American Society of Appraisers
Providing Value Worldwide

Webinar Handout

Webinar Title: The Big Three in Healthcare: Buy-in/Buyout Agreements, Physician Compensation, and Private Equity "Market Data"

Presented by: Mark O. Dietrich, CPA PC

Webinar Description: Valuation is part art and part science, but there is always a risk that some of the art may be lost or not understood. One of the more routine engagements an appraiser may encounter is to value a practice pursuant to a buy-in or buyout agreement, whether it be due to an expected retirement, death or disability, or marital dissolution where contract law is relevant. Such an engagement can be significantly more complex than appears on the surface. Use of physician compensation survey data is likely to distort the valuation as will failure to understand current "market data" from Private Equity deals.

Learning Outcomes:
Upon webinar completion, the participant will:

- Analyze how the terms of a shareholders' agreement or operating agreement impact the level of value;
- Discuss how the local market of the practice determines the appropriate compensation normalization adjustments – just because it plays in Peoria does not mean it will play in Manhattan;
- Identify how Private Equity "Market" transactions reflect specific terms from the buyer that are rarely applicable in a given valuation engagement, but may influence perceived risk and the discount rate; and
- Decipher unique elements to consider in reconciling actual and normal working capital – and what is "normal" anyway?

WEBINAR SURVEY LINK: https://www.surveymonkey.com/r/QT8RCBH

THE BIG THREE IN HEALTHCARE: BUY-IN/BUYOUT AGREEMENTS, PHYSICIAN COMPENSATION AND PRIVATE EQUITY "MARKET DATA"

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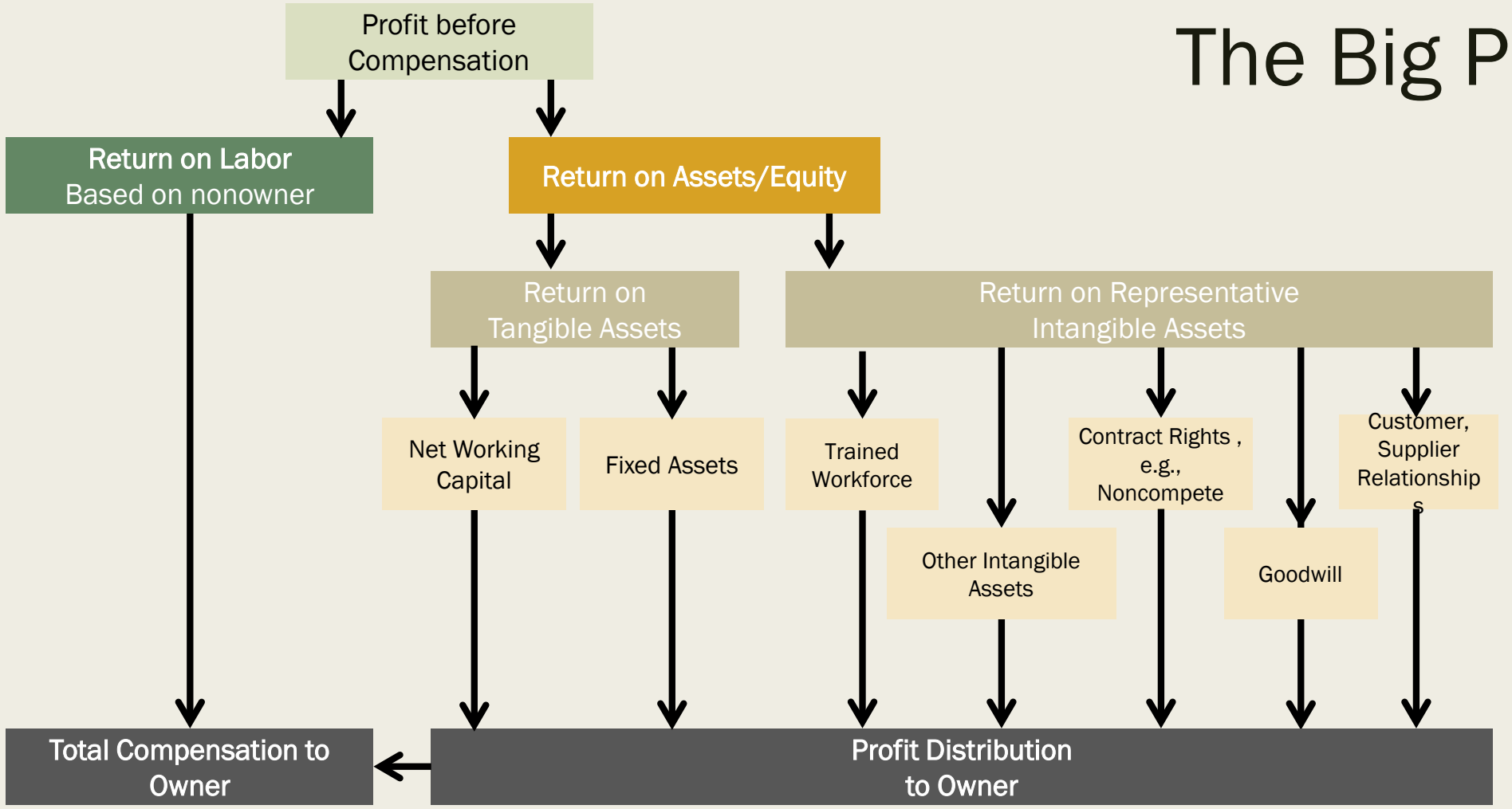
About the Program

- I have been involved in 100's of buy-in and buyout transactions during the course of my 40+ year career and served as an expert in dozens of litigation cases where the underlying agreements were at issue. What I hope to accomplish today is to give you a flavor of some of the key issues that need to be addressed and some insight that might help you avoid costly litigation in the future.

