's Money Digest* back in May, 2005. It was determined that an average 47 year-old physician with \$184,000 annual income, would need about \$5.5 million if they planned on the same lifestyle after retirement, as they had before. Thus, the figures are indeed, daunting.

Unfortunately, divorce seems to be the single most potent destroyer of retirement wealth, bar-none, at least in our experience. Doctors with one, two or three ex-spouses will have to work longer and harder; than not. And, marital dissolution notwithstanding, the doctor who plans to depend entirely on the sale of his or her medical practice to finance a retirement of possibly 20-30 years long is either unwise, or has been gravely misadvised, as described throughout our book; *Financial Planning for Physicians and Advisors* [available at Amazon].

[Will some have to settle for working for hospitals, large corporations in order to make a salary?](#)

Maybe! Look; if you must work for a living, anything is possible as long as it is honest and ethical. But, the extent that we will see older doctors working in large medical corporations or hospitals is not likely. Those older providers who must work will be outside the healthcare space.

Yet, don't forget that about 40% of younger doctor's today are employees; not employers. These younger folk will have 401-k and 403-b retirement plans; health and life insurance plans, and other fringe benefits like deferred compensation arrangements, stock and incentive options, etc. And, this new generation of physicians does not know what it is like to be a medical practice owner, or physician-executive. Unfortunately, many do not even aspire to be. Accordingly, they will not have a practice to sell, down-line.

Interestingly, as an emerging hybrid business model, franchise opportunities currently exist with vein-treatment and medical spa centers. But, non-traditional franchise opportunities also exist for assisted senior-living residences and home healthcare businesses that in many ways are a perfect fit for those in the medical community.

[5. What does this mean for physicians who are going through a divorce? Are judges still looking at goodwill when divvying up assets? Do physicians lose big during divorce?](#)

It all depends on the facts, circumstances, state, judge or jury, etc. In general, when both parties in a divorce agree to the disposition of a community medical practice interest, the rules governing disclosure apply, including disclosure of valuation; as well as fair market value [FMV] which may be defined as:

Medical practice fair-market-value is essentially a future prophesy that must be based on facts available at the required date of appraisal
[Modified from: IRS Revenue Ruling 59-60]

Now, understand that in general, neither spouse may dispose of community property for less than FMV without the written consent of the other. Each has an obligation to fully disclose the proper valuations of assets. In equitable distribution states, similar disclosure rules are applicable. Consult an experienced health law and divorce attorney in your state for more specific details

But, in drafting a medical practice buy-sell agreement [intangible asset] for example, the principals of any medical practice should view it as a marital settlement agreement.

In one such divorce case [Slater v Slater (1979) 100 Cal. App. 3d 241, 245, 160], the asset being divided was the husband's interest in his medical practice partnership. During the parties' marriage, the husband and wife both signed the partnership agreement which specifically provided that the partnership could buy back the husband's interest upon his death, withdrawal, or expulsion. Under the agreement, the purchase price was to be the husband's interest in the capital account plus the total of the accounts receivable [ARs] less than six months old.

The agreement further stated that “the partners agree that a portion of the purchase price as determined above includes the sale of their interest in the goodwill of the partnership, and in the event of their withdrawal or expulsion from the partnership, that they will not enter into the practice of medicine in that portion of Alameda County for a period of three years.”

The trial court proceedings, in determining the value of the husband’s medical practice according to the partnership agreement, found it had a goodwill factor of zero.

The wife appealed claiming the trial court erred in setting a value of zero on the goodwill of the husband’s practice, pursuant to the withdrawal provision of the partnership agreement. The appellate court reversed the trial court’s decision with directions to value of the husband’s interest in the partnership. It rejected the husband’s contention that his wife was bound by the terms of the agreement—even though she had signed it. It found that the agreement was irrelevant because the asset being divided in the dissolution of marriage was not the husband’s contractual withdrawal rights; rather it was his interest in the partnership.

Therefore, the wife was not bound by the terms of the withdrawal provision, and the trial court was not precluded from valuing the goodwill of the husband’s practice. This was a most troubling decision.

