

MEDICAL  
PRACTICE  
VALUATION  
GUIDEBOOK  
**2001/2002**

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## **What some leading experts have said about the *Medical Practice Valuation Guidebook:***

**This book is a masterpiece!** It provides excellent discussions regarding the important nuances of managed care and physician practice acquisitions. Perhaps most importantly, Mr. Dietrich brings within the reach of lawyers extraordinarily complicated concepts about valuations and the valuation process.

Robert Fabrikant, Esq.  
Chairman of the HealthCare Practice of Sidley & Austin,  
co-author of Health Care Fraud, Enforcement and Compliance by Fabrikant, Kalb, Hopson & Busy, published by the Law Journal Press

**This book is a real contribution that I recommend to anyone involved in a medical practice valuation.** This is a very comprehensive and useful book with a lot of information packed into every page in an easy-to-read style. Besides the basic information, the frequent “Author’s Insight and Analysis” paragraphs translate the author’s experiences into useful guidelines for readers. He also succinctly differentiates characteristics and appropriate valuation methodologies among different types of practices.

Shannon P. Pratt, CFA, FASA  
Managing Director  
Willamette Management Associates

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Jim Rigby, CPA-ABV, ASA  
Co-Managing Director  
The Financial Valuation Group

**You can't value what you don't understand.** Mark Dietrich offers the valuation expert, who is not already versed in the intricacies of physician practice management, the knowledge and insight in how to correctly value a medical practice. This book is three books in one: a detailed review of medical practice operations, an excellent review of valuation theory, and a nearly unlimited supply of practical "author's insights" based on his extensive experience. If you value medical practices, you will value this book.

John Mayerhofer, FACHE, FHFMA, CPA  
Mayerhofer & Associates

**Needless to say, the information in this [book] is invaluable to appraisers attempting to value a physician's practice or the (likely) restricted stock of a PPM company.** Chapter 10, "Wall Street Meets Medicine," is must reading for any physician who is considering participating in a roll-up with a PPM. Dietrich captures the essence of the economics of PPMs both from the perspective of the physician and the PPM, as well as providing insights into the very nature of roll-ups.

Z. Christopher Mercer, ASA, CFA  
President  
Mercer Capital



# MEDICAL PRACTICE VALUATION GUIDEBOOK 2001/2002

Including Comprehensive  
Financial Analysis and the  
Influence of Managed Care

Mark O. Dietrich, CPA-ABV

With templates and spreadsheets on CD-ROM

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## ***Free Updates and Valuable Information!***

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## **Material on CD-ROM**

*The files on this CD-ROM are intended to serve as an estimating tool only and are in no way intended to substitute for professional competence. Please study the formulas in the spreadsheets carefully.*

Perhaps the most noticeable new addition to be found on the CD is the “Attorney’s Guide.” Its intended purpose is to provide attorneys with a quick reference to help clarify their understanding and focus their attention on the often hidden issues that need to be considered when reviewing reports or examining experts. Those readers who serve—or plan to serve—as an expert witness will find the guide to clearly be of value as well. For those unfamiliar with Adobe PDF files, you will find a Microsoft Word file on the CD containing a link to obtain a free download of Acrobat Reader and a few tips for easy navigation within the document.

The rest of the CD-ROM is organized into subdirectories, one for each chapter in which a spreadsheet or sample document appears, labeled with the chapter number as shown below. To access the files, simply insert the CD-ROM and open with the appropriate program, e.g. Lotus for .wk4 or .123, Excel for .xls, or Microsoft Word for .doc files. We have saved the files down into earlier file formats for those of you who have not updated; those who have should have no problem opening these prior versions.

In the second edition CD-ROM, I have added notes in various cells

of the valuation model, generally in the EXHIBIT cell of the model or the top left of the spreadsheet, providing hints on how to use the spreadsheet or the thought process behind a particular approach. In Lotus, a small dot appears in the cell to indicate a comment; right click to call up the Range Properties dialog box and then left click on Cell Comment icon at the right of the dialog box. In Excel, a triangle appears in the upper left of the cell; hover the cursor over the triangle and the comment will appear. Right click on the cell and select Show Comment for more info.