FAIR MARKET VALUE IN BUY-IN AND BUYOUT AGREEMENTS

Willing Buyer and Willing Seller not under any Compulsion who have Reasonable Knowledge of Relevant Facts

The Big Picture



These two components MUST be addressed ***simultaneously***; Return on Equity is not simply the residual after Return on Labor. The **Hypothetical Investor** must have a fair return under the Fair Market Value standard.

Levels of Value – Stated or Unstated

- Pro rata Control Value – In my experience, this is what professionals contemplate when they see “fair market value”
  - *It is not necessarily what the lawyer drafting the agreement uses*
- Unmodified Control Value - the agreement specifies that value is at the control level, but without mention of marketability one way or the other
  - *More on this later*
- Noncontrol Value without a Marketability Discount
  - *Agreement provisions may shed light on this*
- Noncontrol Value
  - *Agreement provisions may shed light on this*
- Bottom line –Don’t use terms like “fair market value” without specifying the Level

Levels of Value – The Textbook View

20% Premium – likely much of market data	Synergistic Value	$120
25% Premium for control	Control Value	100
20% Lack of Control Discount -DLOC	Marketable Minority Value-Public Company	80
25% Lack of Marketability Discount - DLOM	Restricted Stock of Public Company	60
Another 20% DLOM for **Private Company**	Nonmarketable/Non-Control Value	44

Levels of Value Insight

- The premiums and discounts in the Chart are ILLUSTRATIVE, not absolutes
  - *These are applied by experts with considerable variability*
  - *Synergistic (also called strategic) value is generally NOT fair market value unless all the buyers in a market are strategic buyers, e.g., Private Equity*
- Aside from often lacking statistical validity, much market data represents either strategic acquisition premiums or control premiums
  - *Remember that "Terms make the Deal"*
  - *In a professional practice, what the buyer is getting is usually determined by the compensation system – what an owner gets versus a nonowner. Thus, the assumption of reasonable compensation for a nonowner in the valuation model is critical – Cash is King*

Enterprise Value

- Valuations of practices should be conducted in the ordinary fashion, then enterprise value should be allocated to fixed assets, working capital and "goodwill"
  - *Certain elements of "goodwill" are related to individual productivity under the practice compensation plan*
  - *Other elements of "goodwill" are related to intangible assets*
    - Certain elements of trained workforce, e.g., accounting firm staff, law firm associates, dental hygienists, nurse practitioners
    - Lab, imaging, ophthalmic, laser and other equipment profits (collectively Ancillaries) in a medical practice
    - Inventory profits, e.g., optical dispensing in an Optometry practice
    - Certificates of need (when present in the practice entity) and other contract rights
    - Drug profits (J codes), etc. (Biologicals like Humira or Remicaid; Lucentis or Avastin)

Enterprise Value-Physician Practices

- The appraiser should focus on professional component income under the **Resource-Based Relative Value Scale** or RBRVS (modifier 26 where appropriate) and technical component income (modifier TC) as a key element of distinguishing return on labor from return on capital.
- Virtually all physician service revenue contains a specific component representing compensation and benefits based on third party contracts with insurers, Medicare, etc.
  - *Arms length terms are solid evidence of fair market value*

Examples

- Primary Care Medical Practices
  - *Widely favored by health insurers in terms of payment rates and potential incentives.*
    - The availability of incentives is a function of relative contracting strength, which is typically not held directly by the individual practice but rather by a network, Independent Practice Association (IPA) or similar entity that the practice is a member of.
  - *Value is generally derived from personal work effort at the higher payment rates, and reflects not only the clinical value of primary care, but the actuarial value to the network as the primary contact point for "claiming" a patient throughout the delivery system.*
    - Certain contract rights may have value, such as a network affiliation agreement or a concierge practice agreement, especially if transferable.
      - *Transferability, of course, is a jurisdictional issue*

Examples

- Dermatology Practices
  - *Two generic service lines – medical dermatology and cosmetic dermatology*
  - *“Hottest” thing in medical practice today, popular targets for Private Equity*
    - Discretionary spending on cosmetic procedures, sales of products
    - Profits on Advanced Practice Providers as well as technicians, lasers, fat freezing
  - *Beware that in any transaction “Terms Make the Deal” and those terms may not true up with your situation if you attempt to use “market data” to value a practice or firm*

Working Capital

- Normal working capital is typically expressed as either a percentage of revenue or a number of days' collections based upon the accounts receivable aging. Other measures are also possible.
  - *WIP in an accounting or law firm*
  - *Retainers in an expert witness practice!*
- Practices maintain books on cash basis for the most part, so incumbent on appraiser to develop accrual data sufficient to assess ***actual*** working capital
- **A valuation or appraisal is of little use in an actual transaction unless working capital is reconciled**

Poll # 1

CONTRACTUAL PROVISIONS IMPACTING DISCOUNTS

Critical Issues in Analyzing Shareholder/Partner/Member Agreements

Employment Contract –Document that often Governs Distributions and DLOCs*

- May be REQUIRED for regulatory reasons for medical practices, such as
  - *Assignment of the right to bill for services to Medicare and other insurers*
  - *Language declaring that no payment is being made in exchange for referrals under the Stark law or Antikickback Statute*
- Typically references compensation plan document or includes same in body of employment agreement or an appendix
  - *Note that the compensation plan often determines who is entitled to what, not equity ownership!*
- **Any noncompete agreement**
  - *See, e.g., Martin Ice Cream, Norwalk v. Commissioner, Larry Howard v Comm, Derby v. Comm,* various state statutes and fiduciary duty standards
- May contain the deferred compensation portion of any buyout or buy-in

*Discount for Lack of Control or Minority Discount

What is the Relevance of Contracts and Law in Structuring a Buy-Sell?

