## A PODIATRY MANAGEMENT PANEL

## Questions about Buying and Selling a Podiatry Practice

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**What overriding factors should one consider when shopping for a podiatric medical practice?**

1. Purchase price [range based on agreed upon economic assumptions] and terms
2. Allocation of purchase price, i.e., how much to allocate soft and hard assets
3. Lease assignment of building
4. Indemnification of liabilities
5. Restrictive Covenant details
6. Transferability of existing physicians, managed care contracts, and employees
7. Deal Negotiations and Structure
8. Hospital privileges.

Now, assuming a practice sale is a private transaction, deal negotiations and structure are based on the following discount and premium, pricing methodologies:

*Seller Financing*

Many transactions involve an earn-out arrangement where the buyer puts money down and pays the balance under a formula based on future revenues, or gives the seller a promissory note under similar terns. Seller financing decreases a buyer's risks, the longer the terms, the lower the risk. Longer terms demand premiums, while shorter terms demand discounts. Premiums that buyers pay for a typical seller-financed practice are usually more than what you would expect from a simple time value of money calculation, as a result of buyer risk reduction from paying over time, rather than up front with a bank loan, or all cash. Sellers usually prefer cash but securing a loan may be difficult for the buyer

*Down Payment*

The greater the amount of the down payment for acquisition of a medical practice, the greater the risk is to the buyer. Consequently, sellers who will take less money up front can command a higher than average price for their practice, while sellers who want more down usually receive less in the end.

*Seller Involvement*

The key to practice purchase success boils down to how many of the selling doctor's patients, employees, and managed care contracts can be transferred to the new doctor, owner. The most important factor in transitioning patients is the involvement of the selling doctor. A system of seller financing and earn out arrangements can work well if the seller continues to be involved in the practice, and can create an incentive for the seller to make the transaction work. Sellers typically remain at least six months, and usually for not more than a year, to ensure a seamless transaction. When a deal fails, it is usually due to lack of seller commitment.

*Location*

Variations can be significant between the value of a practice in a major metropolitan city and one in a small town. Usually, practices in a small town have a larger, but less affluent basis. Managed care penetration is another factor to consider, and DPMs must consider the available of inpatient and outpatient surgical privileges.

*Profit Margin*

Determining medical practice profitability is distinctly different from determining a practice's value. It is not unusual for selling doctors to run every expense imaginable through their practices, in order to reduce profit and hence, taxes. In many cases however, a practice with high overhead can be sold for the same price as one with low overhead, because all expenses are not transferable; or even allowable.

*Taxation*

Tax consequences can have a major impact on the price of a medical practice. For instance, a seller who obtains the majority of the sales price as capital gains, can often afford to sell for a much lower price, and still pocket as much or more than if the sales price was paid as ordinary income. Value attributed to the seller's patient list, medical records, name brand, good will and files qualify for capital gains treatment. Value paid for the selling doctor's continuing assistance after the sale, and value attributed to a non-compete agreement both are taxed at ordinary income. But, a buyer willing to allocate more for items with capital gains treatment, or a seller willing to take more in ordinary income, can frequently negotiate a better price.

**How does one assess the economic value of a practice in today's market place?**

Both the buyer and seller need to understand how industry regulations impact the modern economics of medical practice fair market value. FMV is not accounting book value, and one must have an appreciation for accepted appraisal definitions and methodologies used by qualified appraisers to estimate value [IRS Revenue Ruling 59-60]. The glossary, *Dictionary of Health Economics and Finance* is helpful in this regard.

The *Uniform Standards of Professional Appraisal Practice (USPAP)* promulgates these standards, which provide the minimum requirements to which all professional appraisals must conform. *USPAP* requires the three recognized approaches to value (the income, market, and cost approaches) be considered to estimate value.

However, typically one assess the economic value of a practice today using a Discounted Cash Flow method (DCF) which considers the forecast of projected net cash flows for the practice for the next 2-3 years [the older 3-5 years rubric is no longer valid in the current fast changing climate]. In today's marketplace the DCF produces higher values than most other methods as it is easier to project improved practice performance. With current low interest rates, a physician's required rate of return (ROR) becomes lower. Even with added required risk premiums, using the DCF with lower ROR will turn up more "green light" scenarios for buyers shopping for medical practices since the thresholds for expected return are lower. But remember,

1. The DCF analysis must be done on an "after-tax" basis regardless of the tax status of the prospective buyer.
2. Practice collections must be projected for the DCF based on reasonable and proper assumptions for the practice, market, and industry.
3. Physician compensation must be based on market rates consistent with age, experience, and productivity.