## Chapter 5

**Model\_2DEd.wk4, Model\_2DEd.123, Model\_2DEd.xls, and Model\_2DEdv2.xls:** These spreadsheets contain the valuation model for the sample valuation described in Chapter 5 and all accompanying exhibits. The spreadsheet can be modified since most experienced users have their own particular approach to developing spreadsheet models.

The revenue forecast formula in this model is somewhat sophisticated, being based on the number of Medicare and commercial patients, the reimbursement or revenue per encounter for each, and a rate of increase in the revenue per encounter. (A simplified version of this spreadsheet is also included as modelsmp.wk4, where the revenue forecast is simply a function of a single assumption as to the annual rate of increase in revenues.)

Expenses are based on the increase in the number of patients and the rate of increase (inflation) for that category of expense.

It contains a circular reasoning indicator because the calculation of the amortization deduction (as explained in the text) is a simultaneous equation. The user can strike the F9 key to repeatedly recompute the value, or set the iteration counter to a desired level. Parts of the spreadsheet not used for the valuation Exhibits included in the text have been left in for the user's convenience, although they thus return values of ERR. We find that certain engagements require additional analysis not contained in a standard report and have left these intact for your use. Note: Model\_2DEDv2.xls contains the alternate approach to valuing the tax benefit associated with valuing the goodwill that is described in the text and appears in the spreadsheet pvamort.xls.

Among some of the more useful components of the spreadsheet are the "Common Size" Revenues Collected and Expenses Paid for both historical and forecasted results. These are not included in the sample report

in the text for reasons of space limitations. I find it particularly useful to (1) compare the percentages in the historical results with the initial year of the forecast to make sure that no mathematical or other errors have occurred in setting up the forecast and (2) view each of the forecast years' percentage results to make certain that some error in extrapolating out the first year has not occurred.

## Chapter 6

**reality1.123, etc.:** Example 1 - Buy-in to a solo practice

**reality2.123, etc.:** Example 2 - Buy-out to employ

Tip: You may want to consider linking this spreadsheet back to the main valuation model.

**divorce.123, etc.:** Separating Professional from Practice Goodwill

**damages.123, etc.:** Loss Of Employees: Workforce In Place, Loss of Opportunity for Enhanced Income

**sdrs.123, etc:** Valuing a call schedule preference

## Chapter 7

**goconcern.123, etc.:** Going Concern Value, Workforce-in-Place This spreadsheet contains the example from the text and can be modified by the user for different views as to the period of time (up to two years) required to start up the practice, differences in collection rates, and similar items peculiar to a given example. This version contains the spreadsheet formula for discounting the cashflow difference to present value—you may want to link the discount rate back to the main DCF model from Chapter 5. I have also added an area farther down the page to prepare Historical Cost and Fair Market Value Balance Sheets. This can be internally linked within the various spreadsheets as well if you wish.

**Noncompbook.123, etc.:** This spreadsheet contains the example from the text. The computation is based on the spreadsheet model (Model\_2DEd.123, etc.) in Chapter 5 of the text, using the DCF, except that the accounts receivable are assumed to be sold as part of the practice. The adjustment for accounts receivable is based upon there being 1.5 months of the current year's increase in revenue added to accounts receivable. For example, the first year in the DCF is (5,450) rather than (78,271). If you make the change to the Model DCF formula in Cells F49 through J49 [e.g.,  $((+E9-F9)/(12*1.50))$ ] in Cell F49 for year 1 and so on]

for accounts receivable, you will get the same result . You can then link the spreadsheet Model DCF cashflows and present values to this spreadsheet if you like, or use it as a stand-alone. Be sure to make the adjustment for the tax benefit of amortization if using it as a stand-alone, or to eliminate it (Cell I37) if using a link to the main model.

## Chapter 8

**adverse.123, etc:** Understanding the Financial Impact of Adverse Selection. This spreadsheet contains the data used to develop the example in the text and permits the user to make modifications. It may also be useful in analyzing engagements other than valuations, such as in merger and acquisitions transactions involving physician practices.

## Chapter 10

**ppms.123, etc:** This spreadsheet contains the examples in Chapter 10, including Understanding Acquisition and Same Store Growth, Comparing a PPM Offer to a Cash Transaction, and Accretive versus Dilutive Earnings Per Share in an Acquisition.

**liqpref.123, etc:** This spreadsheet contains the example from the text on how to quantify the liquidation preference

**cashequiv.123, etc:** This spreadsheet uses basic algebra to compute the cash equivalent value of two different offers where one contains some cash and the other contains all stock.