- If the IRS audits the transaction, you want it upheld!
- Noncompetes may or may not be enforceable, or only partially so
- Compensation arrangements that involve kickbacks in healthcare could be illegal
- Deferred compensation is typically a liability that is not recorded and can represent a substantial reduction in the value of Equity!
  - *Assets minus Liabilities equal Equity works for Valuation too!*

Shareholders' or Operating Agreement also Governs DLOC and DLOM*

- Are all shares voted equally or do some shares have more votes than others?
  - *Often times founders will have special deals for themselves*
- Look for a provision that states what minimum annual distributions will be
  - *Common ones include 40% of taxable income to pay income taxes*
  - *or all cash in excess of reserves as determined by the Managers, etc.*
  - *or whatever the Compensation Plan provides*
  - *The primary reason for a lack of control discount is the ability or inability to access the ownership share of cash distributions*
- War Stories

*Discount for Lack of Marketability

Use of Deferred Compensation in Buy-ins and Buyouts

- Often used in lieu of “goodwill” where new owner is stepping into a productivity-based compensation plan based on individual services
  - *Return on labor versus return on capital*
  - *Represents an implicit DLOM due to treatment as ordinary income rather than capital gain*
  - *In divorce, may still have divisible value, similar to a retirement plan, pension or Supplemental Executive Retirement Plan (SERP)*

Other Contractual Provisions Impacting Discounts

- Eligibility for a buyout based on Years of Ownership
- Notification Period before retiring and receiving a buyout
- Death or Disability Buyouts
- Productivity Requirements for Maintaining Shareholder Status
- Mandatory Redemption of an Equity Interest by the Practice
- Transition assistance by retiree to the practice or firm
- Post-retirement noncompete

Mandatory Redemption of an Equity Interest by the Practice or other Entity

- One of the underlying rationales for a **Marketability Discount** is the lack of a ready market for an interest in a professional practice. If the agreement requires that the practice entity re-purchase the interest, that creates liquidity, assuming of course, that the practice has the wherewithal to generate sufficient cash to purchase the interest.
- The reverse is true in that lack of a mandatory repurchase may create a large marketability issue, particularly if other provisions restrict the ability of the holder to sell the interests to a third party
- As a practical matter, I do not see large marketability discounts for noncontrol interests in professional practices

Poll # 2

MISPLACED RELIANCE ON COMPENSATION SURVEY DATA

An Inexplicable and Inexcusable, but Standard, Compensation Valuation Method

General Factors in Assessing Reasonable Compensation

- Qualification of the Employee
- Employee's Contribution to the Success of the Company
- Compensation (not ownership profits) Paid in the Industry
- Compensation (not ownership profits) Paid to Other Employees
- Independent Investor Standard (*Exacto Springs* case)

Reasonable Compensation

- The accepted definition of “reasonable compensation” under the Fair Market Value Standard is the amount required to hire a **nonowner** employee to perform the same functions as the owner

Overview-Physician Practices

- Lack of Statistical Validity
  - *MGMA "Sampling" bias - and not even a random sample to begin with*
    - Dominated by Hospital-employed physicians
    - Concentrated in a few states
    - Does not – and does not pretend to – be representative of what a physician can earn in any given locale
  - *Is NOT the "Market"*
- "Compensation" is not what you think it is, i.e., purely clinical compensation for a physician,
  - *Includes call pay, medical directorships, research stipends, **profit**, kitchen sink*
- Healthcare valuation community is well aware of misuse/abuse, but does it anyway
  - *"Bad data is better than no data"*
  - *"Everyone else is doing it"*
- **Rosenberg Survey** for CPA Firms has same issues
  - *Mulcahy, Pauritsch, Salvador & Co., LTD. v. Commissioner (T.C. Memo. 2011-74)*
  - *Upheld by 7th Circuit*

A Word (or two) About MGMA Data

- In point of FACT, it is **worthless***
  - *Minnesota and Wisconsin accounted for 1 in 7 of every provider in the 2015 MGMA Physician Compensation Survey.*
  - *In the 2017 survey, one in four providers was from Minnesota, Wisconsin or Pennsylvania.*
  - *On average, ~66% of data points are from hospital-employed physicians, NOT private practice physicians.*
  - ***MGMA does NOT support use if its data for determination of fair market value***
  - *Arms' length relationships between physicians and local market health insurers determine compensation in private practice – that rings of Fair Market Value or replacement comp*

  - **Except, maybe, in Minnesota, Wisconsin or Pennsylvania for health system employees*
  - ***And, in case you were wondering, AMGA and Sullivan, Cotter are worse than MGMA*

Surveys: “Statistics”?

- Example: A survey of vacationers at the beach in York, Maine in the month of June finds that 70% of the beachgoers thought the water was too cold, 10% thought it was too warm and 20% thought it was just right. What does this survey tell us about beachgoers in Ocean City, Maryland in June?
- The answer is obvious: Nothing
- The analogy here is the “Eastern Region” data in surveys –
  - *Nothing to suggest that Maryland and Maine, to say nothing of North Carolina and Vermont, have common healthcare markets – or weather*

Dietrich's Published Research in HFMA's *hfm Magazine*, Early Edition

- Summary of Findings

1. Actual data shows a strong correlation between where physicians do their Graduate Medical Education or GME and where they practice medicine; undergraduate medical education is also a significant factor
2. Physicians are not prone to relocate once they have established practice post-GME
3. The physician compensation surveys commonly used for assessing fair market value do not reflect the impact of GME, the actual distribution of physicians from region to region, or the actual post-GME recruiting pattern by state
4. The physician compensation surveys are also not valid for inferential statistical purposes
5. The physician compensation surveys reflect disproportionate data from certain states and regions that does not reflect the actual distribution of physicians
6. Each state has a unique profile in terms of where its physicians' trained that needs to be taken into account in the determination of fair market value
7. There are six (6) distinct forms of physician fair market value determinations that emerge from this research
8. Moving away from the use of surveys and to localized data reflecting actual practice market area conditions will guard against challenges to the commercial reasonableness of physician arrangements.