The main point of this legal case is that in order for a buyout plan to better withstand rigorous examination in court, the buyout price should be related to fair market factors of the business and should not be intended to deprive the non-shareholder spouse of any community interest. A formula should be used based on profitability instead of a fixed price, and an explanation for the formula should be developed. Having the spouse sign the agreement is also a good idea.

Divorce was another major theme in our book; *Insurance and Risk Management Strategies for Physicians and Advisors* [available at Amazon].

6. What does this mean for physicians at tax time? Can they take a write-off when selling, annually?

Depending on whether the likely buyer of a medical practice is a health system, a private physician or a corporate partner, medical practice sale deal structures and tax implications will vary. From the physician’s perspective, deal negotiations are based on consideration of personal as well as financial planning goals. Therefore, some key issues to consider are presented below to help negotiate the “art of the deal”, and may include:

Working Capital – In or Out

Including working capital in the transaction will increase the sale price.

Stock versus Asset Transaction

Structuring the deal as an asset purchase will increase practice value due to the tax amortization benefits received by the buyer for intangible assets of the practice.

Common Stock Premium

The sale price can be as high as 50% more than a cash equivalent price for accepting the risk of common stock as part of the payment.

Physician Compensation

If your personal financing planning goals are to maximize future practice value, negotiating a lower current salary within a range you feel comfortable with will increase the ultimate practice sale price. Do the reverse and “cannibalize or milk” your practice if you wish to increase your current salary. We call this the “[personal net-worth versus practice-worth conundrum].”

Tax Treatment

Currently, IRC Reg. Sec. 1.167(a)-3 specifically prohibits the write-off of "goodwill." Amortization is allowed as long as it meets the following criteria established in Rev. Rul. 74-456: 1) A specific useful life can be determined and 2) the asset has a value separate and distinct from goodwill.

IRC Sec. 1060, resulting from TRA 86, requires both the seller and the buyer to measure goodwill. Under this measurement, goodwill is computed as the difference between the purchase price and the fair market value of the "assets" of the acquired practice. The purchase price is to be allocated to assets in the following order: 1) Cash and items similar to cash, 2) marketable securities and similar items, 3) tangible and intangible assets excluding goodwill and going concern value, and 4) goodwill and going concern value.

The allocated purchase price must be reported to the IRS. Goodwill is considered a capital asset. Therefore, the seller will want to allocate as much of the selling price to goodwill as possible. The buyer will want to allocate more of the selling price to non-goodwill assets because goodwill amortization is not tax deductible while depreciation and amortization of other assets is tax deductible. This "negotiated" goodwill will stand as the IRS value. Thus, the IRS has effectively forced the controversial goodwill determination on practice buyers and sellers. This makes it even more imperative for buyers to specifically identify any hidden practice assets they are acquiring at the time of purchase; or for purchasers to discover them.

Amortization of Goodwill

- The IRS allows the amortization of goodwill for tax purposes using a 15 year life [rather than prior 40 year life] and straight-line amortization.

And, what if doctors are being sued? Does this have any bearing on how much they can be sued for?

Typically, assets are "frozen" immediately when threats of litigation commence. Therefore, alteration may appear as a "fraudulent conveyance" which may be legally suspect.

When seeking a loan?

Any lien, lawsuit, malpractice action, liability or other risk-management issue may affect borrowing ability. Macro-economically, we know how banks have almost frozen the liquidity faucet today. Micro-economically, lenders are also appreciating that doctors may not be the income producers they were in the past; nor the savers and investors that may be required for success in the future. Therefore, loan terms and conditions have adjusted accordingly, and harshly.

7. How do physicians increase goodwill for his/her practice?

To the extent that medical care is a "personal services" business, the goodwill value of a medical practice includes a patient base which is reflected by records and all that effort which has been put in place to make the medical business function and generate a cash-flow or revenue stream.

For example, a medical practice takes trained professionals and human resources fused together, ready and able to provide services. These services are provided according to policies and procedures, which have been developed and in place. They are wrapped within a business context. That is, the practice itself has been legally established. Any necessary licensees have been obtained. Facilities have been secured or leased. Contracts, buy-sell agreements and restrictive-covenants, have been set. Retirement, life and health insurance plans are in place. In other words, it takes time and money to build a medical practice business-entity.