## Chapter 12

**report.doc:** This Word file contains the sample report from the text, along with commentary. I suggest that you use it only as a guideline, but if you find something you would like to use, the “cut and paste” function of Windows can be used to insert it into your own document.

**sample\_engage\_letter.doc:** Contains the sample engagement letter.

**rep\_letter.doc:** Contains the sample representation letter.

**transmittal\_letter.doc:** Contains the sample transmittal letter



## ***Foreword***

The healthcare industry, along with a number of other business sectors of our economy, has undergone an unprecedented consolidation over the course of the last decade. Simultaneously, private and public healthcare expenditures per capita have risen dramatically—well in excess of the rate of inflation—leading to an equally unprecedented expansion of government regulations aimed at controlling costs. These regulations extend to most, and arguably all, acquisitions of medical practices, further complicating what was already a complex area.

There are a variety of professionals engaged in the valuation of businesses, including CPAs, CVAs, CPAs with the new ABV designation, ASAs, CBAs, and others without specific licenses or accreditation. As is the case with most business valuation, achieving a reasonable and defensible result requires an intimate knowledge of the particular industry. In the case of medical practices, this knowledge base was poorly developed in the valuation community due to the general lack of transactions of the type that took place throughout the middle and late 1990s, namely acquisitions by hospitals, integrated delivery systems, practice management companies, and large group practices. The industry knowledge base exists among practice consultants and others who work closely with medical practices, while the valuation expertise tends to reside in the community of valuers. As a result, there have been a variety of circumstances in which valuers unfamiliar with physician practices—and par-

ticularly the regulatory environment—and consultants unfamiliar with valuation theory have produced substandard, if not altogether ridiculous, valuation reports. A reference guide was clearly needed to merge the knowledge of the two groups of experts.

This book is designed to serve four primary audiences:

1. **For business valuation experts**, it will provide the specific industry information and tools needed to perform an accurate and defensible valuation of a medical practice.
2. **For medical practice consultants**, it will demonstrate how to properly apply valuation theory to your specific industry, as well as offer the insight of the author, who has two decades of consulting experience.
3. For **lawyers**, the specially designed Attorney's Guide, which may be found on the CD-ROM, provides a valuable reference designed to provide a quick focus on issues to be considered when reviewing reports or examining experts.
4. For individuals who are none of the above but who have a vested interest in the subject matter (e.g., **investment bankers, healthcare industry executives, and physicians themselves**), the book will provide a solid grounding and quick reference in both areas.

The book is organized to follow the flow of a valuation engagement, from defining the valuation in the engagement letter to preparing the finished written report. Separate chapters cover in detail the often peculiar aspects of valuing specific types of medical practices, and the techniques for addressing circumstances where the purpose of the valuation may be other than in connection with a proposed transaction. Along the way you will find many ready-to-use tools, templates, and sample spreadsheets as well as commentary and insights offered as sidebars. In-text references and a bibliography provide you with sources of Medicare information and other valuation data to be found on the Internet and elsewhere, which is invaluable for the consultant trying to normalize physician practice revenue.

We have been pleased with the very favorable feedback on the book that we have received from some of the leading experts in the country, and we are confident that the *Medical Practice Valuation Guidebook* will serve as a valuable addition to your professional library.

Windsor Professional Information



## ***About the Author***

Mark O. Dietrich holds a Master of Science degree in Taxation from Bentley College, a Master in Business Administration (Accounting) with high honors, and a Bachelor of Science in Business Administration (Accounting), *summa cum laude*, Beta Gamma Sigma, both from Boston University. He is a member of the AICPA and its Management Consulting Section and of the Massachusetts Society of Certified Public Accountants (MSCPA). He is licensed as a CPA in Massachusetts and holds the ABV (Accredited in Business Valuation) designation from the AICPA. Mark is a past chair of the MSCPA's Federal Taxation Committee and of the MSCPA Physician and Healthcare Committee. He also serves on the editorial board of the *Health Niche Advisor*.