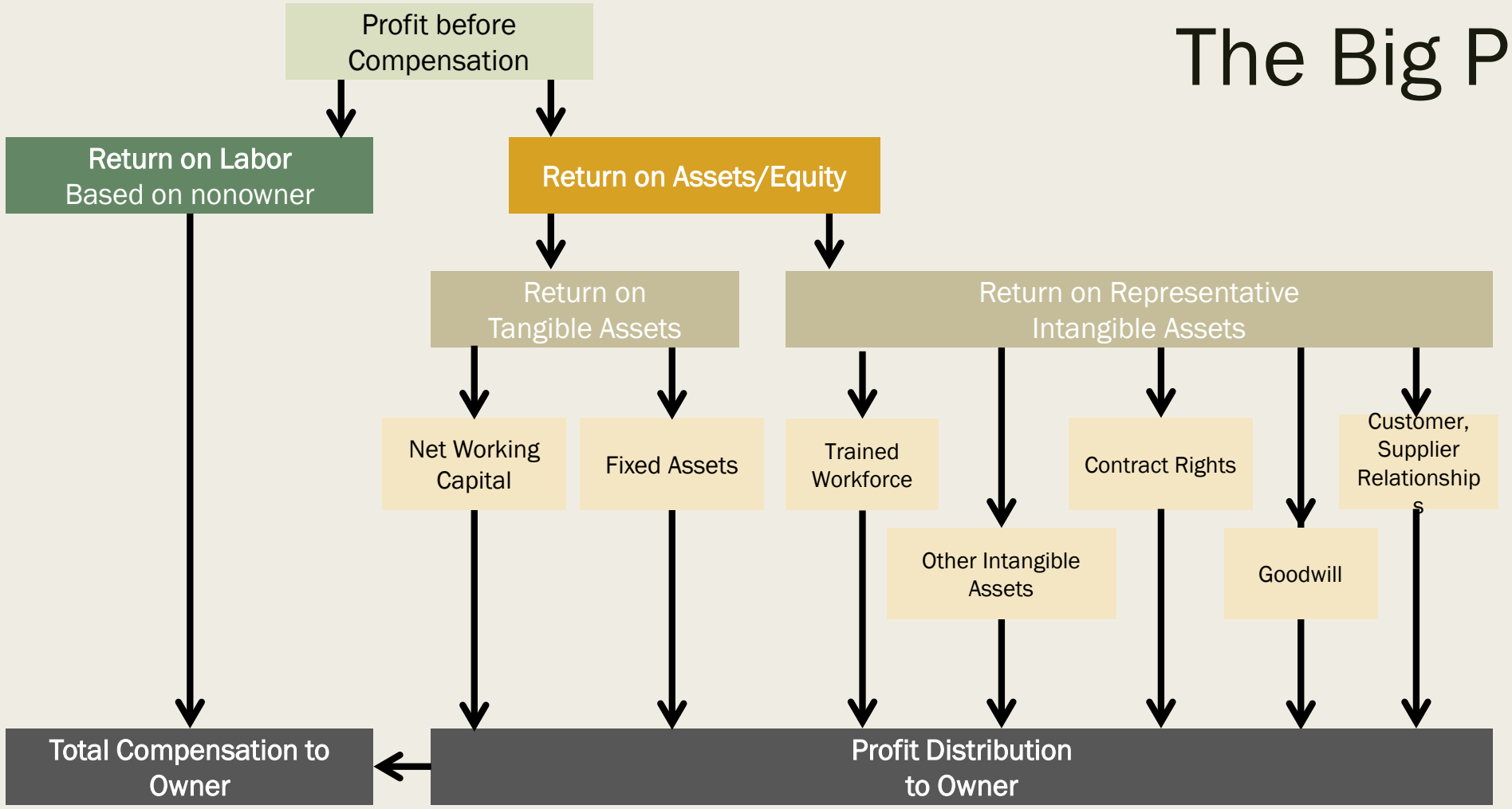
Took me 500 hours to research this and 3 months of peer review to get it published Physician Distribution, Mobility, Fair Market Value and Compensation Surveys, July, 2018

Poll # 3

SURVEYS FAIL TO DISTINGUISH RETURN ON LABOR FROM EQUITY PROFITS

Equity Profits Determine Value

The Big Picture



These two components MUST be addressed ***simultaneously***; Return on Equity is not simply the residual after Return on Labor. The **Hypothetical Investor** must have a fair return under the Fair Market Value standard.

RBRVS *IS* THE MARKET APPROACH

Resource Based Relative Value Scale is used by Medicare and virtually all Health Insurers to pay Physicians

Terms We Will Use Today

- **RBRVS** – Resource Based Relative Value Scale
- **RVU** – Relative Value Unit
  - *A measure of work output, like an hour in a law firm*
  - *Physician compensation and benefits - wRVU*
  - *Physician practice expenses – peRVU*
  - *Physician malpractice insurance – mpRVU*
- Modifier 26 for Professional Services Only and TC for Technical Component
- HCPCS – Healthcare Common Procedure Coding System
- Conversion Factor – a dollar amount that values each RVU type
  - *Like a billing rate in a law firm*
- **GPCI** – Geographic Practice Cost Index (“gypsy’) – county-based adjustment by Medicare to reflect higher expenses – e.g., San Francisco, Manhattan