So, when a medical practice generates a relatively predictable income, we must recognize the value of the efforts that are transferable to a new owner, and those pleasing results. It is, after all, why doctors forego that effort to “start from scratch” and buy an existing practice. All of these things represent the intangible asset called “goodwill” or “going-concern value”.

How does a physician establish goodwill for his/her practice?

Unfortunately, there is no magic rule of thumb to build goodwill and equity into your practice; it is not that simple. However, the following suggestions are offered regardless of the practitioner's specialty or degree designation. It develops what we call an “equity-advantaged-practice”, built-over-time in the following manner:

1. Use the appropriate legal entity status for your practice since it is important for taxation and liability reduction purposes that are often not available to the sole physician proprietor or general partner, as defined below:

2. Maintain good financial records including all three consolidated financial statements, according to FASB (Financial Accounting Standard Board) rules: (a) Balance Sheet, (b) Statement of Cash Flows, and (c) Net Income Statement (Profit and Loss Statement). Keep them for at least the last three years. Consultants are often amazed if one in ten doctors can produce even simple monthly reports of what they've budgeted, what was actually spent, or what was at variance.

3. Continually monitor key financial ratios, such as profitability ratios, creditor ratios, long-term debt management ratios and Medical equity value-added [MEVA].

4. Be profitable since you are in practice not only to help your patients, but also to make money. No one is going to buy a dying practice for more than a few pennies on the dollar, and you can't help anyone if you are not in business. Charity work is fine, as long as you realize that it is *pro-bono*, but real value is a function of the amount and timing of discretionary cash flows, when it is:

- With-drawn from the practice in the form of dividends, a bonus or doctor remuneration above market rates (common in privately held medical offices);
- Retained for growth investment opportunities or held as a redundant asset, like cash to increase value;
- Used to reduce the outstanding interest-bearing debt and increasing the equity component of total practice enterprise value.

5. Obtain Workers' Compensation insurance to provide coverage for lost income due to on-the-job accidents or work-related employee disability or death. Benefits vary by state. Its purpose is not only to provide these benefits but also to reduce potential litigation. Employees accepting the benefit payments from a Workers' Compensation claim generally forego the right to sue their employer. Workers' Compensation rates are established by job descriptions and commercial rates for the medical professional's office are some of the lowest available.

6. Obtain practice business insurance that is offered on a simplified package basis. Similar to homeowner policies, it contains both property and liability coverage. Also like homeowner policies, the medical professional should compile a basic inventory of property to be covered. Medical records and important papers are typically covered for a flat amount. Don't forget to allow for supplies, instruments and leased equipment.

Liability coverage protects the physician owner from claims arising from bodily injury or property damage while the claimant is on the premises. Liability insurance not only pays the damage awarded to the claimant but also the attorney fees and other costs associated with any defense of the suit.

7. Have a practice continuation plan, or buy/sell agreement that stipulates upon the death or disability of a solo doctor or group partner, how the business must be sold or how the practice is to be continued. In a typical buy/sell agreement, the sole proprietor, or partner is the insured of a life insurance policy, which can create the funds to complete the agreement. There are a number of keys to creating a successful buy/sell agreement:

- It must be decided who will buy the practice from the disabled proprietor or partner, or his or her heirs upon death. It may be the remaining partner(s), or the practice entity itself, or, in the case of a sole doctor proprietor, a key physician employee.
- The buy/sell agreement must be stipulated as mandatory. According to the IRS, if the agreement is not mandatory, the value of the practice is not considered fixed. As a result, the IRS might not consider the agreement binding in determining the value of the practice for estate tax purposes.
- Be specific as to what is to be purchased. This can include land, buildings, inventory, licenses, and even goodwill and other intangible (but valuable) assets.
- The most important key is determining the correct value for the practice or share in question. The IRS will rarely challenge a value for being set too high, but will challenge those deemed valued too low.

8. Do not forget to obtain key-person (doctor) insurance. In this case, the practice would purchase and own a life insurance policy on the key doctor. Upon the death of the doctor, the life insurance proceeds could be used to:

- Pay off bank loans.
- Replace the lost profits of the practice.
- Establish a reserve for the search, hiring and training of a replacement physician, etc.