Mark is a prolific writer and has authored numerous articles and course materials on tax matters, valuation, managed care, and capitation, including such topics as partnership taxation, compensation of shareholders of professional service organizations, fair market and strategic value, and capitated contract negotiation, published in national journals such as *Healthcare Financial Management*, the *Health Niche Advisor*, *CPA Expert*, RMA's *Journal of Credit Risk and Management*, *The Practical Accountant*, and *The Tax Adviser*. He has developed several continuing education courses, including "How to Win at Medicare Managed Care," "How to Buy, Sell, and Value a Medical Practice," "Improving Medical Practice Revenues and Value in a Managed Care or Capitated Environment," and "Business Valuation for Attorneys." In addition to the *Medical Practice Valuation Guidebook*, Mark co-authored Practitioners Publishing

Company's *Guide to Healthcare Consulting*, and is a contributing author to Dr. Shannon Pratt's *Lawyers Business Valuation Handbook*, as well as *Valuing Professional Practices and Licenses* from Aspen Publishers. He is a frequent speaker before professional societies on topics including medical practice valuation and the financial and strategic aspects of capitated managed care.

Mark is also an experienced negotiator, with numerous contract and merger and acquisition transactions to his credit, including a sale of an Internet technology company to a Fortune 50, with values from under \$1.0 million to in excess of \$100 million. He has performed more than 100 valuations and testified as an expert witness.

For information on upcoming seminars, recent articles, and other matters, visit his firm's website at <http://www.cpa.net>, the accounting profession's premier web domain.



# **Acknowledgments**

Writing a book is a major undertaking, and I could not have accomplished it without the assistance of the following individuals, who reviewed early drafts of the text or otherwise provided insight and examples or valuation engagements.

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For the 2001–2002 edition, special thanks go to my friend and colleague John Mayerhofer, for his continuing efforts on my behalf and on behalf of the readers of this book.

I would also like to thank my partner, Kathie Wilson, CPA, CVA, for her careful review of my valuations and for her insistence on dotting *i*'s and crossing *t*'s; and my family, for their patience and understanding as I worked away on my laptop for many months at random times as inspiration, real or imagined, moved me to write.



## ***Preface***

I am very excited about the second edition of the *Medical Practice Valuation Guidebook*. The overriding goal of the second edition is to provide in-depth analysis and related problem-solving tools to the financial and valuation issues confronting the medical profession now. Readers of the first edition will note the addition of extensive new material covering such diverse areas as dental practices, ambulatory surgery centers, and litigation. As many who followed the PPMC industry expected, a host of lawsuits has sprung from the near collapse of that industry, and this book addresses many of the related valuation issues, such as valuing the non-competition agreements typically included in such a transaction. Valuers engaged in expert witness and divorce work will find a wealth of new information, including a point-by-point approach to isolating enterprise (practice) goodwill from personal (professional) goodwill, including a spreadsheet model. Chapter 15, "Tax Planning," includes detailed analysis of the impact of recent tax cases such as *Davis* and *Gross*. It also includes a comprehensive description of the issues and approach to valuing a medical practice for donation to a tax-exempt entity, a surprisingly common occurrence. Valuers and physician-advisors will find a solution to the most common of all small medical practice dilemmas, solving the two-person practice buy-out. In addition, the CD-ROM contains a complete *Attorney's Guide* to the book as well as a Checklist to be used by attorneys in evaluating experts and their reports. That checklist should

be invaluable to expert witnesses and valuers as well. Numerous other additions and updates may be found throughout the book. I am certain you will find the second edition the most valuable asset in your medical practice library, whether you are a valuation expert, a consultant, industry executive, or attorney.