The RBRVS Method as The Market Approach

- Medicare Reimbursement: Resource Based Relative Value Scale (RBRVS)
  - *Each procedure paid under the Medicare Physician Fee Schedule (MPFS) has three values assigned to it based on relative value units (RVUs)*
  - ***Work component (wRVU)** – value of the physician's or provider's services*
  - ***Practice expense component (peRVU)** – value of the resources used in providing the services*
  - ***Malpractice component (mpRVU)** – value of resources used for malpractice (with some nuance)*
  - *RVUs by type (w, pe, and mp) are adjusted for geographic location in Medicare by a **Geographic Practice Cost Index** (**GPCI**) (pronounced "gypsy")*
  - *Total GPCI-adjusted RVUs are multiplied by a conversion factor to calculate the amount of the reimbursement*

RVUs and Compensation – Multiplication and Algebra

- The formula looks like this without the GPCI, where CF is the Conversion Factor:
  - *(wRVU + peRVU + mRVU) = RVU x CF = $Fee.*
  - *Restating this formula using the distributive property of algebra results in an equivalent amount:*
  - *(wRVU) x CF + (peRVU) x CF + (mRVU) xCF = $Fee.*
- The formula looks like this with the Geographic Cost Practice Index or GPCI
  - *(wGPCI*wRVU + peGPCI*peRVU + peGPCImRVU) = GPCI RVUs x CF = $Fee*
- **2 wRVU + 1.5 peRVU + .1 mpRVU = 3.6 RVUs * $35 CF = $126 Fee**

Survey Use Fails the Test of Basic Algebra

- Survey users divide **ALL** practice revenues (for **ALL** RVUs) by **wRVUs *only***, giving the mistaken and misleading impression that all revenues are for physician compensation and benefits!
  - *This more or less deliberate misrepresentation accounts for much of the overstatement of physician compensation in surveys*
- 2014 MGMA Physician Compensation and Production Survey: Internal Medicine medians
  - *Compensation per wRVU – 50.74*
  - *Collections per **total RVU** – 37.09 (relevant)*
  - *Collections per wRVU – 80.42 (a BAD data point)*

Example: What You Cannot See in the Survey

Compensation Earned by Median Survey Participant	
Clinical	300,000
Call Coverage	50,000
Administrative	10,000
	60,000
Total Compensation	360,000
Collections for Clinical Services	600,000
Reported Ratio of Compensation (360/600)	60%
Actual Clinical Ratio (300/600)	50%

- The actual components of compensation paid to a physician cannot be discerned in the MGMA data – all you know is the TOTAL compensation from **all** sources
- Total revenue, however, includes **ONLY** clinical revenue
- Thus you have a mismatch between the compensation in the numerator (360) and the revenue in the denominator (600)
- Duhhhh

Example: What Happens to the Typical Survey User's Valuation, here for Divorce

	"Correct"	Wrong
Marital Litigant Earnings	450,000	450,000
Reasonable Compensation		
Marital Litigant Clinical Collections	700,000	700,000
Ratio of Compensation	50%	60%
Reasonable Compensation	350,000	420,000
Excess Earnings to Value	100,000	30,000
Illustrative Valuation Multiple	3.0	3.0
Value	300,000	90,000
Valuation Error	210,000	

- IF the survey user could identify how much of the compensation in the survey was NOT clinical, they could develop an apples to apples clinical compensation to clinical revenue Ratio – but they cannot
- The Survey would still not represent market earnings in any given private practice setting

Example: Using RBRVS

Marital Litigant Clinical Collections	700,000
Total RVUs Billed to Insurers	14,000
Average Amount Paid per RVU	50.00
Total work RVUs Billed to Insurers	7,500
Local Market Compensation	375,000

Marital Litigant Earnings	450,000
Reasonable Compensation	375,000
Excess Earnings to Value	75,000
Illustrative Valuation Multiple	3
Value	225,000

- Only by measuring what insurers in the practice's local market pay can the appraiser assess reasonable or replacement compensation for purposes of valuing the practice in the local jurisdiction.
  - *You cannot value a practice in suburban New Jersey as if it was located in Wisconsin*
- The $225,000 value here reflects the value to the marital estate, whereas the previous two Survey-based values reflect the value to an imaginary situation.

The Bad, the Worse… and the Inexplicable

- MGMA Survey used to determine reasonable compensation for a solo DENTIST!
  - *There were only 70 dentists in the entire national survey, 10 in the Eastern region selected, nine were in Pennsylvania – which was, of course, not the state of the divorce proceeding.*
  - *Of the 70, none worked in a practice with less than $2.0 million in revenue, 62 worked in a not-for-profit organization, and 49 worked in practices with more than $50 million in revenue*

Poll # 4

WHAT IS THE RELEVANCE OF "MARKET" DATA FROM PRIVATE EQUITY BUYERS?

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Basics of Private Equity Transactions

- Invest the fund's capital in businesses
- Seek to exit their investments within three to seven years for a substantial return on invested capital.
  - *Buyer may be another Private Equity firm, or a Pubic company.*
- Investment is also referred to as a "recapitalization"
- Goal is to use private equity firm to provide access to capital and expertise to improve financially and operationally, building out the infrastructure to provide a foundation for future growth.
  - *De novo growth + Add-on growth = Geographic Strength through Market Share*

Based on PROVIDENT PERSPECTIVE, October 2017: Private Equity Investment in Dental Care

Basics of Private Equity Transactions

- EBITDA has to be created by reducing physician-owner compensation
  - *Owner compensation has to be defined, often as % of collections or % of pre-distribution earnings – has to be "market" for nonowner*
    - Without knowing that, reported EBITDA multiple is all but useless
- A negotiated multiple is then applied to the EBITDA to determine Enterprise Value
  - *Likely to be driven by a DCF and/or guideline transactions – competitive market!*
- Working Capital is a key element of the closing adjustments
  - *Yet again, "normal" versus actual drives the ultimate value*
- In a multi-partner practice, you also have to settle capital account differences with the liquidating distribution
  - *These may also include Compensation Plan deficits and surpluses*