9. Develop a forward thinking succession plan, since all doctors should plan to sell their practices at some point in the future; whether to retire, merge or acquire another practice. By understanding how practices are valued and designing sales value into your plan, you can create tremendous value for yourself.

10. Brand your practice. But, brand recognition is not going to come from just adding more managed care patients, shifting your markets or demographics, or specializing in surgery, cosmetics or sports medicine. The real paradigm shift will come from creating value inside your office. You do that by making your business worth buying to someone else. In other words, a group "brand" identity, rather than individual identify, is the hallmark of increased practice value in the future. And, realize that if you project yourself as the medical guru for your area, patients will have a hard time accepting a new doctor or consolidated group. By focusing on something larger than yourself, such as group practice, you will begin to develop a business that others can operate easily. Hot medical groups; not individual "hot-dog" doctors will flourish going forward.

Even if you are a young practitioner not interested in merging your practice, you still want to build it up as if you were going to sell it at some point in the future, because this strategy will maximize value. The secret is to create the best transferable medical systems around.

11. Use proper Management Information Systems (computer hardware, software, internet cloud and peripherals) without spending too much money on gadgetry. You do not necessarily need to become an early adopters of the newest or untested information technology systems, but do become an adopter of mature products, like e-RX, nevertheless.

12. Absent a covenant not to compete, if a physician leaves the practice and immediately competes against it, the departing physician will probably take revenue away from the original practice, and potentially decrease its value significantly and abruptly. Therefore, have a covenant to specify the procedures to follow should a departure occur. Although some believe that the covenant is not worth the time and money necessary to enforce, its existence will add equity value to the existing practice, to the benefit of the remaining practitioners. Obtain an extension of the above non-compete agreement, also known as a non-disclosure agreement, for practice techniques, information, etc.

13. Maintain services, responsiveness and consistency with your patients, referring doctors, fellow physicians and supply vendors. And, be flexible. For example, start a pharmacy services program if you do not have one Or, consider limiting laboratory services if they no longer remain cost effective for you. This is critical because if you do not build strong relationships with these local players, premium value just isn't there because a new doctor will not be able to rely on those established relationships going forward.

14. Use life insurance correctly to benefit your practice in the following three ways:

- A. Physician Executive Bonus Plan
- B. Non-Qualified Salary Continuation
- C. Split Dollar Plans

15. Assist the transfer but don't think you can sell your practice in a couple of months. The average time frame is about 1-2 years. So, if you become sick or disabled, you may lose your practice or have to sell it for a fraction of its value. If you provide owner financing to the buyer, make sure that you purchase an insurance policy on his or her life.

Finally, get professional assistance if you can't, or do not want to, go it alone and align yourself with a trusted fiduciary advisor or practice management (specialty specific) firm. Remember, contemporary physicians still have a huge opportunity to build equity value into their medical practice, for sale or consolidation. Whether or not this becomes a reality depends on the creation of maximum equity value as if a transaction was possible. Then, design your office to enhance its value and achieve everything dreamed about when the practice was first begun, many years ago.

8. How often should physicians have their practice valued, especially since the values have decreased so dramatically in the last 10 years?

Although most doctors inquire about a valuation appraisal only when needed, this is not the ideal time to maximize value, which is a never ending process.

We therefore recommend at least an "ad-hoc" or pro-active "limited" internal valuation every 3-5 years as an organic growth benchmark. Medical office valuation however, is as much art as fair-marketing accounting science. Therefore, when a medical practice changes ownership, both the buyer and seller need to understand how industry regulation impacts practice value, as well as have an appreciation for accepted appraisal definitions and methodologies used by qualified appraisers to estimate value. And, since 1994-95, the Uniform Standards of Professional Appraisal Practice [USPAP] have been promulgated to provide the minimum requirements to which all professional appraisals must conform. And, most physicians are unaware that - much like an IRS audit - there are several levels of acuity which may be obtained for various reasons. Although not standardized, the following three acuity levels are typical valuation engagement types:

1. The Comprehensive Valuation

An extensive service designed to provide physician-owners and/or potential purchasers with an unambiguous opinion range on the value of a medical practice. It is supported by all procedures that appraisers deem relevant to the engagement with onsite visit mandatory. This valuation type is suitable for contentious situations like divorce, partnership dissolution, sale, etc. The report includes a formal written *Opinion of Value* suitable for litigation support activities like depositions and trial. It is also useful for external reporting to bankers, layers, investors, the public, etc.