Unfortunately, uncertainty in today's healthcare environment with expected practice returns in the untested waters of the PP-ACA, create yet another economic variable. Therefore, a professional and reproducible practice specific valuation that is defensible in court is recommended over any "free" practice-broker estimate, back of envelope guess, or vague industry comparables or benchmark percentage approach. Fiduciary accountability is vital.

**As a buyer seeking a successful deal, to what extent can a practice broker be helpful in securing a practice sale arrangement?**

It may be helpful to use a medical business broker to find your dream practice but these intermediaries seem to be more helpful with general medical practices than niche markets like podiatry. And, it's important to remember that unless you've hired the broker, s/he represents the *seller* of the practice.

So, as the potential practice owner, you too require a consultant to represent your own interests. Be sure to get a signed statement of fiduciary accountability which places your interests ahead of the broker, with full transparency.

Of course, some brokers are may be source of information on current market conditions, issues related to third party financing, and many other facets of the practice buying process. But, astute practitioners may have the podiatry edge here, as well. And, I have seen case of brokers “ginning-up the books”, over-estimating future practice profitability expectations, and other ways to increase a commission. Also, beware broker-financing schemes.

On the other hand, if you're selling a practice, a broker may bring in more prospects than you might on your own. They'll also separate the buyers from the lookers, and may get you a better price justifying their commission fee. Brokers who work with appraisers can help you price your business properly [beware of self-dealings], tell you how you can make it more saleable, and serve as a resource throughout the sale. But - at what cost?

Always remember, brokers work on commission and have a vested interest to do a deal – any deal – not necessarily the best deal for you. A DIY informed doctor, with a sound practice succession plan, will usually be far better off financially and professionally.

**What attributes of a buyer should a prospective seller seek in finding someone to buy a practice?**

For the deal to be successful, the buyer should be well financed. An all cash buyer is better than seller financing and less risky. If not an all cash buyer, then the seller should seek a buyer with good collateral (first in line). The seller will want a buyer that doesn’t have too many post deal demands on time or other restrictions.

Moreover, when selling a podiatry practice beware of the following buyer blunders:

- *Overpaying Physician Practice Value*

Some buyers obtain a business enterprise value, and will also obtain separate values for the medical equipment and non-competition agreements. These values can be useful in allocating the overall purchase price. The business enterprise value, however, represents an estimate for a 100% ownership interest in the medical practice. The separate values for the assets are not additive to the business enterprise value, but rather are components of the total value of the business. Some buyers have overpaid for physician practices by adding these separate asset values to the overall business enterprise value to determine the sale price. Not understanding values can be misconstrued as overpaying in exchange for patient referrals [Stark and IRS laws].

- *Overpaying for Physician Compensation*

Past industry economic surveys report that more than 75% of medical practices acquired fall short of projected productivity estimates used in valuations. This is because they are not always linked to modernity, and this fact, coupled with exposure to IRS audit and intermediate sanctions, has increased the need to value practices on reasonable projections of practice collections and market rates for physician compensation.

- *Not Buying Insurance on the Physician*

Much value, not to mention the ability to repay earn out loans, rests with the buying physician's skill and talent to practice after an acquisition. The buyer expects to achieve a return on the investment in the medical practice based on future cash flows and to eventually recoup the purchase price. Since most practice acquisitions are not cash deals, the buyer is at significant personal financial risk due to a business interruption associated with an unexpected loss of life or permanent disability. So too; any bankers, lenders or exiting doctor financiers.

- *Not "Normalizing" Financial Statements*

When analyzing financial statements, adjustments are generally needed in order to produce a clearer picture of likely future income and distributable cash flow. This normalization process usually consists of three types of adjustments to a medical practice's net income (profit and loss) statement.

1. Non-Recurring Items

Estimates of future distributable cash flow should exclude non-recurring items. Proceeds from the settlement of litigation, one-time gains/losses from the selling of assets or equipment, and large write-offs that are not expected to reoccur each represent potential non-recurring items. The impact of non-recurring events should be removed from the practice's financial statements in order to produce a clearer picture of likely future income and cash flow. Unfortunately, our experience is that this is seldom done in podiatry.

2. Perquisites

The buyer of a medical practice may plan to spend more or less than the current doctor-owner for physician executive compensation, travel and entertainment expenses, and other perquisites of current management. When determining future distributable cash flow, income adjustments to the current level of expenditures should be made for these items.

3. Non-Cash Expenses

Depreciation expense, amortization expense, and bad debt expense are all non-cash items which impact reported profitability. When determining distributable cash flow the link between non-cash expenses and expected cash expenditures must be analyzed.