Basics of Investor Equity Transactions

- Purchase price may be paid in cash, or cash and stock. In contrast to prior "rollup" periods, all cash deals are surprisingly common
  - *Taxability of any stock proceeds is complicated*
  - *No definitive way to value stock other than agreed upon value in P&S*
- Some portion of the proceeds are escrowed for potential liabilities
  - *An indemnification provision for liabilities in excess of escrow may also exist*
- If the seller is a C Corporation, negotiation for, and valuation of, personal goodwill is critical
  - *Don't expect buyer to be necessarily familiar with this strategy or cooperative*
  - *If practice has pre-existing noncompetes that survive termination of employment, personal goodwill is problematic*

Example - Pre-Transaction

Equity	35.0%	35.0%	30.0%	100.0%
	Jim	Jane	John	Total
Collections	1,300,000	1,300,000	950,000	3,550,000
COGS	200,000	250,000	80,000	530,000
Net	1,100,000	1,050,000	870,000	3,020,000
Overhead	310,000	310,000	250,000	870,000
Earnings	790,000	740,000	620,000	2,150,000
Profit Shift	60,000	60,000	(120,000)	-
Compensation	850,000	800,000	500,000	2,150,000
EBITDA				-
Share of Comp	36.7%	34.4%	28.8%	100.0%
Comp to Collections	65.4%	61.5%	52.6%	60.6%

- Jim – 65, Jane – 45, John - 37
- John was in the process of buying his 30% share with pre-tax dollars
- COGS is from disposables used in certain treatments
- Substantial profits in midlevel providers
- EBITDA created by using 45% of net collections for compensation
- Comp share is before profit shift

Example - Post-Transaction

	Jim	Jane	John	Total
Collections	1,300,000	1,300,000	950,000	3,550,000
COGS	200,000	250,000	80,000	530,000
Net	1,100,000	1,050,000	870,000	3,020,000
Compensation	495,000	472,500	391,500	1,359,000
Overhead	310,000	310,000	250,000	870,000
EBITDA	295,000	267,500	228,500	791,000
EBITDA %	37.3%	33.8%	28.9%	100.0%
Share of Comp	36.4%	34.8%	28.8%	100.0%
Comp to Collections	45.0%	45.0%	45.0%	45.0%

- Jim's share of comp drops from 36.7% to 36.4%
- Jane's goes up from 34.4% to 34.8%
- Absolute dollar contribution to EBITDA is highest for Jim and is more than his share of equity, while Jane's is almost identical

Example Analysis

	Jim	Jane	John	Total
EBITDA				791,000
Multiple				8.98
Enterprise Value				7,100,000
Cash	1,366,750	1,366,750	1,171,500	3,905,000
Stock	1,118,250	1,118,250	958,500	3,195,000
	2,485,000	2,485,000	2,130,000	7,100,000
Cashflow				
Cash	1,366,750	1,366,750	1,171,500	3,905,000
Taxes	591,430	591,430	506,940	1,689,800
Net	775,320	775,320	664,560	2,215,200
Analysis				
Pre-Tnx Comp	790,000	740,000	620,000	2,150,000
Post-Tnx Comp	495,000	472,500	391,500	1,359,000
Reduction	295,000	267,500	228,500	791,000
Cash	1,366,750	1,366,750	1,171,500	3,905,000
Real Multiple	4.63	5.11	5.13	4.94

- Who knows what illiquid stock with a 5 to 7 year holding period is worth?
- Appeared there was no way to get stock nontaxable
- Does it make sense if ALL proceeds are cash?
  - *Sure does for Jim because near retirement*
  - *John has ~9 year payback but ~30 years left in his career*

Analysis if ALL Cash				
Pre-Tnx Comp	790,000	740,000	620,000	2,150,000
Post-Tnx Comp	495,000	472,500	391,500	1,359,000
Reduction	295,000	267,500	228,500	791,000
Cash	2,485,000	2,485,000	2,130,000	7,100,000
Real Multiple	8.42	9.29	9.32	8.98

Working Capital

- Normal working capital is typically expressed as either a percentage of revenue or a number of days' collections based upon the accounts receivable aging. Other measures are also possible.
- Practices maintain books on cash basis for the most part, so incumbent on appraiser to develop accrual data sufficient to assess ***actual*** working capital
- A valuation or appraisal is of little use in an actual transaction unless working capital is reconciled
  - *AND, an alleged indication of value from the market approach (typically invested capital) is of little use without a reconciliation to "normal" working capital in the market "data"*
  - *Any deficit of actual versus normal working capital reduces Equity*

Working Capital – Good Work for a CPA

- Accounts Receivable
  - *For the experienced medical practice appraiser, determining collectible accounts receivable is a routine component of the engagement, and involves obtaining an aging by insurer (payor) as well as data on charges, payments and contractual adjustments by insurer. The latter is utilized to measure collectability.*
  - *Typically the primary, it not the only, source of working capital*
- Accrued Payroll – Beware!
  - *Practices allocate compensation on the basis of a compensation plan, at any given valuation date, except perhaps for the last day of the taxable year, there will be compensation accruals to the owners as well as nonowner providers.*
  - *As another example, nonowners may be paid on a percentage of collections 30 days in arrears, so that at any valuation date, including year-end, this liability will need to be taken into account in measuring actual working capital.*
  - *PTO or Paid Time Off is often a BIG issue if it accumulates*