2. A Limited Valuation

This engagement type is the next step in acuity from a comprehensive appraisal as it lacks the performance of additional procedures that are suggested in an USPAP appraisal. It can be considered an “agreed upon procedures” appraisal that should only be used in circumstances where the client is the only user of the appraisal or as an organic growth ingredient; but not for external reporting. No onsite visit is needed for this US mail or fax delivered valuation. A formal *Opinion of Value* is not rendered.

3. Ad-Hoc [Brief] Valuation

This is the lowest level engagement where the appraiser is to provide a very gross and non-specific approximate indication of value based upon the performance of limited benchmark procedures by the firm. No onsite visit is needed. Neither a written report nor an *Opinion of Value* is rendered. May be a voice based consultation.

Sadly, most valuations are still done retroactively on a fight-the-fire basis; for cases of divorce, business dissolution, estate planning, death, etc. An excellent valuation and financial benchmarking resource is the quarterly journal-guide: *HealthCare Organizations* [Financial Management Strategies] www.HealthcareFinancials.com

9. Does the economy have any factor on a practice's goodwill? Is a practice in a poorer area, or say one in Detroit, which is hit hard by automobile woes, more likely to lose more value?

Of course, muck like the current housing mess, location counts. If there is no willing buyer, any medical practice, business, in/tangible asset, commodity etc, will hold much less value. In economics, we say that “competition makes a market”. And, this aphorism is no less true in health economics; no buyer means no competitive market, which means much less value than in a growing more vibrant location. In reality, the doctors now fleeing California are not going to Detroit. MI.

The “Goodwill” Registry

Nevertheless, closely held businesses like medical practices, clinics, surgery centers and wound care centers produce economic benefits for their doctor-owners. Unfortunately, the equity-value of these entities cannot always be directly observed by activity in thinly traded private markets, and the percentage attributed to goodwill is often difficult to meter; thus the individualized valuation profession.

Now, the next question is how does one benchmark comparable goodwill-value since some physicians may rightfully agree with IRS Revenue Ruling 59-60; while others may not? The Goodwill Registry is one national database managed by The Health Care Group Inc., in Philadelphia that is used as a broad benchmark pending the validity and timeliness of its always debatable inputs.

Hospitals

And, in the valuation of hospitals for the purpose of acquisition or divestiture, tangible assets are not necessarily itemized and/or valued. These are assumed in the acquisition figure. One might rightly ask why this different from valuing good-will and equipment, furnishing, fixtures and leaseholds in clinics? The answer is simply that this is how the market has traditionally approached the value of hospitals and major clinics, versus physician practices or smaller clinics from a fair market value and USPAP perspective.

10. What steps should a physician take before selling their practice or retiring?

Identify the right buyer, seller or merging partner, be it another physician, larger group practice or multi-disciplinary medical operation, Make sure the buyer has the necessary capital and you are not taking all of the risks in the transaction. You want to risk financial share with the buyer and have faith that he or she can pull off the sale. You also want a good intangible heuristic match, since your life-blood probably went into building the practice and you should want it to flourish going forward. After all, unlike most other pure businesses, the Dr. Seller wants to see his life's work flourish and live-on after his retirement. This can only occur with a successful sales transaction for both parties.

Can you put that in terms of time? One year before, six months before, etc?

We suggest succession planning for at least 3-5 years as a reasonable time-frame to maximize medical practice enterprise value. Of course, building equity value in any business should be a never ending event. As mentioned earlier, some doctors milk the business for their immediate cash needs, and allow it run in less than optimal conditions. Often, these are the same neurotic personality types that wonder why few buyers are bidding for their practices at other than fire sale prices.

There are also several interesting managerial concepts that all physicians should know in order to maximize long term medical practice enterprise value, aka transfer worth.