The annual depreciation expense is a proxy for likely capital expenditures over time. When capital expenditures and depreciation are not similar over time an adjustment to expected cash flow is necessary. For example, a practice may have radiographic equipment with a useful life of fourteen years that are depreciated over seven years for tax and financial reporting. Depreciation expense will likely overstate the funds needed to maintain the equipment as the useful life exceeds the depreciable life and distributable cash flow. In determining distributable cash flow one must add back the annual non-cash depreciation expense and subtract an estimate of funds needed to fund medical equipment replacement. In this way the cash flow available for distribution to owners will be more properly stated.

Some practices reduce income through the use of bad debt expense rather than direct write-offs. Bad-debt expense is a non-cash expense that represents an estimate of the dollar volume of write-offs that are likely to occur during a year. If bad debt expense is understated practice profitability will be overstated. A close examination of accounts receivable to see if any past due accounts need to be written off is generally part of the due diligence a buyer of a practice will undertake. The calculation of distributable cash flow avoids this problem as the actual monies received from patients, and payers, rather than the revenue generated by patients is measured.

*4. Not Making Balance Sheet Adjustments*

Adjustments can also be made to a practice's balance sheet to remove non-operating assets and liabilities and to restate asset and liability value at market rates, rather than cost rates. Assets and liabilities that are unrelated to the core practice being valued should be added to or subtracted from value depending on whether they are acquired by the buyer.

Examples include, the asset value less outstanding debt of a vacant parcel of land, and marketable securities that are not needed to operate the practice. Other non-operating assets such as the cash surrender value of officer life insurance are generally liquidated by the seller and are not part of the business transaction.

*5. Not Understanding Two Types of Goodwill*

Professional/Personal Goodwill results from the charisma, knowledge, skill, and reputation of a specific practitioner and may include such characteristics as: "(1) lacks transferability, (2) specialized knowledge, (3) personalized name, (4) inbound referrals, (5) personal reputation, (6) personal staff, (7) age, health, and work habits, and (8) knowledge of end user."

Since these attributes “go to the grave” with the specific individual doctor and therefore can’t be sold, they have no economic value and are not, as a practical matter, transferable.

Practice/Commercial Goodwill is defined in a medical services enterprise which includes a practice component as “the propensity of patients (and the revenue stream thereof) to return to the practice in the future.” Practice/Commercial Goodwill may include such characteristics as “(1) number of offices, (2) business location, (3) multiple service providers, (4) enterprise staff, (5) systems, (6) the number of years in practice (7) outbound referrals, and (8) marketing.” It has economic value

6. *Splitting the Professional Valuation Fee*

An independent valuation appraiser may be engaged by the buyer or seller, but not both as the conflict of interest is obvious. Free broker estimates, internet calculations and /or other non-professional “rule-of-thumb” methods are not IRS / USPAP recommended, if challenged. Be sure your appraiser is willing to back-up his written valuation, how it was performed, the agreed-upon economic assumptions used, and be willing to act as an expert legal witness, if needed [additional professional fee required].

**What expectations should a buyer have regarding patient flow, and how can that flow be protected during the transition of a practice sale?**

Patient flow can be protected for a new buyer by having a protective (restrictive) covenants in place in the purchase agreement that includes a non-compete clause. Financial interests can be protected where the seller is prohibited from investing in a competing practice within a geographic area. Another covenant clause would involve solicitation in which the seller agrees not to contact existing patients.

Finally, it is recommended that the seller stay onsite for at least 6 months, but no more than 12 months, during the period of transition. Still, even under the best scenario, expect a patient attrition rate of about 30%.

**What other pitfalls should one be concerned about when entering into a buy-sell arrangement—e.g.,terms of leases, restrictive covenants, past malpractice history, local managed care infiltration, etc?**

1. The tax treatment for the different pieces of the puzzle such as the value of a practice’s stock

2. Financing terms and collateral issues

3. Post sale employment of physician seller of practice and related terms

4. Accounts receivable uncollectable accounts

5. Return of deposits on equipment leases and office space

6. Rights of ancillary business, such as skin care business or ancillary products or services.

7. Depending on the buyer, the deal structures will vary. From the physician's perspective, deal negotiations are based on consideration of personal and financial planning goals. Some of the key negotiations considered in the "art of the deal" 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 total sale price can be significantly higher than a cash equivalent price for accepting the risk and relative illiquidity of common stock as part of the payment.

**Physician Compensation**
If your personal financing planning goals are to maximize practice value, negotiating a lower salary within a range you feel comfortable with will increase the sale price. Our firm calls this phenomenon the "medical practice value paradox of thrift."

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**About the Panelist**

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