POLL #5

Balance Sheets

		Accrual Adjustments	Valuation Adjustments	Fair Market	**Enterprise**
Current Assets					
Cash	25,000			25,000	
Accounts Receivable (Net of Reserves)		100,000		100,000	
Prepaid Expenses	5,000			5,000	
Total Current Assets/Working Capital	30,000	100,000	0	130,000	96,000
Fixed Assets:					
Medical & Office Equipment	100,000		-40,000	60,000	
Accumulated Depreciation	-100,000		100,000	0	
Property & Equipment (Net of Dep'n)	0	0	60,000	60,000	60,000
Other Assets:					
Intangible Value			150,000	150,000	150,000
	30,000	100,000	210,000	340,000	306,000
Credit Card Payables	10,000			10,000	
Accounts Payable & Accrued Liabilities		24,000		24,000	
Total Current Liabilities	10,000	24,000	0	34,000	
Long Term Liabilities:	100,000			100,000	
Long Term Debt	100,000	0	0	100,000	100,000
Member's Equity:					
Smith	-25,000	27,000	70,000	72,000	72,000
Jones	-20,000	27,000	70,000	77,000	77,000
Adams	-35,000	22,000	70,000	57,000	57,000
Total Member's Equity	-80,000	76,000	210,000	206,000	206,000
	30,000	100,000	210,000	340,000	306,000

Working Capital – Good Work for a CPA

Revenue	2,000,000
Normal Working Capital %	8%
Normal Working Capital	160,000
Actual Working Capital	96,000
Working Capital Deficit	-64,000
Market Approach MVIC	370,000
MVIC of Subject	306,000
Less: LTD	-100,000
Equity	206,000

- In order for the EBITDA multiple-derived value to be meaningful, the working capital deficit has to reduce MVIC

Basics of Private Equity Transactions

- Buyer may engage in a detailed "quality of earnings" analysis that converts all activity for some period of time from **cash to accrual**
  - *This may involve a **complete** individual claims analysis for multiple years*
  - *May include coding compliance*
  - *One thing that tends to turn up is credit balances*
  - *Another thing is accrued payroll, PTO, etc.*
- Legal and operational due diligence as well

Basics of Investor Equity Transactions

- If the practice has nonowner providers, a portion of the sales proceeds may be contingent upon retention of those providers
  - *Key personnel may catch wind of this and look for a retention bonus out of the sales proceeds*
  - *Yet again, it is impossible to assess the meaningfulness of reported EBITDA multiples without understanding transaction terms*
- Noncompete with sellers is typically 5 years with each seller, could be longer with the seller's practice entity

Basics of Investor Equity Transactions

- Platforms - Among other factors impacting the relevance of any market data is whether or not the valuation subject qualifies as a "platform" ***or*** whether pre-existing platforms exists to which a valuation subject might be attached (**add-on acquisition**)
  - *A platform is a practice or aggregation of practices large enough to provide an equity investor with sufficient scale and local market/geographic strength as well as existing infrastructure to serve as a basis for expansion*
  - *To some extent, the larger the better, along with more centralized management and/or ownership, ancillaries (imaging, lab, affiliated ASC, etc.)*
    - A 50 doctor group with 50 equal partners is not likely to agree on anything anytime soon
  - *An add-on acquisition will NOT attract the same EBITDA multiple as a platform!*

Platform Analysis from Provident Healthcare Partners-Orthopedics

Company	Valuation Range	Rationale	EBITDA	Multiple	EV
Private Equity Platform Investment	7x - 9x	• Regional dominance • Established infrastructure	$5M	8x	$40M
Add-On Acquisition	4x - 6x	• First-mover advantage ensures less competition	$2M	5.0x	$10M
Combined Organization	10x - 12x +	• Value of add-on is enhanced as the organization benefits from premium demanded for the platform company • Combined organization leverages the infrastructure and regional dominance of platform • Synergies from centralizing back-office functions and increased leverage with payors enhance the EBITDA of the combined organization	$7M + $500K in synergies = $7.5M	10.0x	$75M

Provident Perspectives: Private Equity Investment in Orthopedics (undated)

From a Recent Rebuttal

- “Without belaboring the point, I have as yet to see such a small physician practice be seen as a “platform” for purposes of an initial entry into a market by a consolidator. And, there are no “platforms” in State that Valuation Firm 2 has identified that the Valuation Subject could be “attached” to.”

Behavioral Health is HOT

- “Within the Behavioral Healthcare Services industry, companies that offered child and youth-oriented services accounted for 24.3% or 17 of the announced or closed mergers and acquisitions (M&A) year-to-date (YTD). Activity in this segment has largely been driven by the national rise in children with autism (a 15.0% increase from 2016 to 2018, according to Autism Speaks1) and the ongoing battle against opioid abuse (which is most prevalent among young adults ages 18-to-25 years-old)”
- Source: Capstone Headwaters

POLL #6

Investor Equity Transactions in Dentistry

- Been hot for a long time
- Due to market fragmentation, plenty of room left to run
- “Investment by the private equity community has continued unabated for almost 20 years, as well as through two recessions. The sector has attracted capital from some of the largest private equity funds as many national groups have gone through several iterations of private equity.”
- Many platforms for add-ons.

From a Recent Article

- “Real-world transactions are a very different setting than FMV for estate tax purposes, marital dissolution, or litigation where FMV is the standard, or other engagements. This is because the appraiser is compelled to assume or create some hypothetical transaction structure and assumed terms of the hypothetical sale. Importantly, when the market approach is utilized in the determination of fair market value in these nontransaction settings, it is incumbent upon the appraiser to be familiar with typical transaction structures in the industry - if any. This highlights a critical source of error in the use of market data: lack of knowledge of actual transaction terms that influence the price reported in the market databases.”