For example, when having a medical practice individually appraised, be sure to include the Discounted Cash Flow [DCF] method of valuation to estimate practice value. This method consistently produces higher values than some others, but recall USPAP edicts. Now, also consider these three other operational, goodwill and equity-enhancing concepts listed below:

1. Practice Revenue:

Can the practice and local market support adding additional providers such as physicians or mid-level providers? Providers usually take two to four years to ramp up their practice before they begin to significantly contribute to the bottom line. Generally, adding a mid-level provider will produce a greater impact on value, as their compensation levels are lower than physicians. Also be sure to consider:

- What future provider productivity is expected?
- Does the practice plan to offer new services?
- Is the current practice fee schedule at market rates?
- Is there an opportunity for fee increases?
- Is there an opportunity to improve payer mix?

2. Practice Costs:

Perform the following cost reduction strategies to the extent possible:

- Eliminate any unnecessary practice expenses and identify unusual, non-recurring costs.
- Eliminate any physician-related costs not likely to be paid by a potential buyer.
- Eliminate any special perks of business ownership.
- Adjust for any over-inflated salaries of relatives and eliminate unnecessary salaries.

3. Physician Compensation – An Inverse Relationship to Value:

Although physician compensation must be based on market rates, fair market value is a range, and not a discrete number or dollar amount. And, practice value correlates directly with the net cash flows available after all practice expenses including physician compensation, are considered. Again, consider the “current-income *versus* practice-net worth conundrum”:

- As a consequence - the higher physician compensation - the lower practice value.
- And conversely, lower doctor compensation produces a higher practice value.

For example, as little as a \$10,000 swing in salary can have significant impact to value, and as physician compensation rises, practice value falls.

Because goodwill has decreased, or disappeared, should they be putting more into an individual retirement account or other investment avenue to provide for retirement?

Yes; and this should have been done all career long. The “golden economic age of medicine” [1965-90] has long past. A medically focused registered investment advisor, fiduciary vetted Certified Financial Planner™ and/or new-wave Certified Medical Planner™ may be helpful in this regard [www.CertifiedMedicalPlanner.com].

Once again, thank you for any input you can provide, and be sure to add any thoughts that I did not cover in my questions.

Although the above health economics thoughts may be anathema to some physicians, we must remember the admonishment “no margin - no mission.”

Therefore, all medical professionals should realize that at the Institute of Medical Business Advisors Inc, we also face the same medical practice management issues as our clients. And although we may have a professional bias for colleagues, we should never lose sight of the fact that, above all else, medical care should be delivered in a personal and humane manner, with patient-interest, rather than self-interest as our guiding standard; *omnia pro aegroto* [all for the patient].

**Good medicine,
Good business, and
Good day!**

Note:

Readers are encouraged to contact us for an electronic copy of the complimentary white-paper: “*Top Ten Medical Practice Valuation Blunders to Avoid*”, written by Dr. David E. Marcinko and sponsored by the Institute of Medical Business Advisors www.MedicalBusinessAdvisors.com 770.448.0769 [voice]; 775.361.8831 [fax] or email: MarcinkoAdvisors@msn.com

***Full Disclosure:** Dr. Marcinko is the editor of all books mentioned in this interview, as well as the two volume - 1,200 pages - subscription journal guide [\[www.HealthcareFinancials.com\]](http://www.HealthcareFinancials.com) and its interactive companion personal blog forum [\[www.HealthcareFinancials.wordpress.com\]](http://www.HealthcareFinancials.wordpress.com)

About the Interviewee:



Dr. David Edward Marcinko is a nationally known speaker and the Founding Partner of www.MedicalBusinessAdvisors.com a multi-state health-economics consulting, financial advisory and medical practice valuation firm. He is also the Academic Provost for www.CertifiedMedicalPlanner.com, and Editor-in-Chief of the two-volume subscription institutional print journal www.HealthCareFinancials.com with complementary interactive companion blog: www.HealthCareFinancials.wordpress.com Dr. Marcinko is a former insurance professional, Certified Financial Planner™, and Certified Medical Planner™ practicing on behalf of medical colleagues and the healthcare space.

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