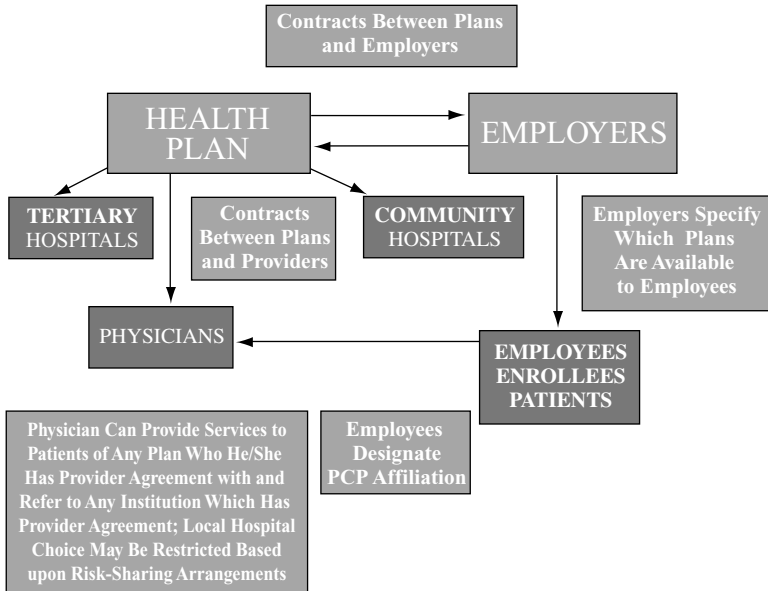
## **THE STRUCTURE OF THE HEALTHCARE INDUSTRY**

In order to understand medical practice valuation in the present market, it is useful to understand the movement toward managed care structures and capitated reimbursement of providers, as well as the underpinnings of the present system. In the commercial market, insurance companies have generally controlled the distribution of patients and dollars via contracts with employers—or less frequently, individuals—and with providers. They set both the cost of health insurance and the rates that providers are paid for their services. In the typical scenario, an insurer and employer sign a group contract, which determines what benefits, which providers, and at what locations the employees covered by the insurance may be treated. A provider, such as a physician or hospital, must have a provider agreement (“be participating”) with the insurer in order to be eligible to treat the insured individuals. The employees then select from among *participating* physicians and hospitals for treatment. (See first chart, “The Historic Structure of the Healthcare Industry.”)

In the many years that the increases in healthcare costs have outstripped the rate of inflation, employers have become increasingly unwilling to pay the costs. They have passed some of these costs along to employees via co-pays, deductibles, and co-insurance of premiums, or via reduced benefits. HMOs and similar structures reduce costs by restricting the insured’s ability to self-refer throughout the system. Insurers, confronted with stable or decreasing premiums, look to minimize their risk assumption, *transferring it to providers*, and retain the *administrative* portion of the premium.

The continuing pressure in the marketplace to reduce premium costs created pressure for new structures that controlled utilization of services and exchanged lower rates for larger streams of business. Hospitals, and particularly tertiary hospitals or academic medical centers, formed integrated delivery systems or networks. The tertiary networks look to take global or full-risk capitation from the insurers. In order to do this, they must “control” a patient’s care along the entire delivery continuum. The

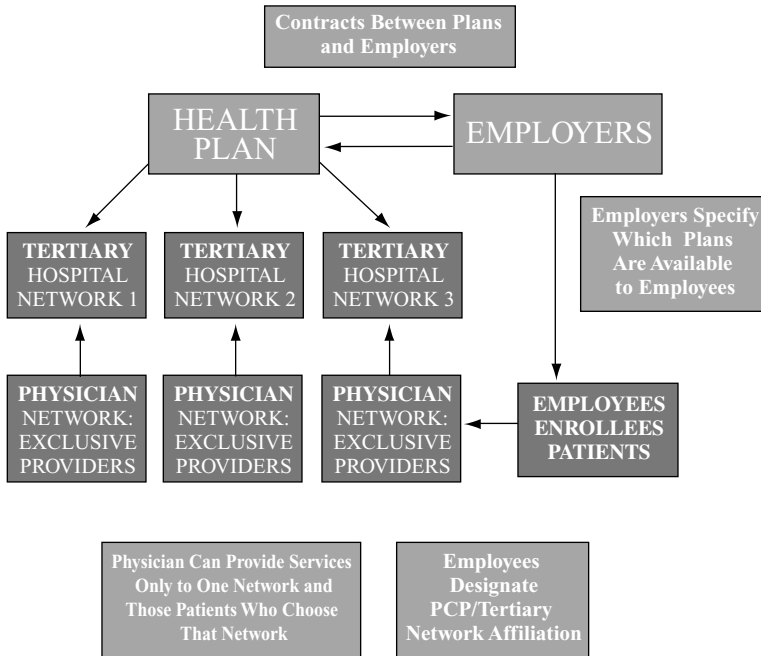
### The Historic Structure of the Healthcare Industry



determination of whether a particular individual has chosen a particular tertiary network is made by that individual's designation of a PCP who is affiliated with the network, continuing the use of the *present* structure of provider agreements. As the industry entered the new millenium, the introduction of capitation into new markets had failed, and managed care in general was experiencing a broad-based backlash.