Using ASC Multiples

EBITDA		2018	$ 2,800,000	Offer	$ 3,300,000
EBITDA Interest Purchased		51%	1,428,000	51%	1,683,000
Management Fee			-		-
Total EBITDA Purchased			1,428,000		1,683,000
EBITDA			1,428,000		1,683,000
Multiple			9.00		9.00
Value of 51% Interest		25,200,000	12,852,000		15,147,000
Total EBITDA Purchased			1,428,000		1,683,000
Actual Mutiple for 51%			9.00		9.00
Pre-transaction EBITDA			2,800,000		3,300,000
Management Fee			-		-
Post-transaction EBITDA			2,800,000		3,300,000
Remaining Interest		49%	1,372,000	49%	1,617,000
Minority Interest Multiple			3.00		3.00
Remaining Minority Value			4,116,000		4,851,000
Value Sold			12,852,000		15,147,000
Control Value for 100%			16,968,000		19,998,000
EBITDA			2,800,000		3,300,000
Actual Multiple for 100%			6.06		6.06

- Offer pre-dated the valuation date and was declined
- As is typically the case, only a 51% interest was to be purchased
- Transaction terms included a fixed 3.0 multiple for post-transaction minority interest buyouts and buy-ins
- “True” control value in this case is a combination of two different multiples

Using ASC Multiples

Value of 51% Interest			12,852,000	Offer	15,147,000
Less: Debt		2,500,000	1,275,000		1,275,000
Equity-Marketable, Control			14,127,000		16,422,000
Discount for Lack of Control*		-20.0%	(2,825,400)	-20.0%	(3,284,400)
Discount for Lack of Marketability*		-5.0%	(565,080)	-5.0%	(656,880)
Nonmarketable Value of Equity			10,736,520		12,480,720
**A noncontrol owner cannot initiate this transaction*					
Value of 49% Interest			4,116,000		4,851,000
Less: Debt			1,225,000		1,225,000
Equity-Nonmarketable, noncontrol			5,341,000		6,076,000
Discount for Lack of Control		-20.0%	(1,068,200)	-2.5%	(151,900)
Discount for Lack of Marketability		-5.0%	(213,640)	-5.0%	(296,205)
Nonmarketable Value of Equity			4,059,160		5,627,895
Total Equity			$ 14,795,680		$ 18,108,615
Aggregate					
Value of 100%		6.06	16,968,000	6.06	19,998,000
Less: Debt			2,500,000		2,500,000
Equity-Nonmarketable, noncontrol			19,468,000		22,498,000
Discount for Lack of Control		-20.0%	(3,893,600)	-15.3%	(3,436,300)
Discount for Lack of Marketability		-5.0%	(778,720)	-5.0%	(953,085)
Nonmarketable Value of Equity			14,795,680		18,108,615

- There were many owners in this ASC and some of those were in group practices which voted the shares and had their own voting rules!
- The ASC required a supermajority to sell
- Assuming the transaction took place, there was little reason for a lack of control discount on the 3.0 EBITDA multiple applied to the post-transaction minority interest, thus my choice of 2.5%
  - *Since it had been voted down, I applied a greater DLOC to the valuation of 20%*

Basics of Investor Equity Transactions

- Summary
  - *Private Equity and Public Equity Transactions have specific deal terms that impact the reported EBITDA Multiples – and only insiders know the terms*
  - *A Platform consisting of a large medical practice is the foundation for the relevance of such a transaction multiple in valuation*
    - Practices interested in Investor sale should pursue a strategy of being a Platform
    - If the valuation subject is not a Platform, these transaction multiples are generally irrelevant
      - *If a Platform exists in the practice's service area, then an Add-on Acquisition multiple may be relevant*
  - *These transactions DO impact perceived value and perceived risk, and have some relevance in the selection of a risk premium for the subject*

Private Equity – More Information

- Provident Healthcare Partners:
  - https://www.providenthp.com/category/industry-reports/
  - *Anesthesia*
  - *Behavioral Health*
  - *Dental*
  - *Dermatology*
  - *Ophthalmology*
  - *Others*

Private Equity – More Information

- Provident Healthcare Partners:
  - https://www.providenthp.com/category/provident-perspectives/
  - *Anesthesia*
  - *Dental*
  - *Urology*
  - *Orthopedics*
  - *Gastroenterology*
  - *Primary Care*
  - *Radiology*
  - *Others*

Private Equity – More Information

- https://www.kevinmd.com/blog/2018/08/a-private-equity-primer-for-physicians.html
- https://www.beckershospitalreview.com/finance/why-large-physician-groups-should-consider-private-equity-5-thoughts-with-todd-mello.html
- Irving Levin Webinar Series featuring public and private equity investors, lenders and investment bankers in various segments of the healthcare industry

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Mark is a summa cum laude, Beta Gamma Sigma *graduate of Boston University where he also earned an MBA with high honors. He is Editor and Contributing Author to the Business Valuation Resources/American Health Lawyers' Association* **Guide to Healthcare Industry Finance and Valuation** *4th Edition, Editor and Principal Author of Business Valuation Resources* **Guide to Physician Practice Valuation** *3rd Edition; and co-editor and contributing author to the Business Valuation Resources/American Health Lawyers' Association* **Guide to Valuing Physician Compensation and Healthcare Service Arrangements** *2nd Edition. Mark served as Chairperson of the American Institute of CPA's (AICPA) National Healthcare Industry Conference for 2012 and 2013, chaired the AICPA Virtual Conference on the Affordable Care Act in January 2014 and the National Healthcare Industry Conference Affordable Care Act section in 2014. Mark's career experience includes working with numerous physician practices as a tax advisor, operational consultant, designing and implementing compensation plans, negotiating managed care and Medicare Advantage contracts on behalf of a primary care physician network, serving as partner-in-charge of the annual Audit of a tax-exempt faculty group practice affiliated with a major teaching hospital and medical school, serving as expert on behalf of both defendants and the government in qui tam actions, and performing valuations on behalf of both medical practices and tax-exempt hospitals as well as for litigation. When he is not writing or researching some obscure healthcare industry topic, he does valuation work and tends to his farm in Virginia.*

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