The second chart ("A Hospital-Dominated Delivery System") shows three tertiary hospital networks, each with a *separate* physician network it owns or controls, entering into exclusive contracts with primary care physicians (PCPs). When a subscriber, for example, chooses a physician who is contracted to such a network, the network will be able to claim the global capitation payment for that patient. Presumably, that PCP will be required to refer the patient along that network's continuum of care, subject to Stark and similar laws. A problem may arise if a PCP exclusively contracted with a network has a patient who is happy with the PCP but would prefer to be referred to another network's institution. In managing full-risk capitation, a network will lose control of—and pay more for—a patient who goes outside the network for care. Thus, there will be signifi-

### A Hospital-Dominated Delivery System

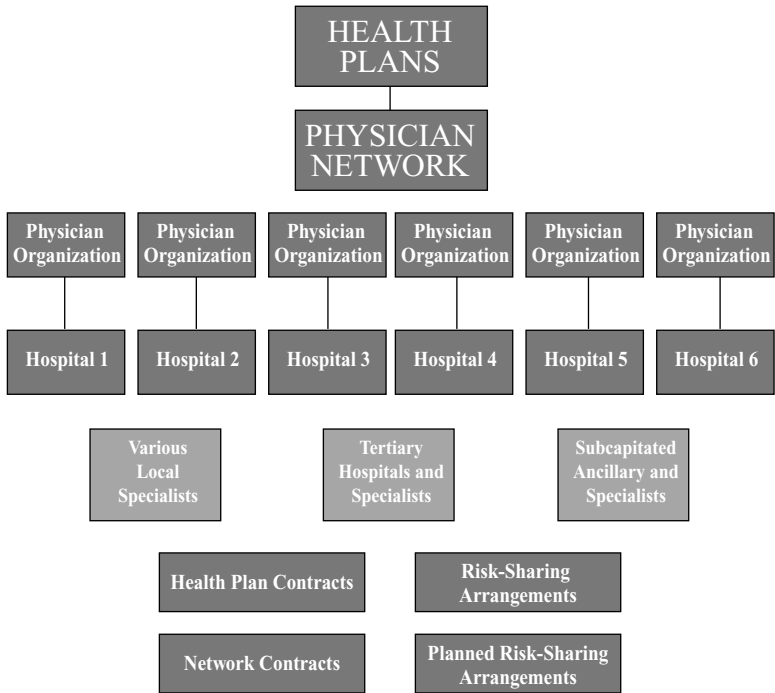


cant constraints—whether contractual, political, or both—upon the PCP in specifying where the patient receives care.

If a physician network is nonexclusive, it will be able to service each hospital network. If the physicians do not pursue this strategy and affiliate with one hospital network, the physicians may find themselves losing patients who prefer to receive their care at a different institution. On the other hand, failure to be exclusive may result in being a “nonfavored” son when it comes to payment for services.

Another problem is that of how a patient will designate a particular network if the designation does *not* come via the PCP. If physicians remain nonexclusive, the patient and/or employer will need to designate a network. This would require the insurers and the networks to “private label” products so that when a patient chooses a particular insurance plan and chooses a PCP who is not exclusive, they would need to simultaneously pick the hospital network they want to be in. Otherwise, there is no

### A Physician Network Contracting Directly with Insurers



way for the patient’s capitation stream to be assigned to a particular hospital network.

If the physician network is left out of such a contract, its member practices may not be able to accept certain patients. Alternatively, and perhaps more likely, those patients using these physicians may only access the networks on a fee-for-service basis, costing the insurer—and ultimately the employer—more money.

This highlights the reason why physician networks are the best structure for capitation, since the designation of the recipient of capitation comes via the choice of a PCP by the patient/subscriber. In established capitation markets such as California, capitation has survived the shake-out, although it cannot be said to be thriving. The third chart (“A Physician Network Contracting Directly with Insurers”) illustrates a physician network to which the author serves as one of two principal advisers.

This type of network contracts directly with health insurers for cap-

itation payments; it may then contract or assist in the contracting process with specialists and community and tertiary hospitals. The choice of the PCP by the patient easily fits within the present structure of the health insurance system, with the PCP joining a physician network and bringing his/her patients along. It is these structures that had attracted great interest on Wall Street, before the collapse of the physician practice management companies (PPMs) led by the failed merger of MedPartners and Phycor.

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